2024 / 2025 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	$3,200	$6,000	$750	$1,500
Family	$6,400	$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	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Hospital Visits/Consultations				
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 Routine Physical Exam Vision Exam Immunizations (Includes Flu Mist Vaccine) Hearing Exams Preventive test, lab & X-Rays ****	0% no copay / no deductible	40% after deductible	0% no copay / no deductible	40% after deductible
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 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	0% no copay / no deductible	40% after deductible	0% no copay / no deductible	40% after deductible

**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)	$80 copay	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
	Preventive, Tobacco Cessation and Contraceptive Drugs -$0 copay after deductible	

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)	0% (Deductible Waived)
	*Examples – Oral Exams, X-Rays, Routine Cleanings, *Fluoride Treatment*	
Basic Services	20%	20%
	Examples – Fillings, Crowns, Root Canal, Extractions	
Major Services	50%	50%
	Examples – Bridges and Dentures	
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.