

Elkhart Lake-Glenbeulah School District
WCA Group Health Trust - Renewal Exhibit (7/1/2018)

Medical

	<u>Plan 1</u>	<u>Plan 2</u>	<u>Plan 3</u>
Single:			
	Per Month \$748.47	Per Month \$717.80	Per Month \$667.69
	x 12 months \$8,981.64	x 12 months \$8,613.60	x 12 months \$8,012.28
Total cost per year:			
Less District contribution per year for 100% FTE employee:	\$7,600.00	\$7,600.00	\$7,600.00
Employee portion per year for 100% FTE employee:	\$1,381.64	\$1,013.60	\$412.28
Monthly cost for 100% FTE employee:	\$115.14	\$84.47	\$34.36
Approximate employee deduction per paycheck for 100% FTE:	\$57.57	\$42.24	\$17.18

	<u>Plan 1</u>	<u>Plan 2</u>	<u>Plan 3</u>
Family:			
	Per Month \$1,695.31	Per Month \$1,624.75	Per Month \$1,511.26
	x 12 months \$20,343.72	x 12 months \$19,497.00	x 12 months \$18,135.12
Total cost per year:			
Less district contribution per year for 100% FTE employee:	\$17,000.00	\$17,000.00	\$17,000.00
Employee portion per year for 100% FTE employee:	\$3,343.72	\$2,497.00	\$1,135.12
Monthly cost for 100% FTE employee:	\$278.64	\$208.08	\$94.59
Approximate employee deduction per paycheck for 100% FTE:	\$139.32	\$104.04	\$47.30

Dental
Single
Family

Per Month	Please note: for any 100% FTE employee enrolled in dental, there is no deduction. It is paid by the District.
\$44.00	
\$126.50	



WCA GROUP HEALTH TRUST

Renewal for Elkhart –Glenbeulah Lake School District

(7/01/18)

	Plan 1		Plan 2	
PPO Network	UHC Choice+		UHC Choice+	
	HMO		HMO	
Prior Authorization	Standard		Standard	
Deductible	Embedded		Embedded	
In Network	\$500/1,000		\$1,000/2,000	
Out of Network	Not Covered		Not Covered	
Coinsurance				
In Network	100%		100%	
Out of Network	N/A		N/A	
Maximum Out of Pocket (Deductible & Coinsurance Only)				
In Network	\$500/1,000		\$1,000/2,000	
Out of Network	N/A		N/A	
Maximum Out of Pocket With OV Copays				
In Network	\$2,500/5,000		\$3,000/6,000	
Out of Network	N/A		N/A	
	In Network	Out of Network	In Network	Out of Network
Hospitalization	Ded/100%	Not Covered	Ded/100%	Not Covered
Office Visit(s)	\$25/Ded/100%	Not Covered	\$25/Ded/100%	Not Covered
Specialist Office Visit(s)	\$25/Ded/100%	Not Covered	\$25/Ded/100%	Not Covered
Preventative Exams				
Chiropractic Office Visits(s)	\$25/Ded/100%	Not Covered	\$25/Ded/100%	Not Covered
Phys, Occ & Speech Therapy	Ded/100%	Not Covered	Ded/100%	Not Covered
Urgent Care	\$50/Ded/100%	Not Covered	\$50/Ded/100%	Not Covered
Emergency Room Care	\$200/Ded/100%	\$200/PPO Ded/100%	\$200/Ded/100%	\$200/PPO Ded/100%
Psych, Chem & Alcohol				
In-patient	Ded/100%	Not Covered	Ded/100%	Not Covered
Out-patient	Ded/100%	Not Covered	Ded/100%	Not Covered
All Other Medical Services	Ded/100%	Not Covered	Ded/100%	Not Covered
High Tech Imaging Coverage	\$100 Copay/Ded/100%	Not Covered	\$100 Copay/Ded/100%	Not Covered
Oral Surgery	Ded/100%	Not Covered	Ded/100%	Not Covered
	22 procedures		22 procedures	
Extractions/Replacement of Teeth	Limited to \$1,500 Per Benefit Period		Limited to \$1,500 Per Benefit Period	
Health Club Reimbursement	\$120/Single; \$240 Family		\$120 Single; \$240 Family	
Pharmacy				
Drug Plan	\$0/20/60/100 (30 Days Retail) \$0/40/120 (31-90 Days Retail) \$0/40/120 (90 Days Mail)		\$0/20/60/100 (30 Days Retail) \$0/40/120 (31-90 Days Retail) \$0/40/120 (90 Days Mail)	
Maximum Out of Pocket (Pharmacy Only)	\$4,000/8,000		\$4,000/8,000	
Waiver of Premium	No		No	

	Plan 3	
PPO Network	UHC Choice+	
	HMO	
Prior Authorization	Standard	
Deductible	Embedded	
In Network	\$2,000/4,000	
Out of Network	Not Covered	
Coinsurance		
In Network	100%	
Out of Network	N/A	
Maximum Out of Pocket (Deductible & Coinsurance Only)		
In Network	\$2,000/4,000	
Out of Network	N/A	
Maximum Out of Pocket With OV Copays		
In Network	\$4,000/8,000	
Out of Network	N/A	
	In Network	Out of Network
Hospitalization	Ded/100%	Not Covered
Office Visit(s)	\$25/Ded/100%	Not Covered
Specialist Office Visit(s)	\$25/Ded/100%	Not Covered
Preventative Exams		
Chiropractic Office Visits(s)	\$25/Ded/100%	Not Covered
Phys, Occ & Speech Therapy	Ded/100%	Not Covered
Urgent Care	\$50/Ded/100%	Not Covered
Emergency Room Care	\$200/Ded/100%	\$200/PPO Ded/100%
Psych, Chem, & Alcohol		
In-patient	Ded/100%	Not Covered
Out-patient	Ded/100%	Not Covered
All Other Medical Services	Ded/100%	Not Covered
High Tech Imaging Coverage	\$100 Copay/Ded/100%	Not Covered
Oral Surgery	Ded/100%	Not Covered
	22 procedures	
Extractions/Replacement of Teeth	Limited To \$1,500 Per Benefit Period	
Health Club Reimbursement	\$120/Single; \$240 Family	
Pharmacy		
Drug Plan	\$0/20/60/100 (30 Days Retail) \$0/40/120 (31-90 Days Retail) \$0/40/120 (90 Days Mail)	
Maximum Out of Pocket (Pharmacy Only)	\$3,000/\$6,000	
Waiver of Premium	No	

<u>Item</u>	<u>District Response</u>	<u>Answer Format</u>
Basic Information		
1. LEA code	1631 Elkhart Lake- Glenbeulah School District	4 digit number; if unknown, can be found at dpi.wi.gov
2. School district name	Many	Text
3. Number of plans offered	Fully insured	Drop-down menu (choose 1)
4. Plan structure	WCA Group Health	Drop-down menu (choose 1)
5. Plan chosen by the majority of employees eligible for coverage	Trust - Plan 1	Text
6. Type of plan	Health Maintenance Organization (HMO)	Drop-down menu (choose 1)
7. Percent of staff eligible for insurance and enrolled in the plan	77% Single (Employee Only), Family (Employee, Spouse, All Dependents), Retiree	Percentage (2 decimal points; i.e., 0.79 to show 79%)
8. Eligibility	Medical, Dental (any), Prescription Drugs	Drop-down menu (choose multiple if applicable)
9. Coverage		Drop-down menu (choose multiple if applicable)
Single Plan Information		
10. Total monthly premium	\$ 748.47	Dollars
11. Employer contribution to premium	\$ 633.33	Dollars
12. Employee contribution to premium	\$ 115.14	Dollars

13.	If HSA, total employer contribution		N/A		Dollars
14.	Deductible	\$	500.00		Dollars
15.	Employer share of deductible		N/A		Dollars
16.	Out of pocket maximum	\$	2,500.00		Dollars

Family Plan Information

17.	Total monthly premium	\$	1,695.31		Dollars
18.	Employer contribution to premium	\$	1,416.67		Dollars
19.	Employee contribution to premium	\$	278.64		Dollars
20.	If HSA, total employer contribution		N/A		Dollars
21.	Deductible	\$	1,000.00		Dollars
22.	Employer share of deductible		N/A		Dollars
23.	Out of pocket maximum	\$	5,000.00		Dollars

Other Plan Information

24.	Describe any premium differential		N/A		Text
25.	Describe any in-network co-pays		25/50/100/200		Text
26.	Co-insurance percentage, if any		100%		Percentage (2 decimal points; i.e., 0.79 to show 79%)
27.	Other information		See attachments		Text