	2021 UnitedHealthcare Out of Area Plan (U00A)
	Active Participants
Plan Name	**UnitedHealthcare Out of Area Plan**
Basics	
HRA	N/A
HSA	N/A
Deductible	Individual: $200, Family: $400
Annual Out-of-Pocket Maximum (including deductible)	Individual: $2,500, Family: $5,000 (The maximum includes deductible, coinsurance and copayments)
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)	Covered at 80% after deductible, subject to Personal Health Support Requirements
Inpatient Surgery (includes pre- and post-operative care, anesthesia, endoscopic exams and circumcision)	Covered at 80% after deductible, subject to Personal Health Support Requirements
Inpatient Physician Services	Covered at 80% after deductible
Outpatient Surgery and Anesthesia	Covered at 80% after deductible
Maternity and Well-Baby Care (including newborn physical and physician charges for circumcision)	Covered at 80% after deductible
Ambulance Services	Covered at 80% after deductible
Emergency Room	Covered at 80% after deductible
Hospital Outpatient Medical Services	Covered at 80% after deductible
Physician's Office Services	Primary Care and Specialist Care: Covered at 80% after deductible. Allergy shots: Primary Care and Specialist Care: Covered at 80% after deductible
Outpatient Diagnostic Lab Tests and X-Rays	Covered at 80% after deductible
Hearing Care	Not covered
Hemodialysis, Chemotherapy, Radiation Therapy	Covered at 80% after deductible
Short-Term Rehabilitative Therapy	Covered at 80% after deductible, limited to 90 visits per calendar year (in an outpatient setting). Note: Therapies covered include physical, speech (restorative only), occupational, cardiac rehabilitation and pulmonary
Chiropractor Services	Covered at 80% after deductible, limited to 20 visits per year
Preventive Pediatric Care	Covered at 100%, no deductible
Preventive Adult Physical Exams	Covered at 100%, no deductible (one per calendar year)
Preventive Annual OB/GYN Exams (one per calendar year)	Covered at 100% (one per calendar year)
Preventive Mammograms and Pap Smears	Covered at 100% after deductible (one per calendar year)

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Nutritional Counseling Preventive	Covered at 100%, limited to 2 visits per person per calendar year (when preventive)
Family Planning (including Depo-Provera injections, diaphragms and IUDs when supplied by physician)	Covered at 100%
Emergency or Urgent Care in a Physician's Office	Covered at 80% after deductible.
Oxygen and Durable Medical Equipment (rental or purchase with Personal Health Support Requirements review)	Covered at 80% after deductible (must meet Personal Health Support Requirements)
Hospice Services (includes respite care in the home or a nursing home)	Covered at 80% after deductible.
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)	Covered at 80% 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.
Nursing Services	
Skilled Nursing Facility	Covered at 80% after deductible, limited to 100 days per calendar year
Home Health Care	Covered at 80% after deductible. Note: Covers services by a coordinated home health care agency and intermittent nursing and physical therapy provided by a Visiting Nurse Association.
Mental Health and Substance Abuse Treatment	
Hospital Admission (including Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder)	Covered at 80% after deductible
Outpatient Care (including Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder)	Covered at 80% after deductible with notification
Prescription Drugs	
Retail:	Carved out through CVS Caremark. Generic: $7, Preferred Brand: 20% coinsurance, Non-Preferred Brand: 30% coinsurance up to a 30-day supply. **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.**

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Mail Order:	Carved out through CVS Caremark. Generic: $14, Preferred Brand: 20% coinsurance, Non-Preferred Brand: 30% coinsurance, 90-day supply
Other Benefits	
Footnotes:	**Important Note:** This is only a summary of certain benefits under the medical plans available to you. For more detail, 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.
Additional Plan Information	
Plan Web Site	http://www.myuhc.com
Plan Telephone Number	800-638-8884