**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 (Contract Period)** | | |
| Individual | $5,000 | $10,000 |
| Family | $10,000 | $20,000 |
| 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 (Contract Period) (includes Copayments, Coinsurance, and Deductibles)** | | |
| Individual | $6,600 | $20,000 |
| Family | $13,200 | $40,000 |
| 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 |

No Annual or Lifetime Dollar Limits apply to Essential Health Benefits.

**Your PPO Policy provides both In-Network and Out-of-Network benefits. Out-of-Network benefits may require prior authorization and a higher Copayment and/or Coinsurance than that for In-Network benefits.**

| 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% | 50% of Allowed Charge after Deductible |
| Immunizations | Covered at 100% | 50% of Allowed Charge after Deductible |
| Laboratory and X-ray | Covered at 100% | 50% of Allowed Charge after Deductible |
| **Physician Office Services** | | |
| Office Visits | 100% after you pay a Copayment of $30 PCP/$60 Specialist per visit. Deductible does not apply. | 50% of Allowed Charge after Deductible |
| Office Surgery | 100% after you pay a Copayment of $30 PCP/$60 Specialist per visit. Deductible does not apply. | 50% of Allowed Charge after Deductible |
| Allergy Testing | 100% after you pay a Copayment of $30 PCP/$60 Specialist per visit. Deductible does not apply. | 50% of Allowed Charge after Deductible |
| Allergy Injections | 70% of Allowed Charge. Deductible does not apply. | 50% of Allowed Charge after Deductible |
| Other Injections | 70% of Allowed Charge. Deductible does not apply. | 50% of Allowed Charge after Deductible |
| Maternity Physician Services | 70% of Allowed Charge after Deductible | 50% 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.* | |

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| **Physician Services at a Facility other than the Office** | | |
| Home Visits | 100% after you pay a Copayment of $30 PCP/$60 Specialist per visit. Deductible does not apply. | 50% of Allowed Charge after Deductible |
| Inpatient Facility Visits | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Outpatient Facility Visits | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Inpatient Surgery | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Outpatient Surgery | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| **Emergency Services** *(Follow-up care obtained in the emergency room is not covered.)* | | |
| 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. *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.* | 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 $60 per visit. Deductible does not apply. | 50% of Allowed Charge after Deductible |
| **Ambulance Services** | 70% of Allowed Charge after Deductible. **Non-emergency transports must be approved in advance by UnitedHealthcare.** | 70% of Allowed Charge after Deductible. **Non-emergency transports must be approved in advance by UnitedHealthcare.** |
| **Laboratory, X-ray and Other Diagnostic Testing** | | |
| Outpatient | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Office | 100% of Allowed Charge. Deductible does not apply. | 50% of Allowed Charge after Deductible |
| **Major Diagnostics (MRI, MRA, CAT and PET Scans)** | 70% of Allowed Charge after Deductible<br><br>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. | 50% of Allowed Charge after Deductible |
| **Chemotherapy, Radiation Therapy, Renal Dialysis Services** | | |
| Hospital (Outpatient) | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Office | 70% of Allowed Charge. Deductible does not apply. | 50% of Allowed Charge after Deductible |
| **Facility Services** | | |
| Inpatient Facility (2) | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Outpatient Facility | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Skilled Nursing Facility (2) - (*Member is limited to 100 days per Contract Period. The 100 In-Network and Out-of-Network days are combined.)* | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| **Medical Equipment** *(Diabetic supplies do not count toward the Durable Medical Equipment benefit maximum.)* | | |
| Durable Medical Equipment (2) | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Prosthetic Devices (2) | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |

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| Hearing Aid Devices (2)<br>*(Plan pays a maximum benefit of $2,500 per Contract Period)* | 70% of Allowed Charge after Deductible | Not covered |
| **Outpatient Rehabilitative Therapy**<br>*Outpatient Rehabilitative Therapy includes physical, speech, and occupational therapy and cardiac (Phase I and II) and pulmonary rehabilitation.*<br>*(Member is limited to 60 outpatient treatment visits per Contract Period. The In-Network and Out-of-Network visits are combined.)* | 100% after you pay a Copayment of $30 per visit. Deductible does not apply. | 50% of Allowed Charge after Deductible |
| **Home Health Services (2)** | 70% of Allowed Charge after Deductible | Not covered |
| **Hospice Services (2)** | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Respite Care (2) | 70% of Allowed Charge after Deductible | 50% 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* | |
| **Mental Health Services** | | |
| Inpatient Facility (2) | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Inpatient Physician Visits (2) | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Outpatient Facility (2) | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Outpatient Physician Services (2) | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Office Visits | 100% after you pay a Copayment of $60 per visit. Deductible does not apply. | 50% of Allowed Charge after Deductible |
| **Substance Abuse Services** | | |
| Inpatient Facility (2) | 70% of Allowed Charge after Deductible | 50%of Allowed Charge after Deductible |
| Inpatient Physician Visits (2) | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Outpatient Facility (2) | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Outpatient Physician Services (2) | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Office Visits | 100% after you pay a Copayment of $60 per visit. Deductible does not apply. | 50% of Allowed Charge after Deductible |
| **Neurobiological Disorders - Autism Spectrum Disorder Services** | | |
| Inpatient Facility (2) | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Inpatient Physician Visits (2) | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Outpatient Facility (2) | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Outpatient Physician Services (2) | 70% of Allowed Charge after Deductible | 50% of Allowed Charge after Deductible |
| Office Visits | 100% after you pay a Copayment of $60 per visit. Deductible does not apply. | 50% of Allowed Charge after Deductible |
| **Cleft Lip and Cleft Palate 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* | |

**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 or when services are rendered by a non-participating facility-based provider (a physician or other provider who provide radiology, anesthesiology, pathology, neonatology, or emergency department services) at a participating facility or participating ambulatory surgical center, 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.*