Oregon School District

HEALTH COVERAGE OPTIONS

HEALTH COVERAGE OPTIONS		Effective: 7/1/2023
Carrier	Group Health Cooperative of South Central Wisconsin	Group Health Cooperative of South Central Wisconsin
Provider Network	GHC HMO	GHC PPO
Deductible	offe finite	5115 11 5
In-Network (Single / Family)	\$500 / \$1,000	\$500 / \$1,000
Out-of-Network (Single / Family)	Not Covered	\$1,000 / \$2,000
Coinsurance		+-,
In-Network	100%	100%
Out-of-Network	Not Covered	90%
Deductible / Coinsurance Limit	Includes Deductible and Coinsurance	Includes Deductible and Coinsurance
In-Network (Single / Family)	\$500 / \$1,000	\$500 / \$1,000
Out-of-Network (Single / Family)	Not Covered	\$2,000 / \$4,000
out of retwork (onigie / runniy)	Includes Deductible, Coinsurance and	Includes Deductible, Coinsurance and
Out-of-Pocket Max	Medical Copays	Medical Copays
In-Network (Single / Family)	\$4,600 / \$9,200	\$4,600 / \$9,200
In-Network (Single / Family) Out-of-Network (Single / Family)	\$4,000 / \$9,200 Not Covered	\$4,600 / \$9,200 \$4,600 / \$9,200
Lifetime Maximum	Unlimited	\$4,600 / \$9,200 Unlimited
Office Visits	Onlinited	Onlinited
In-Network	\$25 Coney	\$25 Congy
In-Network Out-of-Network	\$25 Copay Not Covered	\$25 Copay Ded, 90% Coins
	Not Covered	Ded, 90% Coins
GHCMyChart Video Visit	\$25 Canari	\$25 Company
In-Network	\$25 Copay	\$25 Copay
Specialist	P25 C	©25 C
In-Network	\$25 Copay	\$25 Copay Ded, 90% Coins
Out-of-Network Routine/Preventive Care	Not Covered	Ded, 90% Coms
	1000/ Carraga	1000/ Carraga
In-Network	100% Coverage	100% Coverage
Out-of-Network	Not Covered	Ded, 90% Coins
Inpatient Hospital Services	D-1 1000/ C-i	D. I. 1000/ C
In-Network	Ded, 100% Coins Not Covered	Ded, 100% Coins
Out-of-Network Outpatient Hospital Services	Not Covered	Ded, 90% Coins
•	D-1 1000/ C-i	D. I. 1000/ C
In-Network	Ded, 100% Coins	Ded, 100% Coins
Out-of-Network	Not Covered	Ded, 90% Coins
MRI / PET / CAT Scans	#150 C	#150 C
In-Network	\$150 Copay	\$150 Copay
Out-of-Network	N/A	Ded, 90% Coins
Mental Health / Behavioral Health Services		
Outpatient		
In-Network	\$25 Copay	\$25 Copay
Out-of-Network	Not Covered	Ded, 90% Coins
Inpatient		
In-Network	Ded, 100% Coins	Ded, 100% Coins
Out-of-Network	Not Covered	Ded, 90% Coins
Emergency Room		
In-Network	\$100 Copay	\$100 Copay
Out-of-Network	\$100 Copay	\$100 Copay
Prescription Drugs - In-Network		
	Prescription Max Out of Pocket	Prescription Max Out of Pocket
	\$2,000 Single / \$4,000 Family	\$2,000 Single / \$4,000 Family
Tier 1 / Tier 2 / Tier 3	\$10 / \$30 / \$60	\$10 / \$30 / \$60
Total Monthly Premium		
Employee	\$783.87	\$783.87
Family	\$1,763.71	\$1,763.71

This constitutes only a summary of the Health plan involved. The actual contract or plan document must be consulted to determine the governing contractual provisions, limitations, or exclusions. There is no guarantee, expressed or implied by USI Insurance Services or vendors of plan provisions or level of payments.