

SERFF Tracking Number: UHLC-128524492 State: Arkansas
Filing Company: UnitedHealthcare Insurance Company State Tracking Number:
Company Tracking Number: SBN.OPT.I.11.AR AND SBN.NDF.I.11.AR
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: SBN.OPT.I.11.AR and SBN.NDF.I.11.AR
Project Name/Number: SBN.OPT.I.11.AR and SBN.NDF.I.11.AR/SBN.OPT.I.11.AR and SBN.NDF.I.11.AR

Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: SBN.OPT.I.11.AR and SBN.NDF.I.11.AR SERFF Tr Num: UHLC-128524492 State: Arkansas

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- Closed State Tr Num:

Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: SBN.OPT.I.11.AR AND SBN.NDF.I.11.AR State Status: Approved-Closed

Filing Type: Form

Author: Kelly Smith

Reviewer(s): Rosalind Minor

Date Submitted: 06/28/2012

Disposition Date: 06/28/2012

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: SBN.OPT.I.11.AR and SBN.NDF.I.11.AR

Status of Filing in Domicile: Pending

Project Number: SBN.OPT.I.11.AR and SBN.NDF.I.11.AR

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: 06/28/2012

State Status Changed: 06/28/2012

Deemer Date:

Created By: Kelly Smith

Submitted By: Kelly Smith

Corresponding Filing Tracking Number: SBN.OPT.I.11.AR and SBN.NDF.I.11.AR

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Healthcare.gov ID:

Filing Description:

The revised forms will replace the Options PPO and Non-Differential Schedule of Benefits, filed as part of the 2011 Product series POL.I.11.AR, et al. A redline comparison to reflect the changes to the previously approved form is attached to the Supporting Documentation tab. Our intent is to use these forms for large and small employer groups.

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State Narrative:

Company and Contact

Filing Contact Information

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 Rockville, MD 20850

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: 50.00x2
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	\$100.00	06/28/2012	60483765

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/28/2012	06/28/2012

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Disposition

Disposition Date: 06/28/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter SBN.OPT.I.11.AR and SBN.NDF.I.11.AR	Approved-Closed	Yes
Supporting Document	Redline Comparison to previously approved OPTIONS PPO SBN	Approved-Closed	Yes
Form	SBN.OPT.I.11.AR	Approved-Closed	Yes
Form	SBN.NDF.I.11.AR	Approved-Closed	Yes

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Form Schedule

Lead Form Number: SBN.OPT.I.11.AR and SBN.NDF.I.11.AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/28/2012	SBN.OPT.I.11.AR	Schedule Pages	SBN.OPT.I.11.AR	Initial		54.900	SBN-Medical-INS-2011-Options.pdf
Approved-Closed 06/28/2012	SBN.NDF.I.11.AR	Schedule Pages	SBN.NDF.I.11.AR	Initial		57.200	SBN-Medical-INS-2011-Non-Differential.pdf

UnitedHealthcare [Options PPO]

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

[Designated network benefits are variable for several benefit categories. Include references throughout the schedule as needed when designated network benefits are available for any category.]

You can choose to receive [Designated Network Benefits,] Network Benefits or Non-Network Benefits.

[Designated Network Benefits] apply to Covered Health Services that are provided by a Network Physician or other provider that we have identified as a Designated Facility or Physician. Designated Network Benefits are available only for specific Covered Health Services as identified in the *Schedule of Benefits* table below.]

[Include if non-network RAPLs at a network facility are paid as network benefits.]

[Network Benefits] apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.]

[Include when non-network RAPLs and consultants at a network facility are paid as network benefits and when non-emergent network benefits for these services provided by non-network providers will not be paid at billed charges.]

[Network Benefits] apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. Network Benefits also apply to Covered Health Services that are provided at a Network facility by a non-Network [radiologist] [,] [or] [anesthesiologist] [,] [or] [pathologist] [,] [or] [consulting Physician] [,] [or] [neonatologist] [,] [or] [intensivist] [,] [or] [assistant surgeon] [or] [surgical assistant], however such Covered Health Services, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. As a result you will be responsible for the difference between the amount billed by the provider and the amount we determine to be an Eligible Expense for reimbursement.]

[Include when non-network RAPLs and consultants at a network facility are paid as non-network benefits.]

[Network Benefits] apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility. Emergency Health Services are always paid as Network Benefits.]

[Include when non-network RAPLs and consultants at either a network or non-network facility are paid as non-network benefits.]

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. [Covered Health Services, when not Emergency Health Services, provided in a Network facility by a non-Network [radiologist] [,] [or] [anesthesiologist] [,] [or] [pathologist] [,] [or] [consulting Physician] [,] [or] [neonatologist] [,] [or] [intensivist] [,] [or] [assistant surgeon] [or] [surgical assistant] will be paid as Non-Network Benefits.]

[Include when the enhanced benefits program is sold.]

[You may have an opportunity to elect to receive Covered Health Services from certain Network providers that we've identified as Designated Physicians or Designated Facilities. When you choose to seek care from certain Designated providers, the level of Benefits available to you is enhanced. You can determine the specific situations for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[¹Include when shared savings program applies.]

Depending on the geographic area and the service you receive, you may have access [¹through our [\[Shared Savings Program\]](#)] to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less [¹when you receive Covered Health Services from [\[Shared Savings Program\]](#) providers than from other non-Network providers] because the Eligible Expense may be a lesser amount.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a [\[UnitedHealthcare\]](#) Policy. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

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

Prior Authorization

[¹Include when network providers are responsible for prior authorization for network benefits.]

We require prior authorization for certain Covered Health Services. [In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization.] Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

[¹We recommend that you confirm with us [that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.]

When you choose to receive certain Covered Health Services [¹from non-Network providers], you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number for *Customer Care* on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to determine how far in advance you must obtain prior authorization.

[Include bracketed variable benefit category listed below if: a) the benefit is included in the plan design and b) prior authorization is required. Include dollar amounts as applicable.]

- [_____]
- Ambulance - non-emergent air and ground.
- Clinical trials.
- [Congenital heart disease surgery.]
- [Dental services - accidental.]
- Dental services - anesthesia and hospitalization
- [Diabetes equipment - insulin pumps [over \$[1,000 - 5,000]].]
- [Durable Medical Equipment [over \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)].]
- [Medical Foods.]

[Include when prior authorization is required for only BRCA genetic testing.]

- [Genetic Testing - BRCA.]

[Include when prior authorization is required for all genetic testing.]

- [Genetic Testing, including BRCA Genetic Testing.]
- [Hearing aids [that exceed \$[1,000 - 5,000] in retail purchase cost].]
- [Home health care.]
- [Hospice care - inpatient.]
- Hospital inpatient care - all scheduled admissions [and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery].
- [Infertility services.]
- In vitro fertilization services.
- [Lab, X-ray and diagnostics - sleep studies.]
- [Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA, Nuclear Medicine and Capsule Endoscopy.]

Include when group purchases benefits for musculoskeletal disorders.

- [Musculoskeletal disorders of the face neck or head.]
-
- [Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.]
- [Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), Intensive

Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management [; Applied Behavioral Analysis (ABA)].]

- [Obesity surgery.]

.¹ Include if notification applies only to orthotics that exceeds a specific dollar amount and insert appropriate dollar amount.

- Orthotics devices [¹over\$[1,000-5,000]].
- [Pain management.]
- [Pharmaceutical Products - IV infusions only.]
- [Certain Pharmaceutical Products. You may determine whether a particular Pharmaceutical Product requires authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

.¹ Include if notification applies only to prosthetics that exceed a specific dollar amount and insert appropriate dollar amount.

- Prosthetic devices [¹over \$[1,000 - 5,000]].]
- Reconstructive procedures, including breast reconstruction surgery following mastectomy [and breast reduction surgery].
- [Rehabilitation services [and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy].]
- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- [Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.]

[¹ Do not include pain management procedures if prior authorization is required for all pain management services above.]

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [¹pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgeries]].]
- [Temporomandibular joint services.]
- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound]].]
- Transplants.
- [Ventricular assist device implantation. You must obtain prior authorization as soon as the possibility of implantation arises except in cases of Emergency implantations of partial assist devices.]

[Include paragraph below if plan includes ability to determine alternate levels of benefits.]

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

[As we determine, if one or more alternative health services that meets the definition of a Covered Health Service in the *Certificate* under *Section 9: Defined Terms* are clinically appropriate and not more costly than an alternative health service that is at least as likely to produce equivalent therapeutic or diagnostic results as to their prevention, diagnosis or treatment of a Sickness, Injury, [Mental Illness,] [mental illness,] substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on *Generally Accepted Standards of Medical Practice*, which for some Covered Health Services may be addressed in our clinical policies. After you contact us for prior authorization, we will identify the Benefit level available to you.

These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.]

[¹Include when network providers are responsible for prior authorization for network benefits.]

For all other services, [¹when you choose to receive services from [non-Network providers,] we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.

[The Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

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

Benefit limits are calculated on a [calendar] [Policy] year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
<p><i>[Annual deductible is plan design variable. Include applicable provisions to support the following:</i></p> <p>¹Annual deductible applies only to non-network benefits.</p> <p>²Outpatient Prescription Drug Rider is sold and the annual deductible applies to any combination of medical and RX benefits.</p> <p>³Outpatient Prescription Drug Rider with separate copayments for preventive medications is sold and the annual deductible does not apply to preventive medications.</p> <p>⁴Outpatient Prescription Drug Rider is sold and when the annual deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the annual deductible.</p> <p>⁵There is a deductible for designated and network benefits and the network and non-network amounts apply to the designated network and network annual deductible.</p> <p>⁶Designated network benefits apply to any category.]</p> <p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive [¹Non-Network] Benefits. [²The Annual Deductible applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>. [³Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [⁴Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the <i>Outpatient Prescription Drug Rider</i> are not subject to payment of the Annual Deductible.] [⁵The Annual Deductible for [⁶Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drugs provided under the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include applicable provisions to support the following:</i></p> <p>¹Day/visit limits are reduced by the number of days/visit used toward meeting the deductible.</p> <p>²Carry-over provision applies.</p> <p>³Roll-over provision applies in any circumstance.</p> <p>⁴Roll-over provision applies only to groups changing from calendar to policy year. ⁵Include when roll-over applies only to the individual deductible.</p> <p>⁶Include only when a per occurrence deductible applies.]</p> <p>[¹Amounts paid toward the Annual Deductible for Covered</p>	<p>¹Include separate network and non-network headings and statements when annual deductible provision applies separately.]</p> <p>²Include when designated network benefits apply to any category and when the designated network and network deductible is combined.]</p> <p>³Include when designated network and network are separate.]</p> <p>[¹ [² Designated Network and] Network] [³ Designated Network]</p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p> <p>[No Annual Deductible.]</p> <p>[³ Network]</p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered</p>

Payment Term And Description	Amounts
<p>Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.]</p> <p>[²Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.]</p> <p>[³When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.]</p> <p>[⁴When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [⁵This roll-over feature applies only to the individual Annual Deductible.]]</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>[⁶The Annual Deductible does not include any applicable Per Occurrence Deductible.]</p>	<p>Persons in a family.]</p> <p>[No Annual Deductible.]</p> <p>[¹ Non-Network]</p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p> <p>[No Annual Deductible.]</p> <p><i>⁴Include the combined network and non-network heading and statements when annual deductible provision applies separately to combined network and non-network benefits.</i></p> <p><i>⁵Include when designated network benefits apply to any category.]</i></p> <p>[⁴ ⁵ Designated Network,] Network and Non-Network]</p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p>
<p><i>[Per occurrence deductible is plan design variable.]</i></p>	

Payment Term And Description	Amounts
<p>[Per Occurrence Deductible]</p>	
<p>[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services.</p> <p>You are responsible for paying the lesser of the following:</p> <ul style="list-style-type: none"> • The applicable Per Occurrence Deductible. • The Eligible Expense.] 	<p>[When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.]</p>
<p>Out-of-Pocket Maximum</p>	
<p><i>[Out-of-pocket maximum is plan design variable. Include applicable provisions to support the following:</i></p> <p>¹<i>Includes the annual deductible.</i></p> <p>²<i>Includes the per occurrence deductible.</i></p> <p>³<i>Includes copayments.</i></p> <p>⁴<i>Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.</i></p> <p>⁵<i>OOPM applies to designated and network benefits and the network and non-network amounts paid under the RX rider apply to the designated network and the network OOPM.</i></p> <p>⁶<i>Include bracketed designated network reference when designated network benefits apply to any category.]</i></p> <p>The maximum you pay per year for [¹the Annual Deductible,] [²the Per Occurrence Deductible,] [³Copayments] [¹⁻²⁻³or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [⁴The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.] [⁵The Out-of-Pocket Maximum for [⁶Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when plan design does not apply all copayments/coinsurance to the OOPM.]</i></p> <p>[[Copayments] [and] [Coinsurance] for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Maximum does not include any of the</p>	<p>¹<i>Include separate network and non-network headings and statements when OOPM provision applies separately.]</i></p> <p>²<i>Include when designated network benefits apply to any category and when the designated network and network OOPM is combined.]</i></p> <p>³<i>Include when designated network and network are separate.]</i></p> <p>[¹ [² Designated Network and] Network] [³ Designated Network]</p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p>

Payment Term And Description	Amounts
<p>following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> Any charges for non-Covered Health Services. <p><i>[Include bullet if prior authorization requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.]</i></p> <ul style="list-style-type: none"> [The amount Benefits are reduced if you do not obtain prior authorization as required.] Charges that exceed Eligible Expenses. Copayments or Coinsurance for any Covered Health Service identified in the <i>Schedule of Benefits</i> table that does not apply to the Out-of-Pocket Maximum. <p><i>[Include when an Outpatient Prescription Drug Rider is sold and copayments/coinsurance do not apply to the overall OOPM.]</i></p> <ul style="list-style-type: none"> [Copayments or Coinsurance for Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.] 	<p>[No Out-of-Pocket Maximum.]</p> <p>⁸ Network</p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p>[No Out-of-Pocket Maximum.]</p> <p>¹ Non-Network</p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes</p>

Payment Term And Description	Amounts
	<p>the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p>[No Out-of-Pocket Maximum.]</p> <p>⁴Include combined network and non-network heading and statements below when OOPM provision applies to combined network and non-network benefits and delete the separate "Network" and "Non-Network" provisions above.]</p> <p>⁵Include when designated network benefits apply to any category.]</p> <p>[⁴ ⁵ Designated Network,] Network and Non-Network]</p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p>[No Out-of-Pocket Maximum.]</p>
<p>[Annual maximum benefit is plan design variable. Include applicable provisions to support the following:</p> <p>¹Outpatient Prescription Drug Rider is sold.]</p> <p>[Annual Maximum Benefit]</p>	

Payment Term And Description	Amounts
<p>[The maximum amount we will pay for Benefits during the year.] [¹The Annual Maximum Benefit applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.]</p>	<p>¹ <i>Include separate network and non-network headings and statements when the annual maximum benefit applies separately.</i></p> <p>² <i>Include when designated network benefits apply to any category and when the designated network and network maximum is combined.</i></p> <p>³ <i>Include when designated network and network are separate.</i></p> <p>⁴ <i>Include when combined network and non-network maximums apply.</i></p> <p>[¹ ² Designated Network and Network] [³ Designated Network]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p> <p>[No Annual Maximum Benefit.]</p> <p>[³ Network]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p> <p>[No Annual Maximum Benefit.]</p> <p>[¹ Non-Network]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p> <p>[No Annual Maximum Benefit.]</p> <p>[⁴ ² Designated Network,] Network and Non-Network]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p>
<p>Copayment</p>	
<p>Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.</p> <p>[For Pharmaceutical Products, your Copayments are determined by the tier to which the Pharmaceutical Product List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]</p> <p>Please note that for Covered Health Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> • The applicable Copayment. • The Eligible Expense. <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	

Payment Term And Description	Amounts
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.	
[For Pharmaceutical Products, your Coinsurance is determined by the tier to which the Pharmaceutical Product List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]	
Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.	

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design.]

[Include the following variables according to plan design:

- Benefit limits and levels.*
- Prior authorization requirements and any penalty for failure to prior authorize*
- Designated network benefit levels as applicable.*
- Any other specific conditions for coverage described within the category.]*

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
1. [Acupuncture Services]			
[Limited to [10 - 100] treatments per year.]	[Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[Limited to [10 - 100] treatments per year, not to exceed \$[100 - 5,000] in Eligible Expenses per year.]	[100% after you pay a Copayment of \$[5 - 75] per visit]	[Yes, when Benefits are subject to Coinsurance]	[Yes, when Benefits are subject to Coinsurance]
[Limited to \$[100 - 5,000] in Eligible Expenses per year.]	[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]		[Yes, after the Per Occurrence Deductible of \$[5 - 75] per visit is satisfied]
	[Non-Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of \$[5 - 75] per visit]	[Yes, when Benefits are subject to	[Yes, when Benefits are subject to

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Non-Emergency Ambulance</p> <p>Ground or air ambulance, as we determine appropriate.</p>	<p>to a per day maximum of \$[2,500 - 10,000]</p> <p>Non-Network</p> <p>Same as Network</p> <p>Network</p> <p><i>Ground Ambulance:</i></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[25 - 300] per transport]</p> <p>[100% after you pay a Copayment of \$[300 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[300 - 1,000] per day, up to a per day maximum of \$[300 - 1,000]</p> <p><i>Air Ambulance:</i></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[25 - 2,500] per transport]</p> <p>[100% after you pay a Copayment of \$[2,500 - 10,000] per day]</p> <p>[100% after you pay a Copayment of \$[2,500 - 10,000] per day, up to a per day maximum of \$[2,500 - 10,000]</p> <p>Non-Network</p> <p>Same as Network</p>	<p>Same as Network</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>Same as Network</p>	<p>Same as Network</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 1,000] per [transport] [day] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 10,000] per [transport] [day] is satisfied]</p> <p>Same as Network</p>
<p>[3.] Clinical Trials</p>			

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Prior Authorization Requirement</p> <p>You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
<p>Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i>.</p> <p>Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)</p>	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
<p>[4.] [Congenital Heart Disease Surgeries]</p>			
<p>[Prior Authorization Requirement]</p> <p>[For Designated Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you do not obtain prior authorization and if, as a result, the CHD services are not performed at a Designated Facility, Designated Network Benefits will not be paid.] [Non-Network Benefits will apply.]</p> <p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
<p>[Designated Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac</p>	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i></p> <p>[Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i></p> <p>[For Network Benefits, CHD surgeries must be received at a Designated Facility.</p> <p>Non-Network Benefits include services provided at a Network facility that is not a Designated Facility and services provided at a non-Network facility.</p> <p>Non-Network Benefits under this section include only the CHD surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i></p>	<p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p>[Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p>[Non-Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 -</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	2,000] per Inpatient Stay] [100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]		Stay] is satisfied]
[5.] [Dental Services - Accident Only]			
[Prior Authorization Requirement]			
[For Network and Non-Network Benefits you must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Limited to \$[2,000 - 5,000] per year. Benefits are further limited to a maximum of \$[500 - 1,500] per tooth.]	[Network] [[50 - 100]%] [100% after you pay a Copayment of \$[5 - 75] per visit] [Non-Network] [Same as Network]	[Yes] [No] [Same as Network]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 75] per visit is satisfied] [Same as Network]
[6.] Diabetes Services			

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
five] years].]	<p>the Out-of-Pocket Maximum.]]</p> <p><i>[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]</p> <p>Benefits for diabetes supplies will be the same as those stated in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps and diabetes supplies, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p>Non-Network</p> <p><i>[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]</i></p> <p>[Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]</i></p> <p>[For diabetes equipment, Benefits will be the same as those stated under <i>Durable Medical Equipment</i>.</p> <p>For diabetes supplies the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p><i>[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to</p>		

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>the Out-of-Pocket Maximum.]</p> <p>Benefits for diabetes supplies will be the same as those stated in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps and diabetes supplies, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p>		
<p>[7.] [Durable Medical Equipment]</p>	<p>[Prior Authorization Requirement]</p>		
<p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization before obtaining any Durable Medical Equipment [that exceeds \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>[Limited to \$[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two - five] years]. [This limit does not apply to wound vacuums [, which are subject to a separate limit of \$[4,500 - 13,500] per year and limited to a single purchase (including repair/replacement) every [year] [[two - five] years]].]</p> <p>[Limited per year as follows:</p> <ul style="list-style-type: none"> • [[\$500 - 10,000] in Eligible Expenses for Tier 1. Tier 1 includes disposable supplies necessary for the effective use of covered Durable Medical Equipment.] • [[\$10,001 - 25,000] in Eligible Expenses for Tier 2.] 	<p>[Network]</p> <p>[[50 - 100] %]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per purchase is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<ul style="list-style-type: none"> • [[\$25,001 - 100,000] in Eligible Expenses for Tier 3.] <p>These Tier limits include repair. Benefits for replacement are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].</p> <p>[Benefits are [further] limited to a single Mobility Device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair of the Mobility Device are limited to once every three years. We may, upon review, replace a defective Mobility Device rather than repair it. Benefits are not available for repair or replacement of a Mobility Device resulting from abuse, neglect or normal wear.]</p> <p>[Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every three years. Speech aid and tracheo-esophageal voice devices are [not] included in the annual limits stated above.]</p>	<p>[Non-Network]</p> <p>[[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per purchase is satisfied]</p>
<p>[8.] Emergency Health Services - Outpatient</p>			
<p>Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health</p>	<p>Network</p> <p>[[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.</p> <p>[In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed as an Emergency Health Service:</p> <ul style="list-style-type: none"> • [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient.</i>] • [Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</i>] • [Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient.</i>] • [Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>] • [Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>] • [Outpatient therapeutic 	<p>[100% after you pay a Copayment of \$[5 - 500] per visit. [If you are admitted as an inpatient to a Network Hospital [directly from the Emergency room] [within 24 hours of receiving outpatient Emergency treatment for the same condition], you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 100% after you pay a Copayment of \$[50 - 650] for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 100% after you pay a</p>	<p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 700] per visit is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>procedures described under <i>Therapeutic Treatments - Outpatient.</i></p> <ul style="list-style-type: none"> • [Rehabilitation therapy procedures described under <i>Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].</i>] 	<p>Copayment of \$[50 - 650] per visit for the next [#] visits in a year; 100% after you pay a Copayment of \$[100 - 700] for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 100% after you pay a Copayment of \$[50 - 650] per visit for the next [#] visits in a year; 100% after you pay a Copayment of \$[100 - 500] for the next [#] visits in a year; 100% after you pay a Copayment of \$[150 - 700] for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for a condition defined as an Emergency; 100% after you pay a Copayment of \$[50 - 650] per visit for a condition that does not meet the definition of an Emergency]</p> <p>Non-Network Same as Network</p>	<p>Same as Network</p>	<p>Same as Network</p>
<p><i>Include as standard for groups of 2 to 15 and 15+.</i></p> <p>[9.] Hearing Aids</p>			

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[Network Benefits are limited to [40 - 200] visits per year and Non-Network Benefits are limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.]</p> <p>[This visit limit does not include any service which is billed only for the administration of intravenous infusion.]</p>	<p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 50] per visit]</p>	<p>[Yes] [No]</p>	<p>satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per visit is satisfied]</p>
<p>[11.] Hospice Care</p>			
<p align="center">[Prior Authorization Requirement]</p> <p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p>[In addition, [¹for Non-Network Benefits,] you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]</p>			
	<p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per day]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 -</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per day is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 -</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	of \$[100 - 10,000] per Inpatient Stay]		
[13]. [Infertility Services]			
[Prior Authorization Requirement] [You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Limited to \$[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [This limit includes Benefits for infertility medications provided under the <i>Outpatient Prescription Drug Rider.</i>] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under <i>Physician's Office Services - Sickness and Injury</i> below.]	[Designated Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Non-Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[14.] Lab, X-Ray and Diagnostics - Outpatient			
[Prior Authorization Requirement] <i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i> [[¹ For Non-Network Benefits for] [² For] sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
Lab Testing - Outpatient:	[Designated Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No] [Yes, after the Per

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[[50 - 100]% at a free-standing lab]</p> <p>[[50 - 100]% at a Hospital-based lab]</p> <p>[[50 - 100]% at a Physician office-based lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a Hospital-based lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a Physician office-based lab]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at a free-standing lab]</p> <p>[[50 - 100]% at a Hospital-based lab]</p> <p>[[50 - 100]% at a Physician office-based lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a</p>	<p>[Yes] [No]</p>	<p>Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>X-Ray and Other Diagnostic Testing - Outpatient:</p>	<p>free-standing lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a Hospital-based lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a Physician office-based lab]</p> <p>Non-Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[Designated Network]</p> <p>[[50 - 100]%</p> <p>[[50 - 100]% at a free-standing diagnostic center]</p> <p>[[50 - 100]% at an outpatient Hospital-based diagnostic center]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing diagnostic center]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at an outpatient Hospital-</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>based diagnostic center]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at a free-standing diagnostic center]</p> <p>[[50 - 100]% at an outpatient Hospital-based diagnostic center]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing diagnostic center]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at an outpatient Hospital-based diagnostic center]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p>
<p>[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</p>			

[Prior Authorization Requirement]

[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>500] per service]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service at a free-standing diagnostic center]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service at an outpatient Hospital-based diagnostic center]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 500] per service is satisfied]</p>
<p><i>Include for groups that purchase Mental Health benefits.</i></p> <p><i>[Include as standard for groups of 2 to 15]</i></p> <p><i>¹Include if group purchases SA benefits.</i></p> <p>[16.] Mental Health Services</p>	<p align="center">[Prior Authorization Requirement]</p> <p><i>¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits for] [²For] a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, [¹for Non-Network Benefits] you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible</p>		

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Expenses.]			
<p><i>[Limits will not apply to groups of 51+.]</i></p> <p><i>[Inpatient Mental Health Services are limited to [10 - 100] days per year.]</i></p> <p><i>[Outpatient Mental Health Services are limited to [10 - 100] visits per year.]</i></p> <p><i>[Non-Network Benefits for inpatient Mental Health Services are limited to [10 - 100] days per year.]</i></p> <p><i>[Non-Network Benefits for outpatient Mental Health Services are limited to [10 - 100] visits per year.]</i></p> <p><i>[Benefits for any combination of Mental Health Services described in this section and Neurobiological Disorders - Autism Spectrum Disorder Services described below are limited as follows:</i></p> <ul style="list-style-type: none"> <i>• [10 - 100] days per year for inpatient Mental Health Services and Neurobiological Disorders - Autism Spectrum Disorder Services.</i> <i>• [10 - 100] visits per year for outpatient Mental Health Services and Neurobiological Disorders - Autism Spectrum Disorder Services.]</i> <p><i>[Benefits for any combination of Mental Health Services described in this section and Substance Use Disorder Services described below are</i></p>	<p><i>[Network]</i></p> <p><i>[Inpatient]</i></p> <p><i>[[50 - 100]%]</i></p> <p><i>[100% after you pay a Copayment of \$[100 - 1,000] per day]</i></p> <p><i>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</i></p> <p><i>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</i></p> <p><i>[Outpatient]</i></p> <p><i>[[50 - 100]%]</i></p> <p><i>[100% after you pay a Copayment of \$[5 - 100] per visit]</i></p> <p><i>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</i></p> <p><i>[100% for visits for medication management]</i></p> <p><i>[Non-Network]</i></p> <p><i>[Inpatient]</i></p>	<p><i>[Yes] [No]</i></p> <p><i>[Yes] [No]</i></p> <p><i>[Yes] [No]</i></p> <p><i>[Yes] [No]</i></p>	<p><i>[Yes] [No]</i></p> <p><i>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</i></p> <p><i>[Yes] [No]</i></p> <p><i>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</i></p> <p><i>[Yes] [No]</i></p> <p><i>[Yes, after the Per</i></p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] <p>[Benefits for any combination of <i>Mental Health Services</i> described in this section and <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> and <i>Substance Use Disorder Services</i> described below are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services, Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services, Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] 	<p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p>[Outpatient]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>
<p>[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]</p>	<p>[Prior Authorization Requirement]</p>		
<p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits for] [²For] a scheduled admission for Neurobiological Disorders - Autism</p>			

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Spectrum Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, [¹for Non-Network Benefits] you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management [; Applied Behavioral Analysis].</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
<p>[Limits will not apply to groups of 51+.]</p> <p>[Inpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] days per year.]</p> <p>[Outpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] visits per year.]</p> <p>[Non-Network Benefits for inpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] days per year.]</p> <p>[Non-Network Benefits for outpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] visits per year.]</p> <p>[Benefits for any combination of Neurobiological Disorders - Autism Spectrum Disorder Services described in this section and Mental Health Services described above are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient Neurobiological Disorders - Autism Spectrum Disorder Services and Mental Health Services. 	<p>[Network]</p> <p>[Inpatient]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p>[Outpatient]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<ul style="list-style-type: none"> [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services and Mental Health Services.</i> <p>[Benefits for any combination of <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> described in this section, <i>Mental Health Services</i> described above and <i>Substance Use Disorder Services</i> described further below are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services, Mental Health Services and Substance Use Disorder Services.</i> [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services, Mental Health Services and Substance Use Disorder Services.</i> 	<p>[Non-Network]</p> <p><i>[Inpatient]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p><i>[Outpatient]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>

[18.] [Obesity Surgery]

[Prior Authorization Requirement]

¹Include when network providers are responsible for prior authorization for network benefits. ²Include

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<i>when covered person is responsible for prior authorization for network benefits.]</i>			
<p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p>[In addition, [¹for Non-Network Benefits] you must contact us 24 hours before admission for an Inpatient Stay.]</p> <p>[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]</p>			
<p>[[Any combination of] [Designated Network Benefits] [[,] [and] [Network Benefits] [and Non-Network] Benefits [is] [are] limited to \$[40,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy. [Non-Network Benefits are further limited to \$[5,000 - 30,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]]</p> <p>[Non-Network Benefits include services provided at a Network facility that is not a Designated Facility and services provided at a non-Network facility.]</p>	<p>[Designated Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p> <p>[Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p> <p>[Non-Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>		
[19.] [Ostomy Supplies]			
[Limited to \$[500 - 25,000] per year.]	<p>[Network]</p> <p>[[50 - 100]%</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per item is</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[Non-Network] [[50 - 100]%]</p>	[Yes] [No]	<p>satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per item is satisfied]</p>
[20.] Pharmaceutical Products - Outpatient			
[Prior Authorization Requirement]			
<p>¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</p>			
<p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
<p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires prior authorization through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>			
<p>[The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. <p>When a Pharmaceutical Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.]</p>	<p>[Designated Network] [[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[0 - 75] per Tier 1 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[15 -</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per Pharmaceutical Product is satisfied]</p> <p>[Yes, except when provided during a Physician office visit]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>250] per Tier 2 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[20 - 450] per Tier 3 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[70 - 650] per Tier 4 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[100 - 750] per Tier 5 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[150 - 850] per Tier 6 Pharmaceutical Product]</p> <p>[[50 - 100]% - Tier 1]</p> <p>[[50 - 100]% - Tier 2]</p> <p>[[50 - 100]% - Tier 3]</p> <p>[[50 - 100]% - Tier 4]</p> <p>[[50 - 100]% - Tier 5]</p> <p>[[50 - 100]% - Tier 6]</p> <p>Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[0 - 75]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per Pharmaceutical Product is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>per Tier 1 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[15 - 250] per Tier 2 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[20 - 450] per Tier 3 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[70 - 650] per Tier 4 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[100 - 750] per Tier 5 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[150 - 850] per Tier 6 Pharmaceutical Product]</p> <p>[[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]</p> <p>Non-Network [[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 -</p>	<p>[Yes] [No]</p>	<p>[Yes, except when provided during a Physician office visit]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>100] per Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[0 - 75] per Tier 1 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[15 - 250] per Tier 2 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[20 - 450] per Tier 3 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[70 - 650] per Tier 4 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[100 - 750] per Tier 5 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[150 - 850] per Tier 6 Pharmaceutical Product]</p> <p>[[50 - 100]% - Tier 1]</p> <p>[[50 - 100]% - Tier 2]</p> <p>[[50 - 100]% - Tier 3]</p> <p>[[50 - 100]% - Tier 4]</p> <p>[[50 - 100]% - Tier 5]</p> <p>[[50 - 100]% - Tier 6]</p>		<p>Deductible of \$[5 - 100] per Pharmaceutical Product is satisfied]</p> <p>[Yes, except when provided during a Physician office visit]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[21.] Physician Fees for Surgical and Medical Services			
<p>[When you choose to seek care [as a result of certain diagnoses or] from Designated Network Physicians as identified below, your Benefits will be enhanced as described:]</p> <p>[Specialties:]</p> <ul style="list-style-type: none"> • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] 	<p>[Designated Network] [[50 - 100]%</p> <p>Network [50 - 100]%</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 250] per service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 250] per service is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[Enhanced Benefits:]</p> <ul style="list-style-type: none"> [The Coinsurance you pay for Physician's Fees from a Designated Network Physician will be reduced to [0 - 50] % or \$[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of \$[10 - 1,000].] <p>[You can determine the specific services for which enhanced Benefits are available by going to [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.]</p> <p>[Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Non-Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]</p> <p>[Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]</p>	<p>Non-Network</p> <p>[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 250] per service is satisfied]</p>
<p>[22.] Physician's Office Services - Sickness and Injury</p>			

[Prior Authorization Requirement]

¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]

[¹For Non-Network Benefits you] [²You] must obtain prior authorization as soon as is reasonably possible before [Genetic Testing - BRCA] [Genetic Testing, including BRCA Genetic Testing] is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[When you choose to seek care [as a result of certain diagnoses or] from Designated Network Physicians as identified below, your Benefits will be enhanced as described:]</p> <p>[Specialties:]</p> <ul style="list-style-type: none"> • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we 	<p>[\$5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the office visit]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>provide designation.]</p> <p>[Enhanced Benefits:]</p> <ul style="list-style-type: none"> [The Copayment you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to \$[0 - 1,000]. [The maximum reduction in Copayments is \$[10 - 1,000].]] [The Coinsurance you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to [0 - 50] % or \$[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of \$[10 - 1,000].] <p>[You can determine the specific specialties for which enhanced Benefits are available by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p> <p>[In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office:</p> <ul style="list-style-type: none"> [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient.</i>] [Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and</i> 	<p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the office visit]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<ul style="list-style-type: none"> • <i>Nuclear Medicine - Outpatient.</i>] [Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient.</i>] • [Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>] • [Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>] • [Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i>] • [Rehabilitation therapy procedures described under <i>Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].</i>] 	<p>Physician office visit; [50 - 100]% for a Specialist Physician office visit</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the office visit]</p>		
<p>¹Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude. ²If Maternity Services are excluded, Complications of Pregnancy</p>			

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>must always be included.]</i></p> <p>[23.] Pregnancy - [¹Maternity Services] [²Complications of Pregnancy only]</p>			
<p><i>[Include when benefits are provided for maternity services.]</i></p>			
<p align="center">[Prior Authorization Requirement]</p>			
<p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p>			
<p><i>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</i></p>			
<p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p>			
<p align="center">[Prior Authorization Requirement]</p>			
<p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p>			
<p><i>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before admission for scheduled admissions or within one business day or the same day, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</i></p>			
<p align="center">It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.</p>			
	<p><i>[Include when benefits are provided for maternity services. Bracketed text within is plan design variable.]</i></p> <p>[Network]</p> <p><i>[Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits [except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]]</i></p> <p>[Non-Network]</p> <p><i>[Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits [except that</i></p>		

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]]</p> <p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p> <p>[Network] [Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p> <p>[Non-Network] [Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p>		
[24.] Preventive Care Services			
<p>Physician office services</p> <ul style="list-style-type: none"> Well baby and well child care includes, but is limited to, 20 visits at approximately the following age intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years. <p>No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's immunizations.</p>	<p>Network 100%</p> <p>Non-Network [[50 - 100]%) [100% after you pay a Copayment of \$[5 - 100] per visit] [100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]%) for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]%) for a</p>	<p>No</p> <p>[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available except for children under the age of 19.].]</p>	<p>No</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available except for children under the age of 19.].]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Lab, X-ray or other preventive tests</p> <p>No deductible will be applicable to Network or non-Network Prostate Cancer Screening.</p>	<p>Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for immunizations when no other service is provided during the office visit.]</p> <p>[Non-Network Benefits are not available.]</p> <p>Network 100%</p> <p>Non-Network [[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p>	<p>No</p> <p>[Yes] [No]</p>	<p>No</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p>
<p><i>Prosthetics are a mandated benefit in Arkansas.</i></p> <p>[25.] Prosthetic Devices and Services</p>			
<p align="center">[Prior Authorization Requirement]</p> <p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[¹For Non-Network Benefits you] [²You] must obtain prior authorization before obtaining prosthetic devices [that exceed \$[1,000 - 5,000] in cost per device]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>Benefits for replacement are limited to a single purchase of each type of</p>	<p>[Network]</p>		

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
prosthetic device every three years Benefits for replacement are limited to a single purchase of each type of prosthetic device every three years	[[50 - 100] %] [Non-Network] [[50 - 100] %]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[26.] Reconstructive Procedures			
<p style="text-align: center;">Prior Authorization Requirement</p> <p><i>¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, [¹for Non-Network Benefits] you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]</p>			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]</i></p> <p>[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]</i></p> <p>[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to</p>		

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
the Out-of-Pocket Maximum.]]			
<p>[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]</p>			
<p>[Prior Authorization Requirement]</p>			
<p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p>			
<p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy] or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
<p>[Limited per year as follows:</p> <ul style="list-style-type: none"> • [[10 -100] visits of physical therapy.] • [[10 -100] visits of occupational therapy.] • [[10 -100] Manipulative Treatments.] • [[10 -100] visits of speech therapy.] • [[10 -100] visits of pulmonary rehabilitation therapy.] • [[10 -100] visits of cardiac rehabilitation therapy.] • [[10 -100] visits of post-cochlear implant aural therapy.] • [[10 - 100] visits of cognitive rehabilitation therapy.] • [[10 -100] visits of vision therapy.]] <p>[Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy,</p>	<p>[Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[Non-Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, when</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10 - 160] visits per year.]</p> <p>[Network Benefits for any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] are limited to [10 - 160] visits per year.]</p> <p>[Non-Network Benefits for any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] are limited to [10 - 160] visits per year.]</p>	<p>Copayment of \$[5 - 100] per visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p>	<p>Benefits are subject to Coinsurance]</p>	<p>Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>
<p>[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic</p>	<p align="center">[Prior Authorization Requirement]</p>		
<p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
	<p>[Designated Network]</p> <p>[[50 - 100]%</p> <p>[[50 - 100]% at a free-standing center]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[[50 - 100]% at an outpatient Hospital-based center]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at a free-standing center]</p> <p>[[50 - 100]% at an outpatient Hospital-based center]</p> <p>Non-Network</p> <p>[50 - 100]%</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>
<p>[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</p>	<p align="center">Prior Authorization Requirement</p> <p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits for] [²For] a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, [¹for Non-Network Benefits] you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>		
<p>[Limited to [40 - 180] days per year.]</p> <p>[Limited to:</p> <ul style="list-style-type: none"> • [30 - 180] days per year in a Skilled Nursing Facility. • [30 - 180] days per year in an Inpatient Rehabilitation Facility.] <p>[Network Benefits are limited to [40 - 180] days per year. Non-Network Benefits are limited to [40 - 180] days per year.]</p>	<p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[50 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[50 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[50 -</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>1,000] per day to a maximum Copayment of \$[50 - 5,000] per Inpatient Stay]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[50 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[50 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[50 - 1,000] per day to a maximum Copayment of \$[50 - 10,000] per Inpatient Stay]</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>
<p><i>[Include as standard for groups of 2 to 15]</i></p> <p>[30.] Substance Use Disorder Services</p>			
[Prior Authorization Requirement]			
<p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits for] [²For] a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, [¹for Non-Network Benefits] you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
<p><i>[Limits will not apply to groups of 51+.]</i></p> <p>[Inpatient Substance Use Disorder</p>	[Network]		

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Services are limited to [10 - 100] days per year.]</p> <p>[Outpatient <i>Substance Use Disorder Services</i> are limited to [10 - 100] visits per year.]</p> <p>[Non-Network Benefits for inpatient <i>Substance Use Disorder Services</i> are limited to [10 - 100] days per year.]</p> <p>[Non-Network Benefits for outpatient <i>Substance Use Disorder Services</i> are limited to [10 - 100] visits per year.]</p> <p>[Benefits for any combination of <i>Substance Use Disorder Services</i> described in this section and <i>Mental Health Services</i> described above are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] 	<p>[Inpatient]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>
<p>[Benefits for any combination of <i>Substance Use Disorder Services</i> described in this section and <i>Mental Health Services</i> and <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> described above are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance</i> 	<p>[Outpatient]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgery]] you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at an ambulatory surgical center]</p> <p>[[50 - 100]% at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service at an ambulatory surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[10 - 1,000] per date of service is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as follows:]</p> <ul style="list-style-type: none"> [The Copayment you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [\$0 - 1,000]. [The maximum reduction in Copayments is \$[10 - 1,000].]] [The Coinsurance you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [0 - 50] % or \$[10 - 1,000] will be applied toward any applicable deductible if not already met, to a maximum of \$[10 - 1,000].] <p>[You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>	<p>Copayment of \$[10 - 5,000] per year at an ambulatory surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year at an outpatient Hospital-based surgical center]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at an ambulatory surgical center]</p> <p>[[50 - 100]% at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service at an ambulatory surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 -</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[10 - 1,000] per date of service is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>5,000] per year]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year at an ambulatory surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year at an outpatient Hospital-based surgical center]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[10 - 1,000] per date of service is satisfied]</p>
<p>[32.] Temporomandibular Joint Services</p>			

[Prior Authorization Requirement]

[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]

[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]

[In addition, [¹for Non-Network Benefits] you must contact us 24 hours before admission for scheduled

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
inpatient admissions.]			
[Limited to \$[1,000 - 20,000] per year.]	<p>[Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p> <p>[Non-Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p>		
[33.] Therapeutic Treatments - Outpatient	[Prior Authorization Requirement]		
<p>¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</p> <p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require prior authorization: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound].] If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at a free-standing center]</p> <p>[[50 - 100]% at an outpatient Hospital-based center]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment at a free-standing center]</p> <p>[100% after you pay a</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 100] per treatment is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Copayment of \$[25 - 100] per treatment at an outpatient Hospital-based center]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at a free-standing center]</p> <p>[[50 - 100]% at an outpatient Hospital-based center]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment at a free-standing center]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment at an outpatient Hospital-based center]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 100] per treatment is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 100] per treatment is satisfied]</p>
<p>[34.] Transplantation Services</p>	<p>Prior Authorization Requirement</p> <p>For Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid. [Non-Network Benefits will apply.]</p> <p>[For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant</p>		

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p> <p><i>[¹Include when network providers are responsible for prior authorization for network benefits.]</i></p> <p>[In addition, [¹for Non-Network Benefits] you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			
<p>For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.</p> <p>[Non-Network Benefits are limited to \$[30,000 - 250,000] per transplant.]</p>	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>		
<p>[35.] Urgent Care Center Services</p>			
<p>[Limited to [2 - 10] visits per year.]</p> <p>[In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center:</p> <ul style="list-style-type: none"> • [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient</i>.] • [Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</i>.] • [Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products -</i> 	<p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit to a maximum Copayment of \$[5 - 5,000] per year]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit for the</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 150] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Outpatient.]</i></p> <ul style="list-style-type: none"> • [Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>] • [Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>] • [Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i>] • [Rehabilitation therapy procedures described under <i>Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].]</i>] 	<p>first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit to a maximum Copayment of \$[5 - 5,000] per year]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 150] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	that year]		
[36.] [Vision Examinations]			
<p>[Limited to [1 exam] [[2-3] exams] per year.]</p> <p>[Limited to [1 exam] [[2-3] exams] every [2 - 3] years.]</p>	<p>[Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[Non-Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]		
[37.] [Wigs]			
[Limited to \$[100 - 1,000] per year.] [Limited to \$[100 - 5,000] every [24 - 36] months.]	[Network] [[50 - 100]%] [Non-Network] [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Additional Benefits Required By Arkansas Law			
[38.] Dental Services - Anesthesia and Hospitalization			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
	<p align="center">[Benefits will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>.]</p>		
[39.] In Vitro Fertilization Services			
<p>¹Include applicable reduction in Benefits or no Benefits.</p> <p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Limited to a lifetime maximum of \$15,000.	<p>Network [50 - 100]%</p> <p>Non-Network Same as Network [Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>Same as Network [Non-Network Benefits are not available.]</p>	<p>Network [50 - 100]%</p> <p>Non-Network Same as Network [Non-Network Benefits are not available.]</p>
[40.] Medical Foods			
¹ Include applicable reduction in Benefits or no Benefits.			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
	<p>Network [50 - 100]%</p> <p>Non-Network Same as Network</p>	<p>[Yes] [No]</p> <p>Same as Network</p>	<p>Network [50 - 100]%</p> <p>Non-Network Same as Network</p>
<i>Mandated offer in Arkansas.</i>			
[[41.] Musculoskeletal Disorders of the Face, Neck or Head]			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>[¹ Designated Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>			

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p>		
<p>[[42.] Orthotic Devices and Services</p>			
<p><i>Include if notification is required.</i></p> <p>¹<i>Include when notification applies only to orthotics that exceeds a minimum dollar amount and insert applicable dollar amount.</i></p> <p>²<i>Include applicable reduction in Benefits or no Benefits.</i></p> <p style="text-align: center;">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>Benefits for replacements are limited to a single purchase of each type of orthotic device every three years.</p>	<p>Network</p> <p>[50 - 100%]</p> <p>Non-Network</p> <p>[50 - 100%]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>

Eligible Expenses

¹*Include if non-network RAPLs and consultants at a network facility are paid as network benefits at less than billed charges.*

Eligible Expenses are the amount we determine that we will pay for Benefits. For [Designated Network Benefits and] Network Benefits [¹for Covered Health Services provided by a Network provider], you are not responsible for any difference between Eligible Expenses and the amount the provider bills. [¹For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by us), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below.] For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

[Include if plan includes ability to determine alternate levels of benefits.]

[If one or more alternative health services that meets the definition of a Covered Health Service in the *Certificate* under *Section 9: Defined Terms* are clinically appropriate and not more costly than an

alternative health service that is at least as likely to produce equivalent therapeutic or diagnostic results as to their prevention, diagnosis or treatment of a Sickness, Injury, [Mental Illness,] [mental illness,] substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on *Generally Accepted Standards of Medical Practice*, which for some Covered Health Services may be addressed in our clinical policies.]

For [Designated Network Benefits and] Network Benefits, Eligible Expenses are based on the following:

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

[Include if RAPLs and consultants are paid as network benefits at less than billed charges.]

- [For Covered Health Services received at a Network facility on a non-Emergency basis from a [radiologist] [,] [and] [anesthesiologist] [,] [and] [pathologist] [,] [and] [consulting Physician] [,] [and] [neonatologist] [,] [and] [intensivist] [,] [and] [assistant surgeon] [and] [surgical assistant], the Eligible Expense is based on [[110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market] [50 - 100]% of the provider's billed charge].

When a rate is not published by *CMS* for the service, we use a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by *Ingénue, Inc.* If the *Ingénue, Inc.* relative value scale becomes no longer available, a comparable scale will be used. We and *Ingénue, Inc.* are related companies through common ownership by *UnitedHealth Group*.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.]

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

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:

[PHCS payment option.]

[¹Include if RAPLs and consultants are paid as non-network benefits.]

- [Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
- If rates have not been negotiated, then one of the following amounts:
 - ◆ For Covered Health Services other than Pharmaceutical Products [¹and services from the specific providers identified below], Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.

[²Include when benefits are provided for either Mental Health Services or Substance Use Disorder Services.]

If no fee information is available for a Covered Health Service, the Eligible Expense is based on [50 - 100]% of the provider's billed charge², except that certain Eligible Expenses for [Mental Health Services] [and] [Substance Use Disorder Services] are based on 80% of the billed charge].]

- ◆ [²For [Mental Health Services] [and] [Substance Use Disorder Services] the Eligible Expense will be reduced by [5 - 30]% for Covered Health Services provided by a

psychologist and by [5 - 40]% for Covered Health Services provided by a masters level counselor.]

- ◆ When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [110 - 200] % of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

- ◆ [¹For Covered Health Services received on a non-Emergency basis from a [radiologist] [,] [and] [anesthesiologist] [,] [and] [pathologist] [,] [and] [consulting Physician] [,] [and] [neonatologist] [,] [and] [intensivist] [,] [and] [assistant surgeon] [and] [surgical assistant], the Eligible Expense is based on [[110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market] [50 - 100]% of the provider's billed charge].

When a rate is not published by *CMS* for the service, we use a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by *Ingenix, Inc.* If the *Ingenix, Inc.* relative value scale becomes no longer available, a comparable scale will be used. We and *Ingenix, Inc.* are related companies through common ownership by *UnitedHealth Group.*]]

[MNRP payment option.]

- [Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
- If rates have not been negotiated, then one of the following amounts:

[¹Include if RAPLs and consultants are paid as non-network benefits.]

- ◆ [¹Except for services from the specific providers identified below,] Eligible Expenses are determined based on [110 - 200] % of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
- ◆ [¹For Covered Health Services received on a non-Emergency basis from a [radiologist] [,] [and] [anesthesiologist] [,] [and] [pathologist] [,] [and] [consulting Physician] [,] [and] [neonatologist] [,] [and] [intensivist] [,] [and] [assistant surgeon] [and] [surgical assistant], the Eligible Expense is based on [[110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market] [50 - 100]% of the provider's billed charge].
- ◆ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
 - ▶ For services other than Pharmaceutical Products, we use a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by *Ingenix, Inc.* If the *Ingenix, Inc.* relative value scale becomes no longer available, a comparable scale will be used. We and *Ingenix, Inc.* are related companies through common ownership by *UnitedHealth Group.*

- ▶ For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

^[2]Include when benefits are provided for either Mental Health Services or Substance Use Disorder Services.]

- ◆ When a rate is not published by CMS for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge ^[2], except that certain Eligible Expenses for [Mental Health Services] [and] [Substance Use Disorder Services] are based on 80% of the billed charge.
- ◆ ^[2]For [Mental Health Services] [and] [Substance Use Disorder Services] the Eligible Expense will be reduced by [5 - 30]% for Covered Health Services provided by a psychologist and by [5 - 40]% for Covered Health Services provided by a masters level counselor.]

We update the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.]

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

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

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

You or your Network Physician must notify us of special service needs (such as transplants [[, ventricular assist device implantation](#)] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

UnitedHealthcare [Non-Differential PPO]

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider regardless of their Network status. This Benefit plan does not provide a Network Benefit level or a Non-Network Benefit level.

We arrange for health care providers to participate in a Network. Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network provider, your Coinsurance level will remain the same. However, the portion that you owe may be less than if you received services from a non-Network provider because the Eligible Expense may be a lesser amount.

^[1] *Include when shared savings program applies.*

Depending on the geographic area and the service you receive, you may have access ^[1]through our [Shared Savings Program] to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less ^[1]when you receive Covered Health Services from [Shared Savings Program] providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

You should show your identification card (ID card) every time you request health care services so that the provider knows that you are enrolled under a [UnitedHealthcare] Policy.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

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

Prior Authorization

We require prior authorization for certain Covered Health Services. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

When you choose to receive certain Covered Health Services, you are responsible for obtaining prior authorization before you receive these services. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number for *Customer Care* on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to determine how far in advance you must obtain prior authorization.

[Include bracketed variable benefit category listed below if: a) the benefit is included in the plan design and b) prior authorization is required. Include dollar amounts as applicable.]

- [_____]
- Ambulance - non-emergent air and ground.
- Clinical trials.
- [Congenital heart disease surgery.]
- [Dental services - accidental.]
- Dental services - anesthesia and hospitalization
- [Diabetes equipment - insulin pumps [over \$[1,000 - 5,000]].]
- [Durable Medical Equipment [over \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)].]
- [Medical Foods.]

[Include when prior authorization is required for only BRCA genetic testing.]

- [Genetic Testing - BRCA.]

[Include when prior authorization is required for all genetic testing.]

- [Genetic Testing, including BRCA Genetic Testing.]
- [Hearing aids [that exceed \$[1,000 - 5,000] in retail purchase cost].]
- [Home health care.]
- [Hospice care - inpatient.]
- Hospital inpatient care - all scheduled admissions [and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery].
- [Infertility services.]
- In vitro fertilization services.
- [Lab, X-ray and diagnostics - sleep studies.]
- [Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA, Nuclear Medicine and Capsule Endoscopy.]

Include when group purchases benefits for musculoskeletal disorders.

- [Musculoskeletal disorders of the face neck or head.]
- [Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.]
- [Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond

45 - 50 minutes in duration, with or without medication management [; Applied Behavioral Analysis (ABA)].]

- [Obesity surgery.]

¹Include if notification applies only to orthotics that exceeds a specific dollar amount and insert appropriate dollar amount.

- Orthotics devices [¹over\$[1,000-5,000]].
- [Pain management.]
- [Pharmaceutical Products - IV infusions only.]
- [Certain Pharmaceutical Products. You may determine whether a particular Pharmaceutical Product requires authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

¹Include if notification applies only to prosthetics that exceed a specific dollar amount and insert appropriate dollar amount.

- Prosthetic devices [¹over \$[1,000 - 5,000]].]
- Reconstructive procedures, including breast reconstruction surgery following mastectomy [and breast reduction surgery].
- [Rehabilitation services [and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy].]
- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- [Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.]

¹Do not include pain management procedures if prior authorization is required for all pain management services above.]

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [¹pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgeries]].]
- [Temporomandibular joint services.]
- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound]].]
- Transplants.
- [Ventricular assist device implantation. You must obtain prior authorization as soon as the possibility of implantation arises except in cases of Emergency implantations of partial assist devices.]

[Include paragraph below if plan includes ability to determine alternate levels of benefits.]

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

[As we determine, if one or more alternative health services that meets the definition of a Covered Health Service in the *Certificate* under *Section 9: Defined Terms* are clinically appropriate and not more costly than an alternative health service that is at least as likely to produce equivalent therapeutic or diagnostic results as to their prevention, diagnosis or treatment of a Sickness, Injury, [Mental Illness,] [mental illness,] substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on *Generally Accepted Standards of Medical Practice*, which for some Covered Health Services may be addressed in our clinical policies. After you contact us for prior authorization, we will identify the Benefit level available to you.

These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.]

For all other services, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.

[The Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

Benefit limits are calculated on a [calendar] [Policy] year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
<p><i>[Annual deductible is plan design variable. Include applicable provisions to support the following:</i></p> <p>¹<i>Outpatient Prescription Drug Rider is sold and the annual deductible applies to any combination of medical and RX benefits.</i></p> <p>²<i>Outpatient Prescription Drug Rider with separate copayments for preventive medications is sold and the annual deductible does not apply to preventive medications.</i></p> <p>³<i>Outpatient Prescription Drug Rider is sold and when the annual deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the annual deductible.</i></p> <p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. [¹The Annual Deductible applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>. [²Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [³Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the <i>Outpatient Prescription Drug Rider</i> are not subject to payment of the Annual Deductible.]</p> <p><i>[Include applicable provisions to support the following:</i></p> <p>¹<i>Day/visit limits are reduced by the number of days/visit used toward meeting the deductible.</i></p> <p>²<i>Carry-over provision applies.</i></p> <p>³<i>Roll-over provision applies in any circumstance.</i></p> <p>⁴<i>Roll-over provision applies only to groups changing from calendar to policy year. ⁵Include when roll-over applies only to the individual deductible.</i></p> <p>⁶<i>Include only when a per occurrence deductible applies.]</i></p> <p>[¹Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.]</p> <p>[²Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.]</p> <p>[³When a Covered Person was previously covered under a</p>	<p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p> <p>[No Annual Deductible.]</p>

Payment Term And Description	Amounts
<p>group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.]</p> <p>[⁴When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [⁵This roll-over feature applies only to the individual Annual Deductible.]]</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>[⁶The Annual Deductible does not include any applicable Per Occurrence Deductible.]</p>	
<p>[Per occurrence deductible is plan design variable.]</p> <p>[Per Occurrence Deductible]</p>	
<p>[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services.</p> <p>You are responsible for paying the lesser of the following:</p> <ul style="list-style-type: none"> • The applicable Per Occurrence Deductible. • The Eligible Expense.] 	<p>[When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.]</p>
<p>Out-of-Pocket Maximum</p>	

Payment Term And Description	Amounts
<p><i>[Out-of-pocket maximum is plan design variable. Include applicable provisions to support the following:</i></p> <p>¹<i>Includes the annual deductible.</i></p> <p>²<i>Includes the per occurrence deductible.</i></p> <p>³<i>Includes copayments.</i></p> <p>⁴<i>Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.</i></p> <p>The maximum you pay per year for [¹the Annual Deductible,] [²the Per Occurrence Deductible,] [³Copayments] [¹⁻²⁻³or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [⁴The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when plan design does not apply all copayments/coinsurance to the OOPM.]</i></p> <p>[[Copayments] [and] [Coinsurance] for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> • Any charges for non-Covered Health Services. <p><i>[Include bullet if prior authorization requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.]</i></p> <ul style="list-style-type: none"> • [The amount Benefits are reduced if you do not obtain prior authorization as required.] • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the <i>Schedule of Benefits</i> table that does not apply to the Out-of-Pocket Maximum. <p><i>[Include when an Outpatient Prescription Drug Rider is sold and copayments/coinsurance do not apply to the overall OOPM.]</i></p> <ul style="list-style-type: none"> • [Copayments or Coinsurance for Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.] 	<p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p>[No Out-of-Pocket Maximum.]</p>
<p><i>[Annual maximum benefit is plan design variable. Include applicable provisions to support the following:</i></p>	

Payment Term And Description	Amounts
<p>¹<i>Outpatient Prescription Drug Rider is sold.</i></p> <p>[Annual Maximum Benefit]</p>	
<p>[The maximum amount we will pay for Benefits during the year.] [¹The Annual Maximum Benefit applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.]</p>	<p>[\$[2,000 - 2,500,000] per Covered Person.]</p>

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

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

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

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

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

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design.]

[Include the following variables according to plan design:

- Benefit limits and levels.*
- Prior authorization requirements and any penalty for failure to prior authorize*

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Air Ambulance: [[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[25 - 10,000] per [transport] [day] is satisfied]
[3.] Clinical Trials			
<p align="center">Prior Authorization Requirement</p> <p>You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i> .	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
[4.] [Congenital Heart Disease Surgeries]			
<p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
	[[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]
[5.] [Dental Services - Accident Only]			
<p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
[Limited to \$[2,000 - 5,000] per year. Benefits are further limited to a	[[50 - 100]%	[Yes] [No]	[Yes] [No]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
maximum of \$[500 - 1,500] per tooth.]			[Yes, after the Per Occurrence Deductible of \$[5 - 75] per visit is satisfied]
[6.] Diabetes Services			
<p><i>[¹Include when the durable medical equipment benefit is sold.]</i></p> <p><i>[²Include when the durable medical equipment benefit is not sold.]</i></p> <p style="text-align: center;">Prior Authorization Requirement</p> <p>You must obtain prior authorization before obtaining any [¹Durable Medical Equipment] [²diabetes equipment] for the management and treatment of diabetes [that exceeds \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p>			
<p>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</p> <p>Diabetes Self-Management Items</p> <p>Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under <i>Durable Medical Equipment</i>.</p> <p><i>[Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.]</i></p> <p>[Benefits for insulin pumps are limited to \$[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[two-five] years].]</p>	<p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]</i></p> <p>[Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]</i></p> <p>[For diabetes equipment, Benefits will be the same as those stated under <i>Durable Medical Equipment</i>.</p> <p>For diabetes supplies the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p><i>[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]</p> <p>Benefits for diabetes supplies will be the same as those stated</p>		

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps and diabetes supplies, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p>		
[7.] [Durable Medical Equipment]			
<p>[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization before obtaining any Durable Medical Equipment [that exceeds \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>[Limited to \$[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two - five] years]. [This limit does not apply to wound vacuums [, which are subject to a separate limit of \$[4,500 - 13,500] per year and limited to a single purchase (including repair/replacement) every [year] [[two - five] years]].]</p> <p>[Limited per year as follows:</p> <ul style="list-style-type: none"> • [[\$[500 - 10,000] in Eligible Expenses for Tier 1. Tier 1 includes disposable supplies necessary for the effective use of covered Durable Medical Equipment.] • [[\$[10,001 - 25,000] in Eligible Expenses for Tier 2.] • [[\$[25,001 - 100,000] in Eligible Expenses for Tier 3.] <p>These Tier limits include repair. Benefits for replacement are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].]</p> <p>[Benefits are [further] limited to a single Mobility Device during the entire</p>	[[50 - 100] %]	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per purchase is satisfied]</p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>period of time a Covered Person is enrolled under the Policy. Benefits for repair of the Mobility Device are limited to once every three years. We may, upon review, replace a defective Mobility Device rather than repair it. Benefits are not available for repair or replacement of a Mobility Device resulting from abuse, neglect or normal wear.]</p> <p>[Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every three years. Speech aid and tracheo-esophageal voice devices are [not] included in the annual limits stated above.]</p>			
[8.] Emergency Health Services - Outpatient			
	[[50 - 100] %]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 700] per visit is satisfied]
<i>Include as standard for groups of 2 to 15 and 15+.</i>			
[9.] Hearing Aids			
[Prior Authorization Requirement]			
[You must obtain prior authorization before obtaining a hearing aid [that exceeds \$[1,000 - 5,000] in retail purchase cost]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
<p>Limited to \$[2,800 - 5,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[three-five] years].]</p> <p><i>To be removed for HSA plans.</i></p> <p>[No Copayment, Coinsurance or Deductible will be applicable to</p>	[[50 - 100] %]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[50 - 1,000] per device is satisfied]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Network or non-Network Hearing Aid Coverage.]			
[10.] Home Health Care			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
<p>[Limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.]</p> <p>[Limited to [40 - 200] visits per year to a maximum of \$[500 - 5,000] in Eligible Expenses per year.]</p> <p>[This visit limit does not include any service which is billed only for the administration of intravenous infusion.]</p>	[[50 - 100]%	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per visit is satisfied]</p>
[11.] Hospice Care			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p align="center">[In addition, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]</p>			
	[[50 - 100]%	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per day is satisfied]</p>
[12.] Hospital - Inpatient Stay			
<p align="center">Prior Authorization Requirement</p> <p>For a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]
[13]. [Infertility Services]			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
[Limited to \$[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [This limit includes Benefits for infertility medications provided under the <i>Outpatient Prescription Drug Rider</i> .] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under <i>Physician's Office Services - Sickness and Injury</i> below.]	[[50 - 100]%	[Yes] [No]	[Yes] [No]
[14.] Lab, X-Ray and Diagnostics - Outpatient			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[For sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
Lab Testing - Outpatient:	[[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]
X-Ray and Other Diagnostic Testing - Outpatient:	[[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	center] [[50 - 100]% at an outpatient Hospital-based diagnostic center]		Deductible of \$[5 - 100] per service is satisfied]
[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
	[[50 - 100]%] [[50 - 100]% at a free-standing diagnostic center] [[50 - 100]% at an outpatient Hospital-based diagnostic center]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[25 - 500] per service is satisfied]
<p><i>Include for groups that purchase Mental Health benefits.</i></p> <p><i>[Include as standard for groups of 2 to 15]</i></p> <p><i>¹Include if group purchases SA benefits.</i></p> <p>[16.] Mental Health Services</p>			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[For a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p align="center">In addition, you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p align="center">If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
[Limits will not apply to groups of 51+.] [Inpatient Mental Health Services are	[Inpatient]		

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> described in this section, <i>Mental Health Services</i> described above and <i>Substance Use Disorder Services</i> described further below are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] 	<p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>
<p>[18.] [Obesity Surgery]</p>			
<p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p align="center">[In addition, you must contact us 24 hours before admission for an Inpatient Stay.]</p> <p align="center">[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]</p>			
<p>[Benefits are limited to \$[40,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]</p>	<p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>		
<p>[19.] [Ostomy Supplies]</p>			
<p>[Limited to \$[500 - 25,000] per year.]</p>	<p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per item is satisfied]</p>
<p>[20.] Pharmaceutical Products - Outpatient</p>			
<p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization five business days before scheduled intravenous infusions are</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p> <p>[You must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires prior authorization through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>			
<p>[The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. <p>When a Pharmaceutical Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.]</p>	<p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[0 - 75] per Tier 1 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[15 - 250] per Tier 2 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[20 - 450] per Tier 3 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[70 - 650] per Tier 4 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[100 - 750] per Tier 5 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[150 - 850] per Tier 6 Pharmaceutical Product]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per Pharmaceutical Product is satisfied]</p> <p>[Yes, except when provided during a Physician office visit]</p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]		
[21.] Physician Fees for Surgical and Medical Services			
	[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[50 - 250] per service is satisfied]
[22.] Physician's Office Services - Sickness and Injury			
[Prior Authorization Requirement] [You must obtain prior authorization as soon as is reasonably possible before [Genetic Testing - BRCA] [Genetic Testing, including BRCA Genetic Testing] is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]			
	[[50 - 100]% [100% after you pay a Copayment of \$[5 - 100] per visit] [100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied] [Yes, when Benefits are subject to Coinsurance]

Covered Health Service	Benefit <i>(The Amount We Pay, based on Eligible Expenses)</i>	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the office visit]</p>		
<p><i>¹Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude. ²If Maternity Services are excluded, Complications of Pregnancy must always be included.]</i></p> <p>[23.] Pregnancy - [¹Maternity Services] [²Complications of Pregnancy only]</p>			
<p><i>[Include when benefits are provided for maternity services.]</i></p>			
<p align="center">[Prior Authorization Requirement]</p>			
<p>[You must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p> <p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p> <p>[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization five business days before admission for scheduled admissions or within one business day or the same day, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p> <p>It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.</p>			
<p><i>[Include when benefits are provided for maternity services. Bracketed text within is plan design variable.]</i></p> <p>[Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> [except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]]</p> <p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p> <p>[Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>			
<p>[24.] Preventive Care Services</p>			
<p>Physician office services</p> <ul style="list-style-type: none"> Well baby and well child care includes, but is limited to, 20 visits at approximately the following age intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years. <p>No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's</p>	<p>100%</p>	<p>No</p>	<p>No</p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
immunizations. Lab, X-ray or other preventive tests No deductible will be applicable to Network or non-Network Prostate Cancer Screening.	100%	No	No
<i>[Prosthetics are a mandated benefit in Arkansas.]</i> [25.] Prosthetic Devices and Services	[Prior Authorization Requirement] [You must obtain prior authorization before obtaining prosthetic devices [that exceed \$[1,000 - 5,000] in cost per device]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]		
Benefits for replacement are limited to a single purchase of each type of prosthetic device every three years	[[50 - 100] %]	[Yes] [No]	[Yes] [No]
[26.] Reconstructive Procedures	Prior Authorization Requirement You must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid]. [In addition, you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> . <i>[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]</i> [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before receiving [physical therapy] [,] [and]			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy] or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
<p>[Limited per year as follows:</p> <ul style="list-style-type: none"> • [[10 -100] visits of physical therapy.] • [[10 -100] visits of occupational therapy.] • [[10 -100] Manipulative Treatments.] • [[10 -100] visits of speech therapy.] • [[10 -100] visits of pulmonary rehabilitation therapy.] • [[10 -100] visits of cardiac rehabilitation therapy.] • [[10 -100] visits of post-cochlear implant aural therapy.] • [[10 - 100] visits of cognitive rehabilitation therapy.] • [[10 -100] visits of vision therapy.]] <p>[Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,], [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10 - 160] visits per year.]</p>	<p>[[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>
<p>[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic</p>	<p>[Prior Authorization Requirement]</p>		
<p>[You must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[[50 - 100]% [[50 - 100]% at a free-standing center [[50 - 100]% at an outpatient Hospital-based center]	[Yes] [No]	[Yes] [No]
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			
[Limited to [40 - 180] days per year.] [Limited to: <ul style="list-style-type: none"> • [30 - 180] days per year in a Skilled Nursing Facility. • [30 - 180] days per year in an Inpatient Rehabilitation Facility.] 	[[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[50 - 2,000] per [day] [Inpatient Stay] is satisfied]
[Include as standard for groups of 2 to 15] [30.] Substance Use Disorder Services			
<p style="text-align: center;">[Prior Authorization Requirement]</p> <p>[For a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
[Limits will not apply to groups of 51+.] [Inpatient Substance Use Disorder Services are limited to [10 - 100] days]	[Inpatient] [[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>per year.]</p> <p>[Outpatient <i>Substance Use Disorder Services</i> are limited to [10 - 100] visits per year.]</p> <p>[Benefits for any combination of <i>Substance Use Disorder Services</i> described in this section and <i>Mental Health Services</i> described above are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] <p>[Benefits for any combination of <i>Substance Use Disorder Services</i> described in this section and <i>Mental Health Services</i> and <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> described above are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] 	<p>[Outpatient]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>

[31.] Surgery - Outpatient

[¹ Does not apply if prior authorization is required for all pain management.]

[Prior Authorization Requirement]

[For [all outpatient surgeries] [[blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgery]] you must obtain prior authorization five business days before scheduled

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]			
	[[50 - 100]% [[50 - 100]% at an ambulatory surgical center [[50 - 100]% at an outpatient Hospital-based surgical center]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[10 - 1,000] per date of service is satisfied]
[32.] Temporomandibular Joint Services			
<p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p>[In addition, you must contact us 24 hours before admission for scheduled inpatient admissions.]</p>			
[Limited to \$[1,000 - 20,000] per year.]	[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .]		
[33.] Therapeutic Treatments - Outpatient			
<p align="center">[Prior Authorization Requirement]</p> <p>[²You must obtain prior authorization [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require prior authorization: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound].] If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
	[[50 - 100]% [[50 - 100]% at a free-standing center [[50 - 100]% at an outpatient Hospital-based center]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[25 - 100] per treatment is satisfied]
[34.] Transplantation Services			
Prior Authorization Requirement			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.</p> <p>[In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			
<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>			
<p>[35.] Urgent Care Center Services</p>			
<p>[Limited to [2 - 10] visits per year.]</p> <ul style="list-style-type: none"> • 	<p>[[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 150] per visit is satisfied]</p>
<p>[36.] [Vision Examinations]</p>			
<p>[Limited to [1 exam] [[2-3] exams] per year.]</p> <p>[Limited to [1 exam] [[2-3] exams] every [2 - 3] years.]</p>	<p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>
<p>[37.] [Wigs]</p>			
<p>[Limited to \$[100 - 1,000] per year.]</p> <p>[Limited to \$[100 - 5,000] every [24 - 36] months.]</p>	<p>[[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p>Additional Benefits Required By Arkansas Law</p>			
<p>[38.] Dental Services - Anesthesia and Hospitalization</p>			
<p>[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>[Benefits will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>.]</p>			
<p>[39.] In Vitro Fertilization Services</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
¹ Include applicable reduction in Benefits or no Benefits.			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
Limited to a lifetime maximum of \$15,000.	[50 - 100%]	[Yes] [No]	[Yes] [No]
[40.] Medical Foods			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
	[50 - 100%]	[Yes] [No]	[Yes] [No]
<i>Mandated offer in Arkansas.</i>			
[[41.] Musculoskeletal Disorders of the Face, Neck or Head]			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]Service category in this <i>Schedule of Benefits</i>.]</p>			
	[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .]		
[[42.] Orthotic Devices and Services			
<p><i>Include if notification is required.</i></p> <p>¹Include when notification applies only to orthotics that exceed a minimum dollar amount and insert applicable dollar amount.</p> <p>²Include applicable reduction in Benefits or no Benefits.</p>			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
Benefits for replacements are limited to a single purchase of each type of orthotic device every three years.	[50 - 100%]	[Yes] [No]	[Yes] [No]
	[50 - 100%]	[Yes] [No]	[Yes] [No]

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Covered Health Services from non-Network providers, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

[Include if plan includes ability to determine alternate levels of benefits.]

[If one or more alternative health services that meets the definition of a Covered Health Service in the Certificate under Section 9: Defined Terms are clinically appropriate and not more costly than an alternative health service that is at least as likely to produce equivalent therapeutic or diagnostic results as to their prevention, diagnosis or treatment of a Sickness, Injury, [Mental Illness,] [mental illness,] substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on Generally Accepted Standards of Medical Practice, which for some Covered Health Services may be addressed in our clinical policies.]

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:

[PHCS payment option.]

- *[Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.]*
- *If rates have not been negotiated, then one of the following amounts:*
 - ◆ *For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.*

[¹Include when benefits are provided for either Mental Health Services or Substance Use Disorder Services.]

If no fee information is available for a Covered Health Service, the Eligible Expense is based on [50 - 100]% of the provider's billed charge^[1], except that certain Eligible Expenses for [Mental Health Services] [and] [Substance Use Disorder Services] are based on 80% of the billed charge[.]

- ◆ *[¹For [¹Mental Health Services] [¹and] [¹Substance Use Disorder Services] the Eligible Expense will be reduced by [5 - 30]% for Covered Health Services provided by a psychologist and by [5 - 40]% for Covered Health Services provided by a masters level counselor.]*
- ◆ *When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [110 - 200] % of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.*

When a rate is not published by CMS for the service we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.]

[MNRP payment option.]

- [Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
- If rates have not been negotiated, then one of the following amounts:
 - ◆ Eligible Expenses are determined based on [110 - 200] % of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
 - ◆ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
 - ▶ For services other than Pharmaceutical Products, we use a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by *Ingenix, Inc.* If the *Ingenix, Inc.* relative value scale becomes no longer available, a comparable scale will be used. We and *Ingenix, Inc.* are related companies through common ownership by *UnitedHealth Group*.
 - ▶ For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

[¹Include when benefits are provided for either Mental Health Services or Substance Use Disorder Services.]

- ◆ When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge [¹, except that certain Eligible Expenses for [Mental Health Services] [and] [Substance Use Disorder Services] are based on 80% of the billed charge].
- ◆ [¹For [Mental Health Services] [and] [Substance Use Disorder Services] the Eligible Expense will be reduced by [5 - 30]% for Covered Health Services provided by a psychologist and by [5 - 40]% for Covered Health Services provided by a masters level counselor.]

We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.]

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health

Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

SERFF Tracking Number: UHLC-128524492 State: Arkansas
 Filing Company: UnitedHealthcare Insurance Company State Tracking Number:
 Company Tracking Number: SBN.OPT.I.11.AR AND SBN.NDF.I.11.AR
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: SBN.OPT.I.11.AR and SBN.NDF.I.11.AR
 Project Name/Number: SBN.OPT.I.11.AR and SBN.NDF.I.11.AR/SBN.OPT.I.11.AR and SBN.NDF.I.11.AR

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	06/28/2012
Bypass Reason:	Flesch Score - 54.9 OPT and 57.2 NDF Application - N/A PPACA - N/A		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	06/28/2012
Bypass Reason:	Flesch Score - 50.2 Application - N/A		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	06/28/2012
Bypass Reason:	Not applicable		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter SBN.OPT.I.11.AR and SBN.NDF.I.11.AR	Approved-Closed	06/28/2012

Comments:

Attachment:
SBN.OPT_NDF.I.11.AR CovLtr.pdf

		Item Status:	Status Date:
	Redline Comparison to previously	Approved-Closed	

SERFF Tracking Number: UHLC-128524492 State: Arkansas
Filing Company: UnitedHealthcare Insurance Company State Tracking Number:
Company Tracking Number: SBN.OPT.I.11.AR AND SBN.NDF.I.11.AR
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: SBN.OPT.I.11.AR and SBN.NDF.I.11.AR
Project Name/Number: SBN.OPT.I.11.AR and SBN.NDF.I.11.AR/SBN.OPT.I.11.AR and SBN.NDF.I.11.AR
Satisfied - Item: approved OPTIONS PPO SBN 06/28/2012

Comments:

Attachments:

SBN-Medical-INS-2011-Options rev1 REDLINE.pdf
SBN-Medical-INS-2011-Non-Differential rev1 REDLINE.pdf



June 26, 2012

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

Re: UnitedHealthcare Insurance Company
NAIC No. 79413
Schedule of Benefits
Group Health Forms: SBN.OPT.I.11.AR and SBN.NDF.I.11.AR
Flesch Score: 54.9 and 57.2

Dear Ms. Minor:

On behalf of UnitedHealthcare Insurance Company I am submitting the enclosed group health form for your Department's review and approval. The documents are revised forms, being filed to replace previously approved forms in your state. Our intent is to use this form for large and small employer groups. These new forms incorporate revised language to correct Prior Authorization language for benefits listed as Mandated Covered benefits and a correction to dental anesthesia services. Redlines showing changes is attached under supporting documentation.

If you have any questions or concerns regarding this submission, please feel free to call me at the number shown below.

Sincerely,

Kelly Smith
UnitedHealthcare Insurance Company
800 King Farm Boulevard
Rockville, MD 20850
Toll free: 240-632-8061
Email: kelly_smith@uhc.com

UnitedHealthcare [Options PPO]

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

[Designated network benefits are variable for several benefit categories. Include references throughout the schedule as needed when designated network benefits are available for any category.]

You can choose to receive [Designated Network Benefits,] Network Benefits or Non-Network Benefits.

[Designated Network Benefits] apply to Covered Health Services that are provided by a Network Physician or other provider that we have identified as a Designated Facility or Physician. Designated Network Benefits are available only for specific Covered Health Services as identified in the *Schedule of Benefits* table below.]

[Include if non-network RAPLs at a network facility are paid as network benefits.]

[Network Benefits] apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.]

[Include when non-network RAPLs and consultants at a network facility are paid as network benefits and when non-emergent network benefits for these services provided by non-network providers will not be paid at billed charges.]

[Network Benefits] apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. Network Benefits also apply to Covered Health Services that are provided at a Network facility by a non-Network [radiologist] [,] [or] [anesthesiologist] [,] [or] [pathologist] [,] [or] [consulting Physician] [,] [or] [neonatologist] [,] [or] [intensivist] [,] [or] [assistant surgeon] [or] [surgical assistant], however such Covered Health Services, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. As a result you will be responsible for the difference between the amount billed by the provider and the amount we determine to be an Eligible Expense for reimbursement.]

[Include when non-network RAPLs and consultants at a network facility are paid as non-network benefits.]

[Network Benefits] apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility. Emergency Health Services are always paid as Network Benefits.]

[Include when non-network RAPLs and consultants at either a network or non-network facility are paid as non-network benefits.]

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. [Covered Health Services, when not Emergency Health Services, provided in a Network facility by a non-Network [radiologist] [,] [or] [anesthesiologist] [,] [or] [pathologist] [,] [or] [consulting Physician] [,] [or] [neonatologist] [,] [or] [intensivist] [,] [or] [assistant surgeon] [or] [surgical assistant] will be paid as Non-Network Benefits.]

[Include when the enhanced benefits program is sold.]

[You may have an opportunity to elect to receive Covered Health Services from certain Network providers that we've identified as Designated Physicians or Designated Facilities. When you choose to seek care from certain Designated providers, the level of Benefits available to you is enhanced. You can determine the specific situations for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[¹Include when shared savings program applies.]

Depending on the geographic area and the service you receive, you may have access [¹through our [Shared Savings Program]] to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less [¹when you receive Covered Health Services from [Shared Savings Program] providers than from other non-Network providers] because the Eligible Expense may be a lesser amount.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a [UnitedHealthcare] Policy. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

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

Prior Authorization

[¹Include when network providers are responsible for prior authorization for network benefits.]

We require prior authorization for certain Covered Health Services. [In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization.] Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

[¹We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.]

When you choose to receive certain Covered Health Services [¹from non-Network providers], you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number for *Customer Care* on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to determine how far in advance you must obtain prior authorization.

[Include bracketed variable benefit category listed below if: a) the benefit is included in the plan design and b) prior authorization is required. Include dollar amounts as applicable.]

- [_____]
- Ambulance - non-emergent air and ground.
- Clinical trials.
- [Congenital heart disease surgery.]
- [Dental services - accidental.]
- Dental services - anesthesia and hospitalization
- [Diabetes equipment - insulin pumps [over \$[1,000 - 5,000]].]
- [Durable Medical Equipment [over \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)].]
- [Medical Foods.]

[Include when prior authorization is required for only BRCA genetic testing.]

- [Genetic Testing - BRCA.]

[Include when prior authorization is required for all genetic testing.]

- [Genetic Testing, including BRCA Genetic Testing.]
- [Hearing aids [that exceed \$[1,000 - 5,000] in retail purchase cost].]
- [Home health care.]
- [Hospice care - inpatient.]
- Hospital inpatient care - all scheduled admissions [and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery].
- [Infertility services.]
- In vitro fertilization services.
- [Lab, X-ray and diagnostics - sleep studies.]
- [Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA, Nuclear Medicine and Capsule Endoscopy.]

[Include when group purchases benefits for musculoskeletal disorders.]

- [Musculoskeletal disorders of the face neck or head.]
-
- [Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.]
- [Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), Intensive

Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management [; Applied Behavioral Analysis (ABA)].]

- [Obesity surgery.]

. ¹Include if notification applies only to orthotics that exceeds a specific dollar amount and insert appropriate dollar amount.

- Orthotics devices [¹over\$[1,000-5,000]].
- [Pain management.]
- [Pharmaceutical Products - IV infusions only.]
- [Certain Pharmaceutical Products. You may determine whether a particular Pharmaceutical Product requires authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

. ¹Include if notification applies only to prosthetics that exceed a specific dollar amount and insert appropriate dollar amount.

- Prosthetic devices [¹over \$[1,000 - 5,000]].]
- Reconstructive procedures, including breast reconstruction surgery following mastectomy [and breast reduction surgery].
- [Rehabilitation services [and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy].]
- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- [Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.]

¹Do not include pain management procedures if prior authorization is required for all pain management services above.]

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [¹pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgeries]].]
- [Temporomandibular joint services.]
- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound]].]
- Transplants.
- [Ventricular assist device implantation. You must obtain prior authorization as soon as the possibility of implantation arises except in cases of Emergency implantations of partial assist devices.]

[Include paragraph below if plan includes ability to determine alternate levels of benefits.]

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

[As we determine, if one or more alternative health services that meets the definition of a Covered Health Service in the *Certificate* under *Section 9: Defined Terms* are clinically appropriate and not more costly than an alternative health service that is at least as likely to produce equivalent therapeutic or diagnostic results as to their prevention, diagnosis or treatment of a Sickness, Injury, [Mental Illness,] [mental illness,] substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on *Generally Accepted Standards of Medical Practice*, which for some Covered Health Services may be addressed in our clinical policies. After you contact us for prior authorization, we will identify the Benefit level available to you.

These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.]

[¹Include when network providers are responsible for prior authorization for network benefits.]

For all other services, [¹when you choose to receive services from non-Network providers,] we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.

[The Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

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

Benefit limits are calculated on a [calendar] [Policy] year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
<p><i>[Annual deductible is plan design variable. Include applicable provisions to support the following:</i></p> <p>¹<i>Annual deductible applies only to non-network benefits.</i></p> <p>²<i>Outpatient Prescription Drug Rider is sold and the annual deductible applies to any combination of medical and RX benefits.</i></p> <p>³<i>Outpatient Prescription Drug Rider with separate copayments for preventive medications is sold and the annual deductible does not apply to preventive medications.</i></p> <p>⁴<i>Outpatient Prescription Drug Rider is sold and when the annual deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the annual deductible.</i></p> <p>⁵<i>There is a deductible for designated and network benefits and the network and non-network amounts apply to the designated network and network annual deductible.</i></p> <p>⁶<i>Designated network benefits apply to any category.]</i></p> <p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive ¹Non-Network] Benefits. ²The Annual Deductible applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>. ³Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.] ⁴Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the <i>Outpatient Prescription Drug Rider</i> are not subject to payment of the Annual Deductible.] ⁵The Annual Deductible for ⁶Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drugs provided under the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include applicable provisions to support the following:</i></p> <p>¹<i>Day/visit limits are reduced by the number of days/visit used toward meeting the deductible.</i></p> <p>²<i>Carry-over provision applies.</i></p> <p>³<i>Roll-over provision applies in any circumstance.</i></p> <p>⁴<i>Roll-over provision applies only to groups changing from calendar to policy year. ⁵Include when roll-over applies only to the individual deductible.</i></p> <p>⁶<i>Include only when a per occurrence deductible applies.]</i></p> <p>¹Amounts paid toward the Annual Deductible for Covered</p>	<p>¹<i>Include separate network and non-network headings and statements when annual deductible provision applies separately.]</i></p> <p>²<i>Include when designated network benefits apply to any category and when the designated network and network deductible is combined.]</i></p> <p>³<i>Include when designated network and network are separate.]</i></p> <p>¹ ² Designated Network and] Network] ³ Designated Network]</p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p> <p>[No Annual Deductible.]</p> <p>³ Network]</p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered</p>

Payment Term And Description	Amounts
<p>Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.]</p> <p>[²Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.]</p> <p>[³When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.]</p> <p>[⁴When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [⁵This roll-over feature applies only to the individual Annual Deductible.]]</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>[⁶The Annual Deductible does not include any applicable Per Occurrence Deductible.]</p>	<p>Persons in a family.]</p> <p>[No Annual Deductible.]</p> <p>[¹ Non-Network]</p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p> <p>[No Annual Deductible.]</p> <p><i>¹⁴Include the combined network and non-network heading and statements when annual deductible provision applies separately to combined network and non-network benefits.</i></p> <p><i>⁵Include when designated network benefits apply to any category.]</i></p> <p>[⁶ Designated Network,] Network and Non-Network]</p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p>
<p>[Per occurrence deductible is plan design variable.]</p>	

Payment Term And Description	Amounts
<p>[Per Occurrence Deductible]</p> <p>[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services.</p> <p>You are responsible for paying the lesser of the following:</p> <ul style="list-style-type: none"> • The applicable Per Occurrence Deductible. • The Eligible Expense.] 	<p>[When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.]</p>
<p>Out-of-Pocket Maximum</p> <p><i>[Out-of-pocket maximum is plan design variable. Include applicable provisions to support the following:</i></p> <p>¹<i>Includes the annual deductible.</i></p> <p>²<i>Includes the per occurrence deductible.</i></p> <p>³<i>Includes copayments.</i></p> <p>⁴<i>Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.</i></p> <p>⁵<i>OOPM applies to designated and network benefits and the network and non-network amounts paid under the RX rider apply to the designated network and the network OOPM.</i></p> <p>⁶<i>Include bracketed designated network reference when designated network benefits apply to any category.]</i></p> <p>The maximum you pay per year for [¹the Annual Deductible,] [²the Per Occurrence Deductible,] [³Copayments] [¹⁻²⁻³or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [⁴The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.] [⁵The Out-of-Pocket Maximum for [⁶Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when plan design does not apply all copayments/coinsurance to the OOPM.]</i></p> <p>[[Copayments] [and] [Coinsurance] for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Maximum does not include any of the</p>	<p>¹<i>Include separate network and non-network headings and statements when OOPM provision applies separately.]</i></p> <p>²<i>Include when designated network benefits apply to any category and when the designated network and network OOPM is combined.]</i></p> <p>³<i>Include when designated network and network are separate.]</i></p> <p>[¹ [² Designated Network and] Network] [³ Designated Network]</p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p>

Payment Term And Description	Amounts
<p>following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> Any charges for non-Covered Health Services. <p><i>[Include bullet if prior authorization requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.]</i></p> <ul style="list-style-type: none"> [The amount Benefits are reduced if you do not obtain prior authorization as required.] Charges that exceed Eligible Expenses. Copayments or Coinsurance for any Covered Health Service identified in the <i>Schedule of Benefits</i> table that does not apply to the Out-of-Pocket Maximum. <p><i>[Include when an Outpatient Prescription Drug Rider is sold and copayments/coinsurance do not apply to the overall OOPM.]</i></p> <ul style="list-style-type: none"> [Copayments or Coinsurance for Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.] 	<p>[No Out-of-Pocket Maximum.]</p> <p>² Network</p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p>[No Out-of-Pocket Maximum.]</p> <p>¹ Non-Network</p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes</p>

Payment Term And Description	Amounts
	<p>the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p>[No Out-of-Pocket Maximum.]</p> <p>¹⁴Include combined network and non-network heading and statements below when OOPM provision applies to combined network and non-network benefits and delete the separate "Network" and "Non-Network" provisions above.]</p> <p>¹⁵Include when designated network benefits apply to any category.]</p> <p>[¹⁶ Designated Network,] Network and Non-Network]</p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p>[No Out-of-Pocket Maximum.]</p>
<p>[Annual maximum benefit is plan design variable. Include applicable provisions to support the following:</p> <p>¹Outpatient Prescription Drug Rider is sold.]</p> <p>[Annual Maximum Benefit]</p>	

Payment Term And Description	Amounts
<p>[The maximum amount we will pay for Benefits during the year.] [¹The Annual Maximum Benefit applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.]</p>	<p>¹ <i>Include separate network and non-network headings and statements when the annual maximum benefit applies separately.</i></p> <p>² <i>Include when designated network benefits apply to any category and when the designated network and network maximum is combined.</i></p> <p>³ <i>Include when designated network and network are separate.</i></p> <p>⁴ <i>Include when combined network and non-network maximums apply.</i></p> <p>[¹ ² Designated Network and Network] [³ Designated Network]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p> <p>[No Annual Maximum Benefit.]</p> <p>[³ Network]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p> <p>[No Annual Maximum Benefit.]</p> <p>[¹ Non-Network]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p> <p>[No Annual Maximum Benefit.]</p> <p>[¹ ² Designated Network,] Network and Non-Network]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p>
Copayment	
<p>Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.</p> <p>[For Pharmaceutical Products, your Copayments are determined by the tier to which the Pharmaceutical Product List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]</p> <p>Please note that for Covered Health Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> • The applicable Copayment. • The Eligible Expense. <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	

Payment Term And Description	Amounts
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.	
[For Pharmaceutical Products, your Coinsurance is determined by the tier to which the Pharmaceutical Product List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]	
Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.	

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design.]

[Include the following variables according to plan design:

- *Benefit limits and levels.*
- *Prior authorization requirements and any penalty for failure to prior authorize*
- *Designated network benefit levels as applicable.*
- *Any other specific conditions for coverage described within the category.]*

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
1. [Acupuncture Services]			
[Limited to [10 - 100] treatments per year.]	[Network] [[50 - 100] %]	[Yes] [No]	[Yes] [No]
[Limited to [10 - 100] treatments per year, not to exceed \$[100 - 5,000] in Eligible Expenses per year.]	[100% after you pay a Copayment of \$[5 - 75] per visit]	[Yes, when Benefits are subject to Coinsurance]	[Yes, when Benefits are subject to Coinsurance]
[Limited to \$[100 - 5,000] in Eligible Expenses per year.]	[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90] % for any subsequent visits in that year]		[Yes, after the Per Occurrence Deductible of \$[5 - 75] per visit is satisfied]
	[Non-Network] [[50 - 100] %]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of \$[5 - 75] per visit]	[Yes, when Benefits are subject to	[Yes, when Benefits are subject to

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.</p>	<p>to a per day maximum of \$[2,500 - 10,000]]</p> <p>Non-Network Same as Network</p> <p>Network <i>Ground Ambulance:</i> [[50 - 100] %] [100% after you pay a Copayment of \$[25 - 300] per transport] [100% after you pay a Copayment of \$[300 - 1,000] per day] [100% after you pay a Copayment of \$[300 - 1,000] per day, up to a per day maximum of \$[300 - 1,000]]</p> <p><i>Air Ambulance:</i> [[50 - 100] %] [100% after you pay a Copayment of \$[25 - 2,500] per transport] [100% after you pay a Copayment of \$[2,500 - 10,000] per day] [100% after you pay a Copayment of \$[2,500 - 10,000] per day, up to a per day maximum of \$[2,500 - 10,000]]</p> <p>Non-Network Same as Network</p>	<p>Same as Network</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>Same as Network</p>	<p>Same as Network</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 1,000] per [transport] [day] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 10,000] per [transport] [day] is satisfied]</p> <p>Same as Network</p>
<p>[3.] Clinical Trials</p>			

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Prior Authorization Requirement</p> <p>You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
<p>Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i>.</p> <p>Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)</p>	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
<p>[4.] [Congenital Heart Disease Surgeries]</p>			
<p>[Prior Authorization Requirement]</p> <p>[For Designated Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you do not obtain prior authorization and if, as a result, the CHD services are not performed at a Designated Facility, Designated Network Benefits will not be paid.] [Non-Network Benefits will apply.]</p> <p><i>¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.</i></p> <p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
<p>[Designated Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac</p>	<p>[Designated Network]</p> <p>[[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p> <p>[Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p> <p>[For Network Benefits, CHD surgeries must be received at a Designated Facility.</p> <p>Non-Network Benefits include services provided at a Network facility that is not a Designated Facility and services provided at a non-Network facility.</p> <p>Non-Network Benefits under this section include only the CHD surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>	<p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p>[Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p>[Non-Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 -</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	2,000] per Inpatient Stay] [100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]		Stay] is satisfied]
[5.] [Dental Services - Accident Only]			
<p align="center">[Prior Authorization Requirement]</p> <p>[For Network and Non-Network Benefits you must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
[Limited to \$[2,000 - 5,000] per year. Benefits are further limited to a maximum of \$[500 - 1,500] per tooth.]	<p>[Network] [[50 - 100]%] [100% after you pay a Copayment of \$[5 - 75] per visit]</p> <p>[Non-Network] [Same as Network]</p>	<p>[Yes] [No]</p> <p>[Same as Network]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 75] per visit is satisfied]</p> <p>[Same as Network]</p>
[6.] Diabetes Services			

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Prior Authorization Requirement			
<p>¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</p>			
<p>³Include when the durable medical equipment benefit is sold.]</p>			
<p>⁴Include when the durable medical equipment benefit is not sold.]</p>			
<p>[¹For Non-Network Benefits you] [²You] must obtain prior authorization before obtaining any [³Durable Medical Equipment] [⁴diabetes equipment] for the management and treatment of diabetes [that exceeds \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p>			
<p>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</p>	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
<p>Diabetes Self-Management Items</p> <p>Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under <i>Durable Medical Equipment</i>.</p> <p>[Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.]</p> <p>[Benefits for insulin pumps are limited to \$[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[two-</p>	<p>Network</p> <p>[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p>[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]</p> <p>[For diabetes equipment, Benefits will be the same as those stated under <i>Durable Medical Equipment</i>.</p> <p>For diabetes supplies the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to</p>		

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
five] years.]	<p>the Out-of-Pocket Maximum.]]</p> <p><i>[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]</p> <p>Benefits for diabetes supplies will be the same as those stated in the <i>Outpatient Prescription Drug Rider.</i></p> <p><i>[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps and diabetes supplies, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p>Non-Network</p> <p><i>[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]</i></p> <p>[Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider.</i></p> <p><i>[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]</i></p> <p>[For diabetes equipment, Benefits will be the same as those stated under <i>Durable Medical Equipment.</i></p> <p>For diabetes supplies the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p><i>[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to</p>		

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>the Out-of-Pocket Maximum.]</p> <p>Benefits for diabetes supplies will be the same as those stated in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps and diabetes supplies, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p>		
<p>[7.] [Durable Medical Equipment]</p>			
<p align="center">[Prior Authorization Requirement]</p> <p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization before obtaining any Durable Medical Equipment [that exceeds \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>[Limited to \$[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two - five] years]. [This limit does not apply to wound vacuums [, which are subject to a separate limit of \$[4,500 - 13,500] per year and limited to a single purchase (including repair/replacement) every [year] [[two - five] years]].]</p> <p>[Limited per year as follows:</p> <ul style="list-style-type: none"> • [[\$500 - 10,000] in Eligible Expenses for Tier 1. Tier 1 includes disposable supplies necessary for the effective use of covered Durable Medical Equipment.] • [[\$10,001 - 25,000] in Eligible Expenses for Tier 2.] 	<p>[Network]</p> <p>[[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per purchase is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<ul style="list-style-type: none"> • [25,001 - 100,000] in Eligible Expenses for Tier 3.] <p>These Tier limits include repair. Benefits for replacement are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].</p> <p>[Benefits are [further] limited to a single Mobility Device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair of the Mobility Device are limited to once every three years. We may, upon review, replace a defective Mobility Device rather than repair it. Benefits are not available for repair or replacement of a Mobility Device resulting from abuse, neglect or normal wear.]</p> <p>[Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every three years. Speech aid and tracheo-esophageal voice devices are [not] included in the annual limits stated above.]</p>	<p>[Non-Network]</p> <p>[[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per purchase is satisfied]</p>
<p>[8.] Emergency Health Services - Outpatient</p>			
<p>Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health</p>	<p>Network</p> <p>[[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.</p> <p>[In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed as an Emergency Health Service:</p> <ul style="list-style-type: none"> • [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient.</i>] • [Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</i>] • [Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient.</i>] • [Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>] • [Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>] • [Outpatient therapeutic 	<p>[100% after you pay a Copayment of \$[5 - 500] per visit. [If you are admitted as an inpatient to a Network Hospital [directly from the Emergency room] [within 24 hours of receiving outpatient Emergency treatment for the same condition], you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 100% after you pay a Copayment of \$[50 - 650] for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 100% after you pay a</p>	<p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 700] per visit is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<ul style="list-style-type: none"> procedures described under <i>Therapeutic Treatments - Outpatient.</i> [Rehabilitation therapy procedures described under <i>Rehabilitation Services - Outpatient Therapy</i> [and <i>Manipulative Treatment</i>.]] 	<p>Copayment of \$[50 - 650] per visit for the next [#] visits in a year; 100% after you pay a Copayment of \$[100 - 700] for any subsequent visits in that year</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 100% after you pay a Copayment of \$[50 - 650] per visit for the next [#] visits in a year; 100% after you pay a Copayment of \$[100 - 500] for the next [#] visits in a year; 100% after you pay a Copayment of \$[150 - 700] for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for a condition defined as an Emergency; 100% after you pay a Copayment of \$[50 - 650] per visit for a condition that does not meet the definition of an Emergency]</p> <p>Non-Network Same as Network</p>	<p>Same as Network</p>	<p>Same as Network</p>
<p><i>Include as standard for groups of 2 to 15 and 15+.</i></p> <p>[9.] Hearing Aids</p>			

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[Network Benefits are limited to [40 - 200] visits per year and Non-Network Benefits are limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.]</p> <p>[This visit limit does not include any service which is billed only for the administration of intravenous infusion.]</p>	<p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 50] per visit]</p>	<p>[Yes] [No]</p>	<p>satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per visit is satisfied]</p>
<p>[11.] Hospice Care</p>			
<p align="center">[Prior Authorization Requirement]</p> <p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid.]</p> <p>[In addition, [¹for Non-Network Benefits,] you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]</p>			
	<p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per day]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 -</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per day is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 -</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	of \$[100 - 10,000] per Inpatient Stay]		
[13.] [Infertility Services]			
[Prior Authorization Requirement] [You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Limited to \$[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [This limit includes Benefits for infertility medications provided under the <i>Outpatient Prescription Drug Rider.</i>] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under <i>Physician's Office Services - Sickness and Injury</i> below.]	[Designated Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Non-Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[14.] Lab, X-Ray and Diagnostics - Outpatient			
[Prior Authorization Requirement] ¹ Include when network providers are responsible for prior authorization for network benefits. ² Include when covered person is responsible for prior authorization for network benefits. [[¹ For Non-Network Benefits for] [² For] sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
Lab Testing - Outpatient:	[Designated Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No] [Yes, after the Per

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[[50 - 100]% at a free-standing lab]</p> <p>[[50 - 100]% at a Hospital-based lab]</p> <p>[[50 - 100]% at a Physician office-based lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a Hospital-based lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a Physician office-based lab]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at a free-standing lab]</p> <p>[[50 - 100]% at a Hospital-based lab]</p> <p>[[50 - 100]% at a Physician office-based lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a</p>	<p>[Yes] [No]</p>	<p>Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
X-Ray and Other Diagnostic Testing - Outpatient:	free-standing lab] [100% after you pay a Copayment of \$[5 - 100] per service at a Hospital-based lab] [100% after you pay a Copayment of \$[5 - 100] per service at a Physician office-based lab] Non-Network [[50 - 100]%] [100% after you pay a Copayment of \$[5 - 100] per service]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]
	[Designated Network] [[50 - 100]%] [[50 - 100]% at a free-standing diagnostic center] [[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of \$[5 - 100] per service] [100% after you pay a Copayment of \$[5 - 100] per service at a free-standing diagnostic center] [100% after you pay a Copayment of \$[5 - 100] per service at an outpatient Hospital-	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>based diagnostic center]</p> <p>Network</p> <p>[[50 - 100]%</p> <p>[[50 - 100]% at a free-standing diagnostic center]</p> <p>[[50 - 100]% at an outpatient Hospital-based diagnostic center]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing diagnostic center]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at an outpatient Hospital-based diagnostic center]</p> <p>Non-Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p>

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

[Prior Authorization Requirement]

¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>500] per service]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service at a free-standing diagnostic center]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service at an outpatient Hospital-based diagnostic center]</p> <p>Non-Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 500] per service is satisfied]</p>
<p><i>Include for groups that purchase Mental Health benefits.</i></p> <p><i>[Include as standard for groups of 2 to 15]</i></p> <p>¹<i>Include if group purchases SA benefits.</i></p> <p>[16.] Mental Health Services</p>			
<p align="center">[Prior Authorization Requirement]</p> <p>¹<i>Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits for] [²For] a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, [¹for Non-Network Benefits] you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible</p>			

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Expenses.]			
<p><i>[Limits will not apply to groups of 51+.]</i></p> <p>[Inpatient <i>Mental Health Services</i> are limited to [10 - 100] days per year.]</p> <p>[Outpatient <i>Mental Health Services</i> are limited to [10 - 100] visits per year.]</p> <p>[Non-Network Benefits for inpatient <i>Mental Health Services</i> are limited to [10 - 100] days per year.]</p> <p>[Non-Network Benefits for outpatient <i>Mental Health Services</i> are limited to [10 - 100] visits per year.]</p> <p>[Benefits for any combination of <i>Mental Health Services</i> described in this section and <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> described below are limited as follows:</p> <ul style="list-style-type: none"> • [10 - 100] days per year for inpatient <i>Mental Health Services</i> and <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>. • [10 - 100] visits per year for outpatient <i>Mental Health Services</i> and <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>.] <p>[Benefits for any combination of <i>Mental Health Services</i> described in this section and <i>Substance Use Disorder Services</i> described below are</p> 	<p>[Network]</p> <p><i>[Inpatient]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p><i>[Outpatient]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p> <p>[Non-Network]</p> <p><i>[Inpatient]</i></p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] <p>[Benefits for any combination of <i>Mental Health Services</i> described in this section and <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> and <i>Substance Use Disorder Services</i> described below are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] 	<p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p><i>[Outpatient]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>
<p>[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]</p>	<p>[Prior Authorization Requirement]</p>		

¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]

[[¹For Non-Network Benefits for] [²For] a scheduled admission for Neurobiological Disorders - Autism

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Spectrum Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, [1 for Non-Network Benefits] you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management [; Applied Behavioral Analysis].</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
<p>[Limits will not apply to groups of 51+.]</p> <p>[Inpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] days per year.]</p> <p>[Outpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] visits per year.]</p> <p>[Non-Network Benefits for inpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] days per year.]</p> <p>[Non-Network Benefits for outpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] visits per year.]</p> <p>[Benefits for any combination of Neurobiological Disorders - Autism Spectrum Disorder Services described in this section and Mental Health Services described above are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient Neurobiological Disorders - Autism Spectrum Disorder Services and Mental Health Services. 	<p>[Network]</p> <p>[Inpatient]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p>[Outpatient]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<i>when covered person is responsible for prior authorization for network benefits.]</i>			
<p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p>[In addition, [¹for Non-Network Benefits] you must contact us 24 hours before admission for an Inpatient Stay.]</p> <p>[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]</p>			
<p>[[Any combination of] [Designated Network Benefits] [[,] [and] [Network Benefits] [and Non-Network] Benefits [is] [are] limited to \$[40,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy. [Non-Network Benefits are further limited to \$[5,000 - 30,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]]</p> <p>[Non-Network Benefits include services provided at a Network facility that is not a Designated Facility and services provided at a non-Network facility.]</p>	<p>[Designated Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p> <p>[Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p> <p>[Non-Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p>		
[19.] [Ostomy Supplies]			
[Limited to \$[500 - 25,000] per year.]	<p>[Network]</p> <p>[[50 - 100]%</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per item is</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[Non-Network]</p> <p>[[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per item is satisfied]</p>
<p>[20.] Pharmaceutical Products - Outpatient</p>			
<p align="center">[Prior Authorization Requirement]</p> <p><i>¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p> <p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires prior authorization through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>			
<p>[The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. <p>When a Pharmaceutical Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.]</p>	<p>[Designated Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[0 - 75] per Tier 1 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[15 -</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per Pharmaceutical Product is satisfied]</p> <p>[Yes, except when provided during a Physician office visit]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>250] per Tier 2 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[20 - 450] per Tier 3 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[70 - 650] per Tier 4 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[100 - 750] per Tier 5 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[150 - 850] per Tier 6 Pharmaceutical Product]</p> <p>[[50 - 100]% - Tier 1]</p> <p>[[50 - 100]% - Tier 2]</p> <p>[[50 - 100]% - Tier 3]</p> <p>[[50 - 100]% - Tier 4]</p> <p>[[50 - 100]% - Tier 5]</p> <p>[[50 - 100]% - Tier 6]</p> <p>Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[0 - 75]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per Pharmaceutical Product is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	100] per Pharmaceutical Product] [100% after you pay a Copayment of \$[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a Copayment of \$[15 - 250] per Tier 2 Pharmaceutical Product] [100% after you pay a Copayment of \$[20 - 450] per Tier 3 Pharmaceutical Product] [100% after you pay a Copayment of \$[70 - 650] per Tier 4 Pharmaceutical Product] [100% after you pay a Copayment of \$[100 - 750] per Tier 5 Pharmaceutical Product] [100% after you pay a Copayment of \$[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]		Deductible of \$[5 - 100] per Pharmaceutical Product is satisfied] [Yes, except when provided during a Physician office visit]

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[21.] Physician Fees for Surgical and Medical Services			
<p>[When you choose to seek care [as a result of certain diagnoses or] from Designated Network Physicians as identified below, your Benefits will be enhanced as described:]</p> <p>[Specialties:]</p> <ul style="list-style-type: none"> • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] 	<p>[Designated Network] [[50 - 100]%</p> <p>Network [50 - 100]%</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 250] per service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 250] per service is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[Enhanced Benefits:]</p> <ul style="list-style-type: none"> [The Coinsurance you pay for Physician's Fees from a Designated Network Physician will be reduced to [0 - 50] % or \$[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of \$[10 - 1,000].] <p>[You can determine the specific services for which enhanced Benefits are available by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p> <p>[Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Non-Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]</p> <p>[Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]</p>	<p>Non-Network [50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 250] per service is satisfied]</p>
<p>[22.] Physician's Office Services - Sickness and Injury</p>			

[Prior Authorization Requirement]

[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]

[¹For Non-Network Benefits you] [²You] must obtain prior authorization as soon as is reasonably possible before [Genetic Testing - BRCA] [Genetic Testing, including BRCA Genetic Testing] is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[When you choose to seek care [as a result of certain diagnoses or] from Designated Network Physicians as identified below, your Benefits will be enhanced as described:]</p> <p>[Specialties:]</p> <ul style="list-style-type: none"> • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we 	<p>[\$5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the office visit]</p> <p>Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>provide designation.]</p> <p>[Enhanced Benefits:]</p> <ul style="list-style-type: none"> [The Copayment you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to \$[0 - 1,000]. [The maximum reduction in Copayments is \$[10 - 1,000].]] [The Coinsurance you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to [0 - 50] % or \$[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of \$[10 - 1,000].] <p>[You can determine the specific specialties for which enhanced Benefits are available by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p> <p>[In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office:</p> <ul style="list-style-type: none"> [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient.</i>] [Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and</i> 	<p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the office visit]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Nuclear Medicine - Outpatient.]</i></p> <ul style="list-style-type: none"> • [Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient.</i>] • [Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>] • [Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>] • [Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i>] • [Rehabilitation therapy procedures described under <i>Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].]</i>] 	<p>Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the office visit]</p>		
<p>¹Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude. ²If Maternity Services are excluded, Complications of Pregnancy</p>			

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>must always be included.]</i></p> <p>[23.] Pregnancy - [¹Maternity Services] [²Complications of Pregnancy only]</p>			
<p><i>[Include when benefits are provided for maternity services.]</i></p>			
<p align="center">[Prior Authorization Requirement]</p>			
<p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p>			
<p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
<p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p>			
<p align="center">[Prior Authorization Requirement]</p>			
<p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p>			
<p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before admission for scheduled admissions or within one business day or the same day, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
<p align="center">It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.</p>			
	<p><i>[Include when benefits are provided for maternity services. Bracketed text within is plan design variable.]</i></p> <p>[Network]</p> <p>[Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> [except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]]</p> <p>[Non-Network]</p> <p>[Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> [except that</p>		

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]]</p> <p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p> <p>[Network] [Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p> <p>[Non-Network] [Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p>		
[24.] Preventive Care Services			
<p>Physician office services</p> <ul style="list-style-type: none"> Well baby and well child care includes, but is limited to, 20 visits at approximately the following age intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years. <p>No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's immunizations.</p>	<p>Network 100%</p> <p>Non-Network [[50 - 100]%) [100% after you pay a Copayment of \$[5 - 100] per visit] [100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]%) for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]%) for a</p>	<p>No</p> <p>[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available except for children under the age of 19.]</p>	<p>No</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available except for children under the age of 19.]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Lab, X-ray or other preventive tests	<p>Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for immunizations when no other service is provided during the office visit.]</p> <p>[Non-Network Benefits are not available.]</p> <p>Network</p> <p>100%</p> <p>Non-Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p>	<p>No</p> <p>[Yes] [No]</p>	<p>No</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p>
<p><i>Prosthetics are a mandated benefit in Arkansas.</i></p> <p>[25.] Prosthetic Devices and Services</p>			
[Prior Authorization Requirement]			
<p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p>			
<p>[¹For Non-Network Benefits you] [²You] must obtain prior authorization before obtaining prosthetic devices [that exceed \$[1,000 - 5,000] in cost per device]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
Benefits for replacement are limited to a single purchase of each type of	[Network]		

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
prosthetic device every three years	[[50 - 100] %]	[Yes] [No]	[Yes] [No]
Benefits for replacement are limited to a single purchase of each type of prosthetic device every three years	[Non-Network] [[50 - 100] %]	[Yes] [No]	[Yes] [No]
[26.] Reconstructive Procedures			
<p>Prior Authorization Requirement</p> <p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, [¹for Non-Network Benefits] you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]</p>			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]</i></p> <p>[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]</i></p> <p>[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to</p>		

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
the Out-of-Pocket Maximum.]]			
[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]			
[Prior Authorization Requirement]			
<p>¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</p> <p>[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy] or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
<p>[Limited per year as follows:</p> <ul style="list-style-type: none"> • [[10 -100] visits of physical therapy.] • [[10 -100] visits of occupational therapy.] • [[10 -100] Manipulative Treatments.] • [[10 -100] visits of speech therapy.] • [[10 -100] visits of pulmonary rehabilitation therapy.] • [[10 -100] visits of cardiac rehabilitation therapy.] • [[10 -100] visits of post-cochlear implant aural therapy.] • [[10 - 100] visits of cognitive rehabilitation therapy.] • [[10 -100] visits of vision therapy.]] 	<p>[Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>
<p>[Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy,</p>	<p>[Non-Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p> <p>[Yes, when</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10 - 160] visits per year.]</p> <p>[Network Benefits for any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] are limited to [10 - 160] visits per year.]</p> <p>[Non-Network Benefits for any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] are limited to [10 - 160] visits per year.]</p>	<p>Copayment of \$[5 - 100] per visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p>	<p>Benefits are subject to Coinsurance]</p>	<p>Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>
<p>[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic</p>			
<p>[Prior Authorization Requirement]</p>			
<p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p>			
<p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at a free-standing center]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[[50 - 100]% at an outpatient Hospital-based center]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at a free-standing center]</p> <p>[[50 - 100]% at an outpatient Hospital-based center]</p> <p>Non-Network</p> <p>[50 - 100]%</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>
<p>[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</p>			
<p>Prior Authorization Requirement</p>			
<p><i>¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p>			
<p>[[¹For Non-Network Benefits for] [²For] a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, [¹for Non-Network Benefits] you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			
<p>[Limited to [40 - 180] days per year.]</p> <p>[Limited to:</p> <ul style="list-style-type: none"> • [30 - 180] days per year in a Skilled Nursing Facility. • [30 - 180] days per year in an Inpatient Rehabilitation Facility.] <p>[Network Benefits are limited to [40 - 180] days per year. Non-Network Benefits are limited to [40 - 180] days per year.]</p>	<p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[50 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[50 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[50 -</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>1,000] per day to a maximum Copayment of \$[50 - 5,000] per Inpatient Stay]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[50 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[50 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[50 - 1,000] per day to a maximum Copayment of \$[50 - 10,000] per Inpatient Stay]</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>
<p><i>[Include as standard for groups of 2 to 15]</i></p> <p>[30.] Substance Use Disorder Services</p>	<p>[Prior Authorization Requirement]</p>		
<p><i>¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits for] [²For] a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, [¹for Non-Network Benefits] you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
<p><i>[Limits will not apply to groups of 51+.]</i></p> <p>[Inpatient Substance Use Disorder</p>	<p>[Network]</p>		

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Services are limited to [10 - 100] days per year.]</p> <p>[Outpatient <i>Substance Use Disorder Services</i> are limited to [10 - 100] visits per year.]</p> <p>[Non-Network Benefits for inpatient <i>Substance Use Disorder Services</i> are limited to [10 - 100] days per year.]</p> <p>[Non-Network Benefits for outpatient <i>Substance Use Disorder Services</i> are limited to [10 - 100] visits per year.]</p> <p>[Benefits for any combination of <i>Substance Use Disorder Services</i> described in this section and <i>Mental Health Services</i> described above are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] 	<p>[Inpatient]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>
<p>[Benefits for any combination of <i>Substance Use Disorder Services</i> described in this section and <i>Mental Health Services</i> and <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> described above are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance</i> 	<p>[Outpatient]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgery]] you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]			
	<p><i>[Designated Network]</i></p> <p>[[50 - 100]%</p> <p>[[50 - 100]% at an ambulatory surgical center]</p> <p>[[50 - 100]% at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service at an ambulatory surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[10 - 1,000] per date of service is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as follows:]</p> <ul style="list-style-type: none"> [The Copayment you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [\$0 - 1,000]. [The maximum reduction in Copayments is \$[10 - 1,000].]] [The Coinsurance you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [0 - 50] % or \$[10 - 1,000] will be applied toward any applicable deductible if not already met, to a maximum of \$[10 - 1,000].] <p>[You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>	<p>Copayment of \$[10 - 5,000] per year at an ambulatory surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year at an outpatient Hospital-based surgical center]</p> <p>Network</p> <p>[[50 - 100]%</p> <p>[[50 - 100]% at an ambulatory surgical center]</p> <p>[[50 - 100]% at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service at an ambulatory surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 -</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[10 - 1,000] per date of service is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>5,000] per year]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year at an ambulatory surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year at an outpatient Hospital-based surgical center]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[10 - 1,000] per date of service is satisfied]</p>

[32.] Temporomandibular Joint Services

[Prior Authorization Requirement]

¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]

[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]

[In addition, [¹for Non-Network Benefits] you must contact us 24 hours before admission for scheduled

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
inpatient admissions.]			
[Limited to \$[1,000 - 20,000] per year.]	<p>[Network] [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p> <p>[Non-Network] [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p>		
[33.] Therapeutic Treatments - Outpatient			
[Prior Authorization Requirement]			
<p>¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</p>			
<p>[¹For Non-Network Benefits you] [²You] must obtain prior authorization [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require prior authorization: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound].] If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
	<p>[Designated Network] [[50 - 100]%] [[50 - 100]% at a free-standing center] [[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of \$[25 - 100] per treatment] [100% after you pay a Copayment of \$[25 - 100] per treatment at a free-standing center] [100% after you pay a</p>	[Yes] [No]	<p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[25 - 100] per treatment is satisfied]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Copayment of \$[25 - 100] per treatment at an outpatient Hospital-based center]</p> <p>Network</p> <p>[[50 - 100]%</p> <p>[[50 - 100]% at a free-standing center]</p> <p>[[50 - 100]% at an outpatient Hospital-based center]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment at a free-standing center]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment at an outpatient Hospital-based center]</p> <p>Non-Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 100] per treatment is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 100] per treatment is satisfied]</p>

[34.] Transplantation Services

Prior Authorization Requirement

For Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid. [Non-Network Benefits will apply.]

[For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
<p>^[1]Include when network providers are responsible for prior authorization for network benefits.]</p>			
<p>[In addition, ^[1]for Non-Network Benefits] you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			
<p>For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.</p> <p>[Non-Network Benefits are limited to \$[30,000 - 250,000] per transplant.]</p>	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
<p>[35.] Urgent Care Center Services</p>			
<p>[Limited to [2 - 10] visits per year.]</p> <p>[In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center:</p> <ul style="list-style-type: none"> [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient</i>.] [Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</i>.] [Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products -</i> 	<p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit to a maximum Copayment of \$[5 - 5,000] per year]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit for the</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 150] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Outpatient.]</i></p> <ul style="list-style-type: none"> • [Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>] • [Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>] • [Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i>] • [Rehabilitation therapy procedures described under <i>Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].]</i>] 	<p>first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit to a maximum Copayment of \$[5 - 5,000] per year]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 150] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	that year]		
[36.] [Vision Examinations]			
<p>[Limited to [1 exam] [[2-3] exams] per year.]</p> <p>[Limited to [1 exam] [[2-3] exams] every [2 - 3] years.]</p>	<p>[Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[Non-Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]		
[37.] [Wigs]			
[Limited to \$[100 - 1,000] per year.] [Limited to \$[100 - 5,000] every [24 - 36] months.]	[Network] [[50 - 100]%] [Non-Network] [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Additional Benefits Required By Arkansas Law			
[38.] Dental Services - Anesthesia and Hospitalization			
[Prior Authorization Requirement] [You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
	Network [Benefits will be the same as those stated under each Covered Health Service Category in this <i>Schedule of Benefits</i> .] Non-Network [Benefits will be the same as those stated under each Covered Health Service Category in this <i>Schedule of Benefits</i> .]		
[39.] In Vitro Fertilization Services			

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 Any applicable notification requirements will be the same as those stated under each Covered Health Service Category in this *Schedule of Benefits*.

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>¹Include applicable reduction in Benefits or no Benefits.</p> <p>[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
Limited to a lifetime maximum of \$15,000.	<p>Network</p> <p>[50 - 100]%</p> <p>Non-Network</p> <p>Same as Network</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>Same as Network</p> <p>[Non-Network Benefits are not available.]</p>	<p>Network</p> <p>[50 - 100]%</p> <p>Non-Network</p> <p>Same as Network</p> <p>[Non-Network Benefits are not available.]</p>

[40.] Medical Foods

¹Include applicable reduction in Benefits or no Benefits.

[Prior Authorization Requirement]

[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]

	<p>Network</p> <p>[50 - 100]%</p> <p>Non-Network</p> <p>Same as Network</p>	<p>[Yes] [No]</p> <p>Same as Network</p>	<p>Network</p> <p>[50 - 100]%</p> <p>Non-Network</p> <p>Same as Network</p>
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Mandated offer in Arkansas.

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

[Prior Authorization Requirement]

[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying

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You must notify us as soon as the possibility of the need for in vitro fertilization arises.

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

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
all charges and no Benefits will be paid.]			
	<p>[¹ Designated Network] [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.]</p> <p>[Network] [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.]</p>		
[[42.] Orthotic Devices and Services			
<p>Include if notification is required.</p> <p>¹Include when notification applies only to orthotics that exceeds a minimum dollar amount and insert applicable dollar amount.</p> <p>²Include applicable reduction in Benefits or no Benefits.</p>			
all charges and no Benefits will be paid.]			
all charges and no Benefits will be paid.]			
all charges and no Benefits will be paid.]			
Benefits for replacements are limited to a single purchase of each type of orthotic device every three years.	<p>Network [50 - 100%]</p> <p>Non-Network [50 - 100%]</p>	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

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Eligible Expenses

¹Include if non-network RAPLs and consultants at a network facility are paid as network benefits at less than billed charges.]

Eligible Expenses are the amount we determine that we will pay for Benefits. For [Designated Network Benefits and] Network Benefits [¹for Covered Health Services provided by a Network provider], you are not responsible for any difference between Eligible Expenses and the amount the provider bills. [For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by us), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below.] For Non-Network Benefits, you are responsible for paying,

directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

[Include if plan includes ability to determine alternate levels of benefits.]

[If one or more alternative health services that meets the definition of a Covered Health Service in the *Certificate* under *Section 9: Defined Terms* are clinically appropriate and not more costly than an alternative health service that is at least as likely to produce equivalent therapeutic or diagnostic results as to their prevention, diagnosis or treatment of a Sickness, Injury, [Mental Illness.] [mental illness.] substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on *Generally Accepted Standards of Medical Practice*, which for some Covered Health Services may be addressed in our clinical policies.]

For [Designated Network Benefits and] Network Benefits, Eligible Expenses are based on the following:

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

[Include if RAPLs and consultants are paid as network benefits at less than billed charges.]

- [For Covered Health Services received at a Network facility on a non-Emergency basis from a [radiologist] [,] [and] [anesthesiologist] [,] [and] [pathologist] [,] [and] [consulting Physician] [,] [and] [neonatologist] [,] [and] [intensivist] [,] [and] [assistant surgeon] [and] [surgical assistant], the Eligible Expense is based on [[110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market] [50 - 100]% of the provider's billed charge].

When a rate is not published by *CMS* for the service, we use a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by *Ingénue, Inc.* If the *Ingénue, Inc.* relative value scale becomes no longer available, a comparable scale will be used. We and *Ingénue, Inc.* are related companies through common ownership by *UnitedHealth Group*.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.]

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

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:

[PHCS payment option.]

^[1] *Include if RAPLs and consultants are paid as non-network benefits.]*

- [Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
- If rates have not been negotiated, then one of the following amounts:
 - ♦ For Covered Health Services other than Pharmaceutical Products ^[1] and services from the specific providers identified below], Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.

^[2] *Include when benefits are provided for either Mental Health Services or Substance Use Disorder Services.]*

If no fee information is available for a Covered Health Service, the Eligible Expense is based on [50 - 100]% of the provider's billed charge², except that certain Eligible Expenses for [Mental Health Services] [and] [Substance Use Disorder Services] are based on 80% of the billed charge.]

- ◆ ²For [Mental Health Services] [and] [Substance Use Disorder Services] the Eligible Expense will be reduced by [5 - 30]% for Covered Health Services provided by a psychologist and by [5 - 40]% for Covered Health Services provided by a masters level counselor.]
- ◆ When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [110 - 200] % of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

- ◆ ¹For Covered Health Services received on a non-Emergency basis from a [radiologist] [,] [and] [anesthesiologist] [,] [and] [pathologist] [,] [and] [consulting Physician] [,] [and] [neonatologist] [,] [and] [intensivist] [,] [and] [assistant surgeon] [and] [surgical assistant], the Eligible Expense is based on [[110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market] [50 - 100]% of the provider's billed charge].

When a rate is not published by *CMS* for the service, we use a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by *Ingenix, Inc.* If the *Ingenix, Inc.* relative value scale becomes no longer available, a comparable scale will be used. We and *Ingenix, Inc.* are related companies through common ownership by *UnitedHealth Group.*]]

[MNRP payment option.]

- [Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
- If rates have not been negotiated, then one of the following amounts:

¹Include if RAPLs and consultants are paid as non-network benefits.]

- ◆ [¹Except for services from the specific providers identified below,] Eligible Expenses are determined based on [110 - 200] % of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
- ◆ [¹For Covered Health Services received on a non-Emergency basis from a [radiologist] [,] [and] [anesthesiologist] [,] [and] [pathologist] [,] [and] [consulting Physician] [,] [and] [neonatologist] [,] [and] [intensivist] [,] [and] [assistant surgeon] [and] [surgical assistant], the Eligible Expense is based on [[110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market] [50 - 100]% of the provider's billed charge].
- ◆ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:

- ▶ For services other than Pharmaceutical Products, we use a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by *Ingenix, Inc.* If the *Ingenix, Inc.* relative value scale becomes no longer available, a comparable scale will be used. We and *Ingenix, Inc.* are related companies through common ownership by *UnitedHealth Group*.
- ▶ For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

^[2]Include when benefits are provided for either Mental Health Services or Substance Use Disorder Services.]

- ◆ When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge ^[2], except that certain Eligible Expenses for [Mental Health Services] [and] [Substance Use Disorder Services] are based on 80% of the billed charge].
- ◆ ^[2]For [Mental Health Services] [and] [Substance Use Disorder Services] the Eligible Expense will be reduced by [5 - 30]% for Covered Health Services provided by a psychologist and by [5 - 40]% for Covered Health Services provided by a masters level counselor.]

We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.]

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

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

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

You or your Network Physician must notify us of special service needs (such as transplants [[ventricular assist device implantation](#)] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

<p>Limited to a lifetime maximum of \$15,000.</p>	<p>Network [Benefits will be the same as those stated under each Covered Health Service Category in this <i>Schedule of Benefits</i>.]</p> <p>Non-Network [Benefits will be the same as those stated under each Covered Health Service Category in this <i>Schedule of Benefits</i>.]</p>
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Pre-service Notification Requirement

You must notify us as soon as the possibility of the need for in vitro fertilization arises.

[Depending upon where the Covered Health Service is provided, any applicable notification

the same as those stated under each Covered Health Service category in this *Schedule*

UnitedHealthcare [Non-Differential PPO]

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider regardless of their Network status. This Benefit plan does not provide a Network Benefit level or a Non-Network Benefit level.

We arrange for health care providers to participate in a Network. Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network provider, your Coinsurance level will remain the same. However, the portion that you owe may be less than if you received services from a non-Network provider because the Eligible Expense may be a lesser amount.

^[1]*Include when shared savings program applies.]*

Depending on the geographic area and the service you receive, you may have access ^[1]through our [Shared Savings Program] to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less ^[1]when you receive Covered Health Services from [Shared Savings Program] providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

You should show your identification card (ID card) every time you request health care services so that the provider knows that you are enrolled under a [UnitedHealthcare] Policy.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

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

Prior Authorization

We require prior authorization for certain Covered Health Services. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

When you choose to receive certain Covered Health Services, you are responsible for obtaining prior authorization before you receive these services. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number for *Customer Care* on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to determine how far in advance you must obtain prior authorization.

[Include bracketed variable benefit category listed below if: a) the benefit is included in the plan design and b) prior authorization is required. Include dollar amounts as applicable.]

- [_____]
- Ambulance - non-emergent air and ground.
- Clinical trials.
- [Congenital heart disease surgery.]
- [Dental services - accidental.]
- Dental services - anesthesia and hospitalization
- [Diabetes equipment - insulin pumps [over \$[1,000 - 5,000]].]
- [Durable Medical Equipment [over \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)].]
- [Medical Foods.]

[Include when prior authorization is required for only BRCA genetic testing.]

- [Genetic Testing - BRCA.]

[Include when prior authorization is required for all genetic testing.]

- [Genetic Testing, including BRCA Genetic Testing.]
- [Hearing aids [that exceed \$[1,000 - 5,000] in retail purchase cost].]
- [Home health care.]
- [Hospice care - inpatient.]
- Hospital inpatient care - all scheduled admissions [and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery].
- [Infertility services.]
- In vitro fertilization services.
- [Lab, X-ray and diagnostics - sleep studies.]
- [Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA, Nuclear Medicine and Capsule Endoscopy.]

[Include when group purchases benefits for musculoskeletal disorders.]

- [Musculoskeletal disorders of the face neck or head.]
- [Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.]
- [Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond

45 - 50 minutes in duration, with or without medication management [; Applied Behavioral Analysis (ABA)].]

- [Obesity surgery.]

. ¹Include if notification applies only to orthotics that exceeds a specific dollar amount and insert appropriate dollar amount.

- Orthotics devices [¹over\$[1,000-5,000]].
- [Pain management.]
- [Pharmaceutical Products - IV infusions only.]
- [Certain Pharmaceutical Products. You may determine whether a particular Pharmaceutical Product requires authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

¹Include if notification applies only to prosthetics that exceed a specific dollar amount and insert appropriate dollar amount.

- Prosthetic devices [¹over \$[1,000 - 5,000]].]
- Reconstructive procedures, including breast reconstruction surgery following mastectomy [and breast reduction surgery].
- [Rehabilitation services [and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy].]
- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- [Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.]

¹Do not include pain management procedures if prior authorization is required for all pain management services above.]

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [¹pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgeries]].]
- [Temporomandibular joint services.]
- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound]].]
- Transplants.
- [Ventricular assist device implantation. You must obtain prior authorization as soon as the possibility of implantation arises except in cases of Emergency implantations of partial assist devices.]

[Include paragraph below if plan includes ability to determine alternate levels of benefits.]

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

[As we determine, if one or more alternative health services that meets the definition of a Covered Health Service in the *Certificate* under *Section 9: Defined Terms* are clinically appropriate and not more costly than an alternative health service that is at least as likely to produce equivalent therapeutic or diagnostic results as to their prevention, diagnosis or treatment of a Sickness, Injury, [Mental Illness,] [mental illness,] substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on *Generally Accepted Standards of Medical Practice*, which for some Covered Health Services may be addressed in our clinical policies. After you contact us for prior authorization, we will identify the Benefit level available to you.

These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.]

For all other services, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.

[The Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

Benefit limits are calculated on a [calendar] [Policy] year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
<p>Annual Deductible</p> <p><i>[Annual deductible is plan design variable. Include applicable provisions to support the following:</i></p> <p>¹<i>Outpatient Prescription Drug Rider is sold and the annual deductible applies to any combination of medical and RX benefits.</i></p> <p>²<i>Outpatient Prescription Drug Rider with separate copayments for preventive medications is sold and the annual deductible does not apply to preventive medications.</i></p> <p>³<i>Outpatient Prescription Drug Rider is sold and when the annual deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the annual deductible.</i></p> <p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. [The Annual Deductible applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>. [²Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [³Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the <i>Outpatient Prescription Drug Rider</i> are not subject to payment of the Annual Deductible.]</p> <p><i>[Include applicable provisions to support the following:</i></p> <p>¹<i>Day/visit limits are reduced by the number of days/visit used toward meeting the deductible.</i></p> <p>²<i>Carry-over provision applies.</i></p> <p>³<i>Roll-over provision applies in any circumstance.</i></p> <p>⁴<i>Roll-over provision applies only to groups changing from calendar to policy year.</i> ⁵<i>Include when roll-over applies only to the individual deductible.</i></p> <p>⁶<i>Include only when a per occurrence deductible applies.]</i></p> <p>[¹Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.]</p> <p>[²Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.]</p> <p>[³When a Covered Person was previously covered under a</p>	<p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p> <p>[No Annual Deductible.]</p>

Payment Term And Description	Amounts
<p>group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.]</p> <p>[⁴When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [⁵This roll-over feature applies only to the individual Annual Deductible.]]</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>[⁶The Annual Deductible does not include any applicable Per Occurrence Deductible.]</p>	
<p><i>[Per occurrence deductible is plan design variable.]</i></p> <p>[Per Occurrence Deductible]</p>	
<p>[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services.</p> <p>You are responsible for paying the lesser of the following:</p> <ul style="list-style-type: none"> • The applicable Per Occurrence Deductible. • The Eligible Expense.] 	<p>[When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.]</p>
<p>Out-of-Pocket Maximum</p>	

Payment Term And Description	Amounts
<p><i>[Out-of-pocket maximum is plan design variable. Include applicable provisions to support the following:</i></p> <p>¹<i>Includes the annual deductible.</i></p> <p>²<i>Includes the per occurrence deductible.</i></p> <p>³<i>Includes copayments.</i></p> <p>⁴<i>Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.</i></p> <p>The maximum you pay per year for [¹the Annual Deductible,] [²the Per Occurrence Deductible,] [³Copayments] [¹⁻²⁻³or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [⁴The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when plan design does not apply all copayments/coinsurance to the OOPM.]</i></p> <p>[[Copayments] [and] [Coinsurance] for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> Any charges for non-Covered Health Services. <p><i>[Include bullet if prior authorization requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.]</i></p> <ul style="list-style-type: none"> [The amount Benefits are reduced if you do not obtain prior authorization as required.] Charges that exceed Eligible Expenses. Copayments or Coinsurance for any Covered Health Service identified in the <i>Schedule of Benefits</i> table that does not apply to the Out-of-Pocket Maximum. <p><i>[Include when an Outpatient Prescription Drug Rider is sold and copayments/coinsurance do not apply to the overall OOPM.]</i></p> <ul style="list-style-type: none"> [Copayments or Coinsurance for Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.] 	<p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p>[No Out-of-Pocket Maximum.]</p>
<p><i>[Annual maximum benefit is plan design variable. Include applicable provisions to support the following:</i></p>	

Payment Term And Description	Amounts
<p>¹<i>Outpatient Prescription Drug Rider is sold.</i></p> <p>[Annual Maximum Benefit]</p>	
<p>[The maximum amount we will pay for Benefits during the year.] ¹[The Annual Maximum Benefit applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.]</p>	<p>[\$[2,000 - 2,500,000] per Covered Person.]</p>

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

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

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

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

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

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design.]

[Include the following variables according to plan design:

- *Benefit limits and levels.*
- *Prior authorization requirements and any penalty for failure to prior authorize*

- Any other specific conditions for coverage described within the category.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
1. [Acupuncture Services]			
[Limited to [10 - 100] treatments per year.] [Limited to [10 - 100] treatments per year, not to exceed \$[100 - 5,000] in Eligible Expenses per year.] [Limited to \$[100 - 5,000] in Eligible Expenses per year.]	[[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 75] per visit is satisfied]
[2.] Ambulance Services			
Prior Authorization Requirement			
<p>In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
Emergency Ambulance	<i>Ground Ambulance:</i> [[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[25 - 1,000] per [transport] [day] is satisfied]
	<i>Air Ambulance:</i> [[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[25 - 10,000] per [transport] [day] is satisfied]
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	<i>Ground Ambulance:</i> [[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[25 - 1,000] per [transport] [day] is satisfied]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Air Ambulance: [[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[25 - 10,000] per [transport] [day] is satisfied]
[3.] Clinical Trials			
<p align="center">Prior Authorization Requirement</p> <p>You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i> .	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
[4.] [Congenital Heart Disease Surgeries]			
<p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
	[[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]
[5.] [Dental Services - Accident Only]			
<p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
[Limited to \$[2,000 - 5,000] per year. Benefits are further limited to a	[[50 - 100]%	[Yes] [No]	[Yes] [No]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
maximum of \$[500 - 1,500] per tooth.]			[Yes, after the Per Occurrence Deductible of \$[5 - 75] per visit is satisfied]
[6.] Diabetes Services			
<i>[¹Include when the durable medical equipment benefit is sold.]</i>			
<i>[²Include when the durable medical equipment benefit is not sold.]</i>			
<p>Prior Authorization Requirement</p> <p>You must obtain prior authorization before obtaining any [¹Durable Medical Equipment] [²diabetes equipment] for the management and treatment of diabetes [that exceeds \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p>			
<p>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</p> <p>Diabetes Self-Management Items</p> <p>Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under <i>Durable Medical Equipment</i>.</p> <p><i>[Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.]</i></p> <p>[Benefits for insulin pumps are limited to \$[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[two-five] years].]</p>	<p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]</i></p> <p>[Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]</i></p> <p>[For diabetes equipment, Benefits will be the same as those stated under <i>Durable Medical Equipment</i>.</p> <p>For diabetes supplies the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p><i>[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]</p> <p>Benefits for diabetes supplies will be the same as those stated</p>		

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps and diabetes supplies, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p>		
[7.] [Durable Medical Equipment]			
<p>[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization before obtaining any Durable Medical Equipment [that exceeds \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>[Limited to \$[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two - five] years]. [This limit does not apply to wound vacuums [, which are subject to a separate limit of \$[4,500 - 13,500] per year and limited to a single purchase (including repair/replacement) every [year] [[two - five] years]].]</p> <p>[Limited per year as follows:</p> <ul style="list-style-type: none"> • [[\$[500 - 10,000] in Eligible Expenses for Tier 1. Tier 1 includes disposable supplies necessary for the effective use of covered Durable Medical Equipment.] • [[\$[10,001 - 25,000] in Eligible Expenses for Tier 2.] • [[\$[25,001 - 100,000] in Eligible Expenses for Tier 3.] <p>These Tier limits include repair. Benefits for replacement are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].]</p> <p>[Benefits are [further] limited to a single Mobility Device during the entire</p>	[[50 - 100]%	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per purchase is satisfied]</p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>period of time a Covered Person is enrolled under the Policy. Benefits for repair of the Mobility Device are limited to once every three years. We may, upon review, replace a defective Mobility Device rather than repair it. Benefits are not available for repair or replacement of a Mobility Device resulting from abuse, neglect or normal wear.]</p> <p>[Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every three years. Speech aid and tracheo-esophageal voice devices are [not] included in the annual limits stated above.]</p>			
[8.] Emergency Health Services - Outpatient			
	[[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 700] per visit is satisfied]
<i>Include as standard for groups of 2 to 15 and 15+.</i>			
[9.] Hearing Aids			
[Prior Authorization Requirement]			
[You must obtain prior authorization before obtaining a hearing aid [that exceeds \$[1,000 - 5,000] in retail purchase cost]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
<p>Limited to \$[2,800 - 5,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[three-five] years].]</p> <p><i>To be removed for HSA plans.</i></p> <p>[No Copayment, Coinsurance or Deductible will be applicable to</p>	[[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[50 - 1,000] per device is satisfied]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Network or non-Network Hearing Aid Coverage.]			
[10.] Home Health Care			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
<p>[Limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.]</p> <p>[Limited to [40 - 200] visits per year to a maximum of \$[500 - 5,000] in Eligible Expenses per year.]</p> <p>[This visit limit does not include any service which is billed only for the administration of intravenous infusion.]</p>	[[50 - 100] %]	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per visit is satisfied]</p>
[11.] Hospice Care			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p align="center">[In addition, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]</p>			
	[[50 - 100] %]	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per day is satisfied]</p>
[12.] Hospital - Inpatient Stay			
<p align="center">Prior Authorization Requirement</p> <p>For a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]
[13]. [Infertility Services]			
[Prior Authorization Requirement]			
[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Limited to \$[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [This limit includes Benefits for infertility medications provided under the <i>Outpatient Prescription Drug Rider</i> .] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under <i>Physician's Office Services - Sickness and Injury</i> below.]	[[50 - 100]%	[Yes] [No]	[Yes] [No]
[14.] Lab, X-Ray and Diagnostics - Outpatient			
[Prior Authorization Requirement]			
[For sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
Lab Testing - Outpatient:	[[50 - 100]%	[Yes] [No]	[Yes] [No]
	[[50 - 100]% at a free-standing lab]		[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]
	[[50 - 100]% at a Hospital-based lab]		
	[[50 - 100]% at a Physician office-based lab]		
X-Ray and Other Diagnostic Testing - Outpatient:	[[50 - 100]%	[Yes] [No]	[Yes] [No]
	[[50 - 100]% at a free-standing diagnostic		[Yes, after the Per Occurrence

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	center] [[50 - 100]% at an outpatient Hospital-based diagnostic center]		Deductible of \$[5 - 100] per service is satisfied]
[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
	[[50 - 100]%] [[50 - 100]% at a free-standing diagnostic center] [[50 - 100]% at an outpatient Hospital-based diagnostic center]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[25 - 500] per service is satisfied]
<p><i>Include for groups that purchase Mental Health benefits.</i></p> <p><i>[Include as standard for groups of 2 to 15]</i></p> <p><i>¹Include if group purchases SA benefits.</i></p> <p>[16.] Mental Health Services</p>			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[For a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p align="center">In addition, you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p align="center">If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
<p><i>[Limits will not apply to groups of 51+.]</i></p> <p>[Inpatient Mental Health Services are</p>	[Inpatient]		

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> described in this section, <i>Mental Health Services</i> described above and <i>Substance Use Disorder Services</i> described further below are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. 	<p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>
<p>[18.] [Obesity Surgery]</p> <p style="text-align: center;">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p style="text-align: center;">[In addition, you must contact us 24 hours before admission for an Inpatient Stay.]</p> <p style="text-align: center;">[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]</p>			
<p>[Benefits are limited to \$[40,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]</p>	<p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>		
<p>[19.] [Ostomy Supplies]</p>			
<p>[Limited to \$[500 - 25,000] per year.]</p>	<p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per item is satisfied]</p>
<p>[20.] Pharmaceutical Products - Outpatient</p>			
<p style="text-align: center;">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization five business days before scheduled intravenous infusions are</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p> <p>[You must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires prior authorization through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>			
<p>[The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. <p>When a Pharmaceutical Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.]</p>	<p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[0 - 75] per Tier 1 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[15 - 250] per Tier 2 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[20 - 450] per Tier 3 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[70 - 650] per Tier 4 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[100 - 750] per Tier 5 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[150 - 850] per Tier 6 Pharmaceutical Product]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per Pharmaceutical Product is satisfied]</p> <p>[Yes, except when provided during a Physician office visit]</p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]		
[21.] Physician Fees for Surgical and Medical Services			
	[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[50 - 250] per service is satisfied]
[22.] Physician's Office Services - Sickness and Injury			
[Prior Authorization Requirement] [You must obtain prior authorization as soon as is reasonably possible before [Genetic Testing - BRCA] [Genetic Testing, including BRCA Genetic Testing] is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]			
	[[50 - 100%] [100% after you pay a Copayment of \$[5 - 100] per visit] [100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied] [Yes, when Benefits are subject to Coinsurance]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the office visit]</p>		
<p>¹Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude. ²If Maternity Services are excluded, Complications of Pregnancy must always be included.]</p> <p>[23.] Pregnancy - [¹Maternity Services] [²Complications of Pregnancy only]</p>			
<p><i>[Include when benefits are provided for maternity services.]</i></p> <p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p> <p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p> <p>[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization five business days before admission for scheduled admissions or within one business day or the same day, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p> <p>It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.</p>			
<p><i>[Include when benefits are provided for maternity services. Bracketed text within is plan design variable.]</i></p> <p>[Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> [except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]]</p> <p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p> <p>[Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>			
<p>[24.] Preventive Care Services</p>			
<p>Physician office services</p> <ul style="list-style-type: none"> Well baby and well child care includes, but is limited to, 20 visits at approximately the following age intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years. <p>No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's</p>	<p>100%</p>	<p>No</p>	<p>No</p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
immunizations.	100%	No	No
<p><i>[Prosthetics are a mandated benefit in Arkansas.]</i></p> <p>[25.] Prosthetic Devices and Services</p>			
<p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization before obtaining prosthetic devices [that exceed \$[1,000 - 5,000] in cost per device]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
Benefits for replacement are limited to a single purchase of each type of prosthetic device every three years	[[50 - 100]%	[Yes] [No]	[Yes] [No]
[26.] Reconstructive Procedures			
<p align="center">Prior Authorization Requirement</p> <p>You must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]</p>			
	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]</i></p> <p>[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100] % of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p>		
[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]			
<p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy] or as soon as is reasonably</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]			
<p>[Limited per year as follows:</p> <ul style="list-style-type: none"> • [[10 -100] visits of physical therapy.] • [[10 -100] visits of occupational therapy.] • [[10 -100] Manipulative Treatments.] • [[10 -100] visits of speech therapy.] • [[10 -100] visits of pulmonary rehabilitation therapy.] • [[10 -100] visits of cardiac rehabilitation therapy.] • [[10 -100] visits of post-cochlear implant aural therapy.] • [[10 - 100] visits of cognitive rehabilitation therapy.] • [[10 -100] visits of vision therapy.]] <p>[Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10 - 160] visits per year.]</p>	[[50 - 100]%]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
[Prior Authorization Requirement]			
[You must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]			
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% at a free-standing center]		

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[[50 - 100]% at an outpatient Hospital-based center]		
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	Prior Authorization Requirement		
<p>For a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, [Benefits will be reduced to 50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			
<p>[Limited to 40 - 180] days per year.]</p> <p>[Limited to:</p> <ul style="list-style-type: none"> [30 - 180] days per year in a Skilled Nursing Facility. [30 - 180] days per year in an Inpatient Rehabilitation Facility.] 	[[50 - 100]%]	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>
<p>[Include as standard for groups of 2 to 15]</p> <p>[30.] Substance Use Disorder Services</p>	[Prior Authorization Requirement]		
<p>[For a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
<p>[Limits will not apply to groups of 51+.]</p> <p>[Inpatient Substance Use Disorder Services are limited to [10 - 100] days per year.]</p> <p>[Outpatient Substance Use Disorder Services are limited to [10 - 100] visits</p>	<p>[Inpatient]</p> <p>[[50 - 100]%]</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient</p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>per year.]</p> <p>[Benefits for any combination of <i>Substance Use Disorder Services</i> described in this section and <i>Mental Health Services</i> described above are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] <p>[Benefits for any combination of <i>Substance Use Disorder Services</i> described in this section and <i>Mental Health Services</i> and <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> described above are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] 	<p>[Outpatient]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>
[31.] Surgery - Outpatient			
<p>[†] Does not apply if prior authorization is required for all pain management.]</p> <p style="text-align: center;">[Prior Authorization Requirement]</p> <p>[For [all outpatient surgeries] [[blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgery]] you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[[50 - 100]%] [[50 - 100]% at an ambulatory surgical center] [[50 - 100]% at an outpatient Hospital-based surgical center]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[10 - 1,000] per date of service is satisfied]
[32.] [Temporomandibular Joint Services]			
<p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p>[In addition, you must contact us 24 hours before admission for scheduled inpatient admissions.]</p>			
[Limited to \$[1,000 - 20,000] per year.]	[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .]		
[33.] Therapeutic Treatments - Outpatient			
<p align="center">[Prior Authorization Requirement]</p> <p>[²You must obtain prior authorization [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require prior authorization: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound].] If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>			
	[[50 - 100]%] [[50 - 100]% at a free-standing center] [[50 - 100]% at an outpatient Hospital-based center]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[25 - 100] per treatment is satisfied]
[34.] Transplantation Services			
<p align="center">Prior Authorization Requirement</p> <p>You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .			
[35.] Urgent Care Center Services			
[Limited to [2 - 10] visits per year.] •	[[50 - 100]%]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 150] per visit is satisfied]
[36.] [Vision Examinations]			
[Limited to [1 exam] [[2-3] exams] per year.] [Limited to [1 exam] [[2-3] exams] every [2 - 3] years.]	[[50 - 100%] [100% after you pay a Copayment of \$[5 - 100] per visit]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]
[37.] [Wigs]			
[Limited to \$[100 - 1,000] per year.] [Limited to \$[100 - 5,000] every [24 - 36] months.]	[[50 - 100%]	[Yes] [No]	[Yes] [No]
Additional Benefits Required By Arkansas Law			
[38.] Dental Services - Anesthesia and Hospitalization			
[Prior Authorization Requirement] [You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Benefits will be the same as those stated under each Covered Health Service Category in this <i>Schedule of Benefits</i> .]			
[39.] In Vitro Fertilization Services			
¹ Include applicable reduction in Benefits or no Benefits.			
[Prior Authorization Requirement]			

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Any applicable notification requirements will be the same as those stated under each Covered Health Service Category in this *Schedule of Benefits*.

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Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
Limited to a lifetime maximum of \$15,000.	[50 - 100%]	[Yes] [No]	[Yes] [No]
[40.] Medical Foods			
<p>[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
	[50 - 100%]	[Yes] [No]	[Yes] [No]
<p><i>Mandated offer in Arkansas.</i></p> <p>[[41.] Musculoskeletal Disorders of the Face, Neck or Head]</p>			
<p>[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] Service category in this Schedule of Benefits.]</p>			
	[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.]		
[[42.] Orthotic Devices and Services			
<p><i>Include if notification is required.</i></p> <p><i>¹Include when notification applies only to orthotics that exceed a minimum dollar amount and insert applicable dollar amount.</i></p> <p><i>²Include applicable reduction in Benefits or no Benefits.</i></p>			
<p>[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
Benefits for replacements are limited to a single purchase of each type of orthotic device every three years.	[50 - 100%]	[Yes] [No]	[Yes] [No]
	[50 - 100%]	[Yes] [No]	[Yes] [No]

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Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Covered Health Services from non-Network providers, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

[Include if plan includes ability to determine alternate levels of benefits.]

[If one or more alternative health services that meets the definition of a Covered Health Service in the *Certificate* under *Section 9: Defined Terms* are clinically appropriate and not more costly than an alternative health service that is at least as likely to produce equivalent therapeutic or diagnostic results as to their prevention, diagnosis or treatment of a Sickness, Injury, [Mental Illness.] [mental illness.] substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on *Generally Accepted Standards of Medical Practice*, which for some Covered Health Services may be addressed in our clinical policies.]

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:

[PHCS payment option.]

- [Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
- If rates have not been negotiated, then one of the following amounts:
 - ♦ For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.

[¹Include when benefits are provided for either Mental Health Services or Substance Use Disorder Services.]

If no fee information is available for a Covered Health Service, the Eligible Expense is based on [50 - 100]% of the provider's billed charge¹, except that certain Eligible Expenses for [Mental Health Services] [and] [Substance Use Disorder Services] are based on 80% of the billed charge.]

- ♦ [¹For [¹Mental Health Services] [¹and] [¹Substance Use Disorder Services] the Eligible Expense will be reduced by [5 - 30]% for Covered Health Services provided by a psychologist and by [5 - 40]% for Covered Health Services provided by a masters level counselor.]
- ♦ When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [110 - 200] % of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.]

[MNRP payment option.]

- [Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
- If rates have not been negotiated, then one of the following amounts:
 - ♦ Eligible Expenses are determined based on [110 - 200] % of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
 - ♦ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
 - For services other than Pharmaceutical Products, we use a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by *Ingenix, Inc.* If the *Ingenix, Inc.* relative value scale becomes no longer available, a comparable scale will be used. We and *Ingenix, Inc.* are related companies through common ownership by *UnitedHealth Group*.
 - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

[¹Include when benefits are provided for either Mental Health Services or Substance Use Disorder Services.]

- ♦ When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge [¹, except that certain Eligible Expenses for [Mental Health Services] [and] [Substance Use Disorder Services] are based on 80% of the billed charge].
- ♦ [¹For [Mental Health Services] [and] [Substance Use Disorder Services] the Eligible Expense will be reduced by [5 - 30]% for Covered Health Services provided by a psychologist and by [5 - 40]% for Covered Health Services provided by a masters level counselor.]

We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.]

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health

Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

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Limited to a lifetime maximum of \$15,000.	[Benefits will be the same as those stated under each Covered Health Service Category in this <i>Schedule of Benefits.</i>]
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the same as those stated under each Covered Health

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[For Non-Network Benefits you must notify us before obtaining orthotic devices [1that exceed \$[1,000 - 5,000] in cost per device].