United HealthCare PPO Plan Option 1

UnitedHealthcare Insurance Company of the River Valley
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	Non-Participating Provider (1) Out-of-Network
Deductible (calendar year)		
Individual	$1,000	$2,500
Family	$2,000	$5,000
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) (includes Copayments, Coinsurance, and Deductibles)		
Individual	$3,500	$5,000
Family	$7,000	$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

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%	60% of Allowed Charge after Deductible
Immunizations	Covered at 100%	60% of Allowed Charge after Deductible
Laboratory and X-ray	Covered at 100%	60% of Allowed Charge after Deductible
Physician Office Services		
Office Visits	100% after you pay a Copayment of $25 PCP/$50 Specialist per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Office Surgery	100% after you pay a Copayment of $25 PCP/$50 Specialist per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Allergy Testing	100% after you pay a Copayment of $25 PCP/$50 Specialist per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Allergy Injections	80% of Allowed Charge. Deductible does not apply.	60% of Allowed Charge after Deductible
Other Injections	80% of Allowed Charge. Deductible does not apply.	60% of Allowed Charge after Deductible
Maternity Physician Services	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
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.*	

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Physician Services at a Facility other than the Office		
Home Visits	100% after you pay a Copayment of $25 PCP/$50 Specialist per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Inpatient Facility Visits	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Facility Visits	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Inpatient Surgery	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Surgery	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Emergency Services *(Follow-up care obtained in the emergency room is not covered.)*		
Emergency Room Physician	100% of Allowed Charge. Deductible does not apply.	100% of Allowed Charge. Deductible does not apply.
Emergency Room	100% after you pay a Copayment of $250 per visit for initial care only of a Medical Emergency. Deductible does not apply. Emergency Room Copayment waived if admitted.	100% after you pay a Copayment of $250 per visit for initial care only of a Medical Emergency. Deductible does not apply. Emergency Room Copayment waived if admitted.
	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.	
Urgent Care Facility	100% after you pay a Copayment of $100 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Ambulance Services	80% of Allowed Charge after Deductible. **Non-emergency transports must be approved in advance by UnitedHealthcare.**	80% of Allowed Charge after Deductible. **Non-emergency transports must be approved in advance by UnitedHealthcare.**
Laboratory, X-ray and Other Diagnostic Testing		
Outpatient	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Office	100% of Allowed Charge. Deductible does not apply.	60% of Allowed Charge after Deductible
Major Diagnostics (MRI, MRA, CAT and PET Scans)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
	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.	
Chemotherapy, Radiation Therapy, Renal Dialysis Services		
Hospital (Outpatient)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Office	80% of Allowed Charge. Deductible does not apply.	60% of Allowed Charge after Deductible
Facility Services		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Facility	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Skilled Nursing Facility (2) (*Member is limited to 100 days per calendar year. The 100 In-Network and Out-of-Network days are combined.)*	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Medical Equipment *(Diabetic supplies do not count toward the Durable Medical Equipment benefit maximum.)*		
Durable Medical Equipment (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Prosthetic Devices (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Hearing Aid Devices (2) *(For Covered Persons age 18 and over, Plan pays a maximum benefit of $2,500 per calendar year. For Covered Persons under the age of 18, no dollar limits apply, and Plan covers a minimum of one hearing aid per ear every 36 months.)*	80% 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.*		
(Member is limited to 60 outpatient treatment visits per calendar year. The In-Network and Out-of-Network visits are combined.)	100% after you pay a Copayment of $25 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Spinal Manipulative Services	100% after you pay a Copayment of $25 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Home Health Services (2)	80% of Allowed Charge after Deductible	Not covered.
Hospice Services (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Respite Care (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Organ and Tissue Transplants (2)	*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*	
Temporomandibular Joint Services	*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*	
Mental Health Services		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Physician Services (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Office Visits	100% after you pay a Copayment of $50 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Substance Abuse Services		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Physician Services (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Office Visits	100% after you pay a Copayment of $50 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible

Coverage Limitations:

(1) For services from Non-Participating Providers, the Allowed Charge is the Maximum Allowance. Except when services were rendered in a Medical Emergency, the Member is responsible for paying any amounts exceeding the Maximum Allowance for services received from Non-Participating Providers. Such excess amounts will not count toward the Deductible or Maximum Out-of-Pocket Expense.

(2) Services require Preauthorization. When a Member uses Participating Providers, the Participating Provider is responsible for obtaining Preauthorization. When a Member uses Non-Participating Providers, the Member is responsible for obtaining Preauthorization from UnitedHealthcare (or for mental health and substance abuse services, from UnitedHealthcare's mental health and/or substance abuse treatment program provider). If the Member fails to obtain Preauthorization for Covered Services from Non-Participating Providers, the Member will pay a Penalty of an additional 10 percentage points in his or her Out-of-Network Coinsurance. The Penalty amount paid by the Member will not exceed $1,000, and it will not count toward the Deductible or Maximum Out-of-Pocket Expense.

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.

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 a Certificate of Coverage (COC) describing your coverage in greater detail. The COC will govern the exact terms, conditions, and scope of coverage. In the event of a conflict between this Schedule of Benefits and the COC, the language of the COC controls.

UnitedHealthcare Insurance Company of the River Valley

Prescription Drug Benefits At-A-Glance

Benefit Features — Member Responsibility

Your copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned the prescription drug product. All prescription drug products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.

Prescription Drug Products

Tier 1 .....$10 copayment
Tier 2 .....$35 copayment
Tier 3 .....$60 copayment

Application of Drug Deductible Copayment

- Drug copayments for prescription drug products do not apply toward the medical deductible, but they do apply toward the medical maximum out-of-pocket expense.
- You will be responsible for two and a half copayments for each 90-day supply prescription fill or refill purchased at a retail pharmacy or by mail order.

Limitations

Prescription quantity shall be limited to the amount ordered by the attending physician. Quantity per prescription fill or refill shall not exceed a 31-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.

Specialty prescription drug products supply limits are as written by the provider, up to a consecutive 31-day supply of the specialty prescription drug product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Supply limits apply to specialty prescription drug products whether obtained at a retail pharmacy or through a mail order pharmacy.

Some prescription drug products or pharmaceutical products for which benefits are described under this prescription drug rider or Subscriber Agreement or Summary Plan Description are subject to step therapy requirements. This means that in order to receive benefits for such prescription drug products or pharmaceutical products you are required to use a different prescription drug product(s) or pharmaceutical product(s) first.

Also note that some prescription drug products require that you notify us in advance to determine whether the prescription drug product meets the definition of a covered service and is not experimental, investigational or unproven.

If you require certain prescription drug products, we may direct you to a designated pharmacy with whom we have an arrangement to provide those prescription drug products. If you are directed to a designated pharmacy and you choose not to obtain your prescription drug product from the designated pharmacy, you will be subject to the non-network benefit for that Prescription Drug Product.

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 hormones • therapeutic or prosthetic devices • drugs used for cosmetic purposes •drugs used to enhance physical or mental performance • treatment or supplies to promote smoking cessation • dietary supplements, medications or treatment used for appetite suppression or weight loss, and nutritional formulas and supplements • general vitamins • 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 a certificate of coverage (Subscriber Agreement or Summary Plan Description) describing your coverage in greater detail. The certificate 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 certificate of coverage, the language of the certificate of coverage controls.

United HealthCare PPO Plan Option 1 Including Vision

Semi-Monthly Rates

Employee Only = $ 33.68

Employee & Family = $ 456.17