UnitedHealthcare Insurance Company of the River Valley
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	$1,500	$3,000
Family	$3,000	$6,000
(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.		
Maximum Out-of-Pocket Expense (Calendar Year) (includes Coinsurance and Deductibles)		
Individual	$3,000	$ 6,000
Family	$6,000	$12,000
(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. Member Copayments do not accumulate to the Out-of-Pocket Maximum.		
4th Quarter Deductible Carryover	Applicable	Applicable

Benefits for Covered Services	Participating Provider In-Network Member Pays	Non-Participating Provider (1) Out-of-Network Member Pays
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%.	Not covered
Immunizations	Covered at 100%.	Not covered
Laboratory and X-ray	Covered at 100%.	Not covered
Physician Office Services		
Office Visits, including diagnosis of infertility.	$30 PCP/$60 Specialist Copayment per visit. Deductible does not apply.	40% of Allowed Charge after Deductible
Office Surgery	$30 PCP/$60 Specialist Copayment per visit. Deductible does not apply.	40% of Allowed Charge after Deductible
Allergy Testing	$30 PCP/$60 Specialist Copayment per visit. Deductible does not apply.	Not covered
Allergy Injections	20% of Allowed Charge. Deductible does not apply.	Not covered
Other Injections	20% of Allowed Charge. Deductible does not apply.	40% of Allowed Charge after Deductible
Maternity Physician Services	$500 Copayment per pregnancy. Deductible does not apply.	40% 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	$30 PCP/$60 Specialist Copayment per visit. Deductible does not apply.	40% of Allowed Charge after Deductible
Inpatient Facility Visits	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Facility Visits	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Inpatient Surgery	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Surgery	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Emergency Services	*(Follow-up care obtained in the Emergency Room is not covered)*	
Emergency Room Physician No preauthorization for services is required.	0% of Allowed Charge. Deductible does not apply.	Covered the same as In-Network Services
Emergency Room No preauthorization for services is required.	$250 Copayment per visit for a Medical Emergency. Deductible does not apply. Emergency Room Copayment waived if admitted.	Covered the same as In-Network Services
	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.	

Benefits for Covered Services	Participating Provider In-Network Member Pays	Non-Participating Provider (1) Out-of-Network Member Pays
Urgent Care Facility	$100 Copayment per visit. Deductible does not apply.	40% of Allowed Charge after Deductible
Ambulance Services	20% of Allowed Charge after Deductible	20% of Allowed Charge after Deductible
	Non-emergency transports must be approved in advance by UnitedHealthcare.	
Laboratory and X-ray Services		
Outpatient	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Office	20% of Allowed Charge after Deductible	40% 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)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Office	20% of Allowed Charge. Deductible does not apply.	40% of Allowed Charge after Deductible
Facility Services		
Inpatient Facility (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Facility	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Skilled Nursing Facility (2) - (*Limited to 100 Skilled Nursing Facility days per Calendar Year) (The In-Network and Out-of-Network days are combined.)*	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Medical Equipment *(Diabetic equipment and supplies are not subject to any benefit maximums for Durable Medical Equipment or Prosthetic Device,)*		
Durable Medical Equipment (2) *(Plan pays a maximum benefit of $2,500 per calendar year for Durable Medical Equipment which includes both In-Network and Out-of-Network.)*	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Prosthetic Devices (2) *(Plan pays a maximum benefit of $2,500 per calendar year for Prosthetic Devices which includes both In-Network and Out-of-Network.)*	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Hearing Aid Devices (2) *(Plan pays a maximum benefit of $2,500 per calendar year)*	20% of Allowed Charge after Deductible	Not covered
Outpatient Rehabilitative Therapy (*Limited to 60 visits per Calendar Year) (The In-Network and Out-of-Network visits are combined.)*	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Rehabilitative Therapy includes physical, speech, occupational therapy, cardiac (Phase I and II) and pulmonary rehabilitation.		
Home Health Services (2)	20% of Allowed Charge after Deductible	Not covered
Hospice Services (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Respite Care (2)	20% of Allowed Charge after Deductible	40% 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."*	Not covered
Cornea Transplants	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," and "Facility Services."*	
Mental Health Services		
Inpatient Facility (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Facility (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Physician Services (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Office Visits	0% of Allowed Charge. Deductible does not apply.	40% of Allowed Charge after Deductible
Substance Abuse Services		
Inpatient Facility (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Facility (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Physician Services (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Office Visits	0% of Allowed Charge. Deductible does not apply.	40% of Allowed Charge after Deductible
Cleft Lip and Cleft Palate Services	Covered the same as any other medical condition.	Covered the same as any other medical condition.

Benefits for Covered Services	Participating Provider In-Network Member Pays	Non-Participating Provider (1) Out-of-Network Member Pays
Neurobiological Disorders - Autism Spectrum Disorder Services		
Inpatient Facility (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Facility (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Outpatient Physician Services (2)	20% of Allowed Charge after Deductible	40% of Allowed Charge after Deductible
Office Visits	0% of Allowed Charge. Deductible does not apply.	40% of Allowed Charge after Deductible

Coverage Limitations

(1) For services from Non-Participating Providers, the Allowed Charge is the Maximum Non-Network Reimbursement Program (MNRP). Except when services were rendered in a Medical Emergency, the Member is responsible for paying any amounts exceeding the MNRP 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.

Continuity of Care

If you are under the care of a Network provider for a "serious medical condition" and the Network provider caring for you is terminated from the Network by us, we can arrange, at your request and subject to the provider's attestation as described below, for continuation of Covered Health Services rendered by the terminated provider for the time period shown below. Copayments, Coinsurance, deductibles, or other cost sharing components will be the same as you would have paid for a provider currently contracting with us.

Treatment by the terminated provider may continue until the course of treatment is complete, not to exceed 90 days from the effective date of termination

For the purposes of this section serious medical condition means a health condition or Illness, which requires medical attention, and where failure to provide the current course of treatment through the current provider would place the Covered Person's health in serious jeopardy, and includes cancer, acute myocardial infarction, and Pregnancy. Such attestation by the treating Physician must be made upon the request of the Covered Person and in a written form approved by the *South Carolina Department of Insurance* or prescribed through regulation, order, or bulletin.

We are responsible for determining if a Covered Person qualifies for continuation of care. Upon receipt of the Covered Person's request for continuation accompanied by the Physician's attestation on the prescribed form, we will notify the Covered Person and the provider of the provider's termination date from the Network and the continuation of care provision as described in this section.

When multiple Covered Services are performed, the Copayment, Coinsurance, and/or Deductible applicable to each Covered 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.

Definitions

Allowed Charge: The portion of a charge for a covered service that the health plan will consider in calculating benefits. The Allowed Charge is determined differently depending on the provider status, and whether or not the services from non-participating providers were due to a medical emergency. (NOTE: The Allowed Charge for a participating provider is the contracted rate. The Allowed Charge for a non-participating provider is determined based on the maximum non-network reimbursement program (MNRP) rate set forth in the Certificate of Coverage.)

Copayment: The amount, if any, the Member must pay for each covered health service received, such as a doctor visit. The amount is specified per service. Each Copayment shall be paid at the time the service is provided.

Coinsurance: A percentage of the Allowed Charge that the Member must pay for Covered Services received.

Deductible: The dollar amount, if any, the Member must pay for health services before benefits are payable under the Contract.

4th Quarter Deductible Carryover: Dollar amounts incurred by a Member during the last three months of a Calendar Year, which were counted toward any applicable Deductible during that Calendar Year of a UnitedHealthcare benefit plan with a 4th Quarter Deductible Carryover provision, will also count toward any applicable Deductible for the following Calendar Year.

Maximum Out-of-Pocket Expense: The sum total amount of Coinsurance and Deductibles, as shown for an individual or family and paid for by a Member, after which – for the remainder of the Calendar Year – UnitedHealthcare will pay 100% of the Allowed Charge for that Member's subsequent Covered Services under this Contract.

Exclusions

Non-covered services include, but are not limited to: services not medically necessary • experimental procedures or treatments • personal or convenience items • custodial care • cosmetic services or surgery • reversal of sterilization • infertility • food or food supplements • over-the-counter drugs • dental, vision, hearing and prescription drugs (unless covered by supplemental benefit plan).