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2025 UHC Consumer Driven Health Plan Summary

Benefit	In-Network	Out-of-Network
Deductible Individual Family	 $2,000 $4,000	 $4,000 $8,000
Co-Payments Office Visit	80% after deductible	60% after deductible
Specialist Visits	80% after deductible	60% after deductible
Urgent Care Visits	80% after deductible	60% after deductible
Inpatient Hospital		
Coinsurance	**80%** of eligible expenses after satisfying deductible	**60%** of eligible expenses* after satisfying deductible
Out-of-Pocket Maximums (excludes Prescription Drug expenses, & amounts over Reasonable & Customary)	$6,000 Individual $12,000 Family	$12,000 Individual $24,000 Family
Lifetime Maximum	Unlimited	Unlimited
Physician Office Visits	80% after deductible	60% after deductible

Benefit	In-Network	Out-of-Network
Preventive Care	**100%**	**60%** of eligible expenses* after satisfying deductible.
Adult Routine physical exams, Colorectal Cancer Screenings, Routine Digital Rectal Exams/Prostate Specific Antigen Test	**100%**	**60%** of eligible expenses* after satisfying deductible.

January 1, 2025

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program

Routine gynecological exams, including a PAP	**100%**	**60%** of eligible expenses* after satisfying deductible.
Mammograms, as required	**100%**	**60%** of eligible expenses* after satisfying deductible.
Pediatric Routine physical exams	**100%**	**60%** of eligible expenses* after satisfying deductible.
Pediatric immunizations	**100%**	**60%** of eligible expenses* after satisfying deductible.
Emergency Room Service	**80%** after deductible	**80%** after deductible
Ambulance Emergency Services only	**Ground Transportation:** 100% of eligible expenses. **Air Transportation:** 100% of eligible expenses. **Note:** Notification is required except in life threatening circumstances	
Benefit	**In-Network**	**Out-of-Network**
Maternity Office Visit	**80%** after deductible	**60%** after deductible
Inpatient Admission	**80%** after deductible	**60%** after deductible
Allergy Testing and Treatment	**80%** after deductible	**60%** after deductible

Infertility Counseling, Testing and Treatment	**80%** after deductible • Any combination of In-Network and Out-ofNetwork Benefits for infertility services is limited to a lifetime maximum of **$8,000** per Covered Person. If a Center of Excellence is used the lifetime maximum increases to **$20,000**	**60%** after deductible • Out-of-Network Benefits for infertility services is limited to a lifetime maximum of $4,000 per Cover Person

Benefit	In-Network	Out-of-Network
Hospital Expenses Inpatient Stay in a Hospital Benefits are available for: • Services and supplies received during the Inpatient Stay • Room and board in a Semi-private Room (a room with two or more beds.)	**80%** after deductible	**60%** after deductible
Surgical Expenses	**80%** after deductible	**60%** after deductible
Spinal Manipulations/ Chiropractic Care	**80%** after deductible	**60%** after deductible

Benefit	In-Network	Out-of-Network
Diagnostic Services (Lab, X-Ray, Ultrasound and other tests)	**80%** after deductible	**60%** after deductible
Physical Therapy Limited to 30 visits per calendar year for physical, occupational and speech therapy combined	**80%** after deductible	**60%** after deductible
Speech & Occupational Therapy (Professional) Limited to 30 visits per calendar year for physical, occupational and speech therapy combined	**80%** after deductible	**60%** after deductible
Durable Medical Equipment	**80%** after deductible	**60%** after deductible
Skilled Nursing Facility Care	**80%** after deductible **Any combination of Network and Non-Network Benefits is limited to 60 days per calendar year.**	**60%** after deductible **Any combination of Network and Non-Network Benefits is limited to 60 days per calendar year.**

Benefit	In-Network	Out-of-Network
Home Health Care	**80%** of eligible expenses after satisfying deductible. Care Coordination will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Any combination of Network and Non-Network Benefits is limited to 100 visits per calendar year. One visit equals four hours of skilled care services.	**60%** of eligible expenses* after satisfying deductible. Care Coordination will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Physician- directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Any combination of Network and Non-Network Benefits is limited to 100 visits per calendar year. One visit equals four hours of skilled care services.
Private Duty Nursing	**80%** of eligible expenses after satisfying deductible	**60%** of eligible expenses* after satisfying deductible
Hospice	**80%** of eligible expenses	**60%** of eligible expenses* after satisfying deductible.

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Benefit	In-Network	Out-of-Network
Hearing Care Hearing examinations and associated services **Hearing aids are covered up to a maximum of $5,000 per calendar year**	**80%** after deductible • Covers hearing screenings as part of a routine preventive • Hearing aids are subject to deductible then 80% of eligible expenses	**60%** of eligible expenses* after satisfying deductible
Vision Care	Routine Vision Testing: 100% at routine visit Covers one visit every 12 months	**60%** of eligible expenses* after satisfying deductible. Covers one visit every 12 months
Mental Health Inpatient	**80%** after deductible	**60%** after deductible Notify Care Coordination: Please remember that you must notify Care Coordination as follows: • For elective admissions: 5 business days before admission • For non-elective admissions: as soon as is reasonably possible For Emergency admissions within as soon as is reasonably possible
No Limit on number of treatments or sessions		
Outpatient	**80%** after deductible	**60%** of eligible expenses* after satisfying deductible
No Limit on number of treatments or sessions		
Substance Abuse Inpatient Detoxification	**80%** after deductible	**60%** of eligible expenses* after satisfying deductible

No Limit on number of treatments or sessions		
Rehabilitation Inpatient	**80%** after deductible	**60%** of eligible expenses* after satisfying deductible
No Limit on number of treatments or sessions		
Outpatient	**80%** after deductible	**60%** of eligible expenses* after satisfying deductible
No Limit on number of treatments or sessions		

Benefit	In-Network	Out-of-Network
Pharmacy Coverage Retail Purchases NETWORK Coverage is through Express Scripts 1-888-749-3878	Coverage up to 30-day supply After deductible: • Tier 1 = $10 • Tier 2 = 40% ($45 Min/$100 Maximum) • Tier 3 = 50% ($65 Min/ $130 Maximum) Note: Tier 1 is referred to as Generic, Tier 2 is referred to as Name Brand Formulary and Tier 3 is referred to as name Brand Non-Formulary	n/a

Mail Order Purchases **NETWORK** Coverage is through Express Scripts 866-841-5482	Coverage up to 90-day supply After deductible: ● Tier 1 = $20 ● Tier 2 = 40% ($85 Min/$225 maximum) ● Tier 3 = 50% ($155 Min/ $305 maximum) Note: Tier 1 is referred to as Generic, Tier 2 is referred to as Name Brand Formulary and Tier 3 is referred to as Name Brand Non-Formulary.	n/a
Out-of-Pocket Maximum	Combined with Medical Out-ofPocket Maximum	

* Out of Network Eligible Expenses are equal to Reasonable and Customary Expenses
**Emergency Room - The plan will only pay 60% for out-of-network providers if not a true emergency

UHC Customer Service	866-679-0946
Group Number	702551
United Healthcare Provider Search	www.myuhc.com

***Includes mental health and substance abuse**

+ **Office visit, emergency room and hospital copays will count towards the out-of-pocket maximum.**