

United HealthCare PPO Plan Option 2

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	\$2,000	\$10,000	
Family	\$4,000	\$20,000	
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. Pharmacy cost sharing applies towards the In-Network medical Deductible.			
Maximum Out-of-Pocket Expense (calendar year) (includes Copayments, Coinsurance, and Deductibles)			
Individual	\$5,000	\$25,000	
Family	\$10,000	\$50,000	
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 (<i>“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.</i>)			
Physical Exams/Well-Child Care	Covered at 100%	50% of Allowed Charge after Deductible	
Immunizations	Covered at 100%	50% of Allowed Charge after Deductible	
Laboratory and X-ray	Covered at 100%	50% of Allowed Charge after Deductible	
Physician Office Services			
Office Visits	PCP	100% after you pay a Copayment of \$30 per visit. Deductible does not apply.	50% of Allowed Charge after Deductible
	Specialist	100% after you pay a Copayment of \$60 per visit after Deductible	50% of Allowed Charge after Deductible
Office Surgery	PCP	100% after you pay a Copayment of \$30 per visit. Deductible does not apply.	50% of Allowed Charge after Deductible
	Specialist	100% after you pay a Copayment of \$60 per visit after Deductible	50% of Allowed Charge after Deductible
Allergy Testing	PCP	100% after you pay a Copayment of \$30 per visit. Deductible does not apply.	50% of Allowed Charge after Deductible
	Specialist	100% after you pay a Copayment of \$60 per visit after Deductible	50% of Allowed Charge after Deductible
Allergy Injections		80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Other Injections		80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Maternity Physician Services		100% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Newborn Services			
Inpatient	<i>See “Physician Services at a Facility other than the Office,” “Facility Services,” or other applicable categories.</i>		
Outpatient	<i>See “Physician Services at a Facility other than the Office,” “Facility Services,” or other applicable categories.</i>		

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	PCP	100% after you pay a Copayment of \$30 per visit. Deductible does not apply.	50% of Allowed Charge after Deductible
	Specialist	100% after you pay a Copayment of \$60 per visit after Deductible	50% of Allowed Charge after Deductible
Inpatient Facility Visits		100% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Facility Visits		100% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Inpatient Surgery		100% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Surgery		100% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Emergency Services <i>(Follow-up care obtained in the emergency room is not covered.)</i>			
Emergency Room Physician		100% of Allowed Charge after Deductible	100% of Allowed Charge after Deductible
Emergency Room		100% after you pay a Copayment of \$350 per visit for initial care only of a Medical Emergency after Deductible. Emergency Room Copayment waived if admitted.	100% after you pay a Copayment of \$350 per visit for initial care only of a Medical Emergency after Deductible. Emergency Room Copayment waived if admitted.
		<i>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.</i>	
Urgent Care Facility		100% after you pay a Copayment of \$100 per visit after Deductible	50% 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		100% after you pay a Copayment of \$60 after Deductible	50% of Allowed Charge after Deductible
Office	PCP	100% of Allowed Charge. Deductible does not apply.	50% of Allowed Charge after Deductible
	Specialist	100% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Major Diagnostics (MRI, MRA, CAT and PET Scans)		100% after you pay a Copayment of \$250 after Deductible	50% of Allowed Charge after Deductible
		<i>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.</i>	
Chemotherapy, Radiation Therapy, Renal Dialysis Services			
Hospital (Outpatient)		80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Office		100% after you pay a Copayment of \$30 PCP/\$60 Specialist per visit after Deductible	50% of Allowed Charge after Deductible

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Facility Services		
Inpatient Facility (2)	100% after you pay a Copayment of \$500 per admission after Deductible	50% of Allowed Charge after Deductible
Outpatient Facility	100% after you pay a Copayment of \$250 per admission after Deductible	50% of Allowed Charge after Deductible
Skilled Nursing Facility (2) <i>(Member is limited to 100 days per calendar year. The 100 In-Network and Out-of-Network days are combined.)</i>	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Medical Equipment <i>(Diabetic supplies do not count toward the Durable Medical Equipment benefit maximum.)</i>		
Durable Medical Equipment (2)	100% after you pay a Copayment of \$60 after Deductible	50% of Allowed Charge after Deductible
Prosthetic Devices (2)	100% after you pay a Copayment of \$60 after Deductible	50% of Allowed Charge after Deductible
Hearing Aid Devices (2) <i>(For Covered Persons ages 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.)</i>	100% after you pay a Copayment of \$60 after Deductible	Not covered.
Outpatient Rehabilitative Therapy <i>Outpatient Rehabilitative Therapy includes physical, speech, and occupational therapy and cardiac (Phase I and II) and pulmonary rehabilitation.</i>		
<i>(Member is limited to 60 outpatient treatment visits per calendar year. The In-Network and Out-of-Network visits are combined.)</i>	100% after you pay a Copayment of \$60 per visit after Deductible	50% of Allowed Charge after Deductible
Spinal Manipulative Services	100% after you pay a Copayment of \$30 per visit. Deductible does not apply.	50% of Allowed Charge after Deductible
Home Health Services (2)	100% of Allowed Charge after Deductible	Not covered.
Hospice Services (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Respite Care (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Organ and Tissue Transplants (2)	<i>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</i>	Not covered.
Cornea Transplants	<i>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</i>	
Clinical Trials	<i>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</i>	
Temporomandibular Joint Services	<i>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</i>	

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Mental Health Services		
Inpatient Facility (2)	100% after you pay a Copayment of \$500 per admission after Deductible.	50% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	100% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Facility (2)	100% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Physician Services (2)	100% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Office Visits	100% after you pay a Copayment of \$60 per visit. Deductible does not apply.	50% of Allowed Charge after Deductible
Substance Abuse Services		
Inpatient Facility (2)	100% after you pay a Copayment of \$500 per admission after Deductible	50% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	100% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Facility (2)	100% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Physician Services (2)	100% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Office Visits	100% after you pay a Copayment of \$60 per visit. Deductible does not apply.	50% 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.

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.

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 2 Includes Vision
Semi-Monthly Rates**

Employee Only = \$ 0.00

Employee & Family = \$332.38