2021 UnitedHealthcare Hawaii	
	Active Participants
Plan Name	**UnitedHealthcare Hawaii**
Basics	
Deductible	In & Out of Network - Employee only: $300, Employee and spouse: $600, Employee and child(ren): $600, Employee and family: $900
Annual Out-of-Pocket Maximum (including deductible)	Coinsurance for medical care applies to the out-of-pocket maximum. In & Out of Network - Employee only: $3,000, Employee and spouse: $6,000, Employee and child(ren): $6,000, Employee and family: $9,000
Lifetime Maximum	None
Inpatient Hospital Care (includes semi-private room and special services in a general hospital, chronic disease hospital, rehabilitation hospital or skilled nursing facility)	In Network - covered at 90% after deductible; Out of Network - covered at 70% after deductible
Inpatient Surgery (includes pre- and post-operative care, anesthesia, endoscopic exams and circumcision)	In Network - covered at 90% after deductible; Out of Network - covered at 70% after deductible
Inpatient Physician Services	In Network - covered at 90% after deductible; Out of Network - covered at 70% after deductible
Outpatient Surgery and Anesthesia	In Network - covered at 90% after deductible; Out of Network - covered at 70% after deductible
Maternity and Well-Baby Care	In Network - covered at 90% after deductible; Certain services and supplies covered at 100%;Out of Network - covered at 70% after deductible
Ambulance Services	In Network - covered at 90% for emergencies after deductible*; Out of Network - covered at 90% for emergencies, after deductible*; *non-emergencies covered at 70%, after deductible
Emergency Room	In Network - covered at 90% after deductible; Out of Network - covered at 90% after deductible; For out-of-network facilities, emergency room care is covered at 70% of billed charges after deductible if it is determined that the visit is not for an emergency
Note:	Out of Network - Emergency room care paid at in-network level (based on billed charges)
Hospital Outpatient Medical Services	In Network - covered at 90% after deductible; Out of Network covered at 70% after deductible
Physicians' Office Services	In Network - covered at 90% after deductible; Out of Network - covered at 70% after deductible
Outpatient Diagnostic Lab Tests and X-Rays	In Network covered at 90% after deductible; Out of Network covered at 70% after deductible
Hearing Care	In Network - covered at 90% after deductible; Hearing aids, services and supplies limited to $3,000 per person every three years. Out of Network - covered at 70% after deductible; Hearing aids, services and supplies limited to $3,000 per person every three years.
Hemodialysis, Chemotherapy, Radiation Therapy	In Network - covered at 90% after deductible; Out of Network - covered at 70% after deductible

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Short-Term Rehabilitative Therapy	In Network - covered at 90% after deductible. Health plan coverage limited to 90 visits per person per calendar year per therapy (in- and out- of-network combined) Note: Therapies covered include physical, speech (restorative only), occupational, pulmonary or cardiac rehabilitation. Limited to 90 visits per calendar year INN and OON combined Out of Network - Covered at 70% after deductible. Health plan coverage limited to 90 visits per person per calendar year per therapy (in- and out-of-network combined) Note: Therapies covered include physical, speech (restorative only), occupational, pulmonary or cardiac rehabilitation. 90 visits per cal year INN and OON
Chiropractor Services	In Network - covered at 90% after deductible; 20 visit limit per person per year. In and out-of-network combined Services must be received through the American Chiropractic Network; Out of Network - covered at 70% after deductible; 20 visit limit per person per year
Preventive Pediatric Care	In Network - Covered at 100% without deductible; Out of Network - covered at 70% after deductible.
Preventive Adult Physical Exams	In Network - Covered at 100% without deductible, one per calendar year. Out of Network - covered at 70% after deductible, one per calendar year
Preventive Annual OB/GYN Exams (one per calendar year)	In Network - Covered at 100% without deductible, one per calendar year Out of Network - covered at 70% after deductible, one per calendar year
Preventive Mammograms and Pap Smears	In Network - 100% coverage without deductible, one per calendar year. ; Out of Network - covered at 70% after deductible, one per calendar year
Nutritional Counseling (Preventive)	Preventive Nutritional Counseling: In Network - Covered at 90% without deductible, up to 2 visits per person, per calendar year (in and out of network combined) ; Out of Network - Covered at 70% after deductible, up to 2 visits per person, per calendar year (in and out of network combined)
Family Planning (including Depo-Provera injections, diaphragms and IUDs when supplied by physician)	In Network, covered at 100%, Out of Network covered at 70% after deductible
Emergency or Urgent Care in a Physicians' Office	In Network - Covered at 90% after deductible; Out of Network - covered at 90% after deductible
Oxygen and Durable Medical Equipment (rental or purchase with Care Coordination review)	In Network - Covered at 90% after deductible; Out of Network - covered at 70% after deductible
Hospice Services (includes respite care in the home or a nursing home, bereavement services provided to the family or primary care person following the death of the hospice patient and other covered services and supplies, when billed by an approved hospice)	In Network -, covered at 90% after deductible; Out of Network covered at 70% after deductible
Transgender Surgery/Services	Eligible services covered the same way the plan covers other services. To be eligible for benefits, you must meet all UHC requirements. For information about the requirements and coverage details, contact UHC at 800-638-8884

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Nursing Services	
Skilled Nursing Facility	In Network - Covered at 90% after deductible, 100 days per calendar year (in and out of network combined); Out of Network - Covered at 70% after deductible, 100 days per calendar year (in and out of network combined)
Inpatient Rehabilitation	In Network - Covered at 90% after deductible, 100 days per calendar year (in and out of network combined); Out of Network - Covered at 70% after deductible, 100 days per calendar year (in and out of network combined)
Home Health Care	In Network - Covered at 90% after deductible; Out of Network - Covered at 70% after deductible
Mental Health and Substance Abuse Treatment	
Hospital Admission (including Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder)	In Network -, covered at 90% after deductible; Out of Network - covered at 70% after deductible. For the highest level of benefits, call UHC at 800-638-8884 and follow the prompts for United Behavioral Health *before* receiving care.
Outpatient Care (including Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder)	In Network - covered at 90% after deductible: Out of Network - covered at 70% after deductible. For the highest level of benefits, call UHC at 800-638-8884 and follow the prompts for United Behavioral
Prescription Drugs	
Retail:	Carved out through CVS Caremark. In Network - Generic $7; Preferred Brand: Covered at 80% after deductible (up to 30 day supply); Non-Preferred Brand: Covered at 70% (up to 30 day supply); Preventive drugs on the Treasury Guidance list covered before deductible, coinsurance applies. **If you purchase a brand-name drug when a generic is available, you pay the difference between the cost of the generic drug and the cost of the brand-name drug plus the copayment, if applicable.** See *Your Benefits Handbook* for more details. In-network preventive maintenance medications are not subject to the deductible. Out-of of-network – You pay 20% of the cost *plus* the difference between the cost of the drug at a CVS Caremark-network pharmacy and the out-of-network pharmacy
Mail Order:	Carved out through CVS Caremark. In Network - Generic $14; Preferred Brand: Covered at 80% after deductible (up to 90 day supply); Non-Preferred Brand: Covered at 70% (up to 90 days); Preventive drugs on the Treasury Guidance list covered before deductible, coinsurance applies. Out of Network - Not Covered
Other Benefits	
Footnotes:	**Important Note:** This is only a summary of certain benefits under the medical plans available to you. For more detail, see the UHC Hawaii plan SPD or call the plan's Customer Service number. If there is any difference between the information in this summary and the actual plan documents, the actual plan documents will always govern. ***Benefits for employees represented by a bargaining unit will be in accordance with their collective bargaining agreement.***
Additional Plan Information	
Plan Web Site	http://www.myuhc.com
Plan Telephone Number	800-638-8884