

UnitedHealthcare Plan of the River Valley, Inc.

Medical Benefits At-A-Glance

Benefit Features

Member Responsibility

	Network	Point of Service
Deductible (Calendar Year)	None	\$250 individual \$500 family
Maximum Out-of-Pocket Expense (Calendar Year)	\$1,250 individual \$2,500 family	\$2,000 individual \$4,000 family
4th Quarter Deductible Carryover	Applicable	Applicable
Physician Medical Services		
Allergy Injections	\$3 copayment/injection	Not covered
Allergy Testing	\$20 copayment/visit	Not covered
Home Visits	\$20 copayment/visit	30% after deductible
Immunizations	0% coinsurance	30% coinsurance † *
Injections	10% coinsurance	30% after deductible
Inpatient Hospital Visits & Consultations	10% coinsurance	30% after deductible
Maternity Care	10% coinsurance	30% after deductible
Newborn Baby Care	10% coinsurance	30% after deductible
Nursing Facility Visits	\$20 copayment/visit	30% after deductible
Office Visits	\$20 copayment/visit	30% after deductible
Outpatient Physician Services	10% coinsurance	30% after deductible
Routine/Preventive Physical Exam	\$20 copayment/visit	Not covered
Surgical Services - Inpatient	10% coinsurance	30% after deductible
<u>(Morbid Obesity Surgery</u> <u>Must be approved in advance by UnitedHealthcare.)</u>	10% coinsurance	30% after deductible
Surgical Services - Outpatient	10% coinsurance	30% after deductible
Surgical Services - Office	\$20 copayment/surgery	30% after deductible
Well Child Care	\$20 copayment/visit	30% coinsurance † *
Urgent Care Center	\$20 copayment/visit	30% after deductible
Emergency Services		
Ambulance	10% coinsurance	10% coinsurance †
Emergency Room Facility	\$100 copayment/visit	\$100 copayment/visit †
Emergency Room Physician Care	10% coinsurance	10% coinsurance †
<i>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.</i>		
Hospital/Facility Services		
Inpatient Hospital (Semi-Private Room)	10% coinsurance	30% after deductible
Outpatient Facility or Surgi-Center Services	10% coinsurance	30% after deductible
Nursing Facility (Limited to 100 days per calendar year.)	10% coinsurance	30% 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	10% coinsurance	Not covered
<i>(Foot Orthotics limited (unless part of diabetes treatment) to one custom molded pair of shoe inserts once every 24 months.)</i>		

Benefits

Member Responsibility

	Network	Point of Service
Oral Surgery - Removal of Impacted Wisdom Teeth	10% coinsurance	10% 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	0% coinsurance	30% 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)	0% coinsurance	30% after deductible
<i>Member is limited to 20 outpatient treatment days per calendar year.</i>		
Radiation Therapy & Chemotherapy		
Hospital (Outpatient)	10% coinsurance	30% after deductible
Office	10% coinsurance	30% after deductible
X-Ray and Laboratory Services		
Hospital (Outpatient)	10% coinsurance	30% after deductible
As part of a routine/preventive physical exam	0% coinsurance	30% coinsurance † *
Office	10% coinsurance	30% after deductible
As part of a routine/preventive physical exam	0% coinsurance	30% coinsurance † *
Mental Health Services		
Inpatient Facility	10% coinsurance	30% after deductible
Inpatient Physician Visits	10% coinsurance	30% after deductible
Outpatient Facility	10% coinsurance	30% after deductible
Outpatient Physician Services	10% coinsurance	30% after deductible
Office Visits	\$20 copayment/visit	30% after deductible
Substance Abuse Services		
Inpatient Facility	10% coinsurance	30% after deductible
Inpatient Physician Visits	10% coinsurance	30% after deductible
Outpatient Facility	10% coinsurance	30% after deductible
Outpatient Physician Services	10% coinsurance	30% after deductible
Office Visits	\$20 copayment/visit	30% after deductible

Benefit Maximum

Plan Pays

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