

UnitedHealthcare Plan of the River Valley, Inc.

Medical Benefits At-A-Glance

Member Pays

	Network	Point of Service
Deductible (Calendar Year)	<u>\$750</u> individual <u>\$1,500</u> family	<u>\$1,000</u> individual <u>\$2,000</u> family
Maximum Out-of-Pocket Expense (Calendar Year)	<u>\$2,000</u> individual <u>\$4,000</u> family	<u>\$3,000</u> individual <u>\$5,500</u> family
Lifetime Benefit Maximum		None
4th Quarter Deductible Carryover		Not applicable

Physician Medical Services

Allergy Injections	0% coinsurance †	Not covered
Allergy Testing	\$20 PCP copayment / \$35 Specialist copayment †	Not covered
Home Visits	\$20 PCP copayment / \$35 Specialist copayment †	40% after deductible
Immunizations	0% coinsurance †	40% coinsurance † *
Injections - Physician's Office	20% coinsurance †	40% after deductible
Inpatient Hospital Visits & Consultations	20% after deductible	40% after deductible
Maternity Care	\$250 copayment/pregnancy †	40% after deductible
Newborn Baby Care	20% after deductible	40% after deductible
Nursing Facility Visits	20% after deductible	40% after deductible
Office Visits	\$20 PCP copayment / \$35 Specialist copayment †	40% after deductible
Outpatient Physician Services	20% after deductible	40% after deductible
Routine/Preventive Physical Exam	\$20 PCP copayment / \$35 Specialist copayment †	40% coinsurance † *
Surgical Services - Inpatient	20% after deductible	40% after deductible
Surgical Services - Outpatient	20% after deductible	40% after deductible
Surgical Services - Physician's Office	\$20 PCP copayment / \$35 Specialist copayment †	40% after deductible
Well Child Care	\$20 PCP copayment / \$35 Specialist copayment †	40% coinsurance † *

Urgent Care Center

	\$35 copayment †	40% after deductible
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Emergency Services

Ambulance	20% coinsurance †	20% coinsurance †
Emergency Room Facility	\$200 copayment †	\$200 copayment †
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 waived if admitted.

Hospital/Facility Services

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

Home Health Care

	20% after deductible	Not covered
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(Must be approved in advance by UnitedHealthcare.)

Medical Equipment

Durable Medical Equipment • Prosthetic Devices • Hearing Aid Devices .	20% after deductible	Not covered
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Maximum benefit of \$5,000 per calendar year for Hearing Aid Devices.

Benefits

Member Pays

	Network	Point of Service
Outpatient Rehabilitative Therapy		
Physical • Speech • Occupational	20% after deductible	40% after deductible
<i>Member is limited to 60 outpatient treatment days 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>		
Radiation Therapy & Chemotherapy		
Hospital (Outpatient)	20% after deductible	40% after deductible
Office	20% coinsurance †	40% after deductible
X-Ray and Laboratory Services		
Hospital (Outpatient)	20% after deductible	40% after deductible
As part of a routine/preventive physical exam0% coinsurance †	40% coinsurance † *
Office	20% coinsurance †	40% after deductible
As part of a routine/preventive physical exam0% coinsurance †	40% coinsurance † *
Mental Health Services		
Inpatient Facility	20% after deductible	40% after deductible
Inpatient Physician	20% after deductible	40% after deductible
Outpatient Facility	20% after deductible	40% after deductible
Outpatient Physician	20% after deductible	40% after deductible
Office Visits	\$20 PCP copayment / \$35 Specialist copayment †	40% after deductible
Substance Abuse Services		
Inpatient Facility	20% after deductible	40% after deductible
Inpatient Physician	20% after deductible	40% after deductible
Outpatient Facility	20% after deductible	40% after deductible
Outpatient Physician	20% after deductible	40% after deductible
Office Visits	\$20 PCP copayment / \$35 Specialist copayment †	40% after deductible

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 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. **Member will continue to pay copayment amounts after the maximum out-of-pocket expense is met.**
- 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 • 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.