GHT

WCA GROUP HEALTH TRUST

WATERFORD UNION HIGH SCHOOL

Medical Summary

Effective Date: *7/1/17* ***Benefit Period:*** *January - December* ***Network:*** *United Healthcare Choice Plus*

Benefits	In Network	Out of Network
Deductible – single/family	$2,000/$4,000	$4,000/$8,000
Coinsurance	80%	60%
Maximum Out of Pocket – single/family *Includes Deductible and Coinsurance*	$4,000/$8,000	$8,000/16,000
Maximum Out of Pocket – single/family *Includes Ded/Coins, and all Medical Copays except Rx*	$5,000/$10,000	Unlimited
Maximum Out of Pocket for Prescription Drug – single/family	$1,500/$3,000	Not Applicable
Lifetime Maximum	Unlimited	
Primary Care Office Visits	$10 Copay/Deductible/80%	$25 Copay/Deductible/60%
Specialist Care Office Visits	$25 Copay/Deductible/80%	$50 Copay/Deductible/60%
Routine/Preventive Services *One exam per calendar year paid at 100% in network*	100%-Deductible & coinsurance waived	Deductible/60%
Vision Exam	100%-Deductible & coinsurance waived One exam per Calendar Year	
Vision Materials (contacts OR frames/lenses) Maximum Benefit $150/person/calendar year	In Network Deductible/50%	
Inpatient Hospital Services ** *Including Mental Health & Substance Abuse*	Deductible/80%	Deductible/60%
Outpatient Hospital Services	Deductible/80%	Deductible/60%
Outpatient Mental Health & Substance Abuse	$10 Copay/Deductible/80%	$25 Copay/Deductible/60%
Therapy – Physical, Speech & Occupational	Deductible/80%	Deductible/60%
Emergency Care	$200 Copay/In Network Deductible/80%	
Ambulance	In Network Deductible/80%	
Urgent Care	$40 Copay/In Network Deductible/80%	
Maternity Care	Deductible/80%	Deductible/60%
Chiropractic Manipulations	$10 Copay/Deductible/80%	$25 Copay/Deductible/60%

**All Inpatient admissions require prior authorization. Failure to pre-authorize will result in a penalty of 25% of billed charges up to $250.

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/80%	Deductible/60%
Advanced Imaging - MRI/CT/PET	$150 Copay/Deductible/80%	$150 Copay/Deductible/60%
Hearing Exam *One per calendar Year*	100%-Deductible & Coinsurance waived	Deductible/60%
Durable Medical Supplies	Deductible/80%	Deductible/60%
Prescription Drugs	**Value Choice/Generic/Formulary/Non-Formulary**	
Retail: *30-day supply*	$0/$10/$25/$50	
Retail: *31 – 90 day supply*	$0/$20/$50/$100	
Mail Order: *90-day supply*	$0/$20/$50/$100	
Specialty: *30-day supply*	Specialty copay applies to corresponding tier Specialty drugs may only be obtained through CVS Pharmacy or CVS Mail Order	
Annual Health Club Reimbursement Per Plan Year	$120 Single/$240 Family	

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

EXCEPTIONS TO THE PROVIDER NETWORK RATES (PPO BENEFIT PROVISION)

Some benefits may be processed at In-Network benefit levels when provided by an Out-of-Network provider. When Non-Network charges are covered in accordance with Network benefits, the charges are still subject to the Usual and Customary charge limitations. The following exceptions may apply:

Covered Services provided by a radiologist, anesthesiologist, or pathologist will be payable at the In-Network level of benefits when rendered by an Out-of-Network provider.

Covered Services provided by a Physician during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.

Covered Services provided by an Emergency room Physician will be payable at the In-Network level of benefits when provided at an In-Network Hospital

If there is not an In-Network provider, or no In-Network 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 Out-of-Network charges will be processed as In-Network charges so long as the Covered Person provides appropriate documentation.

UMR Customer Service: 1-800-826-9781 CVS Caremark: 1-866-818-6911