



WCA GROUP HEALTH TRUST

UNION GROVE UNION HIGH SCHOOL

Medical Summary

Effective Date: 7/1/18

Benefit Period: January - December

Network: United Healthcare Choice Plus

Benefits	In Network	Out of Network
Deductible – single/family	\$500/\$1,000	\$1,000/\$2,000
Coinsurance	100%	80%
Maximum Out of Pocket – single/family <i>Includes Deductible and Coinsurance</i>	\$500/\$1,000	\$3,500/\$7,000
Maximum Out of Pocket – single/family <i>Includes Ded/Coins and all Medical Copays except Rx</i>	\$1,750/\$3,500	Unlimited Medical copay limits
Maximum Out of Pocket for Prescription Drug – single/family	\$3,000/\$6,000	
Lifetime Maximum	Unlimited	
Primary Care Office Visits	Deductible/100%	\$10 Copay/Deductible/80%
Specialist Care Office Visits	Deductible/100%	\$10 Copay/Deductible/80%
Routine/Preventive Services	100%	Deductible/80% Exam subject to \$10 copay/Ded/80%
Vision Exam	100%-Deductible & coinsurance waived One exam per Calendar Year	
Vision Materials (contacts OR lenses/frames) <i>Please refer to SPD for plan specifics</i>	In Network Deductible/50% -\$300 Maximum	
Inpatient Hospital Services <i>Including Mental Health & Substance Abuse</i>	Deductible/100%	Deductible/80%
Outpatient Hospital Services	Deductible/100%	Deductible/80%
Therapy – Physical, Speech & Occupational	Deductible/100%	\$10 Copay/Deductible/80%
Emergency Care	\$200 Copay/In Network Deductible/100%	
Ambulance	In Network Deductible/100%	
Urgent Care	\$40 Copay/Deductible/100%	\$40 copay/Deductible/80%
Maternity Care	Deductible/100%	Deductible/80%
Chiropractic Manipulations	Deductible/100%	\$10 Copay/Deductible/80%

See attached list for all services that require Prior Authorization.

This is only a summary. Please refer to your Plan Document for specifics of your Plan.

Benefits (continued...)	In Network	Out of Network
Lab & X-ray	Deductible/100%	Deductible/80%
Advanced Imaging - MRI/CT/PET	\$100 Copay/Deductible/100%	\$100 Copay/Deductible/80%
Durable Medical Supplies	Deductible/100%	Deductible/80%
Prescription Drugs	Value Choice/Generic/Formulary/Brand	
<i>Retail: 30-day supply</i>	\$0/\$10/\$20/\$40	
<i>Retail: 31 – 90 day supply</i>	\$0/\$20/\$40/\$80	
<i>Mail Order: 90-day supply</i>	\$0/\$20/\$40/\$80	
<i>Specialty: 30-day supply</i>	Specialty copay applies to corresponding tier Specialty drugs may only be obtained through CVS Pharmacy or CVS Mail Order	
Annual Health Club Reimbursement Per Calendar Year	\$120 Single/\$240 Family	

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EXCEPTIONS TO THE PROVIDER NETWORK RATES (PPO BENEFIT PROVISION)

PPO Benefit Provision

Some benefits may be processed at the PPO benefit level when provided by a Non-PPO provider. The following exceptions may apply:

1. PPO benefits will be payable for Non-PPO provider services only if you receive treatment that is a covered expense from a PPO provider and as a result of that treatment, a covered expense is incurred for pathology, radiology or anesthesiology services from a Non-PPO provider.
2. Covered Expenses provided by a Qualified Practitioner during an Inpatient stay will be payable at the PPO level of benefits when provided at a PPO Hospital.
3. Covered Expenses provided by an Emergency room Qualified Practitioner will be payable at the PPO level of benefits when provided at a PPO Hospital.
4. If there is not a PPO provider, or no PPO provider is willing or able to provide the necessary service(s) to the Covered Person within a 50 mile radius of the Covered Person's residence, then the Non-PPO charges will be processed as PPO charges so long as the Covered Person provides appropriate documentation.