

State: Arkansas Filing Company: UnitedHealthcare Insurance Company

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

Product Name: SBN.CHP.I.11.AR rev2

Project Name/Number: SBN.CHP.I.11.AR rev2/SBN.CHP.I.11.AR rev2

Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: SBN.CHP.I.11.AR rev2

State: Arkansas

TOI: H16G Group Health - Major Medical

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

Filing Type: Form

Date Submitted: 07/13/2012

SERFF Tr Num: UHLC-128572720

SERFF Status: Closed-Approved-Closed

State Tr Num:

State Status: Approved-Closed

Co Tr Num: SBN.CHP.I.11.AR REV2

Implementation: On Approval

Date Requested:

Author(s): Kelly Smith

Reviewer(s): Rosalind Minor (primary)

Disposition Date: 07/24/2012

Disposition Status: Approved-Closed

Implementation Date:

State Filing Description:

State: Arkansas Filing Company: UnitedHealthcare Insurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: SBN.CHP.I.11.AR rev2
Project Name/Number: SBN.CHP.I.11.AR rev2/SBN.CHP.I.11.AR rev2

General Information

Project Name: SBN.CHP.I.11.AR rev2 Status of Filing in Domicile: Pending
Project Number: SBN.CHP.I.11.AR rev2 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: 07/24/2012
State Status Changed: 07/24/2012
Created By: Kelly Smith Deemer Date:
Corresponding Filing Tracking Number: SBN.CHP.I.11.AR Submitted By: Kelly Smith
rev2

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Filing Description:

SBN.CHP.I.11.AR rev2 - this revised version is submitted to correct the hearing aid mandate limiting language. A redline is attached for reference.

The revised form will replace the Choice Plus 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. Similar forms are part of a nationwide filing.

Company and Contact

Filing Contact Information

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

Filing Company Information

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

Filing Fees

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

SERFF Tracking #: UHLC-128572720 **State Tracking #:** **Company Tracking #:** SBN.CHP.I.11.AR REV2

State: Arkansas **Filing Company:** UnitedHealthcare Insurance Company

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Product Name: SBN.CHP.I.11.AR rev2

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Company	Amount	Date Processed	Transaction #
UnitedHealthcare Insurance Company	\$50.00	07/13/2012	60885627

SERFF Tracking #:	UHLC-128572720	State Tracking #:		Company Tracking #:	SBN.CHP.I.11.AR REV2
State:	Arkansas	Filing Company:	UnitedHealthcare Insurance Company		
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO				
Product Name:	SBN.CHP.I.11.AR rev2				
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/24/2012	07/24/2012
Approved-Closed	Rosalind Minor	07/17/2012	07/17/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	SBN.CHP.I.11.AR rev3	Kelly Smith	07/23/2012	07/23/2012
Supporting Document	Redline Comparison to previously approved CHP SBN - Rev3	Kelly Smith	07/23/2012	07/23/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Revision required to 'Musculoskeletal Disorders of the Face, Neck or Head' benefit language	Note To Reviewer	Kelly Smith	07/20/2012	07/20/2012

SERFF Tracking #:	UHLC-128572720	State Tracking #:		Company Tracking #:	SBN.CHP.I.11.AR REV2
State:	Arkansas	Filing Company:	UnitedHealthcare Insurance Company		
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO				
Product Name:	SBN.CHP.I.11.AR rev2				
Project Name/Number:	SBN.CHP.I.11.AR rev2/SBN.CHP.I.11.AR rev2				

Disposition

Disposition Date: 07/24/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter SBN.CHP.I.11.AR	Approved-Closed	Yes
Supporting Document	No Rate Impact Letter	Approved-Closed	Yes
Supporting Document (revised)	Redline Comparison to previously approved CHP SBN - Rev3	Approved-Closed	Yes
Supporting Document	Redline Comparison to previously approved CHP SBN - Rev2	Replaced	Yes
Form (revised)	SBN.CHP.I.11.AR rev3	Approved-Closed	Yes
Form	SBN.CHP.I.11.AR rev2	Replaced	Yes

SERFF Tracking #:	UHLC-128572720	State Tracking #:		Company Tracking #:	SBN.CHP.I.11.AR REV2
State:	Arkansas	Filing Company:	UnitedHealthcare Insurance Company		
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO				
Product Name:	SBN.CHP.I.11.AR rev2				
Project Name/Number:	SBN.CHP.I.11.AR rev2/SBN.CHP.I.11.AR rev2				

Disposition

Disposition Date: 07/17/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter SBN.CHP.I.11.AR	Approved-Closed	Yes
Supporting Document	No Rate Impact Letter	Approved-Closed	Yes
Supporting Document (revised)	Redline Comparison to previously approved CHP SBN - Rev3	Approved-Closed	Yes
Supporting Document	Redline Comparison to previously approved CHP SBN - Rev2	Replaced	Yes
Form (revised)	SBN.CHP.I.11.AR rev3	Approved-Closed	Yes
Form	SBN.CHP.I.11.AR rev2	Replaced	Yes

SERFF Tracking #:	UHLC-128572720	State Tracking #:		Company Tracking #:	SBN.CHP.I.11.AR REV2
State:	Arkansas	Filing Company:	UnitedHealthcare Insurance Company		
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO				
Product Name:	SBN.CHP.I.11.AR rev2				
Project Name/Number:	SBN.CHP.I.11.AR rev2/SBN.CHP.I.11.AR rev2				

Amendment Letter

Submitted Date: 07/23/2012

Comments:

SBN.CHP.I.11.AR rev3 - this revised version is submitted to correct the Musculoskeletal Disorders of the Face, Neck or Head language. A redline is attached for reference.

The revised form will replace the Choice Plus 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. Similar forms are part of a nationwide filing.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
SBN.CHP.I.11.A R rev3	Schedule Pages	SBN.CHP.I.11.A R rev3	Revised		UHLC-128496800	SBN.CHP.I.11.A R rev2	50.200	SBN_Medical_INS_2011_CHP rev3.pdf

Supporting Document Schedule Item Changes:

User Added -Name: Redline Comparison to previously approved CHP SBN - Rev3

Comment:

Redline SBN_Medical_INS_2011_CHP rev3.pdf

State: Arkansas Filing Company: UnitedHealthcare Insurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: SBN.CHP.I.11.AR rev2
Project Name/Number: SBN.CHP.I.11.AR rev2/SBN.CHP.I.11.AR rev2

Note To Reviewer

Created By:

Kelly Smith on 07/20/2012 10:26 AM

Last Edited By:

Kelly Smith

Submitted On:

07/20/2012 10:26 AM

Subject:

Revision required to 'Musculoskeletal Disorders of the Face, Neck or Head' benefit language

Comments:

Dear Mrs. Minor-

We have discovered a correction required to the above referenced form filing. Language is required to correct the 'Musculoskeletal Disorders of the Face, Neck or Head' benefit to indicate that it is a mandated offering. If possible, please re-open the SERFF filing so that the edits can be applied.

Thank you for your time and attention in review of this filing. Please contact me with any questions or concerns.

-KellySmith
kelly_smith@uhc.com
301-632-8061

State:	Arkansas	Filing Company:	UnitedHealthcare Insurance Company
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO		
Product Name:	SBN.CHP.I.11.AR rev2		
Project Name/Number:	SBN.CHP.I.11.AR rev2/SBN.CHP.I.11.AR rev2		

Form Schedule

Lead Form Number: SBN.CHP.I.11.AR rev2

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 07/24/2012	SBN.CHP.I.11. AR rev3	SCH	SBN.CHP.I.11.AR rev3	Revised: Replaced Form #: SBN.CHP.I.11.AR rev2 Previous Filing #: UHLC- 128496800	50.200	SBN_Medical_INS_2011_ CHP rev3.pdf

Form Type Legend:

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

[This Schedule of Benefits supports both ¹Choice Plus and ²Core products for Place of Service tiering.]

UnitedHealthcare [¹Choice Plus] [²Core] [UnitedHealthcare Insurance Company]

Schedule of Benefits

Accessing Benefits

[Include for the Core product.]

[UnitedHealthcare Core offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a UnitedHealthcare Core Network provider. You can confirm that your provider is a UnitedHealthcare Core Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].]

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

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

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

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

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

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

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

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

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

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

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

[Include when the enhanced benefits program is sold.]

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

[¹Include when shared savings program applies.]

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

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

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

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

Prior Authorization

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

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

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

authorized and what providers are authorized to deliver the services that are subject to the authorization.

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

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

Covered Health Services which Require Prior Authorization

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

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

- [_____]
- Ambulance - non-emergent air and ground.
- Clinical trials.
- [Congenital heart disease surgery.]
- [Dental services - accidental.]
- Dental services - anesthesia and hospitalization
- [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)].]

Contract Specialist: When state mandates require benefits for formulas or specialized food products, always include this bullet and include prior authorization in the benefit description under "Additional Benefits" below. If there is no state mandate, delete this bullet prior to filing. Delete this instruction prior to filing.

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

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

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [¹pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgeries]].]
- Temporomandibular joint services.

- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound]].]
- Transplants.
- [Ventricular assist device implantation. You must obtain prior authorization as soon as the possibility of implantation arises except in cases of Emergency implantations of partial assist devices.]

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

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

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

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

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

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

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

Care Management

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

Special Note Regarding Medicare

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

Benefits

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

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

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

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

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

Payment Term And Description	Amounts
Annual Deductible	
<p><i>[Annual deductible is plan design variable. Include applicable provisions to support the following:</i></p> <p>¹Annual deductible applies only to non-network benefits.</p> <p>²Outpatient Prescription Drug Rider is sold and the annual deductible applies to any combination of medical and RX benefits.</p> <p>³Outpatient Prescription Drug Rider with separate copayments for preventive medications is sold and the annual deductible does not apply to preventive medications.</p> <p>⁴Outpatient Prescription Drug Rider is sold and when the annual deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the annual deductible.</p> <p>⁵There is a deductible for designated and network benefits and the network and non-network amounts apply to the designated network and network annual deductible.</p> <p>⁶Designated network benefits apply to any category.]</p> <p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive [¹Non-Network] Benefits. [²The Annual Deductible applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>. [³Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [⁴Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the <i>Outpatient Prescription Drug Rider</i> are not subject to payment of the Annual Deductible.] [⁵The Annual Deductible for [⁶Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drugs provided under the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include applicable provisions to support the following:</i></p> <p>¹Day/visit limits are reduced by the number of days/visit used toward meeting the deductible.</p> <p>²Carry-over provision applies.</p> <p>³Roll-over provision applies in any circumstance.</p> <p>⁴Roll-over provision applies only to groups changing from calendar to policy year. ⁵Include when roll-over applies only to the individual deductible.</p> <p>⁶Include only when a per occurrence deductible applies.]</p>	<p>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</p>

Payment Term And Description	Amounts
<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 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>to exceed \$[0 - 45,000] for all Covered 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 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>

Payment Term And Description	Amounts
<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>	
<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</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 [Designated Network and] Network] ² 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</p>

Payment Term And Description	Amounts
<p>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>include the Per Occurrence Deductible.]</p> <p>[No Out-of-Pocket Maximum.]</p> <p>³ 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</p>

Payment Term And Description	Amounts
	<p>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>^[4] <i>Include 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.]</i></p> <p>^[5] <i>Include 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 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> <p>¹<i>Outpatient Prescription Drug Rider is sold.]</i></p>	

Payment Term And Description	Amounts
[Annual Maximum Benefit]	
<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 <i>Designated Network and Network</i>] [³ <i>Designated Network</i>]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p> <p>[No Annual Maximum Benefit.]</p> <p>[³ <i>Network</i>]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p> <p>[No Annual Maximum Benefit.]</p> <p>[¹ <i>Non-Network</i>]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p> <p>[No Annual Maximum Benefit.]</p> <p>[⁴ [² <i>Designated Network,</i>] <i>Network and Non-Network</i>]</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. 	

Payment Term And Description	Amounts
Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> 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 <i>Schedule of Benefits</i> table.	

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

[Include the following variables according to plan design:

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

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

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

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

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>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>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</p>	<p>Same as Network</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>- 10,000] per [transport] [day] is satisfied]</p> <p>Same as Network</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[25 - 1,000] per [transport] [day] is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[25 - 10,000] per [transport] [day] 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>- 10,000] per day, up to a per day maximum of \$[2,500 - 10,000]]</p> <p>Non-Network Same as Network</p>	Same as Network	Same as Network
<p>[3.] Clinical Trials</p>			
<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>			
<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>			

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Depending upon where the Covered Health Service is provided, Benefits 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>Stay] [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] [[50 - 100]%) [100% after you pay a Copayment of \$[100 - 1,000] per day] [100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>
<p>[5.] [Dental Services - Accident Only]</p>	<p>[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>		
<p>[Limited to \$[2,000 - 5,000] per year. Benefits are further limited to a maximum of \$[500 - 1,500] per tooth.]</p>	<p>[Network] [[50 - 100]%) [100% after you pay a Copayment of \$[5 - 75] per visit]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 75] 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?
	[Non-Network] [Same as Network]	[Same as Network]	[Same as Network]
[6.] Diabetes Services			
^[1] Include when the durable medical equipment benefit is sold.]			
^[2] Include when the durable medical equipment benefit is not sold.]			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits 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>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><i>Contract Specialist: Include only one of the options below (maintaining brackets) and delete the other (and both sets of instructions) prior to filing.</i></p> <p><i>Include when benefits for durable medical equipment are sold and when state law permits limits on diabetes equipment.</i></p> <p>[Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the</p>	<p>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</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>limit stated under <i>Durable Medical Equipment</i>.]</p> <p><i>Include only when benefits for durable medical equipment are sold and when state law does not permit limits on diabetes equipment.</i></p> <p>[Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are not 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>stated under <i>Durable Medical Equipment</i>.</p> <p>For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p><i>[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p>Benefits for diabetes supplies will be the same as those stated in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <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</i></p>		

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

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

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

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Equipment.]</p> <ul style="list-style-type: none"> • [[\$10,001 - 25,000] in Eligible Expenses for Tier 2.] • [[\$25,001 - 100,000] in Eligible Expenses for Tier 3.] <p>These Tier limits include repair. Benefits for replacement are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].]</p> <p>[Benefits are [further] limited to a single Mobility Device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair of the Mobility Device are limited to once every three years. We may, upon review, replace a defective Mobility Device rather than repair it. Benefits are not available for repair or replacement of a Mobility Device resulting from abuse, neglect or normal wear.]</p> <p>[Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every three years. Speech aid and tracheo-esophageal voice devices are [not] included in the annual limits stated above.]</p> <p>[To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.]</p>	<p>[Non-Network]</p> <p>[[50 - 100]%</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per purchase is satisfied]</p> <p>[Non-Network</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?
			Benefits are not available.]
[8.] Emergency Health Services - Outpatient			
<p>Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.</p> <p>[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>] 	<p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit. [If you are admitted as an inpatient to a Network Hospital [directly from the Emergency room] [within 24 hours of receiving outpatient Emergency treatment for the same condition], you will not have to pay this 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</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 700] per visit is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<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>Copayment of \$[50 - 650] for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 100% after you pay a Copayment of \$[50 - 650] per visit for the next [#] visits in a year; 100% after you pay a Copayment of \$[100 - 700] for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 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</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 day]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per day]</p>	<p>[Yes] [No]</p>	<p>Deductible of \$[5 - 100] per day is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per day is satisfied]</p>
<p>[12.] Hospital - Inpatient Stay</p>	<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>		
	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 10,000] per Inpatient Stay]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[When you choose to seek care from Designated Network facilities for certain surgical procedures [or as a result of certain diagnoses], your Benefits will be enhanced as described below:]</p> <ul style="list-style-type: none"> [The Copayment you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to \$[0 - 1,000]. [The maximum reduction in Copayments is \$[10 - 1,000].] [The Coinsurance you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to [0 - 50]% or \$[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of \$[10 - 1,000].] <p>[You can determine the specific surgical procedures or diagnoses for which enhanced Benefits are available by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p> <p>[[For Network Benefits, ventricular [Ventricular] assist device implantation services must be received at a Designated Facility.]</p> <p>[Non-Network Benefits for ventricular assist device implantation are limited to \$[30,000 - 250,000] per implantation.]</p>	<p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 10,000] per Inpatient Stay]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] 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?
	Copayment of \$[100 - 1,000] per day [100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 10,000] per Inpatient Stay]		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.]	[Designated Network] [[50 - 100]%] [Network] [[50 - 100]%] [Non-Network] [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]

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?
[14.] Lab, X-Ray and Diagnostics - Outpatient			
<p>[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits for sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>Lab Testing - Outpatient:</p>	<p>[Designated Network]</p> <p>[[50 - 100]% [100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[[50 - 100]% at a free-standing lab [or in a Physician's office]] [100% after you pay a Copayment of \$[5 - 100] per service at a free-standing lab [or in a Physician's office]]</p> <p>[[50 - 100]% at a Hospital-based lab] [100% after you pay a Copayment of \$[5 - 100] per service at a Hospital-based lab]</p> <p>[[50 - 100]% at a Physician office-based lab] [100% after you pay a Copayment of \$[5 - 100] per service at a Physician office-based lab]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No] [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>Network</p> <p>[[50 - 100]%] [100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[[50 - 100]% at a free-standing lab [or in a Physician's office]] [100% after you pay a Copayment of \$[5 - 100] per service at a free-standing lab [or in a Physician's office]]</p> <p>[[50 - 100]% at a Hospital-based lab] [100% after you pay a Copayment of \$[5 - 100] per service at a Hospital-based lab]</p> <p>[[50 - 100]% at a Physician office-based lab] [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]%] [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] [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>[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>[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:	[[50 - 100]% at a free-standing lab [or in a Physician's office]]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing lab [or in a Physician's office]]		[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]
	[[50 - 100]% at a Hospital-based lab]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of \$[5 - 100] per service at a Hospital-based lab]		[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]
	[[50 - 100]% at a Physician office-based lab]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of \$[5 - 100] per service at a Physician office-based lab]		[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]
	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]
	[Designated Network]	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		
	[100% after you pay a Copayment of \$[5 - 100] per service]		[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]
	[[50 - 100]% at a free-standing diagnostic center or in a Physician's office]	[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>[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing diagnostic center or in a Physician's office]</p> <p>[[50 - 100]% at an outpatient Hospital-based diagnostic center]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at an outpatient Hospital-based diagnostic center]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[[50 - 100]% at a free-standing diagnostic center or in a Physician's office]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing diagnostic center or in a Physician's office]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No] [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>[[50 - 100]% at an outpatient Hospital-based 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>[[50 - 100]% at a free-standing diagnostic center or in a Physician's office]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing diagnostic center or in a Physician's office]</p> <p>[[50 - 100]% at an outpatient Hospital-based diagnostic center]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at an outpatient Hospital-based diagnostic</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</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>[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?
	center] [Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]
[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
<p>[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
	<p>[Designated Network]</p> <p>[[50 - 100]% [100% after you pay a Copayment of \$[5 - 500] per service]</p> <p>[[50 - 100]% at a free-standing diagnostic center or in a Physician's office [100% after you pay a Copayment of \$[5 - 500] per service at a free-standing diagnostic center or in a Physician's office]</p> <p>[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of \$[5 - 500] per service at an outpatient Hospital-based diagnostic</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>center]</p> <p>Network</p> <p>[[50 - 100]% [100% after you pay a Copayment of \$[5 - 500] per service]</p> <p>[[50 - 100]% at a free-standing diagnostic center or in a Physician's office] [100% after you pay a Copayment of \$[5 - 500] per service at a free-standing diagnostic center or in a Physician's office]</p> <p>[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of \$[5 - 500] per service at an outpatient Hospital-based diagnostic center]</p> <p>Non-Network</p> <p>[[50 - 100]% [100% after you pay a Copayment of \$[5 - 500] per service]</p> <p>[[50 - 100]% at a free-standing diagnostic center or in a</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Physician's office]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per service at a free-standing diagnostic center or in a Physician's office]</p> <p>[[50 - 100]% at an outpatient Hospital-based diagnostic center]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per service at an outpatient Hospital-based diagnostic center]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p> <p>[Non-Network Benefits are not available.]</p>
[16.] [Mental Health Services]			
<p align="center">[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
<p><i>[Limits will not apply to groups of 51+.]</i></p> <p>[Inpatient Mental Health Services are limited to [10 - 100] days per year.]</p> <p>[Outpatient Mental Health Services are limited to [10 - 100] visits per year.]</p>	<p>[Network]</p> <p><i>[Inpatient]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 -</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[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 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 	<p>1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p><i>[Outpatient]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p> <p><i>[Non-Network]</i></p> <p><i>[Inpatient]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient</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 \$[5 - 100] per visit is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>outpatient <i>Mental Health Services and Substance Use Disorder Services.</i></p> <p>[Benefits for any combination of <i>Mental Health Services</i> described in this section and <i>Neurobiological Disorders - Autism Spectrum Disorder Services and 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 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>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, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>
<p>[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]</p>	<p align="center">[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits for a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management[; Applied Behavioral Analysis].</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible</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 Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] days per year.]</i></p> <p><i>[Outpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] visits per year.]</i></p> <p><i>[Non-Network Benefits for inpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] days per year.]</i></p> <p><i>[Non-Network Benefits for outpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] visits per year.]</i></p> <p><i>[Benefits for any combination of Neurobiological Disorders - Autism Spectrum Disorder Services described in this section and Mental Health Services described above are limited as follows:</i></p> <ul style="list-style-type: none"> <i>• [10 - 100] days per year for inpatient Neurobiological Disorders - Autism Spectrum Disorder Services and Mental Health Services.</i> <i>• [10 - 100] visits per year for outpatient Neurobiological Disorders - Autism Spectrum Disorder Services and Mental Health Services.]</i> <p><i>[Benefits for any combination of Neurobiological Disorders - Autism</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>[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>

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>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</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><i>[Inpatient]</i> [[50 - 100]%] [100% after you pay a Copayment of \$[100 - 1,000] per day] [100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p><i>[Outpatient]</i> [[50 - 100]%] [100% after you pay a Copayment of \$[5 - 100] per visit] [100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.] [100% for visits for medication management]</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>[18.] [Obesity Surgery]</p>	<p>[Prior Authorization Requirement]</p>		
<p>[You must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p>[In addition, for Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.]</p> <p>[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best</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?
outcomes for you.]			
<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><i>[Designated Network]</i></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>[Network]</i></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>[Non-Network]</i></p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p> <p>[Non-Network Benefits are not available.]</p>		
[19.] [Ostomy Supplies]			
<p>[Limited to \$[500 - 25,000] per year.]</p>	<p><i>[Network]</i></p> <p>[[50 - 100]%</p> <p><i>[Non-Network]</i></p> <p>[[50 - 100]%</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per item is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per item is</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?
			satisfied] [Non-Network Benefits are not available.]
[20.] Pharmaceutical Products - Outpatient			
<p>[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p> <p>[For Non-Network Benefits you must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires prior authorization through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>			
<p>[The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. <p>When a Pharmaceutical Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.]</p>	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[0 - 75] per Tier 1 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[15 - 250] per Tier 2 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[20 - 450] per Tier 3</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>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] 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>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p>[100% after you pay a</p>	<p></p> <p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p></p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per Pharmaceutical Product 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>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>[Non-Network Benefits are not available.]</p>		<p>satisfied]</p> <p>[Yes, except when provided during a Physician office visit]</p> <p>[Non-Network Benefits are not available.]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[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 	<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>provide designation.]</p> <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>			
<p align="center">[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization as soon as is reasonably possible before [Genetic Testing - BRCA] [Genetic Testing, including BRCA Genetic Testing] is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			

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</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.] 	<p>Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the office visit]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a 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</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"> [Reproductive Endocrinology.] [All specialties for which we provide designation.] <p>[Enhanced Benefits:]</p> <ul style="list-style-type: none"> [The Copayment you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to \$[0 - 1,000]. [The maximum reduction in Copayments is \$[10 - 1,000].]] [The Coinsurance you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to [0 - 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 	<p>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>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</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"> • medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</i> • [Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient.</i>] • [Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>] • [Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>] • [Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i>] • [Rehabilitation therapy procedures described under <i>Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].</i>] 	<p>office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the 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>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>[For Non-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
<p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p>			
<p align="center">[Prior Authorization Requirement]</p>			
<p>[For Non-Network Benefits you must obtain prior authorization five business days before admission for scheduled admissions or within one business day or the same day, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
<p 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</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>Health Service category in this <i>Schedule of Benefits</i> [except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]</p> <p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p> <p>[Network]</p> <p>[Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p> <p>[Non-Network]</p> <p>[Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>		
[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</p> <p>100%</p> <p>Non-Network</p> <p>[[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100] % for a Specialist Physician office visit]</p> <p>[100% for a Primary</p>	<p>No</p> <p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available except for children under the age of 19.].]</p>	<p>No</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available except for children under the age of 19.].]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Lab, X-ray or other preventive tests</p> <p>No deductible will be applicable to Network or non-Network Prostate Cancer Screening.</p>	<p>Physician office visit; [50 - 100]% for a Specialist Physician office visit</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the 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>[Non-Network Benefits are not available.]</p>	<p>No</p> <p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>No</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Non-Network Benefits are not available.]</p>
<p>[25.] [Prosthetic Devices and Services]</p>	<p>[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization before obtaining prosthetic devices [that exceed \$[1,000 - 5,000] in cost per device]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>		

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Benefits for replacement are limited to a single purchase of each type of prosthetic device every three years</p> <p>[Once this limit is reached, Benefits continue to be available for items required by the <i>Women's Health and Cancer Rights Act of 1998.</i>]</p>	<p>[Network] [[50 - 100]%]</p> <p>[Non-Network] [[50 - 100]%] [Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>
<p>[26.] Reconstructive Procedures</p>			
<p align="center">Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]</p>			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]</i></p> <p>[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]</i></p> <p>[For breast prosthesis, mastectomy bras and lymphedema</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?
	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] [For Non-Network Benefits you must obtain prior authorization five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy] or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
<p>[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,</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>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</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>pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10 - 160] visits per year.]</p> <p>[Network 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>[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 Benefits are not available.]</p>	<p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available.]</p>
<p>[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic</p>	<p>[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>		
	<p>[Designated Network]</p> <p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per date of service is</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[[50 - 100]% at a free-standing center or in a Physician's office]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per date of service at a free-standing center or in a Physician's office]</p>	[Yes] [No]	<p>satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per date of service is satisfied]</p>
	<p>[[50 - 100]% at an outpatient Hospital-based center]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per date of service at an outpatient Hospital-based center]</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per date of service is satisfied]</p>
	<p>Network</p> <p>[[50 - 100]%]</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per date of service is satisfied]</p>
	<p>[[50 - 100]% at a free-standing center or in a Physician's office]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per date of service at a free-standing center or in a Physician's office]</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 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?
	2,000] per Inpatient Stay] [100% after you pay a Copayment of \$[50 - 1,000] per day to a maximum Copayment of \$[50 - 10,000] per Inpatient Stay]		satisfied]
[30.] [Substance Use Disorder Services]			
[Prior Authorization Requirement] [For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[Limits will not apply to groups of 51+.] [Inpatient Substance Use Disorder Services are limited to [10 - 100] days per year.] [Outpatient Substance Use Disorder Services are limited to [10 - 100] visits per year.] [Non-Network Benefits for inpatient Substance Use Disorder Services are limited to [10 - 100] days per year.] [Non-Network Benefits for outpatient Substance Use Disorder Services are limited to [10 - 100] visits per year.] [Benefits for any combination of Substance Use Disorder Services described in this section and Mental Health Services described above are	[Network] [Inpatient] [[50 - 100]%] [100% after you pay a Copayment of \$[100 - 1,000] per day] [100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] 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>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><i>[Outpatient]</i></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p> <p><i>[Non-Network]</i></p> <p><i>[Inpatient]</i></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Copayment of \$[100 - 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, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>
<p>[31.] Surgery - Outpatient</p>			
<p><i>[¹ Does not apply if prior authorization is required for all pain management.]</i></p> <p align="center">[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits [for all outpatient surgeries] [for [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [¹pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgery]] you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
<p>[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 	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per date of service]</p> <p>[100% after you pay a Copayment of \$[5 -</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 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>reduction in Copayments is \$[10 - 1,000].]</p> <ul style="list-style-type: none"> [The Coinsurance you pay for the facility charge [and Physician's fees] for 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>1,000] per date of service, to a maximum Copayment of \$[5 - 5,000] per year]</p> <p>[[50 - 100]% at an ambulatory surgical center or in a Physician's office]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per date of service, to a maximum Copayment of \$[5 - 5,000] per year at an ambulatory surgical center or in a Physician's office]</p> <p>[[50 - 100]% at an outpatient Hospital-based surgical center]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per date of service is satisfied]</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% after you pay a Copayment of \$[5 - 1,000] per date of service at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per date of service, to a maximum Copayment of \$[5 - 5,000] per year at an outpatient Hospital-based surgical center]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per date of service]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per date of service, to a maximum Copayment of \$[5 - 5,000] per year]</p> <p>[[50 - 100]% at an ambulatory surgical center or in a Physician's office]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per date of</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>Deductible of \$[5 - 1,000] per date of service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per date of service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per date of service is satisfied]</p>

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

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

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

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

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

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

[32.] Temporomandibular Joint Services

[Prior Authorization Requirement]

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

[In addition, for 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> <p>[Non-Network Benefits are not available.]</p>		
[33.] Therapeutic Treatments - Outpatient	[Prior Authorization Requirement]		
<p>[For Non-Network Benefits you 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>[100% after you pay a Copayment of \$[5 - 1,000] per treatment]</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per treatment is satisfied]</p>
	<p>[[50 - 100]% at a free-standing center or in a Physician's office]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per treatment at a free-standing center or in a Physician's</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per treatment 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?
	office]		satisfied]
	<p>[[50 - 100]% at an outpatient Hospital-based center]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per treatment at an outpatient Hospital-based center]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per treatment]</p> <p>[[50 - 100]% at a free-standing center or in a Physician's office]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per treatment at a free-standing center or in a Physician's office]</p> <p>[[50 - 100]% at an outpatient Hospital-based center]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per treatment at an outpatient Hospital-based center]</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 \$[5 - 1,000] per treatment is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per treatment is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per treatment is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] 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>Non-Network</p> <p>[[50 - 100]%] [100% after you pay a Copayment of \$[5 - 1,000] per treatment]</p> <p>[[50 - 100]% at a free-standing center or in a Physician's office] [100% after you pay a Copayment of \$[5 - 1,000] per treatment at a free-standing center or in a Physician's office]</p> <p>[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of \$[5 - 1,000] per treatment at an outpatient Hospital-based center]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per treatment is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per treatment is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] 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 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.]

[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency

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?
admissions).]			
<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>[Non-Network Benefits are not available.]</p>		
[35.] Urgent Care Center Services			
<p>[Limited to [2 - 10] visits per year.]</p> <p>[In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center:</p> <ul style="list-style-type: none"> • [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient</i>.] • [Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</i>.] • [Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>.] • [Diagnostic and therapeutic 	<p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit to a maximum Copayment of \$[5 - 5,000] per year]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in</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>scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i></p> <ul style="list-style-type: none"> • [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>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 that year]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 150] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[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 Copayment of \$[5 - 75]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not</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?
	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] [Non-Network Benefits are not available.]		available.]
[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]%] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]
Additional Benefits Required By Arkansas Law			
[38.] Dental Services - Anesthesia and Hospitalization			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[For Non-Network Benefits 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>			
	[¹ Designated Network] [Benefits will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i> .] Network Benefits will be the same as those stated under <i>Hospital -</i>		

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>Inpatient Stay in this Schedule of Benefits.</i></p> <p>Non-Network</p> <p>Benefits will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this Schedule of Benefits.</p>		
<p>[39.] In Vitro Fertilization Services</p>			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[For Non-Network Benefits you must obtain prior authorization five business days before 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 a lifetime maximum of \$15,000.</p>	<p>[Designated Network]</p> <p>[50 - 100%]</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> <p>[Yes] [No]</p> <p>[Yes] [No]</p>
<p>[40.] Medical Foods</p>			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[For Non-Network Benefits 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>¹<i>Include when group purchases the Outpatient Prescription Drug Rider.</i></p> <p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be [50 - 100] % [¹or as provided under the <i>Outpatient Prescription Drug Rider</i>].</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?
[Limited to]	<p>Non-Network Same as Network</p> <p>¹Include when group purchases the Outpatient Prescription Drug Rider.</p> <p>Network Depending upon where the Covered Health Service is provided, Benefits will be [50 - 100] % [¹or as provided under the Outpatient Prescription Drug Rider].</p>	<p>Same as Network</p> <p>[Yes] [No]</p>	<p>Same as Network</p> <p>[Yes] [No]</p>
<p><i>Mandated offer in Arkansas.</i></p> <p>[[41.] Musculoskeletal Disorders of the Face, Neck or Head]</p>	<p align="center">[Prior Authorization Requirement]</p> <p align="center">[For Non-Network Benefits 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>		
[Limited to]	<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 <i>Schedule of Benefits</i>.]</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 <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</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>each Covered Health Service category in this Schedule of Benefits.]</i>			
[[42.] Orthotic Devices and Services			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization five business days before receiving services and devices 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.]			
Benefits for replacements are limited to a single purchase of each type of orthotic device every three years.	Network [50 - 100%] Non-Network [50 - 100%]	 [Yes] [No] [Yes] [No]	 [Yes] [No] [Yes] [No]

Eligible Expenses

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

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

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

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

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

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

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

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

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

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

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

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

[PHCS payment option.]

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

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

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

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

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

Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

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

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

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

[MNRP payment option.]

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

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

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

acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

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

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

[Include when Core product is supported.]

We arrange for health care providers to participate in a Network. [The UnitedHealthcare Core product has a limited Network of providers.] Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

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

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

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

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

Continuity of Care

Continuity of care is provided under the Policy. In order for health services to be covered as Network Benefits, you must notify the company immediately if either of the following situations applies to you:

- Newly Eligible Persons who are being treated by a Non-Network provider for a current episode of an acute condition may continue to receive treatment from the Non-Network provider until the earlier of (1) the end of the current episode of treatment or (2) 90 days.
- Covered Persons who are being treated for a current episode of an acute condition by a Network provider when the provider's contract terminates may continue to receive treatment from that provider until the earlier of (1) the end of the current episode of treatment or (2) 90 days.

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

Designated Facilities and Other Providers

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

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

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

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Limitations on Selection of Providers

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

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

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

SERFF Tracking #:	UHLC-128572720	State Tracking #:		Company Tracking #:	SBN.CHP.I.11.AR REV2
State:	Arkansas	Filing Company:	UnitedHealthcare Insurance Company		
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO				
Product Name:	SBN.CHP.I.11.AR rev2				
Project Name/Number:	SBN.CHP.I.11.AR rev2/SBN.CHP.I.11.AR rev2				

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	07/17/2012
Bypass Reason:	Flesch Score - 50.2 Application - N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	07/17/2012
Bypass Reason:	Flesch Score - 50.2 Application - N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	PPACA Uniform Compliance Summary	Approved-Closed	07/17/2012
Comments:			
Attachment(s):	Final_PPACA_UniformComplianceSummaryClean[1]2011.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter SBN.CHP.I.11.AR	Approved-Closed	07/17/2012
Comments:			
Attachment(s):	SBN.CHP.I.11.AR CovLtr.pdf		

		Item Status:	Status Date:
Satisfied - Item:	No Rate Impact Letter	Approved-Closed	07/17/2012
Comments:			
Attachment(s):			

SERFF Tracking #:	UHLC-128572720	State Tracking #:		Company Tracking #:	SBN.CHP.I.11.AR REV2
State:	Arkansas	Filing Company:	UnitedHealthcare Insurance Company		
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO				
Product Name:	SBN.CHP.I.11.AR rev2				
Project Name/Number:	SBN.CHP.I.11.AR rev2/SBN.CHP.I.11.AR rev2				

SG AR UHC INS 2012 08 01_No Rate Impact Letter _2_.pdf
 LG AR UHC INS 2012 08 01_No Rate Impact Letter.pdf

		Item Status:	Status Date:
Satisfied - Item:	Redline Comparison to previously approved CHP SBN - Rev3	Approved-Closed	07/24/2012
Comments:			
Attachment(s):			
Redline SBN_Medical_INS_2011_CHP rev3.pdf			

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

- INDIVIDUAL HEALTH BENEFIT PLANS (Complete [SECTION A](#) only)
 SMALL / LARGE GROUP HEALTH BENEFIT PLANS (Complete [SECTION B](#) only)

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as “major medical” in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. *(If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.)*

***For all filings, include the Type of Insurance (TOI) in the first column.**

Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
UnitedHealthcare Insurance Company	79413	UHLC- 128496800	SBN.CHP.I.11.AR	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans			
TOI	Category	Statute Section	Grandfathered
		Grandfathered	Non-Grandfathered
	<p>Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]</i></p>	<p style="text-align: center;">N/A</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Eliminate Annual Dollar Limits on Essential Benefits Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i></p>	<p style="text-align: center;">N/A</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Eliminate Lifetime Dollar Limits on Essential Benefits</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans			
TOI	Category	Statute Section	Grandfathered Non-Grandfathered
	<p>Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i></p>	<p style="text-align: center;">N/A</p>
	<p>Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Appeals Process – Requires establishment of an internal claims appeal process and external review process.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i></p>	<p style="text-align: center;">N/A</p>
	<p>Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.
	<p>Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.

PPACA Uniform Compliance Summary

Reset Form

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19</p> <p>Explanation: Certificate of Coverage, Section 2 Exclusions. There will be no grandfathered plans as this is a new product filing</p> <p>Page Number: XX</p>	<p><i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i></p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no, please explain.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Eliminate Annual Dollar Limits on Essential Benefits – Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.</p> <p>Explanation: No annual dollar limits on individual essential benefit categories. There will be no grandfathered plans as this is new product filing</p> <p>Page Number: N/A</p>	<p><i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i></p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no, please explain.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Eliminate Lifetime Dollar Limits on Essential Benefits</p> <p>Explanation: No lifetime limits. There will be no grandfathered plans as this is new product filing</p> <p>Page Number: N/A</p>	<p><i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i></p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no, please explain.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.</p> <p>Explanation: Certificate of Coverage, Section 4. There will be no grandfathered plans as this is new product filing</p> <p>Page Number: XX</p>	<p><i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i></p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no, please explain.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>

PPACA Uniform Compliance Summary
SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services</p> <p>Explanation: Certificate, Section 1; Schedules of Benefits under Preventive Care Services</p> <p>Page Number: Certificate page XX, Choice Schedule page XX</p>	<p>[Section 2713 of the PHSA/Section 1001 of the PPACA]</p>	<p>N/A</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊</p> <p>Explanation: Certificate of Coverage, Section 10, definition of Dependent. There will be no grandfathered plans as this is new product filing</p> <p>Page Number: Certificate page ,XX</p>	<p>[Section 2714 of the PHSA/Section 1001 of the PPACA]</p>	<p><input type="checkbox"/> Yes[◊] <input checked="" type="checkbox"/> No If no, please explain.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Appeals Process – Requires establishment of an internal claims appeal process and external review process.</p> <p>Explanation: Certificate of Coverage; Section 6</p> <p>Page Number: pages XX-XX</p>	<p>[Section 2719 of the PHSA/Section 1001 of the PPACA]</p>	<p>N/A</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary
SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation: No prior authorization required. See Emergency Health Services benefit category in each Schedule</p> <p>Page Number: Choice Schedule, page 14</p>	<p>[Section 2719A of the PHSA/Section 10101 of the PPACA]</p>	N/A	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.</p> <p>Explanation: No requirement included to designate a PCP</p> <p>Page Number: N/A</p>	<p>[Section 2719A of the PHSA/Section 10101 of the PPACA]</p>	N/A	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation: No authorization or referral requirements for OB/GYN</p> <p>Page Number: N/A</p>	<p>[Section 2719A of the PHSA/Section 10101 of the PPACA]</p>	N/A	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>

June 20, 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.CHP.I.11.AR
Flesch Score: 50.2

Dear Ms. Minor:

On behalf of UnitedHealthcare Insurance Company I am submitting the enclosed group health form for your Department's review and approval. This document is a new form and is not being filed to replace any form previously approved in your state.

Our intent is to use this form for large and small employer groups. Similar forms are part of a nationwide filing. Because the enclosed forms have been modified to reflect the laws and regulations of Arkansas, they will not be filed with Connecticut, our State of Domicile.

These new forms incorporate the following legislative requirements.

Health Care Reform - Patient Protection and Affordable Care Act (PPACA) requirements including the following:

- Coverage provided for enrolled dependent children until age 26.
- The preexisting condition exclusion does not apply to covered persons under the age of 19.
- No aggregate lifetime benefit limits apply [and restricted annual limits may apply to Essential Benefits as defined under PPACA].
- Network Preventive care services, which are those services recommended by the U.S. Preventive Services Task Force (USPSTF), are not subject to any copayment, coinsurance or deductible provisions.
- Dependent Children/Dependent Child Special Open Enrollment Period provision included to allow the required 30 day opportunity for those children who are not currently enrolled at the time of renewal and have not met the limiting age of 26.
- Rescission limited only to instances of fraud or intentional misrepresentation of a material fact.
- Right to appeal a rescission of coverage determination.
- Right of covered persons to access new or additional evidence that was relied upon or generated by us during a determination of an appeal.
- The inclusion of a federal external review process.
- Direct access to OB/GYN care without a referral or authorization requirement.

- The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
- The ability to designate any primary care physician (PCP) that is accepting new patients.
- Prior authorization is not required before receipt of services in the emergency department of a hospital.
- Non-network benefits for hospital emergency room treatment are subject to the same cost sharing as Network benefits.

Explanation of Insert Forms and Variable Text

The forms contained in this filing are to be used on an insert form basis. Each insert form is made up of:

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

Mandated text appears in green and is included to comply with state requirements. Please note that mandated text will appear as regular black text in the final documents issued to the employer and/or a member.

Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online viewing or issuance. We want to assure the Department that education will be provided to the brokers, employer groups and the employees regarding access and alternatives to electronic issuance.

Time Saving Reviewing Tips

Several notes about schedules:

- Choice and Choice Plus schedules are the same except Choice Plus contains coverage for non-network benefits.
- Navigate Balance and Navigate Plus schedules are the same except the Navigate Plus contains coverage for non-network benefits.
- "Net" and "PLS" outpatient prescription drug riders are the same, except "PLS" contains coverage for drugs at non-network pharmacies.

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



185 Asylum Street, CT039-16B
Hartford, CT 06103
Tel 203-459-6723 Fax 860-702-5016
E-Mail: brupert@uhc.com

June 19, 2012

Ms. Rosalind Minor
Rates and Forms Analyst
Arkansas Department of Insurance
1200 West Third Street
Little Rock, Arkansas 72201

**Re: UnitedHealthcare Insurance Company
Small Group (2-50) Medical and Rx Rate Filing: PPO, Indemnity & POS**

Dear Ms. Minor:

The purpose of this filing is to provide Medical and Rx manual rate change to UnitedHealthcare Insurance Company products. This filing may not be appropriate for other purposes.

The effective date for this filing is 08/01/12 and later for UnitedHealthcare Insurance Company and is applicable to employers with 2 to 50 eligible employees.

Please note that rates will not be impacted as referenced under SERFF policy form filing SBN.CHP.I.11.AR

ACTUARIAL CERTIFICATION

I, Ben Rupert, am employed as an actuary by UnitedHealth Group. I am an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries, and I meet the Qualification Standards of the Academy to render this opinion.

I certify that the changes to the rates were developed in accordance with accepted actuarial principles and were based on reasonable assumptions and that the rates exhibit a reasonable relationship to the benefits provided and are not excessive, not inadequate, and not unfairly discriminatory.

Please contact me if I may be of assistance during your review.

Respectfully,

Ben Rupert, ASA, MAAA
Actuarial Pricing



185 Asylum Street, CT039-16B
Hartford, CT 06103
Tel 203-459-6723 Fax 860-702-5016
E-Mail: brupert@uhc.com

June 19, 2012

Ms. Rosalind Minor
Rates and Forms Analyst
Arkansas Department of Insurance
1200 West Third Street
Little Rock, Arkansas 72201

**Re: UnitedHealthcare Insurance Company
Large Group (51+) Medical and Rx Rate Filing: PPO, Indemnity & POS**

Dear Ms. Minor:

The purpose of this filing is to provide Medical and Rx manual rate change to UnitedHealthcare Insurance Company products. This filing may not be appropriate for other purposes.

The effective date for this filing is 08/01/12 and later for UnitedHealthcare Insurance Company and is applicable to employers with 51 or more eligible employees.

Please note that rates will not be impacted as referenced under SERFF policy form filing SBN.CHP.I.11.AR

ACTUARIAL CERTIFICATION

I, Ben Rupert, am employed as an actuary by UnitedHealth Group. I am an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries, and I meet the Qualification Standards of the Academy to render this opinion.

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Please contact me if I may be of assistance during your review.

Respectfully,

Ben Rupert, ASA, MAAA
Actuarial Pricing

[This Schedule of Benefits supports both ¹Choice Plus and ²Core products for Place of Service tiering.]

UnitedHealthcare [¹Choice Plus] [²Core]

[UnitedHealthcare Insurance Company]

Schedule of Benefits

Accessing Benefits

[Include for the Core product.]

[UnitedHealthcare Core offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a UnitedHealthcare Core Network provider. You can confirm that your provider is a UnitedHealthcare Core Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].]

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

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

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

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

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

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

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

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

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

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

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

[Include when the enhanced benefits program is sold.]

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

[¹Include when shared savings program applies.]

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

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

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

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

Prior Authorization

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

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

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

authorized and what providers are authorized to deliver the services that are subject to the authorization.

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

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

Covered Health Services which Require Prior Authorization

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

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

- []
- Ambulance - non-emergent air and ground.
- Clinical trials.
- [Congenital heart disease surgery.]
- [Dental services - accidental.]
- Dental services - anesthesia and hospitalization
- [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)].]

Contract Specialist: When state mandates require benefits for formulas or specialized food products, always include this bullet and include prior authorization in the benefit description under "Additional Benefits" below. If there is no state mandate, delete this bullet prior to filing. Delete this instruction prior to filing.

- [Formulas/specialized 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.]
- [Medical Foods.]
- [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.]
- [Musculoskeletal disorders of the face neck or head.]
- [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.]
- Orthotics devices [^over\$[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.]
- [Prosthetic devices [over \$[1,000 - 5,000] in cost per device].]
- 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.]

[†]*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] [^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 surgeries]].]
- Temporomandibular joint services

Deleted: []
Deleted: []

- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound]].]
- Transplants.
- [Ventricular assist device implantation. You must obtain prior authorization as soon as the possibility of implantation arises except in cases of Emergency implantations of partial assist devices.]

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

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

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

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

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

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

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

Care Management

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

Special Note Regarding Medicare

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

Benefits

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

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

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

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

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

Payment Term And Description	Amounts
Annual Deductible	
<p><i>[Annual deductible is plan design variable. Include applicable provisions to support the following:</i></p> <p>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>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</p>

Payment Term And Description	Amounts
<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 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>to exceed \$[0 - 45,000] for all Covered 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>⁴<i>Include 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>⁵<i>Include 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>

Payment Term And Description	Amounts
<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>	
<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</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</p>

Payment Term And Description	Amounts
<p>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>include the Per Occurrence Deductible.]</p> <p>[No Out-of-Pocket Maximum.]</p> <p><i>^p Network</i></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><i>ⁱ Non-Network</i></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</p>

Payment Term And Description	Amounts
	<p>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>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>⁴ ⁶ 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>	

Payment Term And Description	Amounts
<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>¹Include separate network and non-network headings and statements when the annual maximum benefit applies separately.]</p> <p>²Include when designated network benefits apply to any category and when the designated network and network maximum is combined.]</p> <p>³Include when designated network and network are separate.]</p> <p>⁴Include when combined network and non-network maximums apply.]</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. 	

Payment Term And Description	Amounts
Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> 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 <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;		[Yes, after the Per Occurrence Deductible of \$[5 - 75] per visit is satisfied]
[This limit applies to Network Benefits only. Non-Network Benefits are not available.]	[50 - 90]% for any subsequent visits in that year]		
	[Non-Network] [[50 - 100]%	[Yes] [No]	[Yes] [No]

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>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>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</p>	<p>Same as Network</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>- 10,000] per [transport] [day] is satisfied]</p> <p>Same as Network</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[25 - 1,000] per [transport] [day] is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[25 - 10,000] per [transport] [day] 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>- 10,000] per day, up to a per day maximum of \$[2,500 - 10,000]]</p> <p>Non-Network Same as Network</p>	Same as Network	Same as Network
[3.] Clinical Trials			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
<p>Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i>.</p> <p>Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)</p>	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
[4.] [Congenital Heart Disease Surgeries]			

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[Prior Authorization Requirement]</p> <p>[For Designated Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you do not obtain prior authorization and if, as a result, the CHD services are not performed at a Designated Facility, Designated Network Benefits will not be paid.] [Non-Network Benefits will apply.]</p> <p>[For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
<p>[Designated Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac 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.</p>	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 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</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 \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>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>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 - 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>[5.] [Dental Services - Accident Only]</p>	<p>[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>		
<p>[Limited to \$[2,000 - 5,000] per year. Benefits are further limited to a maximum of \$[500 - 1,500] per tooth.]</p>	<p>[Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 75] 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?
	[Non-Network] [Same as Network]	[Same as Network]	[Same as Network]
[6.] Diabetes Services			

^[1]Include when the durable medical equipment benefit is sold.]

^[2]Include when the durable medical equipment benefit is not sold.]

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization before obtaining any ^[1]Durable Medical Equipment] ^[2]diabetes equipment] for the management and treatment of diabetes [that exceeds \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].

<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><i>Contract Specialist: Include only one of the options below (maintaining brackets) and delete the other (and both sets of instructions) prior to filing.</i></p> <p><i>Include when benefits for durable medical equipment are sold and when state law permits limits on diabetes equipment.</i></p> <p>[Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the</p>	<p>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</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>limit stated under <i>Durable Medical Equipment</i>.]</p> <p><i>Include only when benefits for durable medical equipment are sold and when state law does not permit limits on diabetes equipment.</i></p> <p>[Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are not 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>stated under <i>Durable Medical Equipment</i>.</p> <p>For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p><i>[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]</p> <p>Benefits for diabetes supplies will be the same as those stated in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <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</i></p>		

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p><i>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>[7.] [Durable Medical Equipment]</p>			
<p>[Prior Authorization Requirement]</p>			
<p>[For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment [that exceeds \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>[Limited to \$[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two - five] years]. [This limit does not apply to wound vacuums], which are subject to a separate limit of \$[4,500 - 13,500] per year and limited to a single purchase (including repair/replacement) every [year] [[two - five] years].]</p> <p>[Limited per year as follows:</p> <ul style="list-style-type: none"> • [500 - 10,000] in Eligible Expenses for Tier 1. Tier 1 includes disposable supplies necessary for the effective use of covered Durable Medical 	<p>[Network]</p> <p>[[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per purchase is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Equipment.]</p> <ul style="list-style-type: none"> • [\\$10,001 - 25,000] in Eligible Expenses for Tier 2.] • [\\$25,001 - 100,000] in Eligible Expenses for Tier 3.] <p>These Tier limits include repair. Benefits for replacement are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].</p> <p>[Benefits are [further] limited to a single Mobility Device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair of the Mobility Device are limited to once every three years. We may, upon review, replace a defective Mobility Device rather than repair it. Benefits are not available for repair or replacement of a Mobility Device resulting from abuse, neglect or normal wear.]</p> <p>[Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every three years. Speech aid and tracheo-esophageal voice devices are [not] included in the annual limits stated above.]</p> <p>[To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.]</p>	<p>[Non-Network]</p> <p>[[50 - 100]%</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per purchase is satisfied]</p> <p>[Non-Network</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?
			Benefits are not available.]
[8.] Emergency Health Services - Outpatient			
<p>Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.</p> <p>[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>] 	<p>Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit. [If you are admitted as an inpatient to a Network Hospital [directly from the Emergency room] [within 24 hours of receiving outpatient Emergency treatment for the same condition], you will not have to pay this 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</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 700] per visit is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<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>Copayment of \$[50 - 650] for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 100% after you pay a Copayment of \$[50 - 650] per visit for the next [#] visits in a year; 100% after you pay a Copayment of \$[100 - 700] for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 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</p>		

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[For Non-Network Benefits you must obtain prior authorization five business days before 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>[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>Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 50] per visit]</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>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per visit is 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>[For Non-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p>[In addition, for Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]</p>			
	<p>Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 -</p>	<p>[Yes] [No]</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?
	100] per day] Non-Network [[50 - 100]%] [100% after you pay a Copayment of \$[5 - 100] per day]	 [Yes] [No]	Deductible of \$[5 - 100] per day is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per day is satisfied]
[12.] Hospital - Inpatient Stay	<p align="center">Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>		
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of \$[100 - 1,000] per day] [100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 10,000] per Inpatient Stay]	 [Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] 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>[When you choose to seek care from Designated Network facilities for certain surgical procedures [or as a result of certain diagnoses], your Benefits will be enhanced as described below:]</p> <ul style="list-style-type: none"> [The Copayment you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to \$[0 - 1,000]. [The maximum reduction in Copayments is \$[10 - 1,000].]] [The Coinsurance you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to [0 - 50]% or \$[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of \$[10 - 1,000].] <p>[You can determine the specific surgical procedures or diagnoses for which enhanced Benefits are available by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p> <p>[[For Network Benefits, ventricular] [Ventricular] assist device implantation services must be received at a Designated Facility.]</p> <p>[Non-Network Benefits for ventricular assist device implantation are limited to \$[30,000 - 250,000] per implantation.]</p>	<p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 10,000] per Inpatient Stay]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per</p>

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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?
[14.] Lab, X-Ray and Diagnostics - Outpatient			
<p>[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits for sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>Lab Testing - Outpatient:</p>	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[[50 - 100]% at a free-standing lab [or in a Physician's office]]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing lab [or in a Physician's office]]</p> <p>[[50 - 100]% at a Hospital-based lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service 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 at a Physician office-based lab]</p>	<p>[Yes] [No]</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 \$[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>[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>Network</p> <p>[[50 - 100]%) [100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[[50 - 100]%) at a free-standing lab [or in a Physician's office]] [100% after you pay a Copayment of \$[5 - 100] per service at a free-standing lab [or in a Physician's office]]</p> <p>[[50 - 100]%) at a Hospital-based lab [100% after you pay a Copayment of \$[5 - 100] per service at a Hospital-based lab]</p> <p>[[50 - 100]%) at a Physician office-based lab [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]%) [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] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No] [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:	[[50 - 100]% at a free-standing lab [or in a Physician's office]]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing lab [or in a Physician's office]]		[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]
	[[50 - 100]% at a Hospital-based lab]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of \$[5 - 100] per service at a Hospital-based lab]		[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]
	[[50 - 100]% at a Physician office-based lab]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of \$[5 - 100] per service at a Physician office-based lab]		[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]
	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]
	[Designated Network]		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of \$[5 - 100] per service]		[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]
	[[50 - 100]% at a free-standing diagnostic center or in a Physician's office]	[Yes] [No]	[Yes] [No] [Yes, after the Per

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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>[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing diagnostic center or in a Physician's office]</p> <p>[[50 - 100]% at an outpatient Hospital-based diagnostic center]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at an outpatient Hospital-based diagnostic center]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[[50 - 100]% at a free-standing diagnostic center or in a Physician's office]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing diagnostic center or in a Physician's office]</p>	<p></p> <p>[Yes] [No]</p> <p></p> <p>[Yes] [No]</p> <p></p> <p>[Yes] [No]</p>	<p>Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p></p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p></p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p></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>[[50 - 100]% at an outpatient Hospital-based 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>[[50 - 100]% at a free-standing diagnostic center or in a Physician's office]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing diagnostic center or in a Physician's office]</p> <p>[[50 - 100]% at an outpatient Hospital-based diagnostic center]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at an outpatient Hospital-based diagnostic</p>	<p>[Yes] [No]</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 \$[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>[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?
	center] [Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]
[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
<p>[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
	<p>[Designated Network]</p> <p>[[50 - 100]% [100% after you pay a Copayment of \$[5 - 500] per service]</p> <p>[[50 - 100]% at a free-standing diagnostic center or in a Physician's office] [100% after you pay a Copayment of \$[5 - 500] per service at a free-standing diagnostic center or in a Physician's office]</p> <p>[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of \$[5 - 500] per service at an outpatient Hospital-based diagnostic</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>center]</p> <p>Network</p> <p>[[50 - 100]% [100% after you pay a Copayment of \$[5 - 500] per service]</p> <p>[[50 - 100]% at a free-standing diagnostic center or in a Physician's office] [100% after you pay a Copayment of \$[5 - 500] per service at a free-standing diagnostic center or in a Physician's office]</p> <p>[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of \$[5 - 500] per service at an outpatient Hospital-based diagnostic center]</p> <p>Non-Network</p> <p>[[50 - 100]% [100% after you pay a Copayment of \$[5 - 500] per service]</p> <p>[[50 - 100]% at a free-standing diagnostic center or in a</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Physician's office] [100% after you pay a Copayment of \$[5 - 500] per service at a free-standing diagnostic center or in a Physician's office]</p> <p>[[50 - 100]% at an outpatient Hospital-based diagnostic center]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per service at an outpatient Hospital-based diagnostic center]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per service is satisfied]</p> <p>[Non-Network Benefits are not available.]</p>
[16.] [Mental Health Services]			
<p align="center">[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
<p><i>[Limits will not apply to groups of 51+.]</i></p> <p>[Inpatient Mental Health Services are limited to [10 - 100] days per year.]</p> <p>[Outpatient Mental Health Services are limited to [10 - 100] visits per year.]</p>	<p>[Network]</p> <p><i>[Inpatient]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 -</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per</p>

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

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

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

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>outpatient <i>Mental Health Services and Substance Use Disorder Services.</i></p> <p>[Benefits for any combination of <i>Mental Health Services</i> described in this section and <i>Neurobiological Disorders - Autism Spectrum Disorder Services and 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 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>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, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>
<p>[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]</p>	<p>[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits for a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management[; Applied Behavioral Analysis].</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible</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 Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] days per year.]</i></p> <p><i>[Outpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] visits per year.]</i></p> <p><i>[Non-Network Benefits for inpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] days per year.]</i></p> <p><i>[Non-Network Benefits for outpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] visits per year.]</i></p> <p><i>[Benefits for any combination of Neurobiological Disorders - Autism Spectrum Disorder Services described in this section and Mental Health Services described above are limited as follows:</i></p> <ul style="list-style-type: none"> <i>• [10 - 100] days per year for inpatient Neurobiological Disorders - Autism Spectrum Disorder Services and Mental Health Services.</i> <i>• [10 - 100] visits per year for outpatient Neurobiological Disorder Services and Mental Health Services.]</i> <p><i>[Benefits for any combination of Neurobiological Disorders - Autism</i></p>	<p>[Network]</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>[Non-Network]</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>

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>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><i>[Inpatient]</i> [[50 - 100]%] [100% after you pay a Copayment of \$[100 - 1,000] per day] [100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p><i>[Outpatient]</i> [[50 - 100]%] [100% after you pay a Copayment of \$[5 - 100] per visit] [100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.] [100% for visits for medication management]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>
<p>[18.] [Obesity Surgery]</p>	<p>[Prior Authorization Requirement]</p>		
<p>[You must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p>[In addition, for Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.]</p> <p>[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best</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?
outcomes for you.]			
<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> <p>[Non-Network Benefits are not available.]</p>		
[19.] [Ostomy Supplies]			
<p>[Limited to \$[500 - 25,000] per year.]</p>	<p>[Network]</p> <p>[[50 - 100]%</p> <p>[Non-Network]</p> <p>[[50 - 100]%</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per item is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per item is</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?
			satisfied] [Non-Network Benefits are not available.]
[20.] Pharmaceutical Products - Outpatient			
<p align="center">[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p> <p>[For Non-Network Benefits you must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires prior authorization through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>			
<p>[The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. <p>When a Pharmaceutical Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.]</p>	<p>[Designated Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[0 - 75] per Tier 1 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[15 - 250] per Tier 2 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[20 - 450] per Tier 3</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>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] 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>Non-Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per Pharmaceutical Product is</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 \$[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>[Non-Network Benefits are not available.]</p>		<p>satisfied]</p> <p>[Yes, except when provided during a Physician office visit]</p> <p>[Non-Network Benefits are not available.]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[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 	<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>provide designation.]</p> <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>	<p>[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization as soon as is reasonably possible before [Genetic Testing - BRCA] [Genetic Testing, including BRCA Genetic Testing] is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>		

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</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.] 	<p>Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the office visit]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a 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</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"> • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] <p>[Enhanced Benefits:]</p> <ul style="list-style-type: none"> • [The Copayment you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to \$[0 - 1,000]. [The maximum reduction in Copayments is \$[10 - 1,000].]] • [The Coinsurance you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to [0 - 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 Customer Care at the telephone number on your ID card.]</p> <p>[In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office:</p> <ul style="list-style-type: none"> • [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient.</i>] • [Major diagnostic and nuclear 	<p>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>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</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"> • medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</i> • [Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient.</i>] • [Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>] • [Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>] • [Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i>] • [Rehabilitation therapy procedures described under <i>Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].</i>] 	<p>office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the 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>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>[For Non-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p> <p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p> <p align="center">[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization five business days before admission for scheduled admissions or within one business day or the same day, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p> <p>It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.</p>			
	<p><i>[Include when benefits are provided for maternity services. Bracketed text within is plan design variable.]</i></p> <p>[Network]</p> <p>[Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> [except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]]</p> <p>[Non-Network]</p> <p>[Benefits will be the same as those stated under each Covered</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>Health Service category in this <i>Schedule of Benefits</i> [except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]]</p> <p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p> <p>[Network]</p> <p>[Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p> <p>[Non-Network]</p> <p>[Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>		
[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</p> <p>100%</p> <p>Non-Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary</p>	<p>No</p> <p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available except for children under the age of 19.]</p>	<p>No</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available except for children under the age of 19.] .]</p>

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

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

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

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Benefits for replacement are limited to a single purchase of each type of prosthetic device every three years</p> <p>[Once this limit is reached, Benefits continue to be available for items required by the <i>Women's Health and Cancer Rights Act of 1998</i>.]</p>	<p>[Network] [[50 - 100]%</p> <p>[Non-Network] [[50 - 100]%</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>
<p>[26.] Reconstructive Procedures</p>			
<p align="center">Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]</p>			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]</i></p> <p>[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]</i></p> <p>[For breast prosthesis, mastectomy bras and lymphedema</p>		

Deleted: [Limited to \$[2,500 - 100,000] per year. Benefits are limited to a single purchase of each type of prosthetic device every [year] [[two-five] years].]¶
 [Limited per year as follows:¶
 <#>A maximum of \$[10,000 - 30,000] per body part for each arm, leg, hand or foot.¶
 <#>A maximum of \$[5,000 - 15,000] per body part for each eye, ear, nose, face or breast.¶
 These limits include repair. Benefits for replacement are limited to a single purchase of each type of prosthetic device every [year] [[two-five] years].]¶

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?
	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] [For Non-Network Benefits you must obtain prior authorization five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy] or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[Limited per year as follows: <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.]] [Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy,	[Network] [[50 - 100]%] [100% after you pay a Copayment of \$[5 - 100] per visit] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that 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] [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]
	[Non-Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]

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>pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10 - 160] visits per year.]</p> <p>[Network 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>[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 Benefits are not available.]</p>	<p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available.]</p>
<p>[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic</p>			
<p>[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
	<p>[Designated Network]</p> <p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per date of service is</p>

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

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

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

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

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

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

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>limited 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><i>[Outpatient]</i></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p> <p><i>[Non-Network]</i></p> <p><i>[Inpatient]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay <i>[Outpatient]</i> [[50 - 100] %] [100% after you pay a Copayment of \$[5 - 100] per visit] [100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.] [100% for visits for medication management]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]
[31.] Surgery - Outpatient			
<i>[¹Does not apply if prior authorization is required for all pain management.]</i>			
<p align="center">[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits [for all outpatient surgeries] [for [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [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>			
[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as follows:] <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 	<i>[Designated Network]</i> [[50 - 100] %] [100% after you pay a Copayment of \$[5 - 1,000] per date of service] [100% after you pay a Copayment of \$[5 -	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per date of 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>[100% after you pay a Copayment of \$[5 - 1,000] per date of service at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per date of service, to a maximum Copayment of \$[5 - 5,000] per year at an outpatient Hospital-based surgical center]</p> <p>Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per date of service]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per date of service, to a maximum Copayment of \$[5 - 5,000] per year]</p> <p>[[50 - 100]% at an ambulatory surgical center or in a Physician's office]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per date of</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>Deductible of \$[5 - 1,000] per date of service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per date of service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per date of service is satisfied]</p>

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

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

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

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

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

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

Deleted: []

Deleted:]

[Prior Authorization Requirement]

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

[In addition, for 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> <p>[Non-Network Benefits are not available.]</p>		
[33.] Therapeutic Treatments - Outpatient	[Prior Authorization Requirement]		
<p>[For Non-Network Benefits you 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>[100% after you pay a Copayment of \$[5 - 1,000] per treatment]</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per treatment is satisfied]</p>
	<p>[[50 - 100]% at a free-standing center or in a Physician's office]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per treatment at a free-standing center or in a Physician's</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per treatment 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?
	office]		satisfied]
	<p>[[50 - 100]% at an outpatient Hospital-based center]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per treatment at an outpatient Hospital-based center]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per treatment]</p> <p>[[50 - 100]% at a free-standing center or in a Physician's office]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per treatment at a free-standing center or in a Physician's office]</p> <p>[[50 - 100]% at an outpatient Hospital-based center]</p> <p>[100% after you pay a Copayment of \$[5 - 1,000] per treatment at an outpatient Hospital-based center]</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 \$[5 - 1,000] per treatment is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per treatment is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per treatment is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] 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>Non-Network</p> <p>[[50 - 100]%) [100% after you pay a Copayment of \$[5 - 1,000] per treatment]</p> <p>[[50 - 100]%) at a free-standing center or in a Physician's office] [100% after you pay a Copayment of \$[5 - 1,000] per treatment at a free-standing center or in a Physician's office]</p> <p>[[50 - 100]%) at an outpatient Hospital-based center] [100% after you pay a Copayment of \$[5 - 1,000] per treatment at an outpatient Hospital-based center]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per treatment is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] per treatment is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 1,000] 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 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.]

[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency

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?
admissions).]			
<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>[Non-Network Benefits are not available.]</p>		
[35.] Urgent Care Center Services			
<p>[Limited to [2 - 10] visits per year.]</p> <p>[In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center:</p> <ul style="list-style-type: none"> • [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient</i>.] • [Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</i>.] • [Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>.] • [Diagnostic and therapeutic 	<p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit to a maximum Copayment of \$[5 - 5,000] per year]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in</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>scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i></p> <ul style="list-style-type: none"> • [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>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 that year]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 150] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[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 Copayment of \$[5 - 75]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not</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?
	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 [Non-Network Benefits are not available.]		available.]
[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]%] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]
Additional Benefits Required By Arkansas Law			
[38.] Dental Services - Anesthesia and Hospitalization			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[For Non-Network Benefits 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>			
	[¹ Designated Network] [Benefits will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i> .] Network Benefits will be the same as those stated under <i>Hospital -</i>		

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>Inpatient Stay in this Schedule of Benefits.</i></p> <p>Non-Network</p> <p>Benefits will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this Schedule of Benefits.</p>		
[39.] In Vitro Fertilization Services			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[For Non-Network Benefits 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 a lifetime maximum of \$15,000.</p>	<p>[Designated Network]</p> <p>[50 - 100%]</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> <p>[Yes] [No]</p> <p>[Yes] [No]</p>
[40.] Medical Foods			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[For Non-Network Benefits 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>¹<i>Include when group purchases the Outpatient Prescription Drug Rider.</i></p> <p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be [50 - 100] % [¹or as provided under the <i>Outpatient Prescription Drug Rider</i>].</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?
[Limited to]	<p>Non-Network Same as Network</p> <p>¹Include when group purchases the Outpatient Prescription Drug Rider.</p> <p>Network Depending upon where the Covered Health Service is provided, Benefits will be [50 - 100] % [¹or as provided under the Outpatient Prescription Drug Rider].</p>	<p>Same as Network</p> <p>[Yes] [No]</p>	<p>Same as Network</p> <p>[Yes] [No]</p>
<i>Mandated offer in Arkansas.</i>			
[[41.] Musculoskeletal Disorders of the Face, Neck or Head]	<div style="border: 1px solid red; border-radius: 10px; padding: 2px; display: inline-block;">Deleted:</div>		
<p>[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits 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>			
[Limited to]	<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 <i>Schedule of Benefits.</i>]</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 <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</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>each Covered Health Service category in this Schedule of Benefits.]</i>			
[[42.] Orthotic Devices and Services			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization five business days before receiving services and devices 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.]			
Benefits for replacements are limited to a single purchase of each type of orthotic device every three years.	Network [50 - 100%]	[Yes] [No]	[Yes] [No]
	Non-Network [50 - 100%]	[Yes] [No]	[Yes] [No]

Eligible Expenses

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

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

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

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

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

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

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

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

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

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

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

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

[PHCS payment option.]

^[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 [¹and 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 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.]
- ♦ 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

[Include when Core product is supported.]

We arrange for health care providers to participate in a Network. [The *UnitedHealthcare Core product has a limited Network of providers.*] Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

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

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

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

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

Continuity of Care

Continuity of care is provided under the Policy. In order for health services to be covered as Network Benefits, you must notify the company immediately if either of the following situations applies to you:

- Newly Eligible Persons who are being treated by a Non-Network provider for a current episode of an acute condition may continue to receive treatment from the Non-Network provider until the earlier of (1) the end of the current episode of treatment or (2) 90 days.
- Covered Persons who are being treated for a current episode of an acute condition by a Network provider when the provider's contract terminates may continue to receive treatment from that provider until the earlier of (1) the end of the current episode of treatment or (2) 90 days.

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

Designated Facilities and Other Providers

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

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

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

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Limitations on Selection of Providers

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

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

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

SERFF Tracking #:	UHLC-128572720	State Tracking #:		Company Tracking #:	SBN.CHP.I.11.AR REV2
State:	Arkansas	Filing Company:	UnitedHealthcare Insurance Company		
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO				
Product Name:	SBN.CHP.I.11.AR rev2				
Project Name/Number:	SBN.CHP.I.11.AR rev2/SBN.CHP.I.11.AR rev2				

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/13/2012	Form	SBN.CHP.I.11.AR rev2	07/23/2012	SBN_Medical_INS_2011_CHP rev2.pdf (Superseded)
07/13/2012	Supporting Document	Redline Comparison to previously approved CHP SBN - Rev2	07/23/2012	SBN_Medical_INS_2011_CHP Redline Rev2.pdf (Superseded)