



**2025 / 2026 MEDICAL / PRESCRIPTION  
DRUGS / DENTAL SUMMARY OF  
BENEFITS for SALINE COUNTY**

|   | BASE PLAN                                   |                        | BUY-UP PLAN                                 |                                  |
|---|---|------------------------|---|----------------------------------|
|   | Qualified High Deductible Plan              |                        | PPO Plan                                    |                                  |
|   | United Healthcare Choice Plus PPO Providers | NON-NETWORK PROVIDERS* | United Healthcare Choice Plus PPO Providers | NON-NETWORK PROVIDERS*           |
| <b>DESCRIPTION OF MEDICAL BENEFITS</b>  |   |                        |   |                                  |
| <b>Plan Year Deductible</b>   |   |                        |   |                                  |
| Individual  | \$3,300                                     | \$6,000                | \$750                                       | \$1,500                          |
| Family  | \$6,600                                     | \$12,000               | \$1,500                                     | \$3,000                          |
| <b>Plan Year Out-of-Pocket Maximum</b> **Includes Medical and RX Deductible and Copays; ***Includes Medical Deductible  |   |                        |   |                                  |
| Individual  | \$4,000**                                   | \$8,000***             | \$3,000**                                   | \$6,000***                       |
| Family  | \$8,000**                                   | \$16,000***            | \$6,000**                                   | \$12,000***                      |
| <b>Hospital Services</b>  |   |                        |   |                                  |
| <b>Inpatient</b> (NOTE: Additional Inpatient Deductible amount for failure to obtain pre-certification prior to admission)  | 20% after deductible                        | 40% after deductible   | 20% after deductible                        | 40% after deductible             |
| Non-Precertification Penalty Per Occurrence   | \$300                                       | \$300                  | \$300                                       | \$300                            |
| Inpatient non-preventive tests, labs, and x-rays  | 20% after deductible                        | 40% after deductible   | 20% after deductible                        | 40% after deductible             |
| Outpatient Services   | 20% after deductible                        | 40% after deductible   | 20% after deductible                        | 40% after deductible             |
| Outpatient non-preventive tests, labs, and x-rays   | 20% after deductible                        | 40% after deductible   | 0% up to \$300, then 20% after deductible   | 40% after deductible             |
| <b>Emergency Room Services</b>  | 20% after In-Network deductible             |                        | 20% after In-Network deductible             |                                  |
| <b>Ambulance</b>  | 20% after In-Network deductible             |                        | 20% after In-Network deductible             |                                  |
| <b>Physician Office Visits, including Telehealth</b> (Office Visits, laboratory, x-ray, medical supplies, allergy injections etc. provided in the Physician's office) |   |                        |   |                                  |
| Primary Care Physician  | 20% after deductible                        | 40% after deductible   | \$25 copay then 0% no deductible            | 40% after deductible             |
| Specialist  |   |                        | \$50 copay then 0% no deductible            |                                  |
| Office Surgery  |   |                        | 20% after deductible                        |                                  |
| <b>Urgent Care Visits</b>   | 20% after deductible                        | 40% after deductible   | \$25 copay then 0% no deductible            | 40% after deductible             |
| <b>Other Physician Services</b>   |   |                        |   |                                  |
| Hospital Visits/Consultations   | 20% after deductible                        | 40% after deductible   | 20% after deductible                        | 40% after deductible             |
| Surgeon and Assistant Surgeon   |   |                        |   |                                  |
| <b>Therapy</b>  |   |                        |   |                                  |
| Occupational Therapy and Physical Therapy   | 20% after deductible                        | 40% after deductible   | 20% after deductible                        | 40% after deductible             |
| Maximum visits combined for PT and OT   | 60  | 60                     | 60  | 60                               |
| Speech Therapy (1 service per day)  | 20% after deductible                        | 40% after deductible   | 20% after deductible                        | 40% after deductible             |
| Maximum daily services per person per Benefit Year  | 90  | 90                     | 90  | 90                               |
| <b>Chiropractic Care</b> (After 26th visit will need proof of medical necessity)  | 20% after deductible                        | 40% after deductible   | \$25 copay then 0% no deductible            | \$25 copay then 0% no deductible |

|  | BASE PLAN                   |                      | BUY-UP PLAN                 |                      |
|--|-----------------------------|----------------------|-----------------------------|----------------------|
| <b>Home Health Care</b>  | 20% after deductible        | 40% after deductible | 20% after deductible        | 40% after deductible |
| <b>Hospice Care</b>  | 20% after deductible        | 40% after deductible | 20% after deductible        | 20% after deductible |
| <b>Wellness Care</b><br>Benefits Yearly Maximum  | No Maximum                  | No Maximum           | No Maximum                  | No Maximum           |
| <b>Birth through Age 2</b>   |                             |                      |                             |                      |
| Routine Physical Exam  | 0% no copay / no deductible | 40% after deductible | 0% no copay / no deductible | 40% after deductible |
| Vision Exam  |                             |                      |                             |                      |
| Immunizations (Includes Flu Mist Vaccine)  |                             |                      |                             |                      |
| Hearing Exams  |                             |                      |                             |                      |
| Preventive test, lab & X-Rays ****   |                             |                      |                             |                      |
| <b>6 Months to 5 Years - Oral Fluoride Supplements Prescribed for Children whose primary water source is deficient in Fluoride</b> | 0% no copay / no deductible | 40% after deductible | 0% no copay / no deductible | 40% after deductible |
| <b>Wellness Care From Age 3</b>  |                             |                      |                             |                      |
| Routine Physical Exam  | 0% no copay / no deductible | 40% after deductible | 0% no copay / no deductible | 40% after deductible |
| Vision Exam  |                             |                      |                             |                      |
| Immunizations (Includes Flu Mist Vaccine)  |                             |                      |                             |                      |
| Preventive test, lab & X-Rays****  |                             |                      |                             |                      |
| Pap Test and Pelvic Exams, PSA Test, Prostate Exam   |                             |                      |                             |                      |
| Mammogram  |                             |                      |                             |                      |
| Age 35- 39 1 baseline  |                             |                      |                             |                      |
| Age 40 and over – 1 every benefit year   |                             |                      |                             |                      |
| Routine colonoscopy, sigmoidoscopy and similar routine procedures – age 50 and over  |                             |                      |                             |                      |
| Routine Alcohol and Substance Abuse, Tobacco Use, Obesity, Diet and Nutrition Counseling   |                             |                      |                             |                      |

\*If there is not an IN-Network provider within a 50 Mile radius of the Covered Person's residence, then the Out-of-Network charges will be processed as In-Network charges so long as the Covered Person provides appropriate documentation

\*\*\*\*Tests, labs, and x-rays other than preventive will be paid based on place of service

PPO Plan Only: For Mammograms and Colonoscopies the First Procedure Whether for Preventive or Medical Diagnosis

0% - no deductible      40% after deductible

Second Procedure for Medical Diagnosis

20% after deductible      40% after deductible

Second Procedure for Preventive Diagnosis

0% - no deductible      40% after deductible

| <b>ORGAN TRANSPLANTS - Services rendered at facilities other than Centers of Excellence include a Doctor's Maximum of \$20,000</b> |                       |                                 |
|--|-----------------------|---------------------------------|
| ORGAN TRANSPLANT   | CENTERS OF EXCELLENCE | ALL OTHER FACILITIES            |
| Heart  | 0%                    | 0% up to a maximum of \$110,000 |
| Lung   | 0%                    | 0% up to a maximum of \$155,000 |
| Bone Marrow  | 0%                    | 0% up to a maximum of \$130,000 |
| Liver  | 0%                    | 0% up to a maximum of \$130,000 |
| Heart / Lung   | 0%                    | 0% up to a maximum of \$150,000 |
| Pancreas   | 0%                    | 0% up to a maximum of \$70,000  |
| Kidney   | 0%                    | 0% up to a maximum of \$55,000  |

|  | BASE PLAN  | BUY-UP PLAN   |
|--|--|---|
| DESCRIPTION OF PRESCRIPTION BENEFITS – Coverage for In-Network Benefits Only (Deductible and Copays apply to In-Network Out-of-Pocket Maximum) | BASE PLAN QHDHP  | BUY-UP PPO  |
| <b>Deductible</b>  | <b>Combined Medical/Rx Deductible applies first then Copays below</b>                    | <b>Separate Prescription Deductible per Benefit Year:</b> |
| Individual   |  | \$50  |
| Family   |  | \$100   |
| <b>Retail - 30 Day Supply (Designated Pharmacies)</b>  |  |   |
| Generic Prescription   | \$10 copay   | \$10 copay  |
| Preferred Brand Prescription   | \$40 copay   | \$40 copay  |
| Non-Preferred Brand Prescription   | \$60 copay   | \$60 copay  |
| Specialty Prescription (Caremark Specialty Pharmacy Only)  | \$80 copay   | 30% or \$0 if enrolled in Prudent Rx                      |
| <b>Retail 90 - 90 Day Supply (Designated Pharmacies)</b>   |  |   |
| Generic Prescription   | \$30 copay   | \$30 copay  |
| Preferred Brand Prescription   | \$120 copay  | \$120 copay   |
| Non-Preferred Brand Prescription   | \$180 copay  | \$180 copay   |
| <b>Mail Order - 90 Day Supply (CVS Caremark)</b>   |  |   |
| Generic Prescription   | \$20 copay   | \$20 copay  |
| Preferred Brand Prescription   | \$80 copay   | \$80 copay  |
| Non-Preferred Brand Prescription   | \$120 copay  | \$120 copay   |
|  | <i>Preventive, Tobacco Cessation and Contraceptive Drugs -\$0 copay after deductible</i> |   |

| DENTAL BENEFITS (Note: No Dental Network - can see any dental provider of choice) | BASE PLAN  | BUY-UP PLAN                    |
|---|--|--------------------------------|
| <b>Deductible</b>   |  |                                |
| <b>Single</b>   | \$25   | \$25                           |
| <b>Family</b>   | \$75   | \$75                           |
| <b>Individual Annual Maximum</b>  | \$1,500  | \$2,500                        |
| <b>Preventive Services</b>  | 0% (Deductible Waived)<br><i>Examples – Oral Exams, X-Rays, Routine Cleanings, *Fluoride Treatment</i> | 0% (Deductible Waived)         |
| <b>Basic Services</b>   | 20%<br><i>Examples – Fillings, Crowns, Root Canal, Extractions</i>                                     | 20%                            |
| <b>Major Services</b>   | 50%<br><i>Examples – Bridges and Dentures</i>  | 50%                            |
| <b>Orthodontia Services</b> (to age 19)   | N/A  | 50% (lifetime maximum \$1,000) |

\*Fluoride Treatment: Dependent children under the age of 19; Limited to two treatments/plan year.

This is a summary of the medical, prescription and dental plans and is not intended to be a complete description. Please refer to the plan booklet for complete information including but not limited to: covered expenses, limitations, and exclusions. If this summary does not match the plan booklet, the plan booklet prevails.