Chequamegon School District
7/01/2017-6/30/2018 Coverage Period
Northern School District Trust
TPA: WPS Insurance

Insurance Comparison

	High Deductible Health Plan Single $867.41 Family $1973.44	**Traditional PPO** Single $984.45 Family $2229.77
What is the overall deductible?	For preferred providers: $1,350/ Single Coverage or $2,700/Family; For non-preferred providers: $1,350/Single Coverage or $2,700/Family	For preferred providers: $500/Covered Person or $1,000/Family; For non- preferred providers: $1,000/Single Coverage or $2,000/Family
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	Yes. Preventive care services are covered before you meet your deductible.
Are there other deductibles for specific services?	No.	No.
What is the out-of-pocket limit for this plan?	For preferred providers: $1,300 Single Coverage/ $2,600 For non-preferred providers: $2,600 Single Coverage/$5,200 Family	For preferred providers: $750 Single Coverage/ $1,500 up to a maximum out-of-pocket (including medical and drug copays) of $7,150 Covered Person/$14,300 Family. For non-preferred providers: $1,750 Covered Person/$3,500 Family
Will you pay less if you use a network provider?	Yes. See https://connect.wpsic.com/Gateway/commercialGateway/unauth/fadHome.do or call 1-800-223-6048 for a list of network providers.	Yes. See https://connect.wpsic.com/Gateway/commercialGateway/unauth/fadHome.do or call 1-800-223-6048 for a list of network providers.

Traditional Plan Copays & Coinsurance		**In-network costs: (Out-of-network 30% coinsurance)**
Primary care visit to treat an	injury or illness	$25 copay/office visit and 10% coinsurance for other outpatient services; deductibel does not apply to the office visit charge
	Specialist visit	$25 copay/office visit and 10% coinsurance for other outpatient services; deductibel does not apply to the office visit charge
If you visit a health care provider's office or clinic	Preventive care/screening/ immunization	No Charge
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance
	Imaging (CT/PET scans, MRIs)	10% coinsurance
If you need drugs to treat your illness or condition	Generic drugs	$5 copay/prescription

More information about prescription drug coverage is available at http://www.wpsic.com/fil es/2017-express-scripts-formulary.pdf	Preferred brand drugs	$15 copay/prescription
	Non-preferred brand drugs	$30 copay/prescription
	Specialty drugs	$30 copay/prescription
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance
	Physician/surgeon fees	10% Coinsurance
If you need immediate medical attention	Emergency room care	$150 Copay and 10% coinsurance for other emergency room services. Deductible does not apply to copay
	Emergency medical transportation	10% Coinsurance
	Urgent care	$150 Copay and 10% coinsurance for other emergency room services. Deductible does not apply to copay
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance