

**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)		
Individual	\$1,000	\$2,500
Family	\$2,000	\$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) (includes Copayments, Coinsurance, and Deductibles)		
Individual	<u>\$6,600</u>	\$7,500
Family	<u>\$13,200</u>	\$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
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Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
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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	<i>See "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories.</i>	
Outpatient	<i>See "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories.</i>	

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	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Surgery	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Emergency Services <i>(Follow-up care obtained in the emergency room is not covered.)</i>		
Emergency Room Physician	100% of Allowed Charge. Deductible does not apply.	100% of Allowed Charge. Deductible does not apply.
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. <i>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.</i>	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.
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
<i>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.</i>		
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) <i>(Member is limited to 100 days per calendar year. The 100 In-Network and Out-of-Network days are combined.)</i>	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
Medical Equipment		
<i>(Diabetic supplies do not count toward the Durable Medical Equipment benefit maximum.)</i>		
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) <i>(No Copayment or Deductible will be applicable to Hearing Aid Coverage.)</i>	80% of Allowed Charge. Deductible does not apply.	Not covered
Outpatient Rehabilitative Therapy and Habilitative Services		
<i>Outpatient Rehabilitative Therapy includes physical, speech, and occupational therapy and cardiac (Phase I and II) and pulmonary rehabilitation.</i>		
<i>(Member is limited to 60 outpatient treatment visits per calendar year. The In-Network and Out-of-Network visits are combined.)</i>	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)	<i>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</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," "Facility Services," or other applicable categories</i>	
Clinical Trials	<i>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</i>	
Temporomandibular Joint Services (2)	<i>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.</i>	
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
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
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
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)	<i>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.</i>	

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Orthotic Devices and Services (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Craniofacial Anomaly Services (2)	<i>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.</i>	

Coverage Limitations:

- (1) For services from Non-Participating Providers, the Allowed Charge is the Maximum Allowance. Except when services were rendered in a Medical Emergency, the Member is responsible for paying any amounts exceeding the Maximum Allowance for services received from Non-Participating Providers. Such excess amounts will not count toward the Deductible or Maximum Out-of-Pocket Expense.
- (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.