The Difference Card

SUMMARY OF BENEFITS

Vanderburgh County Government | UHC | 1/1/2025 to 12/31/2025

UHC High Deductible Health Plan (EB6A)

Your provider is reimbursed when claim is received from your carrier. | You are reimbursed when claim is received from your carrier.

TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	UHC BENEFIT
PHYSICIAN SERVICES			
Primary Care Office Visit Copay	Deductible and Coinsurance	Remaining Amount	Deductible and Coinsurance
Specialist Office Visit Copay	Deductible and Coinsurance	Remaining Amount	Deductible and Coinsurance
Preventive Care / Screening / Immunization	No Charge		
Urgent Care	Deductible and Coinsurance	$0	Deductible and Coinsurance
PHARMACY			
Prescription Deductible Application	Integrated with Medical Deductible		
Prescription Individual Deductible	Int. with Med Ded	Int. with Med Ded	Int. with Med Ded
Prescription Family Deductible	Int. with Med Ded	Int. with Med Ded	Int. with Med Ded
Retail Prescriptions	Deductible and Coinsurance	Remaining Amount	Deductible and Coinsurance
Mail Order Prescriptions	Deductible and Coinsurance	Remaining Amount	Deductible and Coinsurance
DIAGNOSTIC PROCEDURES			
Diagnostic Test- Lab Bloodwork	Deductible and Coinsurance	$0	Deductible and Coinsurance
Diagnostic Test X-Ray	Deductible and Coinsurance	$0	Deductible and Coinsurance
Complex Imaging (CT/Pet Scans, MRIs)	Deductible and Coinsurance	$0	Deductible and Coinsurance
HOSPITAL SERVICES			
Emergency Room Care	Deductible and Coinsurance	$0	Deductible and Coinsurance
Outpatient Surgery	Deductible and Coinsurance	$0	Deductible and Coinsurance
Inpatient Hospital	Deductible and Coinsurance	$0	Deductible and Coinsurance
IN-NETWORK DEDUCTIBLE & COINSURANCE			
Qualified High Deductible Health Plan	Yes		
Deductible Accumulation Period	Calendar year		
Family Deductible Accumulation Type	Individual Accumulation		
In-Network Individual Deductible	First $3,300	Last $200	$3,500
In-Network Family Deductible	First $6,600	Last $400	$7,000
In-Network Individual Coinsurance Limit	$0	First $3,250	30% to $3,250
In-Network Family Coinsurance Limit	$0	First $6,500	$6,500
OUT OF NETWORK DEDUCTIBLE & COINSURANCE			
Out-of-Network Individual Deductible	$5,000	$0	$5,000
Out-of-Network Family Deductible	$10,000	$0	$10,000
Out-of-Network Individual Coinsurance Limit	$10,000	$0	50% to $10,000
Out-of-Network Family Coinsurance Limit	$20,000	$0	50% to $20,000

In-Network Family Multiplier 2 | Out-of-Network Family Multiplier 2 | Mail Order Multiplier 2.5

All claims must be submitted within 3 months of the end of the deductible accumulation period.

Terminated members must submit claims within 3 months of the termination date.

All Out-of-Network Services are subject to the Deductible.

Information on this document based on carrier SBC.

Call 888.343.2110 with any questions.

Download the Mobile App to View and Submit Claims

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