



2025 EMPLOYEE BENEFITS

HEALTH PLAN OPTIONS

Comparison chart for 2025 Health Plan options.

This is a brief summary of the Methodist Health System Employee Health Care Plan options. It does not describe every situation and is not intended to replace the plan document. If there is any conflict between the summary and the plan document, the plan document will govern the resolution.

IN-NETWORK BENEFITS	PPO PLAN			HIGH DEDUCTIBLE HEALTH PLAN		
COVERAGE TIER	TIER 1	TIER 2	TIER 3	TIER 1	TIER 2	TIER 3
CALENDAR YEAR DEDUCTIBLE*						
Employee Only	\$1,200	\$2,000	\$3,600	\$2,000	\$3,000	\$5,000
Employee + 1	\$2,400	\$4,000	\$6,000	\$4,000 ^v	\$6,000 ^v	\$10,000 ^v
Family	\$3,600	\$4,000	\$9,000	\$4,000 ^v	\$6,000 ^v	\$10,000 ^v
OUT-OF-POCKET LIMIT*						
Employee Only	\$4,800	\$4,800	\$7,000	\$6,000	\$7,000	\$7,400
Employee + 1	\$7,800	\$7,800	\$10,000	\$12,000 [^]	\$14,100 [^]	\$15,000 [^]
Family	\$10,800	\$10,800	\$14,000	\$12,000 [^]	\$14,100 [^]	\$15,000 [^]
PHYSICIAN SERVICES						
Preventive Care Visit	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Primary Care Physician Visit	\$25 Copay	\$25 Copay	60% after Ded.	15% after Ded.	20% after Ded.	60% after Ded.
Specialist Visit	\$50 Copay	\$50 Copay	60% after Ded.	15% after Ded.	20% after Ded.	60% after Ded.
Pathology	Included in Copay	Included in Copay	60% after Ded.	15% after Ded.	20% after Ded.	60% after Ded.
All Other	15% after Ded.	20% after Ded.	60% after Ded.	15% after Ded.	20% after Ded.	60% after Ded.
TELEHEALTH SERVICES						
Teladoc & MPC Providers Only	\$15 copay	-----	-----	15% after Ded.	-----	-----
HOSPITAL & OTHER FACILITIES						
Emergency Department	\$300 Copay then 15% after Ded.	\$300 Copay then 20% after Ded.	\$300 Copay then 20% after Ded.	15% after Ded.	20% after Ded.	60% after Ded.
All Other Hospital & Facility	15% after Ded.	20% after Ded.	60% after Ded.	15% after Ded.	20% after Ded.	60% after Ded.
MENTAL HEALTH CARE						
Office Visit/Med Check/Therapy	\$25 Copay	\$25 Copay	60% after Ded.	15% after Ded.	20% after Ded.	60% after Ded.
Virtual Visits	\$15 Copay	\$15 Copay	60% after Ded.	15% after Ded.	20% after Ded.	60% after Ded.
Inpatient & All Other Outpatient	15% after Ded.	20% after Ded.	60% after Ded.	15% after Ded.	20% after Ded.	60% after Ded.
ALL OTHER SERVICES	15% after Ded.	20% after Ded.	60% after Ded.	15% after Ded.	20% after Ded.	60% after Ded.

IN-NETWORK BENEFITS	PPO PLAN		HIGH DEDUCTIBLE HEALTH PLAN	
COVERAGE TIER	RETAIL ^o	MAIL ORDER	RETAIL ^o	MAIL ORDER
PRESCRIPTION DRUGS*				
Generic Brand	35%; \$10 min.\$100 max	35%; \$20 min, \$200 max	Tier 1 Deductible + 35%; \$10 min.\$100 max	Tier 1 Deductible + 35%; \$20 min, \$200 max
Formulary Name Brand	35%; \$40 min, \$120 max	35%; \$70 min, \$230 max	35%; \$40 min, \$120 max	35%; \$70 min, \$230 max
Non-Formulary Name Brand	50%; \$60 min, \$150 max	50%; \$120 min, \$250 max	50%; \$60 min, \$150 max	50%; \$120 min, \$250 max
Specialty Mail Order 30-Day Supply	-----	35%; \$100 min, \$200 max	-----	35%; \$100 min, \$200 max

MONTHLY HEALTH PLAN COVERAGE COST

	PPO PLAN			HIGH DEDUCTIBLE HEALTH PLAN		
	Full-Time	Part-Time	Affordable Care Act (ACA)	Full-Time	Part-Time	Affordable Care Act (ACA)
EMPLOYEE	\$128	\$342	\$766	\$68	\$314	\$668
EMPLOYEE + SPOUSE	\$304	\$708	\$1,644	\$192	\$628	\$1,444
EMPLOYEE + CHILD	\$254	\$640	\$1,460	\$176	\$504	\$1,268
EMPLOYEE + CHILDREN	\$254	\$640	\$1,460	\$176	\$504	\$1,268
EMPLOYEE + FAMILY	\$424	\$1,014	\$2,488	\$296	\$924	\$2,250

PPO NETWORK

Tier 1 – Methodist Health System Facilities, Midwest Surgical Hospital, and Methodist Provider Hospital Organization (PHO)

Tier 2 – Nebraska Medicine, Nebraska Health Partners, Children’s Hospital and Medical Center, Bryan Health, Montgomery County Memorial Hospital, and Boys Town Hospital.

Tier 3 – United Healthcare Choice Plus

www.umar.com | Click *Find a Provider* and type *Nebraska Methodist* into the search bar.

Telehealth Services Website: www.teladoc.com

FILING HEALTH CLAIMS

UMR processes all Methodist Health System health claims. To be reimbursed for health care when you use a Non-Network provider, you may need to complete a claim form and submit it along with your bill. If you have a question about your claim or if you would like to check if a specific service or procedure is covered, contact UMR directly at 1-800-826-9781.

* Non-network benefits: No coverage except Medical Emergency, covered at Tier 2.

* Deductible and Out-of-Pocket Limit expenses cross accumulate for Tier I and Tier II only. For the PPO plan, medical copays and prescription drug co-insurance do not apply toward the Calendar Year Deductible, but do apply toward the Out-of-Pocket limit. For the High Deductible Health Plan (HDHP), prescription drug co-insurance applies toward the Deductible and Out-of-Pocket limit for Tier 1 and Tier 2 only. For the HDHP, prescription drug costs do not apply to Tier 3 Deductible and Out-of-Pocket limit.

* For 2 or more individuals covered, the deductible of \$4,000, \$6,000, or \$10,000 must be satisfied before coinsurance coverage applies.

* No one individual must satisfy more than \$7,050 in out-of-pocket maximum.

* Retail 90-day supply: 3X 30-day co-pay, min/max applies.

