

UnitedHealthcare Plan of the River Valley, Inc.

Medical Benefits At-A-Glance

Benefit Features

Member Responsibility

| | Network | Point of Service |
|---|--------------------------------------|--|
| Deductible (Calendar Year) | None | \$400 individual \$800 family |
| Maximum Out-of-Pocket Expense (Calendar Year) | \$1,500 individual \$3,000 family | <u>\$2,500</u> individual <u>\$5,000</u> family |
| 4th Quarter Deductible Carryover | Applicable | Applicable |

Physician Medical Services

| | | |
|--|--------------------------------|-----------------------------|
| Allergy Injections | <u>\$3 copayment/injection</u> | Not covered |
| Allergy Testing | <u>\$20 copayment/visit</u> | Not covered |
| Home Visits | <u>\$20 copayment/visit</u> | 40% after deductible |
| Immunizations | 0% coinsurance | 40% coinsurance † * |
| Injections | 20% coinsurance | 40% after deductible |
| Inpatient Hospital Visits & Consultations | 20% coinsurance | 40% after deductible |
| Maternity Care | 20% coinsurance | 40% after deductible |
| Newborn Baby Care | 20% coinsurance | 40% <u>after deductible</u> |
| Nursing Facility Visits | <u>\$10 copayment/visit</u> | 40% after deductible |
| Office Visits | <u>\$20 copayment/visit</u> | 40% after deductible |
| Outpatient Physician Services | 20% coinsurance | 40% after deductible |
| Routine/Preventive Physical Exam | <u>\$20 copayment/visit</u> | <u>Not covered</u> |
| Surgical Services - Inpatient | 20% coinsurance | 40% after deductible |
| <i>(Morbid Obesity Surgery Must be approved in advance by UnitedHealthcare.)</i> | <u>20% coinsurance</u> | <u>40% after deductible</u> |
| Surgical Services - Outpatient | 20% coinsurance | 40% after deductible |
| Surgical Services - Office | <u>\$20 copayment/surgery</u> | 40% after deductible |
| Well Child Care | <u>\$20 copayment/visit</u> | 40% coinsurance † * |

Urgent Care Center \$20 copayment/visit 40% after deductible

Emergency Services

| | | |
|---|------------------------------|--------------------------------|
| Ambulance | <u>20% coinsurance</u> | <u>20% coinsurance</u> † |
| Emergency Room Facility | <u>\$100 copayment/visit</u> | <u>\$100 copayment/visit</u> † |
| Emergency Room Physician Care | 20% coinsurance | 20% coinsurance † |

Initial care only of a medical emergency is covered. Follow up care obtained in the emergency room is not covered. Emergency room facility copayment will be waived if admitted.

Hospital/Facility Services

| | | |
|---|------------------------|----------------------|
| Inpatient Hospital (Semi-Private Room) | 20% coinsurance | 40% after deductible |
| Outpatient Facility or Surgi-Center Services | 20% coinsurance | 40% after deductible |
| Nursing Facility (Limited to 100 days per calendar year.) | <u>20% coinsurance</u> | 40% after deductible |

Home Health Care (Must be approved in advance by UnitedHealthcare.) 0% coinsurance Not covered

Infertility Services 20% coinsurance 40% after deductible

Lifetime maximum \$2,500

(Covered services are for artificial insemination, Gamete Intrafallopian Transfer, or in-vitro fertilization.)

Medical Equipment

Durable Medical Equipment • Prosthetic Devices • **Foot Orthotics** 20% coinsurance Not covered
(Foot Orthotics limited (unless part of diabetes treatment) to one custom molded pair of shoe inserts once every 24 months.)

Benefits

Member Responsibility

| | Network | Point of Service |
|---|----------------------|----------------------|
| Oral Surgery - Removal of Impacted Wisdom Teeth | 20% coinsurance | 20% coinsurance † |
| (The ADA codes that are covered: 07220 Removal of impacted tooth-soft tissue; 07230 Removal of impacted tooth-partially bony; 07240 Removal of impacted tooth-completely bony; 07241 Removal of impacted tooth-completely bony-with unusual surgical complications; 09220 General anesthesia-first 30 minutes; 09221 General anesthesia-each additional 15 minutes; 09241 Intravenous sedation-30 minutes; 09242 Intravenous sedation-each additional 15 minutes. | | |
| Outpatient Rehabilitative Therapy | | |
| Physical • Speech • Occupational | 20% coinsurance | 40% after deductible |
| <i>Member is limited to 60 outpatient treatment days per disability per calendar year. Speech therapy will only be covered for residual speech impairment resulting from a stroke, accidental injury, or surgery to the head or neck.</i> | | |
| Speech Therapy (for Pervasive Developmental Disorders) | 20% coinsurance | 40% after deductible |
| <i>Member is limited to 20 outpatient treatment days per calendar year.</i> | | |
| Radiation Therapy & Chemotherapy | | |
| Hospital (Outpatient) | 20% coinsurance | 40% after deductible |
| Office | 20% coinsurance | 40% after deductible |
| X-Ray and Laboratory Services | | |
| Hospital (Outpatient) | 20% coinsurance | 40% after deductible |
| As part of a routine/preventive physical exam | 0% coinsurance | 40% coinsurance † * |
| Office | 20% coinsurance | 40% after deductible |
| As part of a routine/preventive physical exam | 0% coinsurance | 40% coinsurance † * |
| Mental Health Services | | |
| Inpatient Facility | 20% coinsurance | 40% after deductible |
| Inpatient Physician Visits | 20% coinsurance | 40% after deductible |
| Outpatient Facility | 20% coinsurance | 40% after deductible |
| Outpatient Physician Services | 20% coinsurance | 40% after deductible |
| Office Visits | \$20 copayment/visit | 40% after deductible |
| Substance Abuse Services | | |
| Inpatient Facility | 20% coinsurance | 40% after deductible |
| Inpatient Physician Visits | 20% coinsurance | 40% after deductible |
| Outpatient Facility | 20% coinsurance | 40% after deductible |
| Outpatient Physician Services | 20% coinsurance | 40% after deductible |
| Office Visits | \$20 copayment/visit | 40% after deductible |

Benefit Maximum

Plan Pays

| | | |
|-----------------------------------|-----------|-----------|
| Lifetime Maximum | Unlimited | Unlimited |
|-----------------------------------|-----------|-----------|

Definitions

Copayment: The amount the member must pay for each medical service received, such as a physician office visit.

Coinsurance: The percentage of cost that the member must pay for services received.

Deductible: The amount the member must pay for health services, before the health plan begins to pay.

Maximum Out-of-Pocket Expense: The sum total amount of copayments, coinsurance and deductibles, as shown above for an individual or family and paid by the member, after which--for the remainder of the calendar year--the health plan will pay 100% of the allowed charge for that member's subsequent covered health care services. However, amounts paid by the member in connection with any supplemental benefit riders will not apply toward the maximum out-of-pocket expense.

NOTE: The network and point of service maximum out-of-pocket expense are not combined.

Exclusions

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

Note

- When multiple services are performed, the member may be subject to multiple copayments and/or coinsurance in addition to any applicable deductible.
- "Preventive Care" refers to routine/physical examinations and services recommended by the U.S. Preventive Services Task Force.
- † Deductible does not apply.
- * Non-network preventive services benefit applies only to children newborn through 6 years of age. Individuals over the age of 6 are not covered.

This document is provided as a brief summary and is not intended to be a complete description of the benefit plan. After you become covered, you will be issued an evidence of coverage (Subscriber Agreement or Summary Plan Description) describing your coverage in greater detail. The evidence of coverage will govern the exact terms, conditions, and scope of coverage. In the event of a conflict between this *Medical Benefits At-A-Glance*, and the evidence of coverage, the language of the evidence of coverage controls.

Prescription Drug Benefits At-A-Glance



Prescription Drugs

| | |
|--|--------------------------------------|
| Generic Equivalent (Low Copayment) | \$10 copayment |
| Brand Name or Compounded Prescriptions (High Copayment) | \$20 copayment |
| Brand Name Prescriptions with A rated Generic Equivalent | \$10 copayment plus Ancillary Charge |

Diabetic Supplies

| | |
|--|---|
| Insulin Syringes | \$10 copayment |
| Test strips, lancets, glucose monitors | Refer to your medical benefits (See Durable Medical Equipment) |

Limitations

Prescription quantity will be limited to the amount ordered by the prescribing provider. Quantity per prescription fill or prescription refill shall not exceed a 30-day supply except for items on the 90-Day Supply List may be dispensed in quantities up to a maximum of 90-day supply. You will be responsible for two (2) copayments for each 90-day supply prescription fill or prescription refill purchased through retail pharmacy or mail order. Copayments and coinsurance for outpatient prescription drugs do not apply towards the medical maximum out-of-pocket expense or deductible, if applicable.

Exclusions

Non-covered items include, but are not limited to: growth hormone • infertility • therapeutic or prosthetic devices • appliances or supports • drugs used for cosmetic purposes • drugs used to enhance athletic performance • experimental drugs or dosage forms • drugs used for experimental purposes • over-the-counter drugs • non-prescription drugs • medications for the treatment of sexual dysfunction or impotence, or to improve sexual performance or functioning.

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Chiropractic Benefits At-A-Glance

| BENEFITS | MEMBER RESPONSIBILITY |
|----------|-----------------------|
|----------|-----------------------|

| | |
|---|-------------------------------|
| <p>Chiropractic Services (Maximum 30 visits per calendar year)</p> <p>Diathermy • Electric Stimulation • Hot/Cold Packs • Manipulation • Massage Office Calls • Traction • Ultrasound • Medical Supplies • X-Ray and Lab</p> | <p><u>20% coinsurance</u></p> |
|---|-------------------------------|

| | |
|--|-------------------------------|
| <p>Emergency Services</p> | <p><u>20% coinsurance</u></p> |
|--|-------------------------------|

Exclusions

Non-covered items include, but are not limited to: acupressure • acupuncture • arch supports • cervical pillow • chelation therapy • colonic therapy or irrigations • computerized axial tomography • graphic x-ray analysis • hair analysis, toxic metal analysis, heavy metal screening, and mineral cellular analysis • hand held doppler • inertial extensilizer • iris analysis, iridology • kinesiology • living cell analysis • magnetic resonance imaging • maintenance care • moire contourographic analysis, biosterometric studies • nutritional counseling • nutritional supplements • over-the-counter drugs or preparations • oxygen therapy • Ream’s lab or Ream’s test • rolfing • sublingual or oral therapy • thermographic procedures.

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