2017 Individual & Family Plan Options
ProHealth on the Elite Network

(Waukesha County)

Unity Health Insurance
Affiliated with UW Health

Gold Plans

These plans will cover about 80% of your service and you are responsible for the other 20%

Benefits	ProHealth Gold Deductible*	ProHealth Gold 30 / 60	ProHealth Gold Wise Savings	ProHealth Gold Standard
Deductible (Single / Family)	$1,500 / $3,000	$1,200 / $2,400	$3,000 / $6,000	$1,250 / $2,500
Coinsurance	10%	20%	20%	20%
Maximum Out-of-Pocket	$5,450 / $10,900	$6,500 / $13,000	$6,000 / $12,000	$4,750 / $9,500
e-Visits	Deductible then Coinsurance	$20	$15	$10
Office Visit Copay (PCP / Specialist)	Deductible then Coinsurance	$30 / $60	$25 / $50	$20 / $50
Urgent Care Copay	Deductible then Coinsurance	$60	$50	$65
Emergency Room Copay	Deductible then Coinsurance	$200	$200	$250 copay after deductible
Mental Health Outpatient Copay	Deductible then Coinsurance	$30	$25	$20
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	Deductible then Coinsurance	$10 / $40 / $80 / 50%	$10 / $40 / $80 / 50%	$10 / $30 / $75 / 30%
Dental Coverage Available for an Additional Charge?	No	Yes	Yes	No
HSA Eligible?	Yes*	No	No	No
Summary of Benefits of Coverage (SBC) Tracking ID	INDPH1500	INDPH4500	INDPH6000	INDPH6500

** Unity's Value / HSA plans have an aggregate deductible. This means if more than one person is covered by the plan, the "per person" deductible does not apply. The family deductible must be met before Unity will pay benefits and one person may accumulate to the entire family deductible. The "per person" maximum-out-of-pocket limit also does not apply. However, one member of a family will not pay more than $7,150.*

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Silver Plans

These plans will cover about 70% of your service and you are responsible for the other 30%

Benefits	ProHealth Silver 30 / 60	ProHealth Silver Deductible*	ProHealth Silver Maintenance	ProHealth Silver 25 / 50 Value*	ProHealth Silver 40 / 90 Value*	ProHealth Silver Standard
Deductible (Single / Family)	$5,250 / $10,500	$2,650 / $5,300	$1,750 / $3,500	$3,200 / $6,400	$4,350 / $8,700	$3,500 / $7,000
Coinsurance	10%	30%	0%	20%	10%	20%
Maximum Out-of-Pocket	$7,100 / $14,200	$5,400 / $10,800	$7,150 / $14,300	$7,000 / $14,000	$7,100 / $14,200	$7,150 / $14,300
e-Visits	$20	Deductible then Coinsurance	$20	$15	$25	$20
Office Visit Copay (PCP / Specialist)	$30 / $60	Deductible then Coinsurance	$30 / $75	$25 / $50	$40 / $90	$30 / $65
Urgent Care Copay	$60	Deductible then Coinsurance	$75	$50	$90	$75
Emergency Room Copay	$300	Deductible then Coinsurance	$500	$250	$350	$400 copay after deductible
Mental Health Outpatient Copay	$30	Deductible then Coinsurance	$30	$25	$40	$30
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	$2,500 per diem / Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	$10 / $50 / $100 / $400	Deductible then Coinsurance	$5 / $75 / $150 / $500	$10 / $50 / $100 / $400	$10 / $50 / $100 / $400	$15 / $50 / $100 / 40%
Dental Coverage Available for an Additional Charge?	Yes	No	Yes	Yes	Yes	No
HSA Eligible?	No	Yes*	No	No	No	No
Summary of Benefits of Coverage (SBC) Tracking ID	INDPH4700	INDPH1700	INDPH4900	INDPH5100	INDPH5300	INDPH7000

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Bronze Plans

These plans will cover about 60% of your service and you are responsible for the other 40%

Benefits	ProHealth Bronze HSA*	ProHealth Bronze 55 / 125	ProHealth Bronze Standard
Deductible (Single / Family)	$6,550 / $13,100	$6,900 / $13,800	$6,650 / $13,300
Coinsurance	0%	0%	50%
Maximum Out-of-Pocket	$6,550 / $13,100	$7,150 / $14,300	$7,150 / $14,300
e-Visits	Deductible then Coinsurance	$25	Deductible then Coinsurance
Office Visit Copay (PCP / Specialist)	Deductible then Coinsurance	$55 / $125	$45** / Deductible then Coinsurance
Urgent Care Copay	Deductible then Coinsurance	$125	Deductible then Coinsurance
Emergency Room Copay	Deductible then Coinsurance	$500	Deductible then Coinsurance
Mental Health Outpatient Copay	Deductible then Coinsurance	$55	$45
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	Deductible then Coinsurance	$20 / $75 / $150 / $500	$35 / 35% / 40% / 45%
Dental Coverage Available for an Additional Charge?	No	Yes	No
HSA Eligible?	Yes*	No	No
Summary of Benefits of Coverage (SBC) Tracking ID	INDPH1900	INDPH5500	INDPH7500

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** *Only applies to the first three office visits with PCP then deductible then coinsurance applies.*

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(Waukesha County)

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Catastrophic Plans

Only individuals under 30 years old or with a hardship exemption qualify for Catastrophic Plans

Benefits	ProHealth Catastrophic
Deductible (Single / Family)	$7,150 / $14,300
Coinsurance	0%
Maximum Out-of-Pocket	$7,150 / $14,300
e-Visits	Deductible then Coinsurance
Office Visit Copay (PCP / Specialist)	$0** / Deductible then Coinsurance
Urgent Care Copay	Deductible then Coinsurance
Emergency Room Copay	Deductible then Coinsurance
Mental Health Outpatient Copay	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance
Pharmacy Copay	Deductible then Coinsurance
Dental Coverage Available for an Additional Charge?	No
HSA Eligible?	No
Summary of Benefits of Coverage (SBC) Tracking ID	INDPH2100

*** Only applies to the first three office visits with PCP then deductible then coinsurance applies.*

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Optional Family Dental

Adult Benefits	In-Network	Out-Of-Network	Benefit Maximum
Cleanings / x-rays (Class A) Includes exams, x-rays, bitewings, cleanings and fluoride.	100% Coverage	No Coverage	1 visit per 6 months
Basic Restorative (Class B) Includes therapeutic pulpotomy, repair / adjustment of dentures and oral surgery procedures such as wisdom tooth or other tooth extractions. Benefit limits may apply to posterior composite fillings.	20% Coinsurance	No Coverage	$1,000 Benefit Maximum per Year
Major Restorative (Class C) Includes such services as crowns, root canals, apicoectomy, gingivectomy, dentures, implants and occlusal guards.	50% Coinsurance	No Coverage	
Orthodontics	Not Covered	Not Covered	Not Covered

Pediatric (up to age 19) Benefits	In-Network	Out-Of-Network	Benefit Maximum
Cleanings / x-rays (Class A) Includes exams, x-rays, bitewings, cleanings, fluoride, sealants and space maintainers.	100% Coverage	No Coverage	1 visit per 6 months
Basic Restorative (Class B) Includes therapeutic pulpotomy, repair / adjustment of dentures and oral surgery procedures such as wisdom tooth or other tooth extractions. Benefit limits may apply to posterior composite fillings; age limits may apply to certain procedures.	30% Coinsurance	No Coverage	No Benefit Maximum
Major Restorative (Class C) Includes such services as crowns, root canals, apicoectomy, gingivectomy, dentures, implants and occlusal guards.	50% Coinsurance	No Coverage	No Benefit Maximum
Orthodontics Covered only when medically necessary and a 24 month wait period is satisfied.	50% Coinsurance	No Coverage	No Benefit Maximum

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