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	$2,500
Family	$3,000	$5,000
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.		
Maximum Out-of-Pocket Expense (calendar year)/(Contract Period) (includes Copayments, Coinsurance, and Deductibles)		
Individual	$5,000	$7,500
Family	$10,000	$15,000
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 *("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	Covered at 100%	60% of Allowed Charge after Deductible
Immunizations	Covered at 100%	100% of Allowed Charge. Deductible does not apply.
Laboratory and X-ray	Covered at 100%	60% of Allowed Charge after Deductible
Physician Office Services		
Office Visits	100% after you pay a Copayment of $25 PCP/$50 Specialist per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Office Surgery	100% after you pay a Copayment of $25 PCP/$50 Specialist per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Allergy Testing	100% after you pay a Copayment of $25 PCP/$50 Specialist per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Allergy Injections	80% of Allowed Charge. Deductible does not apply.	60% of Allowed Charge after Deductible
Other Injections	80% of Allowed Charge. Deductible does not apply.	60% of Allowed Charge after Deductible
Maternity Physician Services	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
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.*	

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	100% after you pay a Copayment of $25 PCP/$50 Specialist per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Inpatient Facility Visits	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Facility Visits	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Inpatient Surgery (1)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Surgery (1)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Emergency Services (1) *(Follow-up care obtained in the emergency room is not covered.)*		
Emergency Room Physician	100% of Allowed Charge. Deductible does not apply.	Same as In Network
Emergency Room	100% after you pay a Copayment of $250 per visit for initial care only of a Medical Emergency. Deductible does not apply. Emergency Room Copayment waived if admitted.	Same as In Network
	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 $75 per visit. Deductible does not apply.	60% 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	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Office	100% of Allowed Charge. Deductible does not apply.	60% of Allowed Charge after Deductible
Major Diagnostics (MRI, MRA, CAT and PET Scans)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
	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.	
Chemotherapy, Radiation Therapy, Renal Dialysis Services		
Hospital (Outpatient)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Office	80% of Allowed Charge. Deductible does not apply.	60% of Allowed Charge after Deductible
Facility Services		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Facility	80% of Allowed Charge after Deductible	60% 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.)*	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Medical Equipment *(Diabetic supplies do not count toward the Durable Medical Equipment benefit maximum.)*		

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Durable Medical Equipment (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Prosthetic Devices (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Hearing Aid Devices (2) *(No Copayment or Deductible will be applicable to Hearing Aid Coverage.)*	80% of Allowed Charge. Deductible does not apply.	Not covered
Outpatient Rehabilitative Therapy and Habilitative Services *Outpatient Rehabilitative Therapy includes physical, speech, and occupational therapy and cardiac (Phase I and II) and pulmonary rehabilitation.*		
(Member is limited to 60 outpatient treatment visits per (calendar year)/(Contract Period). The In-Network and Out-of-Network visits are combined.)	100% after you pay a Copayment of $25 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Habilitative Services – Outpatient Therapy *30 outpatient visits for any combination of physical therapy, occupational therapy and speech therapy for Habilitative Services.* *Any combination of physical therapy, occupational therapy and speech therapy, is limited to 180 hours per year for Habilitative, medically necessary developmental Services.*	100% after you pay a Copayment of $25 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Home Health Services (2)	80% of Allowed Charge after Deductible	Not Covered
Hospice Services (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Respite Care (2)	80% of Allowed Charge after Deductible	60% 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*	Not covered
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*	
Temporomandibular Joint Services (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.*	
Mental Health Services		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Physician Services (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Partial Hospitalization/Intensive Outpatient Treatment (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Office Visits	100% after you pay a Copayment of $50 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Substance Abuse Services		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Outpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Physician Services (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Partial Hospitalization/Intensive Outpatient Treatment (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Office Visits	100% after you pay a Copayment of $50 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Physician Services (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Partial Hospitalization/Intensive Outpatient Treatment (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Office Visits	100% after you pay a Copayment of $50 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
In vitro fertilization (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Medical Foods (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Musculoskeletal Disorders of the Face, Neck or Head (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.*	
Orthotic Devices and Services (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Craniofacial Anomaly Services (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.*	
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.	100% after you pay a Copayment of $25 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible

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 benefit 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.

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.