



Feature	2010 UnitedHealthcare EPO - Out-of-Area
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Deductible	None
Maximum Benefit While Covered	\$5,000,000
Annual Copayment Maximum	\$1,000/individual \$3,000/family
Emergency Care	Covered at 100% (of allowed charges) after a \$100 copayment per visit
Pre-Existing Conditions	All conditions covered provided they are covered benefits
Ambulance Services	Covered at 100% (of allowed charges). Pre-service notification is required for non-emergency ambulance services prior to transport. If you fail to notify us as required, you will be responsible for paying all charges and no Benefits will be paid.
Inpatient Hospital Care	Covered at 100% (of allowed charges) Pre-service notification is required to avoid a reduction in benefits paid.
Inpatient Physician Services	Covered at 100% (of allowed charges)
Office Visits	\$10 copayment
Outpatient Diagnostic Laboratory and Radiology	Covered at 100% (of allowed charges)
Outpatient Allergy Tests	Covered at 100% (of allowed charges)
Outpatient Surgery	Covered at 100% (of allowed charges)
Outpatient Physical/Rehabilitation Therapy	\$10 copayment (Benefits are limited as follows - chiropractic treatment: 24 visits; physical therapy: 20 visits; occupational therapy: 20 visits; speech therapy: 20 visits; pulmonary rehabilitation: 20 visits; cardiac rehabilitation: 36 visits; post-cochlear implant aural therapy: 30 visits. Pre-service notification is required for certain services to avoid a reduction in benefits paid.)
Routine Physical Exam	\$10 copayment
Well-Woman Care	\$10 copayment
Maternity and Well-Baby Care	Depending upon where the covered health service is provided, benefits will be the same as those stated under each covered health service category in the benefit summary. Pre-service notification is required to avoid a reduction in benefits paid if the inpatient stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Family Planning (special services require certain copayments and coinsurance)	Depending on where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the Schedule of Benefits.
Chiropractor Services	\$10 copayment (Benefit is limited to 24 visits. Pre-service notification is required to avoid a reduction in benefits paid.)
Hearing Screening	Covered at 100% (of allowed charges). Fitting and testing charges for hearing aids, BAHA, and all other hearing assistive devices are not covered
Hearing Aids	Covered at 100% (of allowed charges) (Up to \$3,000 per year and limited to a single purchase of a type of durable medical equipment, including repair and replacement, every three years)
Home Health Care	Covered at 100% (of allowed charges) (Benefit is limited to 100 visits per calendar year.) Pre-service notification is required to avoid a reduction in benefits paid.
Skilled Nursing Care	Covered at 100% (of allowed charges) (Benefit is limited to 90 days as inpatient per calendar year) Pre-service notification is required to avoid a reduction in benefits paid.



Hospice Care	Covered at 100% (of allowed charges) <i>Pre-service notification is required for inpatient stays to avoid a reduction in benefits paid.</i>
Retail Prescription Drugs	Generic: \$5 Preferred brand: \$15 Non-preferred brand: \$30 Covered through Medco, 30-day supply. If you purchase a brand name drug when a generic alternative is available, you will pay the generic drug copay plus the difference in cost between the brand name and generic drug, even if your doctor writes 'dispense as written' on the prescription. <i>You may obtain the first three fills of your long-term prescriptions at the retail pharmacy copay. On the fourth and subsequent fills, you pay the Medco By Mail copay whether you purchase a 30-day supply at a retail pharmacy or up to a 90-day supply through Medco By Mail.</i>
Mail Order Prescription Drugs	Generic: \$10 Preferred brand: \$30 Non-preferred brand: \$60 Covered through Medco, 90-day supply
Mental Health Services	Preauthorization required through PacifiCare Behavioral Health, PCP referral not required Inpatient: No charge; unlimited days Outpatient: \$10 copay/visit, unlimited visits
Substance Abuse Services	Preauthorization required through PacifiCare Behavioral Health, PCP referral not required Inpatient: \$25 copay/day, 30 day maximum Outpatient: visits 1-20: \$0 copay; visits 21-40: \$20 copay; visits 41-60: \$25 copay
Plan Availability	Available to all VEBA districts or associations
Disclaimer	This summary is merely a brief description of the major benefits of the plan(s) and is not intended to alter or expand benefits rights or liabilities as set forth in the official plan documents/contracts. Limitations may apply. See the Certificate/Evidence of Coverage for details.