UnitedHealthcare Insurance Company of the River Valley
Schedule of Benefits

Please refer to the Member's 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	$0	$5,000
Family	$0	$10,000
(The In-Network Deductible and Out-of-Network Deductible are separate.) 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 deductibles in this Schedule will apply toward the Out-of-Pocket Maximum not to exceed $7,150 for an Individual or $14, 300 for a family.		
Maximum Out-of-Pocket Expense (calendar year) / (contract period) (includes Copayments, Coinsurance, and Deductibles)		
Individual	$3,000	$10,000
Family	$6,000	$20,000
(The In-Network Maximum Out-of-Pocket Expense and Out-of-Network Maximum Out-of-Pocket Expense are separate.) All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.		
Maximum Policy Benefit per Member	None	None
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 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.	Covered at 100%	60% of Allowed Charge after Deductible
Immunizations	Covered at 100%	60% of Allowed Charge after Deductible
Laboratory and X-ray	Covered at 100%	60% of Allowed Charge after Deductible
Physician Office Services		
Office Visits, including diagnosis of infertility		
PCP	$15 per visit Deductible does not apply.	60% of Allowed Charge after Deductible
Specialist	$45 per visit after Deductible.	60% of Allowed Charge after Deductible

Office Surgery		
PCP	$15 per visit Deductible does not apply.	60% of Allowed Charge after Deductible
Specialist	$45 per visit after Deductible.	60% of Allowed Charge after Deductible
Allergy Testing		
PCP	$15 per visit Deductible does not apply.	60% of Allowed Charge after Deductible
Specialist	$45 per visit after Deductible.	60% of Allowed Charge after Deductible
Allergy Injections	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Other Injections	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Maternity Physician Services	100% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Newborn Physician Services		
Inpatient	*See "Physician Services at a Facility other than the Office" and "Facility Services."*	
Outpatient	*See "Physician Office Services."*	
Physician Services at a Facility other than the Office		
Home Visits	$15 Copayment per visit Deductible does not apply. $45 Copayment per visit after Deductible.	60% of Allowed Charge after Deductible
Inpatient Facility Visits	100% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Facility Visits	100% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Inpatient Surgery(1)	100% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Surgery(1)	100% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Emergency Medical Services		
Emergency Room Physician	100% after you pay a Copayment	Same as In-Network
Emergency Room	$350 per visit for a Medical Emergency after Deductible. Emergency Room Copayment waived if admitted. 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.	Same as In-Network
Urgent Care Facility	$100 Copayment per visit after Deductible	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 and X-ray Services Lab, X-Ray and Other Diagnostic Testing - Outpatient	100% after Deductible	60% of Allowed Charge after Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	$250 Copayment after Deductible	60% of Allowed Charge after Deductible
Office	100% of Allowed Charge per PCP Deductible does not apply 100% of Allowed Charge per Specialist 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	$15 PCP Copayment per visit after Deductible.	60% of Allowed Charge after Deductible
Facility Services Inpatient Facility (2)	$250 Copayment per admission after Deductible	60% of Allowed Charge after Deductible
Outpatient Facility	$250 Copayment per surgery after Deductible	60% of Allowed Charge after Deductible
Skilled Nursing Facility (2) - (*Limited to 100 Skilled Nursing Facility days per* **(***calendar year) / (contract period). (The In-Network and Out-of-Network days are combined.)*	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Medical Equipment *(Diabetic equipment and supplies are not subject to any benefit maximums for Durable Medical Equipment.)*		
Durable Medical Equipment (2) *Benefits are limited to a single purchase of a type of DME every three years.*	$45 Copayment after Deductible	60% of Allowed Charge after Deductible
Prosthetic Devices and Prosthetic Services	$45 Copayment after Deductible	60% of Allowed Charge after Deductible

Hearing Aid Devices. *Benefits are further limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.* *For Covered Persons 17 years of age and under, limited to a single purchase (including repair/replacement) per hearing impaired ear every three years*.	$45 Copayment after Deductible	Out-of-Network Benefits are not available
Outpatient Rehabilitative Therapy *Therapy treatment for Autism Spectrum Disorders may not impose visit limits for Dependents under the age of twenty-one (21).* *Any combination of outpatient rehabilitative therapies is limited to 60 visits per year. This limit does not apply to Manipulative Services.*	$45 Copayment after Deductible	60% of Allowed Charge after Deductible
Outpatient Rehabilitative Therapy includes physical, speech, occupational therapy, cardiac (Phase I and II), pulmonary, post-cochlear implant aural, and cognitive rehabilitation.		
Home Health Services (2)	100% of Allowed Charge after Deductible	Out-of-Network Benefits are not available
Hospice Services (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," and "Facility Services."*	Out-of-Network Benefits are not available
Cornea Transplants (2)	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," and "Facility Services."*	
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.*	
Mental Health Services		
Inpatient Facility (2)	$250 Copayment per admission after Deductible.	60% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	100% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Facility (2)	100% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Physician Services (2)	100% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Partial Hospitalization/Intensive Outpatient Treatment (2)	100% of Allowed Charge after Deductible.	60% of Allowed Charge after Deductible
Office Visits (2)	$45 Specialist Copayment Deductible does not apply.	60% of Allowed Charge after Deductible
Substance Use Disorder Services	$250 Copayment per admission after Deductible.	
Inpatient Facility (2)		60% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	100% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Facility (2)	100% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible

Outpatient Physician Services (2)	100% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Partial Hospitalization/Intensive Outpatient Treatment (2)	100% of Allowed Charge after Deductible.	60% of Allowed Charge after Deductible
Office Visits (2)	$45 Specialist Copayment Deductible does not apply.	60% of Allowed Charge after Deductible
Dental Services - Anesthesia and Hospitalization (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.*	*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 (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.*	*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.*
Cleft Lip and Cleft Palate Services (2) *Benefits for amplification devices that meet the definition of Durable Medical Equipment are not subject to the limit stated under* Durable Medical Equipment.	*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.*	*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.*
Medical Foods (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.*	*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*
Qualified Interpreter/Translator 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.*	*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.*
Telemedicine 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.*	*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.*
Gender Dysphoria Treatment	*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.*	*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.*
Manipulative Services	100% after you pay a Copayment of $45 per visit after Deductible.	60% of Allowed Charge after Deductible.
Virtual Visits	100% after you pay a copayment of $10 Copayment Deductible does not apply.	Out-of-Network Benefits are not available.

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 an Emergency Medical Service 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.

When multiple Covered Health Services are performed, the Copayment, Coinsurance, and/or Deductible applicable to each Covered Health Service will apply. For example, a laboratory and x-ray service separately charged by an independent laboratory outside of the Physician's office has a separate Copayment, Coinsurance and/or Deductible in addition to the Physician's office Copayment, Coinsurance or Deductible.