2021 UnitedHealthcare Advantage Plan (HDHP)	
	Active Participants
Plan Name	**UnitedHealthcare Advantage Plan**
Basics	
HRA	N/A
HSA	Company Contribution: Employee only: $750, Employee and spouse partner: $1,125, Employee and child(ren): $1,125, Employee and family: $1,500
Deductible	In Network – Employee only: $2,100, Employee and spouse: $3,150, Employee and child(ren): $3,150, Employee and family: $4,200; Out of Network deductible: Employee only: $2,600, Employee and spouse: $3,900, Employee and child(ren): $3,900, Employee and family: $5,200.
Annual Out-of-Pocket Maximum (including deductible)	Employee only: $4,100, Employee and spouse: $6,150, Employee and child(ren): $6,150, Employee and family: $8,200; While the family in-network OOP max is $8,200, the most any one individual family member needs to spend is $7,150, to satisfy the OOP max Out of Network – Employee only coverage: $5,100, Employee and spouse: $7,650, Employee and child(ren) coverage: $7,650, Employee and family coverage: $10,200 (The maximum includes deductibles, 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)	In Network - Covered at 80% after deductible; Out of Network - Covered at 60% after deductible
Inpatient Surgery (includes pre- and post-operative care, anesthesia, endoscopic exams and circumcision)	In Network - Covered at 80% after deductible; Out of Network - Covered at 60% after deductible
Inpatient Physician Services	In Network - Covered at 80% after deductible; Out of Network - Covered at 60% after deductible
Outpatient Surgery and Anesthesia	In Network - Covered at 80% after deductible; Out of Network - Covered at 60% after deductible
Maternity and Well-Baby Care (including newborn physical and physician charges for circumcision)	In Network - Covered at 80% after deductible; Out of Network - Covered at 60% after deductible

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Ambulance Services	In Network - Covered at 80% for emergencies, after deductible; Covered at 60% for non-emergencies, after deductible; Out of Network - Covered at 80% for emergencies, after deductible; Covered at 60% for non-emergencies, after deductible
Emergency Room	In Network - Covered at 80% for emergencies after deductible; Out of Network - Covered at 80% of billed charges after deductible
Note:	Out of Network - Emergency room care paid at in-network level (based on billed charges)
Hospital Outpatient Medical Services	In Network - Covered at 80% after deductible; Out of Network - Covered at 60% after deductible
Physicians' Office Services	In Network - Covered at 80% after deductible; Out of Network - Covered at 60% after deductible
Outpatient Diagnostic Lab Tests and X-Rays	In Network - Covered at 80% after deductible; Out of Network - Covered at 60% after deductible
Hearing Care	In Network - Covered at 80% after deductible. Hearing Aids, services and supplies: limited to $3,000 per person every three years (in-network and out-of-network combined); Out of Network - Covered at 60% after deductible.Hearing Aids, services and supplies limited to $3,000 per person every three years(in-network and out-of-network combined)
Hemodialysis, Chemotherapy, Radiation Therapy	In Network - Covered at 80% after deductible; Out of Network - Covered at 60% after deductible
Short-Term Rehabilitative Therapy	In Network - Covered at 80% 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; Out of Network - Covered at 60% 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.
Chiropractor Services	In Network - Covered at 80% after deductible, 20 visit limit per person, per calendar year, in and out of network combined. Services must be received through the American Chiropractic Network; Out of Network - Covered at 60% after deductible, 20 visit limit per person, per calendar year
Preventive Pediatric Care	In Network - Covered at 100% no deductible.; Out of Network - Covered at 60% after deductible
Preventive Adult Physical Exams	In Network - Covered at 100% no deductible, limited to 1 routine office visit and exam per calendar year Out of Network – Covered at 60% after deductible, 1 per person per calendar year
Preventive Annual OB/GYN Exams (one per calendar year)	In Network - Covered at 100% no deductible, limited to 1 well woman exam per calendar year Out of Network – Covered at 60% after deductible, 1 per person per calendar year

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Preventive Mammograms and Pap Smears	In Network - Covered at 100% no deductible, limited to 1 of each routine service per calendar year Out of Network – Covered at 60% after deductible, 1 per person per calendar year
Nutritional Counseling (Preventive)	In-network: Covered at 100% no deductible, limited to 2 visits per person, per calendar year (in and out of network combined); Out-of-network: Covered at 60% after deductible, limited 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 60% after deductible
Emergency or Urgent Care in a Physicians' Office	In Network - Covered at 80% after deductible; Out of Network - Covered at 60% after deductible
Oxygen and Durable Medical Equipment (rental or purchase with Care Coordination review)	In Network - Covered at 80% after deductible; Out of Network - Covered at 60% 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 80% after deductible; Out of Network - Covered at 60% after deductible
Transgender Surgery/Services (See note below table)	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	In Network - Covered at 80% after deductible. Health plan coverage limited to 120 days per calendar year (in and out of network combined); Out of Network - Covered at 60% after deductible. Health plan coverage limited to 120 days per calendar year (in and out of network combined)
Home Health Care	In Network - Covered at 80% after deductible; Out of Network - Covered at 60% after deductible
Mental Health and Substance Abuse Treatment	
Hospital Admission (including Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder)	In Network - Covered at 80% after deductible. Out of Network - Covered at 60% 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.

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Outpatient Care (including Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder)	In Network - Covered at 80% after deductible. Out of Network - Covered at 60% 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.
Prescription Drugs	
Retail:	Through CVS Caremark. In Network - Generic or brand: Covered at 80% after deductible (up to 30 day supply); In-network generic preventive drugs and diabetes insulin drugs covered at 100%, before deductible, no coinsurance. Brand name drugs on the Treasury Guidance list covered before deductible, coinsurance applies. Contact CVS Caremark with questions about prescription drug coverage. **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.** Out of Network – Generic or Brand: Covered at 60% after deductible. Out-of network – You pay 40% 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 or Brand: Covered at 80% after deductible, (up to 90 day supply); Out of Network - Not Covered. Contact CVS Caremark with questions about prescription drug coverage.
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