

UnitedHealthcare Plan of the River Valley, Inc. Benefit Summary

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

Deductibles and Maximums	Participating/Network Provider	Point-of-Service Option
Deductible (calendar year)		
Individual	None	\$ 200
Family	None	\$ 400
All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.		
Maximum Out-of-Pocket Expense (calendar year)		
Individual	\$1,000	\$1,500
Family	\$2,500	\$3,000
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.		
Lifetime Maximum	None	
4th Quarter Deductible Carryover	<u>Applicable</u>	<u>Applicable</u>
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/Network Provider Enrollee Pays	Point-of-Service Option Enrollee Pays
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	\$20 Copayment per visit. Deductible does not apply.	20% of Allowed Charge for children newborn through 6 years of age. Deductible does not apply. Services not covered for age 7 years and up.
Immunizations	\$0 Copayment per visit. Deductible does not apply.	20% of Allowed Charge for children newborn through 6 years of age. Deductible does not apply. Services not covered for age 7 years and up.
Laboratory and X-ray	\$0 Copayment per visit. Deductible does not apply.	20% of Allowed Charge for children newborn through 6 years of age. Deductible does not apply. Services not covered for age 7 years and up.
Physician Office Services		
Office Visits	\$20 Copayment per visit	20% of Allowed Charge after Deductible
Office Surgery	\$20 Copayment per surgery	20% of Allowed Charge after Deductible
Allergy Testing	\$20 Copayment per visit	Not Covered
Allergy Injections	\$0 Copayment per injection	Not Covered
Other Injections	\$0 Copayment per injection	20% of Allowed Charge after Deductible
Maternity Physician Services	\$100 Copayment per pregnancy	20% of Allowed Charge after Deductible

Benefits for Covered Services	Participating/Network Provider Enrollee Pays	Point-of-Service Option Enrollee Pays
Newborn Physician Services		
Inpatient	<i>See "Physician Services at a Facility other than the Office" and "Facility Services."</i>	
Outpatient	<i>See "Physician Services at a Facility other than the Office."</i>	
Physician Services at a Facility other than the Office		
Home Visits	\$20 Copayment per visit	20% of Allowed Charge after Deductible
Inpatient Facility Visits	\$20 Copayment per visit	20% of Allowed Charge after Deductible
Outpatient Facility Visits	\$20 Copayment per visit	20% of Allowed Charge after Deductible
Inpatient Surgery	\$100 Copayment per surgery	20% of Allowed Charge after Deductible
Outpatient Surgery	\$100 Copayment per surgery	20% of Allowed Charge after Deductible
Emergency Services <i>(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.</i>		
Emergency Room Physician	\$20 Copayment per visit	\$20 Copayment per visit
Emergency Room	\$75 Copayment per visit for a Medical Emergency. Emergency Room Copayment waived if admitted.	\$75 Copayment per visit for a Medical Emergency. Emergency Room Copayment waived if admitted.
Urgent Care Facility	\$20 Copayment per visit	20% of Allowed Charge after Deductible
Ambulance Services	\$0 Copayment	\$0 Copayment. Deductible does not apply.
Laboratory and X-ray Services		
Hospital (Outpatient)	\$0 Copayment	20% of Allowed Charge after Deductible
Office	\$0 Copayment	20% of Allowed Charge after Deductible
Radiation Therapy, Intravenous Chemotherapy		
Hospital (Outpatient)	\$0 Copayment	20% of Allowed Charge after Deductible
Office	\$0 Copayment	20% of Allowed Charge after Deductible
Renal Dialysis Services	\$0 Copayment	20% of Allowed Charge after Deductible
Chemotherapeutic Drug Agents	0% of Allowed Charge. Deductible does not apply.	
Facility Services		
Inpatient Facility	\$100 Copayment per admission	20% of Allowed Charge after Deductible
Outpatient Facility	\$50 Copayment per admission	20% of Allowed Charge after Deductible
Nursing Facility	\$0 Copayment per admission	20% of Allowed Charge after Deductible
<i>(Enrollee is limited to 100 Nursing Facility days per calendar year. The 100 Network and Point-of-Service days are combined.)</i>		
Medical Equipment		
Durable Medical Equipment	\$0 Copayment	Not Covered
Prosthetic Devices	\$0 Copayment	20% of Allowed Charge after Deductible
Hearing Aid Devices	\$0 Copayment	Not Covered
<i>(Plan pays a maximum benefit of \$5,000 per calendar year.)</i>		

Benefits for Covered Services	Participating/Network Provider Enrollee Pays	Point-of-Service Option Enrollee Pays
Outpatient Rehabilitative Therapy <i>Outpatient Rehabilitative Therapy includes physical, speech, and occupational therapy and cardiac (Phase I and II) and pulmonary rehabilitation.</i> <i>(Enrollee is limited to 60 visits per calendar year. The Participating/Network and Point-of-Service days are combined.)</i>	\$0 Copayment	20% of Allowed Charge after Deductible
Home Health Services (1)	\$0 Copayment	Not Covered
Hospice Services (1)	\$0 Copayment per day	20% of Allowed Charge after Deductible
Respite Care	Not Covered	Not Covered
Organ and Tissue Transplants (1)	<i>Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," and "Facility Services."</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," and "Facility Services."</i>	Not Covered
Mental Health Services		
Inpatient Facility	\$100 Copayment per admission	20% of Allowed Charge after Deductible
Inpatient Physician Visits	\$20 Copayment per visit	20% of Allowed Charge after Deductible
Outpatient Facility	\$50 Copayment per admission	20% of Allowed Charge after Deductible
Outpatient Physician Services	\$20 Copayment per visit	20% of Allowed Charge after Deductible
Office Visits	\$20 Copayment per visit	20% of Allowed Charge after Deductible
Substance Abuse Services		
Inpatient Facility	\$100 Copayment per admission	20% of Allowed Charge after Deductible
Inpatient Physician Visits	\$20 Copayment per visit	20% of Allowed Charge after Deductible
Outpatient Facility	\$50 Copayment per admission	20% of Allowed Charge after Deductible
Outpatient Physician Services	\$20 Copayment per visit	20% of Allowed Charge after Deductible
Office Visits	\$20 Copayment per visit	20% of Allowed Charge after Deductible

Coverage Limitation

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

Definitions

Allowed Charge: The portion of a charge for a covered service that the health plan will consider in calculating benefits. The Allowed Charge is determined differently depending on the provider status, and whether or not the services from non-participating providers were due to a medical emergency.

(NOTE: The Allowed Charge for a participating provider is the contracted rate. The Allowed Charge for a non-participating provider is the Reasonable and Customary.)

Copayment: The amount the enrollee must pay for each medical service received, such as a physician office visit.

Coinsurance: The percentage of cost that the enrollee must pay for services received.

Deductible: The amount the enrollee 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 enrollee, after which—for the remainder of the calendar year—the health plan will pay 100% of the allowed charge for that enrollee's subsequent covered health care services. However, amounts paid by the enrollee 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 • respite 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).

Notes

- When multiple services are performed, the enrollee 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.

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.