AAOA HEALTHCARE

Group Medical Plans

A Better Way to Buy Healthcare

Consumer-Directed Plans

Choice Plus Network

UnitedHealthcare®

UnitedHealthcare®

	HSA Plans - Choice Plus Network					
	HSA - WF-K		HSA -WF-L		HSA -WF-I	
	80% In Network	60% Out of Network	80% In Network	60% Out of Network	70% In Network	50% Out of Network
Annual Deductible						
• Individual	$1,500	$3,000	$2,000	$4,000	$3,000	$6,000
• Family	$3,000	$6,000	$4,000	$8,000	$6,000	$12,000
Annual Out-of-Pocket Maximum						
• Individual (Includes annual deductible)	$3,000	$6,000	$4,000	$8,000	$5,000	$10,000
• Family (Includes annual deductible)	$6,000	$12,000	$8,000	$16,000	$10,000	$20,000
Professional/Office Visit Copay	20%	40%	20%	40%	30%	50%
Lifetime Maximum	No Maximum		No Maximum		No Maximum	
Preventive Care						
• Office Visit	No Co-pay	No Benefit	No Co-pay	No Benefit	No Co-pay	No Benefit
• Diagnostics	No Co-pay	No Benefit	No Co-pay	No Benefit	No Co-pay	No Benefit
Professional Services						
• Office Visits	20%	40%	20%	40%	30%	50%
• Professional fees surgical and medical	20%	40%	20%	40%	30%	50%
• Outpatient						
- Surgery	20%	40%	20%	40%	30%	50%
- Lab, X-Ray and Diagnostics	20%	40%	20%	40%	30%	50%
- CT Scans, MRI, Nuclear Medicine	20%	40%	20%	40%	30%	50%
• Outpatient Theraputic treatments	20%	40%	20%	40%	30%	50%
Hospital Facility (Inpatient & Outpatient)						
• Inpatient and outpatient including diagnostic x-ray and laboratory	20%	*40%	20%	*40%	30%	*50%
• Emergency room visit (Co-pay waived if admitted)	20%	20%	20%	20%	30%	30%
• Urgent care visit	20%	40%	20%	40%	30%	50%
Ambulance Services	20% Eligible Expense		20% Eligible Expense		30% Eligible Expense	
Substance Use Disorder Services						
- Outpatient	20%	*40%	20%	*40%	30%	*50%
- Inpatient: Intermediate Care	20%	*40%	20%	*40%	30%	*50%
Home Health and Hospice						
• Home Health - 130 visits per calendar year maximum	20%	*40%	20%	*40%	30%	*50%
• Hospice	20%	*40%	20%	*40%	30%	*50%
Durable Medical Equipment Limit: $5,000 per calendar year	20%	**40%	20%	**40%	30%	**50%
Maternity (Provided for the subscriber or spouse)	20%	*40%	20%	*40%	30%	*50%
Mental Health Services						
• Inpatient	20%	*40%	20%	*40%	30%	*50%
• Outpatient	20%	*40%	20%	*40%	30%	*50%
Acupuncture - Limit: 10 visits per calendar year	20%	40%	20%	40%	30%	50%
Manipulative Treatment - Limit: 24 visits per calendar year	20%	40%	20%	40%	30%	50%
Neurodevelopmental Therapy	20%	*40%	20%	*40%	30%	*50%
Massage Therapy - Limit: 20 visits per calendar year	20%	40%	20%	40%	30%	50%
Rehabilitation						
• Inpatient - Limit 60 days per calendar year (Includes skilled nursing)	20%	*40%	20%	*40%	30%	*50%
• Outpatient - Limits vary based on service	20%	40%	20%	40%	30%	50%
Skilled Nursing Facility - Limit: 60 days per calendar year	20%	*40%	20%	*40%	30%	*50%
Transplants (1)	20%	*(1)40%	20%	*(1)40%	30%	*(1)50%
Prescription Drugs	Deductible (then $20/$40/$70)		Deductible (then $20/$40/$70)		Deductible (then $20/$40/$70)	
Vision Exam - Vision Service Plans (VSP) Providers (one exam/year)	100% after $20 Co-pay		100% after $20 Co-pay		100% after $20 Co-pay	
Employer Life and AD&D Benefit	$20,000		$20,000		$20,000	
Care 24 Program	Included		Included		Included	

HRA Plans - Choice Plus Network

HSA - WF-J		Choice Plus - WD-O		Choice Plus - WD-P		Choice Plus - WD-Q		Choice Plus -WD-R	
70% In Network	50% Out of Network	80% In Network	60% Out of Network	80% In Network	60% Out of Network	70% In Network	50% Out of Network	70% In Network	50% Out of Network
$4,000	$8,000	$1,000	$2,000	$2,000	$4,000	$1,000	$2,000	$1,500	$3,000
$8,000	$16,000	$2,000	$4,000	$4,000	$8,000	$2,000	$4,000	$3,000	$6,000
$5,950	$11,900	$3,000	$10,000	$6,000	$12,000	$5,000	$10,000	$4,500	$8,000
$11,900	$23,800	$6,000	$20,000	$12,000	$24,000	$10,000	$20,000	$9,000	$16,000
30%	50%	$25 Co-pay	40%	$25 Co-pay	40%	$25 Co-pay	50%	$30 Co-pay	50%
No Maximum		No Maximum		No Maximum		No Maximum		No Maximum	
No Co-pay	No Benefit	$25 Co-pay	No Benefit	$25 Co-pay	No Benefit	$25 Co-pay	No Benefit	$30 Co-pay	No Benefit
No Co-pay	No Benefit	No Co-pay	No Benefit	No Co-pay	No Benefit	No-Co-pay	No Benefit	No Co-pay	No Benefit
30%	50%	$25 Co-pay	40%	$25 Co-pay	40%	$25 Co-pay	50%	$30 Co-pay	50%
30%	50%	20%	40%	20%	40%	30%	50%	30%	50%
30%	50%	20%	40%	20%	40%	30%	50%	30%	50%
30%	50%	0%	40%	0%	40%	0%	50%	0%	50%
30%	50%	20%	40%	20%	40%	30%	50%	30%	50%
30%	50%	20%	40%	20%	40%	30%	50%	30%	50%
30%	*50%	20%	*40%	20%	*40%	30%	*50%	30%	*50%
30%	30%	$150 Co-pay plus Coinsurance -Deductible Waived-		$150 Co-pay plus Coinsurance -Deductible Waived-		$200 Co-pay plus Coinsurance -Deductible Waived-		$200 Co-pay plus Coinsurance -Deductible Waived-	
30%	50%	$75/visit	40%	$75/visit	40%	$75/visit	50%	$75/visit	50%
30% Eligible Expense		20% Eligible Expense		20% Eligible Expense		30% Eligible Expense		30% Eligible Expense	
30%	*50%	$25/visit	*40%	$25/visit	*40%	$25/visit	*50%	$30/visit	*50%
30%	*50%	20%	*40%	20%	*40%	30%	*50%	30%	*50%
30%	*50%	20%	*40%	20%	*40%	30%	*50%	30%	*50%
30%	*50%	20%	*40%	20%	*40%	30%	*50%	30%	*50%
30%	**50%	20%	**40%	20%	**40%	30%	**50%	30%	**50%
30%	*50%	20%	*40%	20%	*40%	30%	*50%	30%	*50%
30%	*50%	20%	*40%	20%	*40%	30%	*50%	30%	*50%
30%	*50%	$25/visit	*40%	$25/visit	*40%	$25/visit	*50%	$30/visit	*50%
30%	50%	$25/visit	40%	$25/visit	40%	$25/visit	50%	$30/visit	50%
30%	50%	$25/visit	40%	$25/visit	40%	$25/visit	50%	$30/visit	50%
30%	*50%	20%	*40%	20%	*40%	30%	*50%	30%	*50%
30%	50%	$25/visit	40%	$25/visit	40%	$25/visit	50%	$30/visit	50%
30%	*50%	20%	*40%	20%	*40%	30%	*50%	30%	*50%
30%	50%	$25/visit	40%	$25/visit	40%	$25/visit	50%	$30/visit	50%
30%	*50%	20%	*40%	20%	*40%	30%	*50%	30%	*50%
30%	*(1) 50%	20%	*(1) 40%	20%	*(1) 40%	30%	*(1) 50%	30%	*(1) 50%
Deductible (then $20/$40/$70)		Select a Plan		Select a Plan		Select a Plan		Select a Plan	
100% after $20 Co-pay		100% after $20 Co-pay		100% after $20 Co-pay		100% after $20 Co-pay		100% after $20 Co-pay	
$20,000		$20,000		$20,000		$20,000		$20,000	
Included		Included		Included		Included		Included	

*Pre-service notification is required for certain services. **Pre-service notification is required when cost is more than $1,000. (1) Non-Network Benefits are limited to $30,000 per transplant, subject to a 6 month exclusion period with credit for prior Continuous Creditable Coverage. This exclusion does not apply to Covered Persons under age 19. This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expense. More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage. Vision exam coverage is provided through Vision Service Plan (VSP) and VSP Providers. Pre-existing condition waiting period three months with no previous credible coverage. Selected plan(s) must include a prescription drug option. See back of this brochure for your options.

06-03-2011 (Revised 5-2011)

Prescription Drug Plan Options

Plan	Tier 1	Tier 2	Tier 3	90-Day Mail Order
H9	$10	$30	$50	2½ x co-pay
6H	$10	$40	$70	2½ x co-pay
FF	$20	$40	$70	2½ x co-pay
NJ	$15	$50	50%	2½ x co-pay
NK	$20	$40*	$70*	2½ x co-pay
	*$100 Deductible per Individual $300 Deductible Maximum per Family (Applies to Tier 2 & 3 Only)			

Select the prescription drug coverage from the chart above. A prescription drug plan must be selected for all medical plan options.

Need a Quote?

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We'll be happy to answer your questions and provide a free no-obligation quote for your business.

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