Oregon School District

HEALTH COVERAGE OPTIONS

Effective: 7/1/2024

Carrier	Group Health Cooperative of South Central Wisconsin	Group Health Cooperative of South Central Wisconsin
Provider Network	GHC HMO	GHC PPO
Deductible		
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-Pocket Max	*Includes Deductible, Coinsurance and Medical Copays*	*Includes Deductible, Coinsurance and Medical Copays*
In-Network (Single / Family)	$4,600 / $9,200	$4,600 / $9,200
Out-of-Network (Single / Family)	Not Covered	$4,600 / $9,200
Lifetime Maximum	Unlimited	Unlimited
Office Visits		
In-Network	$25 Copay	$25 Copay
Out-of-Network	Not Covered	Ded, 90% Coins
GHCMyChart Video Visit		
In-Network	$25 Copay	$25 Copay
Specialist		
In-Network	$25 Copay	$25 Copay
Out-of-Network	Not Covered	Ded, 90% Coins
Routine/Preventive Care		
In-Network	100% Coverage	100% Coverage
Out-of-Network	Not Covered	Ded, 90% Coins
Inpatient Hospital Services		
In-Network	Ded, 100% Coins	Ded, 100% Coins
Out-of-Network	Not Covered	Ded, 90% Coins
Outpatient Hospital Services		
In-Network	Ded, 100% Coins	Ded, 100% Coins
Out-of-Network	Not Covered	Ded, 90% Coins
MRI / PET / CAT Scans		
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 $2,000 Single / $4,000 Family	*Prescription Max Out of Pocket $2,000 Single / $4,000 Family*
Tier 1 / Tier 2 / Tier 3	$10 / $30 / $60	$10 / $30 / $60
Total Monthly Premium		
Employee	$819.14	$819.14
Family	$1,843.08	$1,843.08

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.

