



**2026 / 2027 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*
DESCRIPTION OF MEDICAL BENEFITS				
Plan Year Deductible				
Individual	\$3,400	\$6,000	\$750	\$1,500
Family	\$6,800	\$12,000	\$1,500	\$3,000
Plan Year Out-of-Pocket Maximum **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***
Hospital Services				
Inpatient (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
Emergency Room Services	20% after In-Network deductible		20% after In-Network deductible	
Ambulance	20% after In-Network deductible		20% after In-Network deductible	
Physician Office Visits, including Telehealth (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	
Urgent Care Visits	20% after deductible	40% after deductible	\$25 copay then 0% no deductible	40% after deductible
Other Physician Services				
Hospital Visits/Consultations	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Surgeon and Assistant Surgeon				
Therapy				
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
Chiropractic Care (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	
Home Health Care	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Hospice Care	20% after deductible	40% after deductible	20% after deductible	20% after deductible
Wellness Care Benefits Yearly Maximum	No Maximum	No Maximum	No Maximum	No Maximum
Birth through Age 2	0% no copay / no deductible	40% after deductible	0% no copay / no deductible	40% after deductible
Routine Physical Exam				
Vision Exam				
Immunizations (Includes Flu Mist Vaccine)				
Hearing Exams				
Preventive test, lab & X-Rays ****				
6 Months to 5 Years - Oral Fluoride Supplements Prescribed for Children whose primary water source is deficient in Fluoride	0% no copay / no deductible	40% after deductible	0% no copay / no deductible	40% after deductible
Wellness Care From Age 3	0% no copay / no deductible	40% after deductible	0% no copay / no deductible	40% after deductible
Routine Physical Exam				
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

ORGAN TRANSPLANTS - Services rendered at facilities other than Centers of Excellence include a Doctor's Maximum of \$20,000		
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
Deductible	Combined Medical/Rx Deductible applies first then Copays below	Separate Prescription Deductible per Benefit Year:
Individual		\$50
Family		\$100
Retail - 30 Day Supply (Designated Pharmacies)		
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)	30% or \$0 if enrolled in Prudent Rx	30% or \$0 if enrolled in Prudent Rx
Retail 90 - 90 Day Supply (Designated Pharmacies)		
Generic Prescription	\$30 copay	\$30 copay
Preferred Brand Prescription	\$120 copay	\$120 copay
Non-Preferred Brand Prescription	\$180 copay	\$180 copay
Mail Order - 90 Day Supply (CVS Caremark)		
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
Deductible		
Single	\$25	\$25
Family	\$75	\$75
Individual Annual Maximum	\$1,500	\$2,500
Preventive Services	0% (Deductible Waived) <i>Examples – Oral Exams, X-Rays, Routine Cleanings, *Fluoride Treatment</i>	0% (Deductible Waived)
Basic Services	20% <i>Examples – Fillings, Crowns, Root Canal, Extractions</i>	20%
Major Services	50% <i>Examples – Bridges and Dentures</i>	50%
Orthodontia Services (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.