UnitedHealthcare Plan of the River Valley, Inc.
Attachment D - Schedule of Benefits

Please refer to your Provider Directory for listings of Participating Physicians, Hospitals, and other Providers.

Deductibles and Maximums	Participating Provider In-Network	Point-of-Service Option Out-of-Network
Deductible (calendar year) (Contract Period)		
Individual	$3,000	$5,000
Family	$6,000	$10,000
All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount. The In-Network Deductible and Out-of-Network Deductible are separate.		
Maximum Out-of-Pocket Expense (calendar year) (Contract Period) (includes Copayments, Coinsurance, and Deductibles)		
Individual	$3,000	$5,000
Family	$6,000	$10,000
All individual Maximum Out-of-Pocket amounts will count toward the family Maximum Out-of-Pocket Expense, but an individual will not have to pay more than the individual Maximum Out-of-Pocket Expense. The In-Network Maximum Out-of-Pocket Expense and Out-of-Network Maximum Out-of-Pocket Expense are separate. Pharmacy cost sharing applies towards the Maximum Out-of-Pocket.		
4th Quarter Deductible Carryover	Not Applicable	Not Applicable
Excess of Reasonable and Customary Covered Charges	Enrollees who receive services as a result of a Medical Emergency or with a Preauthorized Referral are not responsible for Non-Network Provider fees in excess of Reasonable and Customary.	Amounts in excess of Reasonable and Customary will be the responsibility of the Enrollee.

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Preventive Care Services *("Preventive Care" refers to examinations and services recommended by the U.S. Preventive Services Task Force or preventive care services mandated by state or federal law or regulation.)*		
Physical Exams/Well-Child Care	Covered at 100%.	100% of Allowed Charge for children newborn through 6 years of age. Deductible does not apply. Services not
Immunizations	Covered at 100%.	100% of Allowed Charge for children newborn through 6 years of age. Deductible does not apply. Services not
Laboratory and X-ray	Covered at 100%.	100% of Allowed Charge for children newborn through 6 years of age. Deductible does not apply. Services not
Physician Office Services		
Office Visits	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Office Surgery	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Allergy Testing	100% of Allowed Charge after Deductible	Not Covered
Allergy Injections	100% of Allowed Charge after Deductible	Not Covered
Other Injections	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Maternity Physician Services	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Newborn Services		
Inpatient	*See "Physician Services at a Facility other than the Office," "Facility Services" or other applicable categories.*	
Outpatient	*See "Physician Services at a Facility other than the Office," "Facility Services" or other applicable categories.*	
Physician Services at a Facility other than the Office		
Home Visits	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Inpatient Facility Visits	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Outpatient Facility Visits	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Inpatient Surgery	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Outpatient Surgery	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Emergency Services *(Follow-up care obtained in the emergency room is not covered.)* *Emergency Services are only available from a Non-Participating Provider until the Enrollee is stabilized and able to transfer to a Participating Provider.*		
Emergency Room Physician	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Emergency Room	100% of Allowed Charge after Deductible. *Physician's services or other services separately charged may require a separate Copayment and/or Coinsurance in addition to any applicable Deductible, beyond the emergency room facility charge.*	100% of Allowed Charge after Deductible.
Urgent Care Facility	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Ambulance Services	100% of Allowed Charge after Deductible. *Non-emergency transports must be approved in advance by UnitedHealthcare.*	100% of Allowed Charge after Deductible. *Non-emergency transports must be approved in advance by UnitedHealthcare.*
Laboratory, X-ray and Other Diagnostic Testing *Note X-ray and laboratory services separately charged by an independent laboratory may require separate Coinsurance and/or Deductible, beyond the physician's office Copayment, Coinsurance and/or Deductible.*		
Hospital (Outpatient)	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Office	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Major Diagnostics (MRI, MRA, CAT and PET Scans)	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Radiation Therapy and Intravenous Chemotherapy		
Hospital (Outpatient)	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Office	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Renal Dialysis Services	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Chemotherapeutic Drug Agents	Covered at 100%. Deductible does not apply.	Covered at 100%. Deductible does not apply.
Facility Services		
Inpatient Facility (1)	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Outpatient Facility	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Skilled Nursing Facility (1) - *(Enrollee is limited to 100 days per calendar year Contract Period. (The In-Network and Out-of-Network days are combined.)*	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Medical Equipment		
Durable Medical Equipment (1)	100% of Allowed Charge after Deductible	Not Covered
Prosthetic Devices (1)	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Hearing Aid Devices (1) *(Plan pays a maximum benefit of $5,000 per calendar year Contract Period)*	100% of Allowed Charge after Deductible	Not covered
Outpatient Rehabilitative Therapy *Outpatient Rehabilitative Therapy includes physical, speech, and occupational therapy and cardiac (Phase I and II) and pulmonary rehabilitation.*		
(Enrollee is limited to 60 outpatient treatment visits per calendar year Contract Period) (The In-Network and Out-of-Network visits are combined.)	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Home Health Services (1)	100% of Allowed Charge after Deductible	Not covered
Hospice Services (1)	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Respite Care	Not covered	Not covered
Organ and Tissue Transplants (1)	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories*	Not covered
Cornea Transplants	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories*	
Clinical Trials	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories*	
Virtual Visits (1) Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling Customer Care at the telephone number on your ID card.	100% of Allowed Charge after Deductible	Not covered
Mental Health Services Inpatient Facility (1)	100% of Allowed Charge after Deductible	100%of Allowed Charge after Deductible
Inpatient Physician Visits (1)	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Outpatient Facility (1)	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Outpatient Physician Services (1)	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Partial Hospitalization/Intensive Outpatient Treatment (1)	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Office Visits	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Substance Abuse Services Inpatient Facility (1)	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Inpatient Physician Visits (1)	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Outpatient Facility (1)	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Outpatient Physician Services (1)	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Partial Hospitalization/Intensive Outpatient Treatment (1)	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Office Visits	100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible

Coverage Limitations:

(1) Services require Preauthorization. Participating Providers are responsible for obtaining Preauthorization for Participating/Network benefits.

For Covered Services received from Non-Participating Providers, the Allowed Charge is the Maximum Non-Network Reimbursement Program (MNRP). Except when services were rendered in a Medical Emergency or when services are rendered by a non-participating facility-based provider (a physician or other provider who provide radiology, anesthesiology, pathology, neonatology, or emergency department services) at a participating facility or participating ambulatory surgical center, the Enrollee is responsible for paying any amounts exceeding the Maximum Allowance or MNRP for services received from Non-Participating Providers. Such excess amounts will not count toward the Deductible or Maximum Out-of-Pocket Expense.

The Allowed Charge for Covered Health Services rendered by a Non-Participating Provider in a Medical Emergency will be determined as described in *Article 1* of the *Certificate of Coverage*. **As a result, the Enrollee will be responsible for the difference between the Non-Participating Provider's Billed Charges and the Allowed Charge. Such excess amounts will not count toward the Deductible or Maximum Out-of-Pocket Expense.**

For both Inpatient Surgery and Outpatient Surgery, Covered Services provided by facility based Non-Participating Physicians in a Participating Hospital or facility will be paid at the In-Network cost sharing level, however the Allowed Charge will be determined as described in *Article 1* of the *Certificate of Coverage*. **As a result, the Enrollee will be responsible for the difference between the Non-Participating Physician's Billed Charges and the Allowed Charge. Such excess amounts will not count toward the Deductible or Maximum Out-of-Pocket Expense. In order to obtain the highest level of benefits, the should confirm whether a Physician is a Participating Physician prior to obtaining Covered Services.**

When multiple Covered Services are performed, the Copayment, Coinsurance, and/or Deductible applicable to each Covered Service will apply. For example, a laboratory and x-ray service separately charged by an independent laboratory outside of the Physician's office has a separate Copayment, Coinsurance and/or Deductible in addition to the Physician's office Copayment, Coinsurance or Deductible.

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UnitedHealthcare Plan of the River Valley, Inc

Prescription Drug Benefits

At-A-Glance

Benefit Features	Member Responsibility

The applicable deductible as shown in the Medical Benefits At-A-Glance must be met before UnitedHealthcare begins to pay for outpatient prescription drugs covered under this Prescription Drug Benefits At-A-Glance.

Prescription Drugs

Generic Equivalent (Tier 1) ..... 0% coinsurance after deductible
Formulary Brand Name (Tier 2) ..... 0% coinsurance after deductible
Non-Formulary Brand Name or Compounded Prescriptions (Tier 3) ..... 0% coinsurance after deductible

Diabetic Supplies

Insulin Syringes ..... 0% coinsurance after deductible
Test Strips, lancets, glucose monitors ..... Refer to your medical benefits (*reference Durable Medical Equipment*)

Application of Drug Coinsurance

Drug coinsurance for outpatient prescription drugs apply toward the medical maximum out-of-pocket expense.

No Drug Copayment or Drug Coinsurance applies to oral chemotherapeutic agents on any Tier.

Limitations

Prescription quantity shall be limited to the amount ordered by the attending physician. Quantity per prescription fill or refill shall not exceed a 30-day supply or such other day supply as authorized by UnitedHealthcare. However, items on the 90-day supply list may be dispensed in quantities up to a maximum of 90-day supply through retail pharmacy or by mail order. UnitedHealthcare reserves the right to establish criteria and require prior authorization for certain outpatient prescription drugs.

Benefit Exclusions

Non-covered items include, but are not limited to: medications available over the counter (OTC), unless (1) such OTC medication has been designated by UnitedHealthcare as eligible for coverage as if it were an outpatient prescription drug, and (2) such OTC medication is obtained with a prescription from an attending physician • growth hormone • therapeutic or prosthetic devices • drugs used for cosmetic purposes •drugs used to enhance physical or mental performance • dietary supplements, medications or treatment used for appetite suppression or weight loss, and nutritional formulas and supplements • medication for the treatment or enhancement of sexual performance or function • drugs used for treatment of infertility • drugs used for experimental purposes.

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 Prescription Drug Benefits At-A-Glance, and the evidence of coverage, the language of the evidence of coverage controls.