State of Rhode Island Benefits Summary:

Retiree Value Plan

Covered Health Service	*Within the UHC Network you pay:*	*Outside of the UHC Network you pay:*
Annual Deductible	$2,000 per Covered Person, not to exceed $4,000 for all Covered Persons	$5,000 per Covered Person, not to exceed $10,000 for all Covered Persons
Out of Pocket Maximum	$4,000 per Covered Person, not to exceed $8,000 for all Covered Persons. The Out-of-Pocket Maximum does not include the Annual Deductible.	$10,000 per Covered Person, not to exceed $20,000 for all Covered Persons. The Out-of-Pocket Maximum does not include the Annual Deductible.
1. Ambulance Services – Emergency		
Ground Transportation	30% of Eligible Expenses atfer deductible	Same as Network Benefit
Air/Water Transportation	30% of Eligible Expenses atfer deductible	Same as Network Benefit
2. Cardiac Rehabilitation 36 visits	$35 per visit	50% of Eligible Expenses after deductible
3. Chiropractic Treatment Maximum 24 visits per calendar year.	$35 per visit	50% of Eligible Expenses after deductible
4. Dental Services– Accident only	*30% of Eligible Expenses atfer deductible *Prior notification is required before follow-up treatment begins.	*Same as Network Benefit *Prior notification is required before follow-up treatment begins.
5. Diabetes Education	$35 per visit	*50% of Eligible Expenses atfer deductible *Prior notification is required when the cost is more than $1,000.

Covered Health Service	*Within the UHC Network you pay:*	*Outside of the UHC Network you pay:*
6. Durable Medical Equipment Network and Non-Network Benefits for Durable Medical Equipment are limited to $2,500 per calendar year.	*30% of Eligible Expenses atfer deductible *Prior notification is required when the cost is more than $1,000.	*50% of Eligible Expenses atfer deductible *Prior notification is required when the cost is more than $1,000.
7. Emergency Health Services Covered anYy~w^~here in the world.	$150 per visit *Notification is required if results in an Inpatient Stay.	Same as Network Benefit *Notification is required if results in an Inpatient
8. Eye Examinations Refractive eye examinations are limited to one every other calendar year from a Network Provider	$35 per visit	50% of Eligible Expenses atfer deductible. Eye Examinations for refractive errors are not covered.
9. Hearing Aids Must be ordered by physician. Limited to $1,500 per hearing aid per ear every three years for members under age 19, and $700 per hearing aid per ear every three years for members age 19 and older.	0% of Eligible Expenses See maximum plan benefit at letf	50% of Eligible Expenses atfer deductible See maximum plan benefit at letf
10. Home Health Care Network and Non-Network Benefits are limited to 6 home or office Physician's visits per month, 3 nursing visits per week and 20 hours of home health aide visits per week.	*30% of Eligible Expenses atfer deductible	*50% of Eligible Expenses atfer deductible
11. Hospice Care Network and Non-Network Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Policy	*30% of Eligible Expenses atfer deductible	*50% of Eligible Expenses atfer deductible
12. Hospital – Inpatient Stay	*30% of Eligible Expenses atfer deductible	*50% of Eligible Expenses atfer deductible
13. Infertility Services	20% of Eligible Expenses atfer deductible	20% of Eligible Expenses atfer deductible
14. Injections Received in a Physician's Office	$35 per visit	50% of Eligible Expenses atfer deductible

Covered Health Service	*Within the UHC Network you pay:*	*Outside of the UHC Network you pay:*
15. Maternity Services	Same as 12, 17, 19 and 20 No copayment applies to Physician office visits for prenatal care atfer the first visit in which a $35 copayment applies. Notification is required if Inpatient Stay exceeds 48 hours following a normal	50% of Eligible Expenses after deductible
16. Mental Health and Substance Abuse Services – Outpatient Mental Health: Maximum of 30 visits per calendar year Substance Abuse: 30 hours per calendar year	$35 per individual visit; $30 per group visit.	50% of Eligible Expenses atfer deductible
Inpatient and Intermediate Mental Health: Unlimited days *Substance Abuse Rehabilitation*: 30 days per calendar year. *Substance Abuse Detoxification:* 5 admissions or 30 days per calendar year, which ever comes first.	30% of Eligible Expenses after deductible	50 o o of Eligible Expenses atfer deductible
17. Outpatient Services		
Outpatient Surgery	30% of Eligible Expenses atfer deductible	50% of Eligible Expenses atfer deductible
Outpatient Diagnostic/Therapeutic Services – Laboratory Tests, CT Scans, Pet Scans, and MRI	30% of Eligible Expenses atfer deductible	50% of Eligible Expenses atfer deductible
Outpatient Diagnostic Services	For lab and radiology/X-ray: No Copayment	50% of Eligible Expenses atfer deductible
	For mammography testing: No Copayment	50% of Eligible Expenses atfer deductible
18. Physical/Occupational Therapy Network and Non-Network benefits are limited to 20 visits of physical therapy; 20 visits of occupational therapy	$35 per visit	50% of Eligible Expenses atfer deductible

Covered Health Service	*Within the UHC Network you pay:*	*Outside of the UHC Network you pay:*
19. Physician's Office Services	$35 per visit.	50% of Eligible Expenses atfer deductible
20. Professional Fees for Surgical and Medical Services	30% of Eligible Expenses atfer deductible	50% of Eligible Expenses atfer deductible
21. Prosthetic Devices Network and Non-Network Benefits for prosthetic devices are limited to $2,500 per calendar year.	30% of Eligible Expenses atfer deductible	50% of Eligible Expenses atfer deductible
22. Scalp Hair Prosthesis Network and Non-Network Benefits for a scalp hair prosthesis are limited to $350 per calendar year.	30% of Eligible Expenses atfer deductible See maximum plan benefit at letf	50% of Eligible Expenses atfer deductible See maximum plan benefit at letf
23. Skilled Care in a Nursing Facility Network and Non-Network Benefits are limited to 60 days per calendar year.	*30% of Eligible Expenses atfer deductible	*50% of Eligible Expenses atfer deductible
24. Speech Therapy Outpatient Network and Non-Network are limited to 20 visits per calendar year	$35 per visit	50% of Eligible Expenses after deductible
25. Transplantation Services Must be performed at a Center of Excellence	*30% of Eligible Expenses atfer deductible	*50% of Eligible Expenses atfer deductible. Benefits are limited to $30,000 per transplant.
26. Tobacco Cessation Treatment – Outpatient Visits Network and Non-Network Benefits are limited to eight, thirty (30) minute counseling sessions each calendar year.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Certificate of Coverage.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Certificate of Coverage.
27. Urgent Care Center Services	$50 per visit	50% of Eligible Expenses atfer deductible

Covered Health Service	*Within the UHC Network you pay:*	*Outside of the UHC Network you pay:*
Pharmacy Coverage **Quantity Limit per co-payment:** Up to a 31-day supply	$10 Tier 1 $30 Tier 2 $50 Tier 3	$10 Tier 1 $30 Tier 2 $50 Tier 3
Mail Order **Quantity Limit per co-payment:** Up to a 90-day supply	$25 Tier 1 $75 Tier 2 $125 Tier 3	Not covered

*Pre-authorization is recommended for this service. If you do not obtain pre-authorization and the services are determined to be not medically necessary or the setting where services were received is determined to be inappropriate, this plan will not cover these services.

**Out-of-pocket amounts on this benefit will not accumulate to the annual maximum out-of-pocket expense. This benefit level will not increase due to having satisfied the annual maximum out-of-pocket expense through other benefits.

Non-Network Charges: If you choose to seek care outside the Network, you will also be responsible for payment of the difference between the provider's billed charges and the expenses eligible for

Dependent Age: Until the end of the calendar year atfer their 19th birthday.

Student Status: Until the end of the calendar year atfer their 25th birthday. If student status ends, coverage will end the last day of the calendar year of the student status change.

This Summary of Benefits is intended only to highlight your benefits and should not be relied upon to fully determine coverage. More complete descriptions of Benefits and the terms under which they are provided, including related exclusions, are contained in the Summary Plan Description available online at www.ersri.org. This plan may not cover all your health care expenses. Please refer to the Summary Plan Description for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conlficts in any way with the Summary Plan Description, the Summary Plan Description prevails. Terms that are capitalized in the Benefits Summary are defined in the Summary Plan Description.