UnitedHealthcare®
A UnitedHealth Group Company

2025 UHC Option 1 Plan Summary

Benefit	In-Network	Out- of- Network
Deductible Individual Family	 $750 $1,500	 $1,500 $3,000
Co-Payments Office Visit	 $30	 Deductibles & Coinsurance Apply
Specialist Visits	$50	Deductibles & Coinsurance Apply
Urgent Care Visits	$30	
Inpatient Hospital	$500	$700
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)	$4,000 Individual $8,000 Family	$8,000 Individual $16,000 Family
Lifetime Maximum	**Unlimited**	**Unlimited**
Physician Office Visits	100% after co-payment	60% of eligible expenses* after satisfying deductible

Benefit	In-Network	Out- of-Network
Preventive Care		

January 1, 2025
This is not intended as a contract of benefits. It is designed purely as a reference of many benefits available under your program.

Adult Routine Physical exams, Colorectal Cancer Screenings, Routine Digital Rectal Exams/ Prostate Specific Antigen Test	**100%**	**60%** of eligible expenses* after satisfying deductible
Routine gynecological exams, including a PAP test	**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- Co-pay waived if admitted	**80%** after $250 co-pay	**80%**** after **$250** co-pay
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. Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed	

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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.)	**$500** inpatient co-pay per confinement then **80%** of eligible expenses	**$700** co-pay per confinement then **60%** of eligible expenses after satisfying 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: as soon as is reasonably possible
Outpatient	**80%** of eligible expenses after satisfying deductible	**60%** of eligible expenses* after satisfying deductible
Maternity Office Visit Inpatient Admission	No co-payment applies to Physician office visits for prenatal care after the first visit in which a **$30 PCP/$50 Specialist** co-payment applies **$500** co-pay per confinement then 80% of eligible expenses	**60%** of eligible expenses* after satisfying deductible **$700** co-pay confinement then **60%** of eligible expenses after satisfying deductible
Allergy Testing and Treatments	**$30 PCP/$50** Specialist co-pay • Testing in Physician's office • Treatment (injection administered by a Nurse) • Co-pay applies to Physicians office visit only (i.e. If Physician administers injection and bills as an office visit	**60%** of eligible expenses* after satisfying deductible

Benefit	In-Network	Out- of -Network
Infertility Counseling, Testing, and Treatment	**$50** co-pay per visit • Any combination of In-Network and Out-of-Network 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%** of eligible expenses* after satisfying deductible Out-of-Network Benefits for infertility services is limited to a lifetime maximum of **$4,000** per Covered Person
Surgical Expenses	• **80%** of eligible expenses after satisfying deductible	• **60%** of eligible expenses* after satisfying deductible
Spinal Manipulations/ Chiropractic Care	**$30 PCP/ $50 Specialist** co-pay	**60%** of eligible expenses* after satisfying deductible
Diagnostic Services (Lab, XRay, Ultrasound and other tests) Inpatient Inpatient Outpatient	**80%** of eligible expenses after satisfying deductible **80%** of eligible expenses after satisfying deductible **80%** of eligible expenses after satisfying deductible	 **60%** of eligible expenses* after satisfying deductible **60%** of eligible expenses* after satisfying deductible
Physical Therapy (limited to 30 visits per calendar year)	**$50** Specialist co-pay	**60%** of eligible expenses* after satisfying deductible
Speech & Occupational Therapy (Professional) (limited to 30 visits per calendar year)	**$50** Specialist co-pay	**60%** of eligible expenses* after satisfying deductible

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Benefit	In-Network	Out-of Network
Durable Medical Equipment	**80%** of eligible expenses after satisfying deductible	**60%** of eligible expenses* after satisfying deductible
Skilled Nursing Facility Care	**$500** inpatient co-pay per confinement then 80% of eligible expenses Any combination of In-Network and Out-of-Network Benefits is limited to 60 days per calendar year.	**$700** co-pay then **60%** of eligible expenses after satisfying deductible Any combination of In-Network and Out-of-Network Benefits is limited to 60 days per calendar year.
Home Health Care	**80%** of Eligible expenses after satisfying deductible • Care Coordination will decide 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 InNetwork and Out-of-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 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 InNetwork and Out-of-Network benefits is limited to 100 visits per calendar year. One visit equals four hours of skilled care services • Notify Care Coordination: Please remember that for Out-of-Network Benefits you should notify care Coordination 5 business days before receiving services
Private Duty Nursing	**80%** of eligible expenses after satisfying deductible	**60% o**f eligible expenses* after satisfying deductible

Benefit	In-Network	Out-of-Network
Hospice	**80%** of eligible expenses	**60%** of Eligible expenses* after satisfying deductible • Notify Care Coordination: Please remember that for Outof-Network Benefits you should notify care Coordination 5 business days before receiving services
Hearing Care Hearing examinations and associated covered services received from a health care provider in the provider's office **Hearing aids are covered up to a maximum of $5,000 per calendar year**	**Routine Hearing Testing** **$30 PCP/$50 Specialist co-pay** • Covers hearing screenings as part of routine preventive office visit by a PCP or a Specialist • Hearing aids are subject to deductible, then 80% of eligible expenses	**60% of eligible expenses* after satisfying deductible**
Vision Care	**Routine Vision Testing:** **$30 PCP / $50 Specialist co-pay** Covers one visit every 12 months	**60%** of eligible expenses* after satisfying deductible Covers one visit every 12 months

Benefits	In-Network	Out-of Network
Mental Heath Inpatient	**$500** inpatient co-pay per confinement then 80% of eligible expenses	**$700** co-pay then 60% of eligible expenses* after satisfying deductible Notify Care Coordination: Please remember that for Out-of-Network Benefits you should notify care Coordination 5 business days before receiving services
No Limit on number of treatments or sessions		
Outpatient	**$30** co-pay	**60%** of eligible expenses* after satisfying deductible
No Limit on number of treatments or sessions		
Substance Abuse Inpatient Detoxification	**$500** inpatient co-pay per confinement then **80%** of eligible expenses	**$700** co-pay then **60%** of eligible expenses* after satisfying deductible
No Limit on number of treatments or sessions		
Rehabilitation Inpatient	**$500** inpatient co-pay per confinement then **80%** of eligible expenses	**$700** co-pay then 60% of eligible expenses* after satisfying deductible
Outpatient	**100%** after **$30** co-pay	**60%** of eligible expenses* after satisfying deductible
No Limit on number of treatments or sessions		

Pharmacy Coverage Retail Purchases NETWORK Coverage is through Express Scripts 1-888-749-3878	Coverage up to 30-day supply • 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 NonFormulary	N/A

Benefits	In-Network	Out-of Network
Mail Order Purchases **NETWORK** Coverage is through Express Scripts 1-866-841-5482 **Out-of-Pocket Maximum** (combined retail and mail order): Individual: $2,000 Family: $4,000	Coverage up to 90-day supply ● 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 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
+ **Office visit, emergency room and hospital copays will now count towards the out-of-pocket maximum.**

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

***Includes mental health and substance abuse**