

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

Filing at a Glance

Company: UnitedHealthcare Insurance Company
Product Name: BENSUM.CPON.I.11.AR
State: Arkansas
TOI: H16G Group Health - Major Medical
Sub-TOI: H16G.001A Any Size Group - PPO
Filing Type: Form
Date Submitted: 08/30/2012
SERFF Tr Num: UHLC-128667283
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: BENSUM.CPON.I.11.AR

Implementation: On Approval
Date Requested:
Author(s): Kelly Smith
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 09/10/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

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General Information

Project Name: BENSUM.CPON.I.11.AR	Status of Filing in Domicile: Not Filed
Project Number: BENSUM.CPON.I.11.AR	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 09/10/2012	Deemer Date:
State Status Changed: 09/10/2012	Submitted By: Kelly Smith
Created By: Kelly Smith	
Corresponding Filing Tracking Number: BENSUM.CPON.I.11.AR Benefit Summary for Shared Rx Rider - Network & Non-Network	

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:
 BENSUM.CPON.I.11.AR - Benefit Summary Medical 2011

AR 2011: The template was updated based upon the draft filing (i.e. update to Hearing Aids, women's preventive, advanced tiering options.)

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

Filing Fees

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

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Company	Amount	Date Processed	Transaction #
UnitedHealthcare Insurance Company	\$50.00	08/30/2012	62171886

State: Arkansas Filing Company: UnitedHealthcare Insurance Company
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/10/2012	09/10/2012

SERFF Tracking #:

UHLC-128667283

State Tracking #:

Company Tracking #:

BENSUM.CPON.I.11.AR

State:

Arkansas

Filing Company:

UnitedHealthcare Insurance Company

TOI/Sub-TOI:

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Disposition

Disposition Date: 09/10/2012

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
Form	BENSUM.CPON.I.11.AR	Approved-Closed	Yes

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

Lead Form Number: BENSUM.CPON.I.11.AR

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 09/10/2012	BENSUM.CPO N.I.11.AR	OTH	BENSUM.CPON.I.11.AR	Initial:	56.800	BENSUM.CPON.I.11.AR. pdf

Form Type Legend:

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



Benefit Summary

Arkansas – [Non-Differential PPO] [Choice Plus] [Options PPO] [Core]
[Plan Category Name]— [Plan Description] Plan [XX-X]

We want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- Check personalized data: Find individualized information on your benefit coverage, check the status of claims, and search for physicians and hospitals using www.myuhc.com.
- Researching health information: Find resources by calling Care24 or NurseLine® or by logging on to www.myuhc.com.
- Get help: Contact Customer Care at the telephone number on the back of your ID card when you need assistance locating physicians and other health care professionals in your network, or when you have coverage or benefit questions.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible – [Combined Medical and Pharmacy]		
[Individual Deductible][Single Coverage Deductible]	[\$[0-15,000] per year][No Annual Deductible]	[\$[0-15,000] per year][No Annual Deductible]
[Family Deductible][Family Coverage Deductible]	[\$[0-45,000] per year][No Annual Deductible]	[\$[0-45,000] per year][No Annual Deductible]
[This benefit plan contains a Per Occurrence Deductible that applies to certain Covered Health Services. This Per Occurrence Deductible must be met prior to and in addition to the Annual Deductible.][Member Copayments do [not] accumulate towards the Deductible.][No one in the family is eligible for Benefits until the family coverage Deductible is met.]		
[All individual Deductible amounts will count towards the family Deductible, but an individual will not have to pay more than the individual Deductible amount.]		
Out-of-Pocket Maximum – [Combined Medical and Pharmacy]		
[Individual Out-of-Pocket Maximum]	[\$[0-45,000] per year][No Out-of-Pocket Maximum]	[\$[0-45,000] per year][No Out-of-Pocket Maximum]
[Single Coverage Out-of-Pocket Maximum]	[\$[0-135,000] per year][No Out-of-Pocket Maximum]	[\$[0-135,000] per year][No Out-of-Pocket Maximum]
[Family Out-of-Pocket Maximum] [Family Coverage Out-of-Pocket Maximum]	Maximum]	Maximum]
[The Out-of-Pocket Maximum [includes] [does not include] [the Annual Deductible] [and] [Per Occurrence Deductible].]		
[If more than one person in a family is covered under the Policy, the [individual][single coverage] Out-of-Pocket Maximum stated above does not apply.][Member Copayments [and Per Occurrence Deductibles] do not accumulate towards the Out-of-Pocket Maximum.]		
[All individual Out-of-Pocket Maximum amounts will count towards the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.]		
Benefit Plan Coinsurance – The Amount We Pay		
	[[50-100]% [after Deductible has been met][Deductible does not apply]]	[[50-100]% [after Deductible has been met][Deductible does not apply]]

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), the COC shall prevail. It is recommended that you review your COC for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

[Plan Name]

Item #

[XXX-XXXX]

Rev. Date

[XX-XX]

[Benefit Accumulator]

[[Calendar][Policy] Year]

UnitedHealthcare Insurance Company

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
[Annual Maximum Benefit]	[Combined Network and Non-Network Maximum of \$[2,000-2,500,000] per Covered Person]	
[The maximum amount we will pay for Benefits during the year.]	[\$[2,000-2,500,000] per Covered Person]	[\$[2,000-2,500,000] per Covered Person]

[Prescription Drug Benefits]
 [Prescription drug benefits are shown under separate cover.]

Information on Benefit Limits

- [The [Annual Deductible,] [and] [Out-of-Pocket Maximum] [and] [Benefit limits] are calculated on a [Policy][calendar] year basis.]
- [All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Certificate of Coverage.]
- [The UnitedHealthcare Core product is designed to offer a limited Network of participating providers. Except in Emergency situations, please confirm that your provider is participating in this product before receiving services to receive the highest level of Benefits. You may call Customer Care at the number indicated on your ID card or access www.myuhc.com to determine Network status.]
- [When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.]

MOST COMMONLY USED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	<p>[Designated Network:][[50-100]% [after Deductible has been met][Deductible does not apply]][100% after you pay a \$[5-100] Copayment per visit][[50-100]% after: Per Occurrence Deductible of \$[5 - 100] [and Annual Deductible have been met]][100% for allergy injections when no other service is provided during the office visit]</p> <p>[Network:][[50-100]% [after Deductible has been met][Deductible does not apply]][100% after you pay a \$[5-100] Copayment per visit][[50-100]% after: Per Occurrence Deductible of \$[5-100] [and Annual Deductible have been met]][100% for allergy injections when no other service is provided during the office visit]</p>	<p>[[50-100]% [after Deductible has been met][Deductible does not apply]][100% after you pay a \$[5-100] Copayment per visit][[50-100]% after: Per Occurrence Deductible of \$[5-100] [and Annual Deductible have been met]][100% for allergy injections when no other service is provided during the office visit]</p>
Specialist Physician Office Visit	<p>[Designated Network:][[50-100]% [after Deductible has been met][Deductible does not apply]][100% after you pay a \$[5-100] Copayment per visit][[50-100]% after: Per Occurrence Deductible of \$[5 - 100] [and Annual Deductible have been met]][100% for allergy injections when no other service is provided during the office visit]</p> <p>[Network:][[50-100]% [after Deductible has been met][Deductible does not apply]][100% after you pay a \$[5-100] Copayment per visit][[50-100]% after: Per Occurrence Deductible of \$[5-100] [and Annual Deductible have been met]][100% for allergy injections when no other service is provided during the office visit]</p> <p><i>[Prior Authorization is required for Genetic Testing – BRCA]</i></p>	<p><i>Prior Authorization is required for Genetic Testing – BRCA</i></p>

[In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: [Lab, X-ray;] [CT, PET, MRI, MRA, Nuclear Medicine;] [Pharmaceutical Products;] [Scopic Procedures;] [Surgery;] [Therapeutic Treatments;] [Rehabilitation Services-Outpatient Therapy [and Manipulative Treatment].]]

MOST COMMONLY USED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit 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.	100%, Copayments and Deductibles do not apply.	[Non-Network Benefits are not available except for children under the age of 19][50-100% [after Deductible has been met]][Deductible does not apply]]
No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's immunizations.		
Specialist Physician Office Visit	100%, Copayments and Deductibles do not apply	
Lab, X-Ray or other preventive tests No deductible will be applicable to Network or non-Network Prostate Cancer Screening.	100%, Copayments and Deductibles do not apply	
The health care reform law provides for coverage of certain preventive services, based on your age, gender and other health factors, with no cost-sharing. The preventive care services covered under this section are those preventive services specified in the health care reform law. UnitedHealthcare also covers other routine services as described in other areas of this summary, which may require a copayment, coinsurance or deductible. Always refer to your plan documents for your specific coverage.		

Urgent Care Center Services

[Benefits are limited as follows: [2-10] visits per year.]	[[50-100]% [after Deductible has been met]][Deductible does not apply]] [100% after you pay a \$[5-150] Copayment per visit] [[50-100]% after: Per Occurrence Deductible of \$[5 - 150] [and Annual Deductible have been met]] [100% after you pay a \$[5-150] Copayment per visit to a maximum \$[5-5,000] Copayment per year][100% for the first [#] visits in a year; [50-90]% for any subsequent visits in that year][100% after you pay a \$[5-150] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]	[[50-100]% [after Deductible has been met]][Deductible does not apply]] [100% after you pay a \$[5-150] Copayment per visit][50-100]% after: Per Occurrence Deductible of \$[5 - 150] [and Annual Deductible have been met]][100% after you pay a \$[5-150] Copayment per visit to a maximum \$[5-5,000] Copayment per year][100% for the first [#] visits in a year; [50-90]% for any subsequent visits in that year][100% after you pay a \$[5-150] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]
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[In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: [Lab, X-ray;] [CT, PET, MRI, MRA, Nuclear Medicine;] [Pharmaceutical Products;] [Scopic Procedures;] [Surgery;] [Therapeutic Treatments;] [Rehabilitation Services-Outpatient Therapy [and Manipulative Treatment].]]

MOST COMMONLY USED BENEFITS

Types of Coverage

Network Benefits

Non-Network Benefits

Emergency Health Services – Outpatient

[In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: [Lab, X-ray;] [CT, PET, MRI, MRA, Nuclear Medicine;] [Pharmaceutical Products;] [Scopic Procedures;] [Surgery;] [Therapeutic Treatments;] [Rehabilitation Services-Outpatient Therapy [and Manipulative Treatment].]]

[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-500] Copayment 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.]] [[50-100]% after: Per Occurrence Deductible of \$[5-700] [and Annual Deductible have been met]] [100% for the first [#] visits in a year; [50-90]% for any subsequent visits in that year] [100% after you pay a \$[5-500] Copayment per visit for the first [#] visits in a year; [50 – 90]% for any subsequent visits in that year][100% after you pay a \$[5-500] Copayment per visit for the first [#] visits in a year; 100% after you pay a \$[50-650] Copayment for any subsequent visits in that year][100% after you pay a \$[5-500] Copayment per visit for the first [#] visits in a year; 100% after you pay a \$[5 -650] Copayment per visit for the next [#] visits in a year; 100% after you pay a \$[100-700] Copayment for any subsequent visits in that year][100% after you pay a \$[5-500] Copayment per visit for the first [#] visits in a year; 100% after you pay a \$[50-650] Copayment per visit for the next [#] visits in a year; 100% after you pay a \$[100-500] Copayment for the next [#] visits in a year; 100% after you pay a \$[150-700] Copayment for any subsequent visits in that year][100% after you pay \$[5-500] Copayment per visit for a condition defined as an Emergency; 100% after you pay a \$[50-650] Copayment per visit for a condition that does not meet the definition of an Emergency]

[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-500] Copayment 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.]] [[50-100]% after: Per Occurrence Deductible of \$[5-700] [and Annual Deductible have been met]] [100% for the first [#] visits in a year; [50-90]% for any subsequent visits in that year] [100% after you pay a \$[5-500] Copayment per visit for the first [#] visits in a year; [50 – 90]% for any subsequent visits in that year][100% after you pay a \$[5-500] Copayment per visit for the first [#] visits in a year; 100% after you pay a \$[50-650] Copayment for any subsequent visits in that year][100% after you pay a \$[5-500] Copayment per visit for the first [#] visits in a year; 100% after you pay a \$[50-650] Copayment per visit for the next [#] visits in a year; 100% after you pay a \$[100-700] Copayment for any subsequent visits in that year][100% after you pay a \$[5-500] Copayment per visit for the first [#] visits in a year; 100% after you pay a \$[5 -650] Copayment per visit for the next [#] visits in a year; 100% after you pay a \$[100-700] Copayment for any subsequent visits in that year][100% after you pay a \$[5-500] Copayment per visit for the first [#] visits in a year; 100% after you pay a \$[50-650] Copayment per visit for the next [#] visits in a year; 100% after you pay a \$[100-500] Copayment for the next [#] visits in a year; 100% after you pay a \$[150-700] Copayment for any subsequent visits in that year][100% after you pay \$[5-500] Copayment per visit for a condition defined as an Emergency; 100% after you pay a \$[50-650] Copayment per visit for a condition that does not meet the definition of an Emergency]

[Notification is required if confined in a non-Network Hospital].

Notification is required if confined in a non-Network Hospital.

MOST COMMONLY USED BENEFITS

Types of Coverage

Network Benefits

Non-Network Benefits

Hospital – Inpatient Stay

[Designated Network:][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[100-1,000] Copayment per day] [100% after you pay a \$[100-2,000] Copayment per Inpatient Stay] [[50-100]% after: Per Occurrence Deductible of \$[100-2,000] [and Annual Deductible have been met]] [100% after you pay a \$[100-1,000] Copayment per day to a maximum \$[100-10,000] Copayment per Inpatient Stay] [Network:][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[100-1,000] Copayment per day] [100% after you pay a \$[100-2,000] Copayment per Inpatient Stay] [[50-100]% after: Per Occurrence Deductible of \$[100-2,000] [and Annual Deductible have been met]] [100% after you pay a \$[100-1,000] Copayment per day to a maximum \$[100-10,000] Copayment per Inpatient Stay]

[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[100-1,000] Copayment per day] [100% after you pay a \$[100-2,000] Copayment per Inpatient Stay] [[50-100]% after: Per Occurrence Deductible of \$[100-2,000] [and Annual Deductible have been met]] [100% after you pay a \$[100-1,000] Copayment per day to a maximum \$[100-10,000] Copayment per Inpatient Stay]

[Prior Authorization is required.]

Prior Authorization is required.

ADDITIONAL CORE BENEFITS

Types of Coverage

Network Benefits

Non-Network Benefits

[Acupuncture Services]

[Benefits are limited as follows: [[10-100] treatments per year.] [[10-100] treatments per year, not to exceed \$[100-5,000] in Eligible Expenses per year.] [\$[100-5,000] in Eligible Expenses per year.]]

[100% after you pay a \$[5-75] Copayment per visit] [[50-100]% [after Deductible has been met][Deductible does not apply]] [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] [[50-100]% after: Per Occurrence Deductible of \$[5-75] [and Annual Deductible have been met]]

[Non-Network Benefits are not available][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-75] Copayment per visit] [[50-100]% after: Per Occurrence Deductible of \$[5-75] [and Annual Deductible have been met]]

Ambulance Services – Emergency and Non-Emergency

Ground Ambulance

[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[300-1,000] Copayment per day][100% after you pay a \$[25-300] Copayment per transport] [100% after you pay a \$[300-1,000] Copayment per day, up to a per day maximum of \$[300-1,000]][[50-100]% after: Per Occurrence Deductible of [\$[25-1,000] [and Annual Deductible have been met]]

[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[300-1,000] Copayment per day][100% after you pay a \$[25-300] Copayment per transport] [100% after you pay a \$[300-1,000] Copayment per day, up to a per day maximum of \$[300-1,000]][[50-100]% after: Per Occurrence Deductible of [\$[25-1,000] [and Annual Deductible have been met]]

Air Ambulance

[[50-100]% [after Deductible has been met][Deductible does not apply]][100% after you pay a \$[2,500-10,000] Copayment per day][100% after you pay a \$[25-2,500] Copayment per transport] [100% after you pay a \$[2,500-10,000] Copayment per day, up to a per day maximum of \$[2,500-10,000]]

[[50-100]% [after Deductible has been met][Deductible does not apply]][100% after you pay a \$[2,500-10,000] Copayment per day][100% after you pay a \$[25-2,500] Copayment per transport] [100% after you pay a \$[2,500-10,000] Copayment per day, up to a

[[50-100]% after: Per Occurrence Deductible of [\$[25-10,000] [and Annual Deductible have been met]]

Prior Authorization is required for non-Emergency Ambulance.

per day maximum of \$[2,500-10,000]]
[[50-100]% after: Per Occurrence Deductible of [\$[25-10,000] [and Annual Deductible have been met]]

Prior Authorization is required for non-Emergency Ambulance.

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
[Congenital Heart Disease (CHD) Surgeries]	<p>[Designated Network:] [[50-100]% [after Deductible has been met]] [Deductible does not apply] [100% after you pay a \$[100-1,000] Copayment per day] [100% after you pay a \$[100-2,000] Copayment per Inpatient Stay] [[50-100]% after: Per Occurrence Deductible of \$[100-2,000] [and Annual Deductible have been met]] [100% after you pay a \$[100-1,000] Copayment per day to a maximum \$[100-5,000] Copayment per Inpatient Stay] [Network:] [[50-100]% [after Deductible has been met]] [Deductible does not apply] [100% after you pay a \$[100-1,000] Copayment per day] [100% after you pay a \$[100-2,000] Copayment per Inpatient Stay] [100% after you pay a \$[100-1,000] Copayment per day to a maximum \$[100-5,000] Copayment per Inpatient Stay] [[50-100]% after: Per Occurrence Deductible of \$[100-2,000] [and Annual Deductible have been met]]</p> <p><i>[Prior Authorization is required.]</i></p>	<p>[[50-100]% [after Deductible has been met]] [Deductible does not apply] [100% after you pay a \$[100-1,000] Copayment per day] [100% after you pay a \$[100-2,000] Copayment per Inpatient Stay] [[50-100]% after: Per Occurrence Deductible of \$[100-2,000] [and Annual Deductible have been met]] [100% after you pay a \$[100-1,000] Copayment per day to a maximum \$[100-5,000] Copayment per Inpatient Stay]</p> <p><i>[Prior Authorization is required.]</i></p>
[Dental Services – Accident Only] [Benefits are limited as follows: \$[2,000-5,000] maximum per year \$[500-1,500] maximum per tooth.]	<p>[[50-100]% [after Deductible has been met]] [Deductible does not apply] [100% after you pay a \$[5-75] Copayment per visit] [[50-100]% after: Per Occurrence Deductible of \$[5-75] [and Annual Deductible have been met]]</p> <p><i>Prior Authorization is required.</i></p>	<p>[[50-100]% [after Deductible has been met]] [Deductible does not apply] [100% after you pay a \$[5-75] Copayment per visit] [[50-100]% after: Per Occurrence Deductible of \$[5-75] [and Annual Deductible have been met]]</p> <p><i>Prior Authorization is required.</i></p>
Diabetes Services Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care Diabetes Self Management Items [Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment.]	<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 Benefit Summary. Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider.</p> <p><i>[Prior Authorization is required for Durable Medical Equipment in excess of \$[1,000-5,000].]</i></p>	<p><i>Prior Authorization is required for Durable Medical Equipment in excess of \$[1,000-5,000].</i></p>

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
[Durable Medical Equipment]		
<p>[Benefits are limited as follows: \$[500-100,000] per year and are limited to a single purchase of a type of DME (including repair and 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>[[50-100]% [after Deductible has been met][Deductible does not apply]][[50-100]% after: Per Occurrence Deductible of \$[5-500] [and Annual Deductible have been met]]</p>	<p>[Non-Network Benefits are not available][[50-100]% [after Deductible has been met][Deductible does not apply]][[50-100]% after: Per Occurrence Deductible of \$[5-500] [and Annual Deductible have been met]]</p>
<p style="text-align: center;"><i>[Prior Authorization is required for Durable Medical Equipment in excess of \$[1,000-5,000].]</i></p>		
<p>[This benefit category contains services/devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.]</p>		
Hearing Aids		
<p>[Benefits are limited as follows: \$[2,500-5,000] per [calendar year] [Contract Period], but shall at least be \$1,400 per ear and are limited to a single purchase (including repair/ replacement) every [year] [[two-three] years].]</p>	<p>[[50-100]% [after Deductible has been met][Deductible does not apply]][[50-100]% after: Per Occurrence Deductible of \$[50-1,000] [and Annual Deductible have been met]]</p>	<p>[Non-Network Benefits are not available][[50-100]% [after Deductible has been met][Deductible does not apply]][[50-100]% after: Per Occurrence Deductible of \$[50-1,000] [and Annual Deductible have been met]]</p>
<p>[No Copayment, Coinsurance or Deductible will be applicable to Network or non-Network Hearing Aid Coverage.]</p>		
<p style="text-align: center;"><i>[Prior Authorization is required.]</i></p>		
Home Health Care		
<p>[Benefits are limited as follows: [[40-200] visits per year. One visit equals up to four hours of skilled care services.][[40-200] visits per year to a maximum of \$[500-5,000] in Eligible Expenses per year.][[This visit limit does not include any service which is billed only for the administration of intravenous infusion.]</p>	<p>[[50-100]% [after Deductible has been met] [Deductible does not apply]][100% after you pay a \$[5-50] Copayment per visit][[50-100]% after: Per Occurrence Deductible of \$[5-50] [and Annual Deductible have been met]]</p>	<p>[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-50] Copayment per visit][[50-100]% after: Per Occurrence Deductible of \$[5-50] [and Annual Deductible have been met]]</p>
<p style="text-align: center;"><i>[Prior Authorization is required.]</i></p>		
Hospice Care		
<p>[Benefits are limited as follows: \$[2,000-30,000] per Covered Person per lifetime.]</p>	<p>[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-100] Copayment per day][[50-100]% after: Per Occurrence Deductible of \$[5-100] [and Annual Deductible have been met]]</p>	<p>[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-100] Copayment per day][[50-100]% after: Per Occurrence Deductible of \$[5-100] [and Annual Deductible have been met]]</p>
<p style="text-align: center;"><i>[Prior Authorization is required for Inpatient Stay.]</i></p>		
[Infertility Services]		
<p>[Benefits are limited as follows: \$[2,000-30,000] per Covered Person per lifetime.]</p>	<p>[[50-100]% [after Deductible has been met][Deductible does not apply]]</p>	<p>[Non-Network Benefits are not available][[50-100]% [after Deductible has been met][Deductible does not apply]]</p>

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Lab, X-Ray and Diagnostics – Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	<i>Include headers if plan design uses free-standing lab and/or hospital-based lab payment options.</i>	<i>Include headers if plan design uses free-standing lab and/or hospital-based lab payment options.</i>
Lab Testing – Outpatient	[Free-standing lab [or in a Physician’s office]] [Hospital-based lab][Physician office-based lab]	[Free-standing lab [or in a Physician’s office]] [Hospital-based lab][Physician office-based lab]
	<p>[Designated Network:][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-100] Copayment per service] [[50-100]% after: Per Occurrence Deductible of \$[5-100] [and Annual Deductible have been met]]</p> <p>[Network:][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-100] Copayment per service] [[50-100]% after: Per Occurrence Deductible of \$[5-100] [and Annual Deductible have been met]]</p>	<p>[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-100] Copayment per service] [[50-100]% after: Per Occurrence Deductible of \$[5-100] [and Annual Deductible have been met]]</p> <p>[Non-Network Benefits are not available]</p>
	<i>Include headers if plan design uses free-standing lab and/or hospital-based lab payment options.</i>	<i>Include headers if plan design uses free-standing lab and/or hospital-based lab payment options.</i>
X-Ray and Other Diagnostic Testing – Outpatient	[Free-standing diagnostic center or in a Physician’s office] [Outpatient Hospital-based diagnostic center]	[Free-standing diagnostic center or in a Physician’s office] [Outpatient Hospital-based diagnostic center]
	<p>[Designated Network:][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-100] Copayment per service] [[50-100]% after: Per Occurrence Deductible of \$[5-100] [and Annual Deductible have been met]]</p> <p>[Network:][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-100] Copayment per service] [[50-100]% after: Per Occurrence Deductible of \$[5-100] [and Annual Deductible have been met]]</p>	<p>[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-100] Copayment per service] [[50-100]% after: Per Occurrence Deductible of \$[5-100] [and Annual Deductible have been met]]</p> <p>[Non-Network Benefits are not available]</p>
	<i>[Prior Authorization is required.]</i>	<i>Prior Authorization is required.</i>

Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient

Include headers if plan design uses free-standing lab and/or hospital-based lab payment options.

[Free-standing diagnostic center or in a Physician’s office] [Outpatient Hospital-based diagnostic center]

[Designated Network:][[50-100]% [after Deductible has been met]][Deductible does not apply]] [100% after you pay a \$[5-500] Copayment per service] [[50-100]% after: Per Occurrence Deductible of \$[5-500] [and Annual Deductible have been met]]

[Network:][[50-100]% [after Deductible has been met]][Deductible does not apply]] [100% after you pay a \$[5-500] Copayment per service] [[50-100]% after: Per Occurrence Deductible of \$[5-500] [and Annual Deductible have been met]]

[Prior Authorization is required.]

Include headers if plan design uses free-standing lab and/or hospital-based lab payment options.

[Free-standing diagnostic center or in a Physician’s office] [Outpatient Hospital-based diagnostic center]

[[50-100]% [after Deductible has been met]][Deductible does not apply]] [100% after you pay a \$[5-500] Copayment per service] [[50-100]% after: Per Occurrence Deductible of \$[5-500] [and Annual Deductible have been met]] [Non-Network Benefits are not available]

Prior Authorization is required.

[Obesity Surgery]

[Benefits are limited as follows: \$[40,000-250,000] per Covered Person per lifetime.]

[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 Benefit Summary.]

Prior Authorization is required.

Prior Authorization is required.

[Ostomy Supplies]

[Benefits are limited as follows: \$[500-25,000] per year.]

[[50-100]% [after Deductible has been met]][Deductible does not apply]][[50-100]% after: Per Occurrence Deductible of \$[5-50] [and Annual Deductible have been met]]

[Non-Network Benefits are not available][[50-100]% [after Deductible has been met]][Deductible does not apply]]

Pharmaceutical Products - Outpatient

This includes medications administered in an outpatient setting, in the Physician’s Office, or in a Covered Person’s home.

[[50-100]% [after Deductible has been met[, except when provided in a Physician office visit]][Deductible does not apply]] [100% after you pay a \$[5-100] Copayment per Pharmaceutical Product] [[50-100]% after: Per Occurrence Deductible of \$[5-100] [and Annual Deductible have been met]]

[Non-Network Benefits are not available][[50-100]% [after Deductible has been met[, except when provided in a Physician office visit]][Deductible does not apply]] [100% after you pay a \$[5-100] Copayment per Pharmaceutical Product] [[50-100]% after: Per Occurrence Deductible of \$[5-100] [and Annual Deductible have been met]]

[Prior Authorization is required for certain services.]

Prior Authorization is required for certain services.

Physician Fees for Surgical and Medical Services

[Designated Network:][[50-100]% [after Deductible has been met]][Deductible does not apply] [[50-100]% after: Per Occurrence Deductible of \$[50-250] [and Annual Deductible have been met]]

[[50-100]% [after Deductible has been met]][Deductible does not apply]]

[Network:][[50-100]% [after Deductible has been met]][Deductible does not apply] [[50-100]% after: Per Occurrence Deductible of \$[50-250] [and Annual Deductible have been met]]

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Pregnancy – [Maternity Services][Complications of Pregnancy only]	<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 Benefit Summary [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 services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]</p> <p><i>[Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.]</i></p>	<p><i>Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</i></p>
Prosthetic Devices and Services Benefits for replacement are limited to a single purchase of each type of prosthetic device every three years. [Once this limit is reached, Benefits continue to be available for items required by the Women's Health and Cancer Rights Act of 1998.]	<p>[[50-100]% [after Deductible has been met][Deductible does not apply]]</p> <p><i>[Prior Authorization is required for prosthetic devices in excess of \$[1,000-5,000].]</i></p>	<p>[Non-Network Benefits are not available][[50-100]% [after Deductible has been met][Deductible does not apply]]</p> <p><i>Prior Authorization is required for prosthetic devices in excess of \$[1,000-5,000].</i></p>
Reconstructive Procedures	<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 Benefit Summary.</p> <p><i>[Prior Authorization is required.]</i></p>	<p><i>Prior Authorization is required.</i></p>
[Rehabilitation Services – Outpatient Therapy [and Manipulative Treatment]] [Benefits are limited as follows: [[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, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10- 160] visits per year.]	<p>[[50-100]% [after Deductible has been met][Deductible does not apply]]</p> <p>[[50-100]% after: Per Occurrence Deductible of \$[50-100] [and Annual Deductible have been met]]</p> <p>[100% after you pay a \$[5-100] Copayment per visit]</p> <p>[100% for the first [#] visits in a year; [50-90]% for any subsequent visits in that year] [100% after you pay a \$[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]</p> <p><i>[Prior Authorization is required for Manipulative Treatment.]</i></p>	<p>[Non-Network Benefits are not available][[50-100]% [after Deductible has been met][Deductible does not apply]][[50-100]% after: Per Occurrence Deductible of \$[50-100] [and Annual Deductible have been met]][100% after you pay a \$[5-100] Copayment per visit]</p> <p><i>Prior Authorization is required for Manipulative Treatment.</i></p>

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
<p>Diagnostic scopic procedures include, but are not limited to:</p> <ul style="list-style-type: none"> Colonoscopy Sigmoidoscopy Endoscopy <p>For Preventive Scopic Procedures, refer to the Preventive Care Services category.</p>	<p><i>Include headers if plan design uses free-standing lab and/or hospital-based lab payment options.</i></p> <p>[Free-standing center or in a Physician’s office][Outpatient Hospital-based center]</p> <p>[Designated Network:][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-1,000] Copayment per date of service] [[50-100]% after: Per Occurrence Deductible of \$[5-1,000] [and Annual Deductible have been met]]</p> <p>[Network:][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-1,000] Copayment per date of service] [[50-100]% after: Per Occurrence Deductible of \$[5-1,000] [and Annual Deductible have been met]]</p>	<p><i>Include headers if plan design uses free-standing lab and/or hospital-based lab payment options.</i></p> <p>[Free-standing center or in a Physician’s office][Outpatient Hospital-based center]</p> <p>[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-1,000] Copayment per date of service] [[50-100]% after: Per Occurrence Deductible of \$[5-1,000] [and Annual Deductible have been met]]</p>
<p><i>[Prior Authorization is required.]</i></p>		
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
<p>[Benefits are limited as follows: [[40-180] days per year.] [[30 - 180] days per year in a Skilled Nursing Facility. [30 - 180] days per year in an Inpatient Rehabilitation Facility.]</p>	<p>[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[50-1,000] Copayment per day] [100% after you pay a \$[50-2,000] Copayment per Inpatient Stay][100% after you pay a \$[50-1,000] Copayment per day to a maximum \$[50-5,000] Copayment per Inpatient Stay] [[50-100]% after: Per Occurrence Deductible of \$[50 - 2,000] [and Annual Deductible have been met]]</p>	<p>[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[50-1,000] Copayment per day] [100% after you pay a \$[50-2,000] Copayment per Inpatient Stay][100% after you pay a \$[50-1,000] Copayment per day to a maximum \$[50-10,000] Copayment per Inpatient Stay][[50-100]% after: Per Occurrence Deductible of \$[50 - 2,000] [and Annual Deductible have been met]]</p>
<p><i>[Prior Authorization is required.]</i></p>		
Surgery – Outpatient		
	<p><i>Include headers if plan design uses free-standing lab and/or hospital-based lab payment options.</i></p> <p>[Ambulatory surgical center or in a Physician’s office][Outpatient Hospital-based surgical center]</p> <p>[Designated Network:][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-1,000] Copayment per date of service] [100% after you pay a \$[5-1,000] Copayment per date of service, to a maximum \$[5-5,000] Copayment per</p>	<p><i>Include headers if plan design uses free-standing lab and/or hospital-based lab payment options.</i></p> <p>[Ambulatory surgical center or in a Physician’s office][Outpatient Hospital-based surgical center]</p> <p>[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-1,000] Copayment per date of service] [100% after you pay a \$[5-1,000] Copayment per date of service, to a maximum \$[5-5,000] Copayment per year] [[50-100]% after: Per</p>

year][[50-100]% after: Per Occurrence Deductible of \$[5-1,000] [and Annual Deductible have been met]]

Occurrence Deductible of \$[5-1,000] [and Annual Deductible have been met]]

[Network:][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-1,000] Copayment per date of service][100% after you pay a \$[5-1,000] Copayment per date of service, to a maximum \$[5-5,000] Copayment per year][[50-100]% after: Per Occurrence Deductible of \$[5-1,000] [and Annual Deductible have been met]]

[Prior Authorization is required for certain services.]

Prior Authorization is required for certain services.

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
<p>Temporomandibular Joint Services [Benefits are limited as follows: \$[1,000 - 20,000] per year.]</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 Benefit Summary.] <i>[Prior Authorization is required for Inpatient Stay.]</i></p>	<p><i>Prior Authorization is required for Inpatient Stay.</i></p>
<p>Therapeutic Treatments - Outpatient Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology</p>	<p><i>Include headers if plan design uses free-standing lab and/or hospital-based lab payment options.</i> [Free-standing center or in a Physician's office][Outpatient Hospital-based center]</p> <p>[Designated Network:][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-1,000] Copayment per treatment] [[50-100]% after: Per Occurrence Deductible of \$[5-1,000] [and Annual Deductible have been met]]</p> <p>[Network:][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-1,000] Copayment per treatment] [[50-100]% after: Per Occurrence Deductible of \$[5-1,000] [and Annual Deductible have been met]]</p> <p><i>[Prior Authorization is required for certain services.]</i></p>	<p><i>Include headers if plan design uses free-standing lab and/or hospital-based lab payment options.</i> [Free-standing center or in a Physician's office][Outpatient Hospital-based center]</p> <p>[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-1,000] Copayment per treatment] [[50-100]% after: Per Occurrence Deductible of \$[5-1,000] [and Annual Deductible have been met]]</p> <p><i>Prior Authorization is required for certain services.</i></p>
<p>Transplantation Services</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 Benefit Summary.</p> <p>[For Network Benefits, services must be received at a Designated Facility] <i>Prior Authorization is required.</i></p>	<p>[Benefits are limited to \$[30,000-250,000] per Transplant.] <i>Prior Authorization is required.</i></p>

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
[Vision Examinations] [Benefits are limited as follows: [1 exam] [[2-3] exams] [every [2-3] years] [per year].]	[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a [\$5-100] Copayment per visit] [[50-100]% after: Per Occurrence Deductible of \$[5-100] [and Annual Deductible have been met]]	[Non-Network Benefits are not available][[50-100]% [after Deductible has been met][Deductible does not apply]][100% after you pay a [\$5-100] Copayment per visit][[50-100]% after: Per Occurrence Deductible of \$[5-100] [and Annual Deductible have been met]]
[Wigs] [Benefits are limited as follows: [\$[100 - 1,000] per year.] [\$[100 - 5,000] every [24 - 36] months].]	[[50-100]% [after Deductible has been met][Deductible does not apply]]	[Non-Network Benefits are not available][[50-100]% [after Deductible has been met][Deductible does not apply]]

STATE MANDATED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Clinical Trials [Participation in a qualifying clinical trial for the treatment of: Cancer Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees]	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 Benefit Summary. <i>Prior Authorization is required.</i>	 <i>Prior Authorization is required.</i>
Dental Services – Anesthesia and Hospitalization	Benefits will be the same as those stated under Hospital – Inpatient Stay in this Benefit Summary. <i>[Prior Authorization is required.]</i>	<i>Prior Authorization is required.</i>
In Vitro Fertilization Services Benefits are limited to a lifetime maximum of \$15,000.	[[50-100]% [after Deductible has been met][Deductible does not apply]] <i>[Prior Authorization is required.]</i>	[[50-100]% [after Deductible has been met][Deductible does not apply]] <i>Prior Authorization is required.</i>
Medical Foods	Depending upon where the Covered Health Service is provided, Benefits will be [50-100]% [after Deductible has been met][Deductible does not apply] [or as provided under the Outpatient Prescription Drug Rider]. <i>[Prior Authorization is required.]</i>	Same as Network. <i>Prior Authorization is required.</i>
Mental Health Services <i>[Limits will not apply to groups of 51+]</i>	[For groups with [50 or less total][51 or more total] employees:] [Inpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[100-1,000] Copayment per day][100% after you pay a \$[100-2,000] Copayment per Inpatient Stay][100% after you pay a \$[100-1,000] Copayment per day to a maximum \$[100 - 5,000] Copayment per Inpatient Stay] [[50-100]% after:	[For groups with [50 or less total][51 or more total] employees:] [Inpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]][100% after you pay a \$[100-1,000] Copayment per day][100% after you pay a \$[100-2,000] Copayment per Inpatient Stay][100% after you pay a \$[100-1,000] Copayment per day to a maximum \$[100 - 5,000] Copayment per Inpatient Stay][[50-100]% after: Per Occurrence

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STATE MANDATED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Orthotic Devices and Services		
Benefits for replacements are limited to a single purchase of each type of orthotic device every three years.	[[50-100]% [after Deductible has been met][Deductible does not apply]]	[[50-100]% [after Deductible has been met][Deductible does not apply]]
	<i>[Prior Authorization is required.]</i>	<i>Prior Authorization is required.</i>
Substance Use Disorder Services		
[For groups with 50 or less total employees:	[For groups with [50 or less total][51 or more total] employees:]	[For groups with [50 or less total][51 or more total] employees:]
Benefits are limited for [any combination of] [Mental Health,] [Neurobiological Disorders – Autism Spectrum Disorder Services] [and] Substance Use Disorder Services as follows:	[Inpatient]	[Inpatient]
[[10-100] days per year for Inpatient] [[10-100] visits per year for Outpatient]]	[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[100-1,000] Copayment per day][100% after you a \$[100-2,000] Copayment per Inpatient Stay][100% after you pay a \$[100-1,000] Copayment per day to a maximum \$[100 - 5,000] Copayment per Inpatient Stay] [[50-100]% after: Per Occurrence Deductible of \$[100-2,000] [and Annual Deductible have been met]]	[[50-100]% [after Deductible has been met][Deductible does not apply]][100% after you pay a \$[100-1,000] Copayment per day][100% after you pay a \$[100- 2,000] Copayment per Inpatient Stay][100% after you pay a \$[100-1,000] Copayment per day to a maximum \$[100 - 5,000] Copayment per Inpatient Stay][[50-100]% after: Per Occurrence Deductible of \$[100-2,000] [and Annual Deductible have been met]]
[For groups with 51 or more total employees:	[Outpatient]	[Outpatient]
Benefit limits do not apply]	[[50-100]% [after Deductible has been met][Deductible does not apply]][100% after you pay a \$[5-100] Copayment per visit][100% after you pay a \$[5-75] Copayment per individual visit; \$[5-75] per group visit.][100% for visits for medication management][[50-100] %: Per Occurrence Deductible of \$[5-100] [and Annual Deductible have been met]]	[[50-100]% [after Deductible has been met][Deductible does not apply]][100% after you pay a \$[5-100] Copayment per visit][100% after you pay a \$[5-75] Copayment per individual visit; \$[5-75] per group visit.][100% for visits for medication management][[50-100] %: Per Occurrence Deductible of \$[5-100] [and Annual Deductible have been met]]
	<i>[Prior Authorization is required for certain services.]</i>	<i>Prior Authorization is required for certain services.</i>

MEDICAL EXCLUSIONS

It is recommended that you review your COC for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; [and acupuncture]; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to [Manipulative Treatment and] non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). [This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 1 of the COC.] Dental Services – Anesthesia and Hospitalization for which Benefits are provided as described in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. [This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 1 of the COC.] Dental Services – Anesthesia and Hospitalization for which Benefits are provided as described in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. [This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 1 of the COC.] Dental Services – Anesthesia and Hospitalization for which Benefits are provided as described in Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. This exclusion does not apply to orthotics as described under Durable Medical Equipment in Section 1 of the COC. Cranial banding. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to assist in communication and speech [except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC]. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy. [Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.] [New Pharmaceutical Products and/or new dosage forms until the date they are assigned to a tier by our Pharmaceutical Product List Management Committee.]

Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

MEDICAL EXCLUSIONS CONTINUED

Medical Supplies [and Equipment]

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters [Ostomy supplies.] This exclusion does not apply to:

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

Tubings and masks [except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in Section 1 of the COC]. [Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.]

Mental Health

[Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.] [Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association]. [Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, and paraphilias.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.] [Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.] [Learning, motor skills, and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.] [Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for autism spectrum disorder as a primary diagnosis are described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1 of the COC.] [Services or supplies for the diagnosis or treatment of Mental Illness, that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

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

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

Neurobiological Disorders – Autism Spectrum Disorders

[Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.] [Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.] [Mental retardation as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.] [Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.] [Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.] [Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

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

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

MEDICAL EXCLUSIONS CONTINUED

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

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

Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to medical foods for which Benefits are provided as described in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. [Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.] [Wigs regardless of the reason for the hair loss.]

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. [Rehabilitation services [and Manipulative Treatment] to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.] [Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or [autism spectrum disorders] [Autism Spectrum Disorders].] [Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.] [Outpatient rehabilitation services. Examples include physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, manipulative treatment, post-cochlear implant aural therapy, cognitive rehabilitation therapy and vision therapy.] Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. [Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).] [Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.] [The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.] Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea. [This exclusion does not apply to Musculoskeletal Disorders of the Face, Neck or Head for which Benefits are provided as described in Section 1 of the COC under Additional Benefits Required By Arkansas Law.] [Surgical and non-surgical treatment of obesity.] [Non-surgical treatment of obesity.] [Surgical treatment of obesity.] Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. [Breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC.] [Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a

physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC.] [Ventricular assist device implantation that is not performed at a Designated Facility. This exclusion does not apply to partial assist devices which are intended for short-term purposes or to Emergency implantations of partial assist devices.] [Network Benefits for ventricular assist device implantation that is not performed at a Designated Facility. This exclusion does not apply to partial assist devices which are intended for short-term purposes or to Emergency implantations of partial assist devices.]

MEDICAL EXCLUSIONS CONTINUED

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

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

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

Surrogate parenting, donor eggs, donor sperm and host uterus. [Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.] The reversal of voluntary sterilization [and voluntary sterilization].

[Health services and associated expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).] [Contraceptive supplies and services.] [Fetal reduction surgery.] [Maternity related medical services for prenatal care, postnatal care and delivery (other than a non-elective cesarean delivery).] [Maternity related medical services for Enrolled Dependent children.]

Services Provided under Another Plan

[Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or [Mental Illness] [mental illness] that would have been covered under workers' compensation or similar legislation had that coverage been elected.] [Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes coverage required by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.] Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Substance Use Disorder

[Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.] [Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.] [Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

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

medical practice and benchmarks.]

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

MEDICAL EXCLUSIONS CONTINUED

Transplants

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

Travel

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

Types of Care

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

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. [Routine vision examinations, including refractive examinations to determine the need for vision correction.] Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). [Eye exercise or vision therapy.] Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. [Bone anchored hearing aids except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Person who meet the above coverage criteria, other than for malfunctions.] [Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.]

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp [travel,] [career or employment,] insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC); required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a “complication” is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a “complication” are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

[Preexisting Conditions (Applies only to groups of 50 or less employees)]

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

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

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

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), the COC shall prevail. It is recommended that you review your COC for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

UnitedHealthcare Insurance Company

SERFF Tracking #:

UHLC-128667283

State Tracking #:

Company Tracking #:

BENSUM.CPON.I.11.AR

State:

Arkansas

Filing Company:

UnitedHealthcare Insurance Company

TOI/Sub-TOI:

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

Product Name:

BENSUM.CPON.I.11.AR

Project Name/Number:

BENSUM.CPON.I.11.AR /BENSUM.CPON.I.11.AR

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	09/10/2012
Bypass Reason:	Advertising /Marketing Material Benefit summary filings - Not Applicable		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/10/2012
Bypass Reason:	Advertising /Marketing Material Benefit summary filings - Not Applicable		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	09/10/2012
Bypass Reason:	Advertising /Marketing Material Benefit summary filings - Not Applicable		
Comments:			