

State of Rhode Island Benefits Summary: 2009 Early Retirees

Effective January 1 2009.

Covered Health Service	Within the UHC Network you pay:	Outside of the UHC Network you pay:
1. Ambulance Services – Emergency Ground Transportation Air/Water Transportation	0% of Eligible Expenses 0% of Eligible Expenses up to \$3,000	Same as Network Benefit Same as Network Benefit
2. Cardiac Rehabilitation Inpatient – Up to 12 weeks or 36 visits, whichever comes first. Outpatient – 3 visits per week up to 12 weeks.	0% of Eligible Expenses 20% of Eligible Expenses	20% of Eligible Expenses **20% of Eligible Expenses
3. Chiropractic Treatment Maximum 12 visits per year.	\$20 per visit	20% of Eligible Expenses
4. Dental Services– Accident only	0% of Eligible Expenses	*Same as Network Benefit
5. Diabetes Education 1 pre-assessment, 5 individual, and 7 group sessions.	\$20 per visit	20% of Eligible Expenses
6. Durable Medical Equipment / Medical Supplies/Prosthetic Devices Inpatient Outpatient	0% of Eligible Expenses 20% of Eligible Expenses	20% of Eligible Expenses **20% of Eligible Expenses
7. Emergency Health Services Covered anywhere in the world.	\$100 per visit (Waived if admitted to hospital within 24-hours)	Same as Network Benefit
8. 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 left.	20% of Eligible Expenses See maximum plan benefit at left.
9. Hemodialysis Services Inpatient or in <i>your</i> home, when under the supervision of a hospital or program approved by	0% of Eligible Expenses	20% of Eligible Expenses
10. Hemophilia Services Up to 56 treatments/calendar year. Subject to office visit co-payment if received in doctor's office.	0% of Eligible Expenses	20% of Eligible Expenses

Covered Health Service	Within the UHC Network you pay:	Outside of the UHC Network you pay:
11. Home Health Care/Home Infusion Therapy When part of a coordinated home care program. When not part of a coordinated home care program	0% of Eligible Expenses 20% of Eligible Expenses	*20% of Eligible Expenses *,**20% of Eligible Expenses
12. Hospice Care Approved hospice care providers only.	0% of Eligible Expenses	*20% of Eligible Expenses
13. Hospital – Inpatient Stay Unlimited days at a general hospital; 45 days/calendar year at specialty hospital or in a general hospital for specialty services. Doctor's Hospital Services – 1 visit per day per specialty Surgery Services - Inpatient	0% of Eligible Expenses 0% of Eligible Expenses	*20% of Eligible Expenses 20% of Eligible Expenses **20% of Eligible Expenses
14. House Calls	\$10 per visit for PCP \$20 per visit for Specialist	20% of Eligible Expenses
15. Human Leukocyte Antigen Testing Once per member per lifetime	0% of Eligible Expenses	20% of Eligible Expenses
16. Infertility Services Includes infertility drugs not obtained at pharmacy	20% of Eligible Expenses	**20% of Eligible Expenses
17. Injections Received in a Physician's Office	20% per injection Allergy: \$20 per visit, No copayment applies when no Physician charge is assessed.	20% per injection
18. Maternity Services Pre-natal, post-natal, and delivery. Notification is required if inpatient stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a caesarian section delivery.	0% of Eligible Expenses No Copayment applies to Physician office visits for prenatal care after the ifrst visit in which a \$20 copayment applies	*20% of Eligible Expenses
19. Mental Health and Substance Abuse Services – Outpatient Mental Health: Maximum of 45 visits per calendar year Substance Abuse: 30 hours per calendar year 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	\$20 per individual or group visit 0% of Eligible Expenses	20% of Eligible Expenses *20% of Eligible Expenses

Covered Health Service	Within the UHC Network you pay:	Outside of the UHC Network you pay:
20. Nutritional Counseling 6 visits per calendar year when prescribed by a physician for treatment of illness.	\$20 per visit	20% of Eligible Expenses
21. Outpatient Services		
Outpatient Surgery	0% of Eligible Expenses	20% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services – Laboratory Tests, CT Scans, Pet Scans, and MRI	0% of Eligible Expenses	20% of Eligible Expenses
22. Physical/Occupational Therapy		
Inpatient	0% of Eligible Expenses	20% of Eligible Expenses
Outpatient – Therapy beginning within 30 days following a hospital stay, home care program, or ambulatory surgical procedure.	0% of Eligible Expenses	20% of Eligible Expenses
Outpatient – Not Following a Hospital Stay	20% of Eligible Expenses	**20% of Eligible Expenses
Outpatient – In a Doctor's or Therapist's Office	20% of Eligible Expenses	**20% of Eligible Expenses
23. Physician's Office Services		
Primary Care Physician Internal Medicine, Family Practice, Pediatrics and Geriatrics	\$10 per visit.	20% of Eligible Expenses
Specialist Physician Office Visits All physicians other than Primary Care Physicians (see above)	\$20 per visit. No copay applies when a Physician charge is not assessed	20% of Eligible Expenses
Routine Annual Physicals and Annual Gynecological visits	0% of Eligible Expenses	20% of Eligible Expenses
Pediatric Preventive Birth - 12 months: 7 visits 13 - 35 months: 3 visits 36 months - 19 years: 1 per calendar year	0% of Eligible Expenses	20% of Eligible Expenses
24. Private Duty Nursing If no intensive care unit available	0% of Eligible Expenses	*0% of Eligible Expenses
25. Radiation/Chemotherapy Services		
Radiation Therapy/Chemotherapy – Inpatient/Outpatient	0% of Eligible Expenses	20% of Eligible Expenses
Chemotherapy Services in a doctor's office. Includes drugs and administration	20% of Eligible Expenses	**20% of Eligible Expenses
26. Respiratory Therapy	0% of Eligible Expenses	20% of Eligible Expenses

Covered Health Service	Within the UHC Network you pay:	Outside of the UHC Network you pay:
27. Scalp Hair Prosthesis Network and Non-Network Benefits for a scalp hair prosthesis are limited to \$350 per calendar year.	20% of Eligible Expenses See maximum plan benefit at left.	20% of Eligible Expenses See maximum plan benefit at left.
28. Skilled Care in a Nursing Facility	0% of Eligible Expenses	*20% of Eligible Expenses
29. Speech Therapy Outpatient In a doctor's/therapist's office	20% of Eligible Expenses	* **20% of Eligible Expenses
30. Transplantation Services Must be performed at a Center of Excellence	0% of Eligible Expenses	Not available
31. 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 Summary Plan Document.	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 Summary Plan Document.
32. Urgent Care Center Services	\$35 per visit	20% of Eligible Expenses
Prescription Coverage		
Injectable Drugs obtained at the pharmacy	Same as pharmacy coverage	Same as pharmacy coverage
Injectable drugs provided by a doctor and administered in a doctor's office	20% of Eligible Expenses	**20% of Eligible Expenses
Oral or injectable chemotherapy drugs If used for other than cancer treatment and not otherwise covered under pharmacy	20% of Eligible Expenses	**20% of Eligible Expenses
Pharmacy Coverage		
Quantity Limit per co-payment:		
Up to a 31-day supply	\$5 Tier 1 \$20 Tier 2 \$40 Tier 3	**\$5 Tier 1 **\$20 Tier 2 **\$40 Tier 3
Mail Order network pharmacies:	\$10 Tier 1 \$40 Tier 2 \$80 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.

Covered Health Service

**Within the UHC
Network you pay:**

**Outside of the UHC
Network you pay:**

Network Out-of-Pocket Maximum: No Out-of-Pocket maximum

Non-Network Out-of-Pocket Maximum: \$3,000 per Covered Person per calendar year, not to exceed \$9,000 for all Covered Persons in a family. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the SPD.

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 reimbursement.

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

Student Status: Until the end of the calendar year after 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 more complete descriptions of Benefits and the terms under which they are provided, including related exclusions, contained in the Summary Plan Description available online at www.employeebenefits.ri.gov. 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 conflicts 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.