GHT
WCA Group Health Trust

ELKHART LAKE – GLENBEULAH SCHOOL DISTRICT
BENEFIT SUMMARY
(Effective 7/1/2022 – 6/30/2024)

	Plan Benefits		
Network	UHC Choice Plus		
Plan Type	PPO		
Accumulation Type	Embedded		
Benefit Accumulator	Calendar Year		
	In-Network	***Out-of-Network***	
Deductible	$3,000/$6,000	$5,000/$10,000	
Coinsurance	100%	80%	
Total Maximum Out-of-Pocket (Deductible, Coinsurance Medical Copays)	$5,000/$10,000	$10,000/$20,000	
Medical Benefits			
Inpatient Hospital	Deductible/100%	Deductible/80%	
Outpatient Hospital	Deductible/100%	Deductible/80%	
Office Visit	$30 Copay/Deductible/100%	$60 Copay/ Deductible/80%	
Specialist Office Visit	$60 Copay/Deductible/100%	$120 Copay/ Deductible/80%	
Preventive Exam	100%/Deductible Waived	$60 Copay/ Deductible/80%	
Convenient Care/Retail Clinic	100%/Deductible Waived	$60 Copay/ Deductible/80%	
Manipulation	$30 Copay/Deductible/100%	$60 Copay/ Deductible/80%	
Phys/Occ/Sp/Resp Therapy	$30 Copay/Deductible/100%	$60 Copay/ Deductible/80%	
Urgent Care	$100 Copay/PPO Deductible/100%		
Emergency Room Care	$300 Copay/PPO Deductible/100%		
Mental Health/Subst. Abuse: Office Visit Inpatient Outpatient	 $30 Copay/Deductible/100% Deductible/100% Deductible/100%	 $60 Copay/Deductible/80% Deductible/80% Deductible/80%	
High Tech Imaging Coverage	$100/Deductible/100%	$200/Deductible/80%	
Oral Surgery	Deductible/100%	Deductible/80%	
All Other Covered Medical Services	Deductible/100%	Deductible/80%	
Teladoc Benefits	100% Deductible Waived		
Pharmacy Benefits			
Drug Plan Formulary	Generic	Preferred	Non-Preferred
Retail, 30 Days Retail, 31-90 Days Mail Order, 90 Days	$20 $60 $40	$75 $225 $150	$100 $300 $200
Specialty, 30 Days	20% (maximum $250)		
	Value Priced Generic: $0		
	Mandatory Generic: Yes		
	Rx Max Out-of-Pocket: $4,000/$8,000		

This is a summary of the plan benefits. For more detailed benefit information, please refer to the Summary Plan Description (SPD). If a discrepancy is found between this renewal summary and your policy's SPD, the terms of the SPD will govern.

UMR: ELKHART LAKE-GLENBEULAH SCHOOL DISTRICT: 76-440316 001

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.umr.com or by calling 1-800-207-3172. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.umr.com or call 1-800-207-3172 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$3,000 person / $6,000 family In-network $5,000 person / $10,000 family Out-of-network	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$5,000 person / $10,000 family In-network $10,000 person / $20,000 family Out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Penalties, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.umr.com or call 1-800-207-3172 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment costs shown in this chart are applied before the deductible; coinsurance costs are applied after your deductible has been met, as applicable.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 Copay per visit	$60 Copay per visit. 20% Coinsurance	None
	Specialist visit	$60 Copay per visit	$120 Copay per visit. 20% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	$60 Copay per visit PCP. $120 Copay per visit Specialist; 20% Coinsurance for Preventive care; 20% Coinsurance for Preventive screenings. No charge. Deductible Waived for Immunizations	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge office setting. $100 Copay per day outpatient setting	20% Coinsurance office setting; $200 Copay per day. 20% Coinsurance outpatient setting	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.caremark.com	Generic drugs (Tier 1)	$20 for a 30-day supply, retail; $60 for a 31–90-day supply, retail; $40 for up to a 90-day supply, mail order.	$20 for a 30-day supply, retail; $60 for a 31–90-day supply, retail; $40 for up to a 90-day supply, mail order.	Deductible waived. Covered prescriptions on the Value Priced Generic Drug List have no copay. If you choose a non-preferred drug when a generic is available, you will pay the cost difference between the two plus the non-preferred copay. However, if your physician indicates dispense as written (DAW) on prescription, then only the non-preferred copay will apply. Separate prescription drug out of pocket maximum: $4,000 person / $8,000 family. *This is in addition to the medical maximum out-of-pocket shown on page 1.* *Specialty prescriptions can only be obtained through a CVS Pharmacy or by CVS Caremark mail order to a maximum 30-day supply.
	Preferred brand drugs (Tier 2)	$75 for a 30-day supply, retail; $225 for a 31–90-day supply, retail; $150 for up to a 90-day supply, mail order.	$75 for a 30-day supply, retail; $225 for a 31–90-day supply, retail; $150 for up to a 90-day supply, mail order.	
	Non-preferred brand drugs (Tier 3)	$100 for a 30-day supply, retail; $300 for a 31–90-day supply, retail; $200 for up to a 90-day supply, mail order.	$100 for a 30-day supply, retail; $300 for a 31–90-day supply, retail; $200 for up to a 90-day supply, mail order.	
	Specialty drugs (Tier 4)	20% to a $250 maximum for up to a 30-day supply*.	20% to a $250 maximum for up to a 30-day supply*.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% Coinsurance	None
	Physician/surgeon fees	No charge	20% Coinsurance	None
If you need immediate medical attention	Emergency room care	$300 Copay per visit	$300 Copay per visit	In-network deductible applies to Out-of-network benefits. Copay may be waived if admitted
	Emergency medical transportation	No charge	No charge	In-network deductible applies to Out-of-network benefits
	Urgent care	$100 Copay per visit	$100 Copay per visit	In-network deductible applies to Out-of-network benefits
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% up to $250 of the total cost of the service for Out-of-network.
	Physician/surgeon fees	No charge	20% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$30 Copay per office visit. No charge other outpatient services	$60 Copay per visit. 20% Coinsurance office visits 20% Coinsurance other outpatient services	None
	Inpatient services	No charge	20% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% up to $250 of the total cost of the service for Out-of-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you are pregnant	Office visits	No charge; Deductible Waived	20% Coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	20% Coinsurance	
	Childbirth/delivery facility services	No charge	20% Coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% Coinsurance	None
	Rehabilitation services	$30 Copay per visit	$60 Copay per visit. 20% Coinsurance	Preauthorization is required.
	Habilitation services	$30 Copay per visit	$60 Copay per visit. 20% Coinsurance	
	Skilled nursing care	No charge	20% Coinsurance	60 Maximum days per confinement. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% up to $250 of the total cost of the service for Out-of-network.
	Durable medical equipment	No charge	20% Coinsurance	Preauthorization is required for DME in excess of $1,000 for rentals or for purchases. If you don't get preauthorization, benefits could be reduced by 25% up to $250 per occurrence for Out-of-network.
	Hospice service	No charge	20% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge; Deductible Waived	No charge; Deductible Waived	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Dental care (Adult)	• Private-duty nursing
• Bariatric surgery	• Infertility treatment	• Routine foot care
• Cosmetic surgery	• Long-term care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult)
• Hearing aids		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this plan Provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan Meet the Minimum Value Standard? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

This is only a summary. It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for the complete terms of this plan.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ **The plan's overall deductible**	**$3,000**
■ **Specialist copayment**	**$60**
■ **Hospital (facility) coinsurance**	**0%**
■ **Other coinsurance**	**0%**

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$3,070**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$3,000**
■ **Specialist copayment**	**$60**
■ **Hospital (facility) coinsurance**	**0%**
■ **Other coinsurance**	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$3,000**
■ **Specialist copayment**	**$60**
■ **Hospital (facility) coinsurance**	**0%**
■ **Other coinsurance**	**0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,300
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,810**

The plan would be responsible for the other costs of these EXAMPLE covered services.