WAUWATOSA SCHOOL DISTRICT
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Wauwatosa School District Employees

HSA Qualified - High Deductible Health Plan

Base Plan

October 1, 2019 - September 30, 2020

Benefit Description	In - Network	Out - of - Network
Annual Plan Year Deductible (This is a combined limit between In-Network and Out-of-Network benefits. **Family deductible must be met in total before coinsurance applies**) *	$1,500 single** $3,000 family** **(Per Plan Year)**	$3,000 single $6,000 family **(Per Plan Year)**
Coinsurance Percentage **(What you pay after deductible)**	0%	30%
Annual Out-of-Pocket Maximum (This is a combined maximum between In-Network and Out-of-Network benefits and includes deductible amount paid.	$1,500 single $3,000 family	$3,500 single $7,000 family
Non-Precertification Penalty for Out of Network Inpatient Admissions	NA	$200 per confinement (does not apply to annual out-of-pocket maximum)
Participant Lifetime Maximum Benefit Limit	Unlimited	
Home and Office Visit	0% after deductible	30% after deductible
Emergency Room Visit	0% after in-network deductible	
Urgent Care	0% after deductible	30% after deductible
Outpatient Diagnostic Radiology and Pathology	0% after deductible	30% after deductible
Inpatient Hospital Facility and Services	0% after deductible	30% after deductible
Outpatient Hospital Facility and Services	0% after deductible	30% after deductible
Covered Dental Services	0% after deductible	30% after deductible
Ambulance Services	0% after deductible	0% after in network deductible
Oral Surgery	0% after deductible	30% after deductible
Durable Medical Equipment	0% after deductible	30% after deductible
Adult and Child Periodic Exams with Preventive Tests	0%, not subject to the deductible	30% after deductible
Women's Preventive Care Screenings (See SPD for further details)	0%, not subject to the deductible	30% after deductible
Contraceptive Coverage (Includes all FDA approved contraceptive methods (as prescribed), sterilization procedures, and patient education and counseling)	0%, not subject to the deductible	30% after deductible
Immunizations	0%, not subject to the deductible	30% after deductible
Chiropractic & Physical Therapy (Unlimited, based upon medical necessity)	0% after deductible	30% after deductible
Inpatient Hospital Services for Nervous or Mental Disorders, Alcoholism and Drug Abuse	0% after deductible	30% after deductible
Outpatient Services for Nervous or Mental Disorders, Alcoholism and Drug Abuse	0% after deductible	30% after deductible
Transitional Treatment Arrangements for Nervous or Mental Disorders, Alcoholism and Drug Abuse	0% after deductible	30% after deductible
Skilled Nursing Care in a Licensed Skilled Nursing Facility (Maximum benefit limit of 90 days per participant, per year)	0% after deductible	30% after deductible
Home Health Care Services	0% after deductible	30% after deductible
Prescription Drugs on UHC Preventive List. ***Copays accumulate toward annual out of pocket maximum.***	**1 - 34 days at Retail**: $10 copay Tier 1 $20 copay Tier 2 $30 copay Tier 3 **35 - 60 days at Retail:** $20 copay Tier 1 $40 copay Tier 2 $60 copay Tier 3 **61 - 90 days at Retail:** $20 copay Tier 1 $60 copay Tier 2 $90 copay Tier 3	**90 days through Mail Order:** $20 copay Tier 1 $40 copay Tier 2 $60 copay Tier 3
Prescription Drugs not on UHC Preventive List	0% after deductible	30% after deductible

*** Annual Plan Year runs October 1 through September 30. Deductible resets every October 1.**

**** Deductibles may be adjusted annually in compliance with regulatory requirements.**

This is a brief description of your benefits. For further information, please refer to the benefit booklet, which can be found on line at www.uhc.com. In order to view, you must log into www.myuhc.com, using your member id number located on you UHC ID card.