The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.welcometouhc.com or by calling 1-800-782-3740. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Participating $1,500 Individual / $3,000 Family Non-Participating $5,000 Individual / $10,000 Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Participating $2,000 Individual / $4,000 Family Non-Participating $15,000 Individual / $30,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.welcometouhc.com or call 1-800-782-3740 for a list of Participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit, deductible does not apply	20% coinsurance	Virtual visits (Telehealth) - $10 copay per visit by a Designated Virtual Participating Provider, deductible does not apply. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery. Children under age 19: No Charge.
	Specialist visit	$50 copay per visit, deductible does not apply	20% coinsurance	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening/immunization	No Charge	* 20% coinsurance	Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. *Deductible/coinsurance may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance	If services performed in outpatient hospital setting, deductible/coinsurance may apply.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouhc.com.	Tier 1 - Your Lowest-Cost Option	Deductible does not apply. Retail: $7 copay Mail-Order: $21 copay	Deductible does not apply. Retail: $7 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. If you use a non-Participating pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. If a dispensed drug has a chemically equivalent drug, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. Certain preventive medications and Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Deductible does not apply. Retail: $15 copay Mail-Order: $45 copay	Deductible does not apply. Retail: $15 copay	
	Tier 3 - Your Midrange-Cost Option	Deductible does not apply. Retail: $50 copay Mail-Order: $150 copay	Deductible does not apply. Retail: $50 copay	
	Tier 4 - Additional High-Cost Options	Deductible does not apply. Retail: $150 copay Mail-Order: $450 copay	Deductible does not apply. Retail: $150 copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	None
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay per visit, deductible does not apply	$250 copay per visit, deductible does not apply	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	Participating deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Urgent care	$50 copay per visit, deductible does not apply	20% coinsurance	If you receive services in addition to urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Preauthorization required for non-Participating or benefit will be reduced 10% but not more than $1,000.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay per visit, deductible does not apply	20% coinsurance	Outpatient Facility services - 0% coinsurance . Participating Partial hospitalization/intensive outpatient treatment: 0% coinsurance Preauthorization required for certain non-Participating services or benefit will be reduced 10% but not more than $1,000.
	Inpatient services	0% coinsurance	20% coinsurance	Preauthorization required for non-Participating or benefit will be reduced 10% but not more than $1,000.
If you are pregnant	Office visits	No Charge	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	Inpatient preauthorization may apply for non-Participating or benefit will be reduced 10% but not more than $1,000.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	Preauthorization required for non-Participating or benefit will be reduced 10% but not more than $1,000.
	Rehabilitation services	$25 copay per outpatient visit, deductible does not apply	20% coinsurance	Limits per calendar year: Physical, Speech, Occupational, 37 visits each. Cardiac and Pulmonary Unlimited.
	Habilitation services	$25 copay per outpatient visit, deductible does not apply	20% coinsurance	Limits per calendar year: Physical, Speech, Occupational, 37 visits each.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participa-ting Provider (You will pay the most)	
	Skilled nursing care	0% coinsurance	20% coinsurance	Skilled Nursing is limited to 100 days per calendar year. Preauthorization required for non-Participating or benefit will be reduced 10% but not more than $1,000.
	Durable medical equipment	0% coinsurance	20% coinsurance	Preauthorization required for non-Participating or benefit will be reduced 10% but not more than $1,000.
	Hospice services	0% coinsurance	20% coinsurance	Preauthorization required for non-Participating or benefit will be reduced 10% but not more than $1,000.
If your child needs dental or eye care	Children's eye exam	$10 copay per visit, deductible does not apply	20% coinsurance	One exam every 12 months.
	Children's glasses	$25 copay per frame, deductible does not apply	20% coinsurance	One pair every 12 months. Costs may increase depending on the frames selected. You may choose contact lenses instead of eyeglasses. The benefit does not cover both.
	Children's dental check-up	0% coinsurance	20% coinsurance	Cleanings covered 2 times per 12 months. Additional limitations may apply.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)				
Bariatric Surgery	Cosmetic Surgery	Dental Care (Adult)	Infertility Treatment	Long-Term Care
Private-Duty Nursing	Routine Eye Care (Adult)	Routine Foot Care	Weight Loss Programs	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
Acupuncture	Chiropractic care-20 visits per calendar year	Hearing Aids-$2,500/ calendar year	Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration, or 1-877-267-2323 x61565 or www.cciio.cms.gov for the U.S. Department of Health and Human Services. Other coverage options may be available to you too,

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) (Contract Period)		
Individual	$1,500	$5,000
Family	$3,000	$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. Pharmacy cost sharing applies towards the In-Network medical Deductible.		
Maximum Out-of-Pocket Expense (calendar year) (Contract Period) (includes Copayments, Coinsurance, and Deductibles)		
Individual	$2,000	$15,000
Family	$4,000	$30,000
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	Applicable	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	100% of Allowed Charge	80% of Allowed Charge after Deductible
Well child care, including periodic review of a child's physical and emotional status, is not subject to any deductible. Children under the age of five are not subject to any limit on visits		
Immunizations	100% of Allowed Charge	80% of Allowed Charge after Deductible
Laboratory and X-ray	100% of Allowed Charge	80% of Allowed Charge after Deductible
Physician Office Services		
Office Visits, including diagnosis of infertility for Members age 19 and over	100% after you pay a Copayment of $25 PCP/$50 Specialist per visit. Deductible does not apply.	80% of Allowed Charge after Deductible
Office Visits, including diagnosis of infertility for Members under the age of 19	100% after you pay a Copayment of $0 PCP/ $50 Specialist per visit. Deductible does not apply.	80% of Allowed Charge after Deductible
Office Surgery	100% after you pay a Copayment of $25 PCP/$50 Specialist per visit. Deductible does not apply.	80% of Allowed Charge after Deductible
Allergy Testing	100% after you pay a Copayment of $25 PCP/$50 Specialist per visit. Deductible does not apply.	80% of Allowed Charge after Deductible
Allergy Injections	100% of Allowed Charge. Deductible does not apply.	80% of Allowed Charge after Deductible
Other Injections	100% of Allowed Charge. Deductible does not apply.	80% of Allowed Charge after Deductible
Maternity Physician Services	100% of Allowed Charge after Deductible	80% 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% after you pay a Copayment of $25 PCP/$50 Specialist per visit. Deductible does not apply.	80% of Allowed Charge after Deductible
Inpatient Facility Visits	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Outpatient Facility Visits	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Inpatient Surgery	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Outpatient Surgery	100% of Allowed Charge after Deductible	80% 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 after Deductible	100% of Allowed Charge after Deductible
Emergency Room	$250 Copayment per visit. Deductible does not apply	$250 Copayment per visit. Deductible does not apply
	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 $50. Deductible does not apply.	80% 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		
Outpatient	100% of Allowed Charge. Deductible does not apply.	80% of Allowed Charge after Deductible
Office	100% of Allowed Charge. Deductible does not apply.	80% of Allowed Charge after Deductible
Major Diagnostics (MRI, MRA, CAT and PET Scans)	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
	Note: *When an independent laboratory charges separately for X-ray and laboratory services, separate Coinsurance and/or Deductible may apply, in addition to the physician's office Copayment, Coinsurance and/or Deductible.*	
Chemotherapy, Radiation Therapy, Renal Dialysis Services		
Hospital (Outpatient)	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Office	100% of Allowed Charge. Deductible does not apply.	80% of Allowed Charge after Deductible
Facility Services		
Inpatient Facility (2)	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Outpatient Facility	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Skilled Nursing Facility (2) - (*Member is limited to 100 days per calendar year Contract Period. The 100 In-Network and Out-of-Network days are combined.)*	100% of Allowed Charge after Deductible	80% 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)	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Prosthetic Devices (2)	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Hearing Aid Devices (2) Limited to one hearing aid per hearing impaired ear not to exceed $3,000 per hearing aid including its medically necessary services and supplies. Repair and/or replacement of a hearing aid is limited to a single purchase per hearing impaired ear every three years.	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Gender Dysphoria	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," and "Facility Services."*	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," and "Facility Services."*
Outpatient Rehabilitative Therapy		
Physical, speech and occupation therapy are limited to 37 visits each, per year.	100% after you pay a Copayment of $25 per visit. Deductible does not apply.	80% of Allowed Charge after Deductible
Outpatient Rehabilitative Therapy includes physical, speech, occupational therapy, cardiac (Phase I and II) and pulmonary rehabilitation. Cardiac and pulmonary rehabilitation are not subject to visit limits.		
Habilitative Services		
Inpatient	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," and "Facility Services."*	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," and "Facility Services."*
Outpatient	100% after you pay a Copayment of $25 Deductible does not apply.	80%of Allowed Charge after Deductible
Home Health Services (2)	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
[Hospice Services [(1)][(2)]] [Inpatient]	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
[Outpatient	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Respite Care (2)	100% of Allowed Charge after Deductible	80% 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.*	
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*	
Autism Spectrum Disorder 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)	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Outpatient Facility (2)	100% of Allowed Charge after Deductible	80% 80% of Allowed Charge after Deductible

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Partial Hospitalization/Intensive Outpatient Treatment (2)	100% of Allowed Charge after Deductible.	80% of Allowed Charge after Deductible
Outpatient Physician Services (2)	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Office Visits	100% after you pay a Copayment of $25. Deductible does not apply.	80% of Allowed Charge after Deductible
Substance Abuse Services		
Inpatient Facility (2)	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Outpatient Facility (2)	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Partial Hospitalization/Intensive Outpatient Treatment (2)	100% of Allowed Charge after Deductible.	80% of Allowed Charge after Deductible
Outpatient Physician Services (2)	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Office Visits	100% after you pay a Copayment of $25. Deductible does not apply.	80% of Allowed Charge after Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services Inpatient Facility (2)	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Outpatient Facility (2)	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Outpatient Physician Services (2)	100% of Allowed Charge after Deductible	80%80% of Allowed Charge after Deductible
Office Visits (2)	100% after you pay a Copayment of$25. Deductible does not apply.	80% of Allowed Charge after Deductible
Dental Services – Anesthesia and Hospitalization	Covered the same as any other medical condition.	Covered the same as any other medical condition.
Virtual Visits 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.	$10 Copayment. Deductible does not apply	80% of Allowed Charge after Deductible
Temporomandibular Joint Services (2)	Covered the same as any other medical condition.	Covered the same as any other medical condition.

Coverage Limitations:

(1) For services from Non-Participating Providers, the Allowed Charge is defined in Article 1 of the Certificate of Coverage. The Member is responsible for paying any amounts exceeding the Allowed Charge 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 Services rendered by a Non-Participating Provider in a Medical Emergency will be determined as described in Section 1.1.2 of the Certificate of Coverage. **As a result, the Member 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 Section 1.1.3 of the Certificate of Coverage. **As a result, the Member 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 Member should confirm whether a Physician is a Participating Physician prior to obtaining Covered Services.**

(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.

Continuity of Care

If you are under the care of a Participating provider for one of the medical conditions stated below, and the Participating provider caring for you is terminated from the network, we can arrange, at your request and subject to the provider's agreement, for continuation of Covered Services rendered by the terminated provider for the time periods shown below. Copayments, Coinsurance, Deductibles, or other cost sharing components will be the same as you would have paid for a provider currently contracting with us.

Medical conditions for which treatment by a terminated Participating provider will be covered under this Contract are:

- Chronic Sickness
- Terminal Sickness
- Inpatient care
- Pregnancy.

Benefits will be covered until the earliest of the following dates:

- The date you are discharged from inpatient Facility.
- The date you meet any maximum Benefit that applies.
- Sixty days after the date the provider's contract terminates.
- The 60-day period may be extended for Pregnancy through the delivery of the child and for six weeks of post-delivery care.

This section does not apply when:

- The provider's contract terminated due to medical incompetence or professional behavior.
- You choose to change health care providers.
- You move out of the geographic service area of the health care provider.
- You require only routine monitoring for a chronic condition that is not in an acute phase of the condition.

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
Schedule of Benefits – Pediatric Dental and Vision

Deductibles and Maximums	Participating Provider In-Network	Non-Participating Provider Out-of-Network
Pediatric Vision Care Services Deductible		
Individual	Included in Annual Medical Deductible	Included in Annual Medical Deductible
Family	Included in Annual Medical Deductible	Included in Annual Medical Deductible
Pediatric Dental Services Deductible		
Individual	Included in Annual Medical Deductible	Included in Annual Medical Deductible
Family	Included in Annual Medical Deductible	Included in Annual Medical Deductible

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider Out-of-Network
Pediatric Vision Services (Benefits covered up to age 19)		
You may access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.		
Routine Vision Examination *Benefits are limited to1 exam every year.*	100% after you pay a $10 copayment. Deductible does not apply.	80% after Deductible
Eyeglass Lenses *Benefits are limited to once per year. Coverage includes polycarbonate lenses and standard scratch-resistant coating.*	100% after you pay a $25 copayment. Deductible does not apply.	80% after Deductible
Eyeglass Frames *Benefits are limited to once per year.*		
Eyeglass frames with a retail cost up to $130	100%. Deductible does not apply	80% after Deductible
Eyeglass frames with a retail cost of $130 - 160.	100% after you pay a $15 copayment. Deductible does not apply.	80% after Deductible
Eyeglass frames with a retail cost of $160 - 200.	100% after you pay a $30 copayment. Deductible does not apply.	80% after Deductible
Eyeglass frames with a retail cost of $200 - 250.	100% after you pay a $50 copayment. Deductible does not apply.	80% after Deductible
Eyeglass frames with a retail cost greater than $250.	60%. Deductible does not apply	80% after Deductible
Contact Lenses/Necessary Contact Lenses *Benefits are limited to a 12 month supply. Contacts are in lieu of Frames and Lenses. Reference www.myuhcvision.com for a complete list of covered contacts.*	100% after you pay a $25 copayment. Deductible does not apply.	80% after Deductible
Pediatric Dental Services (Benefits covered up to age 19)		
Preventive Services		
Dental Prophylaxis (Cleanings) *Benefit is limited to 2 times per 12 months.*	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Fluoride Treatments *Benefit is limited to 2 times per 12 months.*	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Sealants (Protective Coating) *Benefit is limited to once per first or second permanent molar every 36 months.*	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Space Maintainers	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Diagnostic Services		
Evaluations (Check-up Exams) *Benefits are limited to 2 times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays.*	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Radiographs *Benefits are limited to 2 series of films per 12*	100% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider Out-of-Network
months. 1 time per 36 months for Complete/Panorex.		
Basic Dental Services		
Endodontics	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Adjunctive Services (Including Emergency treatment) Palliative Treatment: *Covered as a separate benefit only if no other service was done during the visit other than X-rays.* General Anesthesia: *Covered when clinically necessary.* Occlusal Guard: *Benefit is limited to 1 guard every 12 months and only covered if prescribed to control habitual grinding.*	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Oral Surgery (including Surgical Extractions)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Periodontics Periodontal Surgery: *Benefit is limited to 1 quadrant or site per 36 months per surgical area.* Scaling and Root Planing: *Benefit is limited to 1 time per quadrant per 24 months.* Periodontal Maintenance: *Benefit is limited to 4 times per 12 monthsin combination with prophylaxis.*	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Restorations (Amalgam or Composite)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Major Restorative Services		
Inlays/Onlays/Crowns *Benefit is limited to 1 time per tooth per 60 months.*	60% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Dentures and other removal Prosthetics *(Full denture/partial denture)* *Benefit is limited to 1 per 60 months.*	60% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Fixed Partial Dentures (Bridges)	60% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Implants *Benefit is limited to 1 time per tooth per 60 months.*	60% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Medically Necessary Orthodontics		
Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.	60% of Allowed Charge after Deductible *Prior Authorization required for orthodontic treatment.*	50% of Allowed Charge after Deductible *Prior Authorization required for orthodontic treatment.*

UnitedHealthcare Insurance Company of the River Valley
SUPPLEMENTAL BENEFITS RIDER TO CERTIFICATE OF COVERAGE
UNDER GROUP HEALTH CONTRACT

MANIPULATIVE SERVICES RIDER

This rider is subject to all provisions of the Certificate of Coverage under Group Health Contract that are not in conflict with the provisions of this rider. In the event of such a conflict, the provisions in this rider shall govern benefits for manipulative services.

Benefits will be payable for Members for manipulative services provided by a Participating Provider who is licensed to provide such care and who has entered into an agreement with OptumHealth Care Solutions, Inc. to provide manipulative services for UnitedHealthcare. Services are subject to preauthorization by OptumHealth Care Solutions, Inc.

Benefits payable under this supplemental rider do not apply toward any Outpatient Rehabilitative Therapy limits as defined in Attachment D of the Certificate of Coverage. These Benefits are limited to 20 visits per calendar year Contract Period. Benefits payable under this rider are not subject to Deductibles, and Copayments do apply toward the Maximum Out-of-Pocket Expense as shown in Attachment D of the Certificate of Coverage.

The following services are covered by UnitedHealthcare subject to a $25 Copayment.

Covered Spinal Manipulation Services

- Diathermy
- Electric Stimulation
- Emergency Room
- Massage
- Medical Supplies
- Office Visits
- Diagnostic Evaluation and X-ray services for the purpose of diagnosing the appropriateness of treatment under this rider.
- Spinal Manipulation
- Traction
- Ultrasound

Note: Services received from a Non-Network Provider will be paid according to the Out-of-Network benefits indicated in the Attachment D to your Certificate of Coverage.

The following services are not payable under this rider:

Acupressure • Acupuncture • Arch Supports • Biosoterometric Studies • Cervical Pillow • Chelation Therapy • Colonic Therapy or Irrigations • Computerized Axial Tomography • Durable Medical Equipment • Graphic X-ray Analysis • Hair Analysis • Hand Held Doppler • Heavy Metal Screening • Iridology • Iris Analysis • Kinesiology • Living Cell Analysis • Magnetic Resonance Imaging • Maintenance Care • Mineral Cellular Analysis • Moire Contourographic Analysis • Nutritional Counseling • Nutritional Supplements • Over-the-Counter Drugs or Preparations • Oxygen Therapy • Ream's Lab or Ream's Test • Rolfing • Sublingual or Oral Therapy • Thermographic Procedures • Toxic Metal Analysis.

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, Tier 3 or Tier 4.

Prescription Drug Products

Tier 1 ..... $7 copayment
Tier 2 ..... $15 copayment
Tier 3 ..... $50 copayment
Tier 4 ..... $150 copayment

Application of Drug 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 three copayments for each 90-day supply prescription fill or refill purchased at a retail pharmacy or by mail order.
- An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at the Member's or the provider's request and there is another drug that is Chemically Equivalent. An Ancillary Charge does not apply to any Annual Deductible or Out-of-Pocket Maximum.

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 prescription drug products.

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 a prescription drug product, and (2) such OTC medication is obtained with a prescription from an attending physician • therapeutic or prosthetic devices • drugs used for cosmetic purposes • drugs used to enhance physical or mental performance • certain 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 the 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 (Certificate of Coverage 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.

The company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

- **Online:** UHC_Civil_Rights@uhc.com
- **Mail**: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the member toll-free phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

- **Online:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
- **Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)
- **Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card TTY 711, Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說**中文 (Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русским (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج على بطاقة التعريف الخاصة بك.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.