For more information about your coverage, or to get a copy of the complete terms of coverage, contact United Healthcare at www.myuhc.com or by calling 866-844-4864. For general definitions of common terms, such as allowed amount, balance billing, en. nBT/w48,va g

			Mail-Order: Not Covered	
	Tier 4 Additional High-Cost Option	$75 at a Retail Pharmacy $112.50 Mail Service	$75 at a Retail Pharmacy Mail-Order: Not Covered	
	Facility fee (e.g., ambulatory surgery center)	$60 copay	20% coinsurance after deductible	Preauthorization is required. Medical necessity is required
	Physician/surgeon fees	No Charge	20% coinsurance after deductible	Medical necessity is required
	Emergency room care	$70 copay per visit	$70 copay per visit	Copayment is waived if admitted.
	Emergency medical transportation	No Charge for the first $50, then 20% co-ins for the balance	No Charge for the first $50, then 20% co-ins for the balance	
	Urgent care	$25 copay	20% coinsurance after deductible	
	Facility fee (e.g., hospital room)	$100 per confinement	$100 per confinement	

		One deductible does not apply	for provider services not billed by hospital	coinsurance may apply. Routine pre-natal care is covered at No Charge
	Childbirth/delivery facility services	$100 per confinement	$100 per confinement after deductible	
	Home health care	No Charge	50% coinsurance	Limited to 4 hours per day, Preauthorization is required; non-network benefits apply if not precertified. No non-network coverage for the first 48 hours of home nursing. Custodial Care is not covered.
	Rehabilitation services	$30 copay	20% coinsurance after deductible	Outpatient hospital rehabilitation services covered when medically necessary following a related hospitalization or surgery.
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	No Charge	No Charge	In-Network coverage only, limited to 4 hours per day. Custodial care not covered
	Durable medical equipment	10% coinsurance	20% coinsurance after deductible	Pre-Notification is required for DME over $1,000 when you use a Non-Network provider. Covers 1 per type of DME (including repTm0 greW* nBT/F4 12 Tf1 0 0 1 664.68 27T