Wild Rose School District

Renewal Health Plan Options
July 1, 2022

Tuesday, March 29, 2022

	Current Rates / Current Benefits			Renewal Rates / Current Benefits		
Health Plan	Essential PPO			Essential PPO		
Deductible (Single/Family)						
Network	$1,000/$2,000			$1,000/$2,000		
Non-Network	$2,000/$4,000			$2,000/$4,000		
Coinsurance						
Network	100%			100%		
Non-Network	80%			80%		
Maximum Out-of-Pocket (Single/Family)						
Excludes Medical Copayments	No			No		
Excludes Pharmacy Copayments	Yes			Yes		
Network	$2,000/$4,000			$2,000/$4,000		
Non-Network	$4,000/$8,000			$4,000/$8,000		
Copayments	Primary	Specialty		Primary	Specialty	
Network Office Visit	$30	$60	then ded/coins	$30	$60	then ded/coins
Non-Network Office Visit	$60	$120	then ded/coins	$60	$120	then ded/coins
Network Convenient Care/Telehealth Office Visit	$0		copay only	$0		copay only
Urgent Care	$100		then ded/coins	$100		then ded/coins
Emergency Room	$300		then ded/coins	$300		then ded/coins
Advanced Imaging Copay	$100/$200		then ded/coins	$100/$200		then ded/coins
~imum Out-of-Pocket Medical Copay	$0/$0			$0/$0		
macy						
Drug Plan	$0/10/40/50% VCDP			$0/10/40/50% VCDP		
Maximum Out-of-Pocket Pharmacy Copay	$2,000/$4,000			$2,000/$4,000		
Includes Erectile Dysfunction Benefits	No			No		
Specialty Pharmacy Coinsurance	Yes			Yes		
Optional Benefits						
Vision Benefit	No Vision Coverage			No Vision Coverage		
Extraction/Replacement of Teeth	No Extraction Coverage			No Extraction Coverage		
Waiver of Premium	No			No		
Vitality	Elevate - Employee Only			Elevate - Employee Only		

Premium Rates	Current Subscribers	Current Rates / Current Benefits	Renewal Rates / Current Benefits
Single	14	$1,072.10	$1,104.26
Family	47	$2,426.16	$2,498.94
Single Medicare	-	$658.86	$678.62
Family Medicare	-	$1,317.72	$1,357.24
Special Medicare (1 over/1 under) both Rx	2	$1,730.96	$1,782.88
Monthly Premium	63	$132,500.84	$136,475.58
			3.0%

The rates include the following commission: This calculation includes standard commission

The rates in this chart are renewal options for illustrative purposes and are not a contract for coverage. The pricing assumes a single plan design per employee segment with the Trust as the sole carrier. These rates are subject to change and contain no guarantee. Moreover, this information is intended only for the use of the individual or entity to which it is addressed. It may contain information that is privileged, confidential, and prohibited from disclosure under law. If the reader of this message is not the intended recipient, you are notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

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_______________ Date

Wild Rose School District

Health Insurance Benefit Comparison

Effective Date: 7/1/2022

Health Carrier	WEA	
	Essential PPO	
Insurance Type	PPO	
Provider Network	Trust Preferred	
Deductible	Single	Family
In Network	$1,000	$2,000
Out of Network	$2,000	$4,000
Co-Insurance		
In Network	100%	
Out of Network	80%	
Maximum Out-of-Pocket	Single	Family
In Network	$2,000	$4,000
Out of Network	$4,000	$8,000
Office Visits	PCP	Specialist
In Network	$30 Copay	$60 Copay
Teladoc	100% Covered	
Out of Network	$60 Copay	$120 Copay
Routine/Preventive Care		
In Network	Select Services Covered in Full	
Out of Network	Deductible and Coinsurance	
Urgent Care		
In Network	$100 Copay, then Deductible	
Out of Network	Deductible and Coinsurance	
Emergency Room		
	$300 Copay, then Deductible	
Hospital Services		
In Network	Subject to Deductible	
Out of Network	Deductible and Coinsurance	
Prescription Drugs		
	$0/$10/$40/50%	
Rx Maximum Out-of-Pocket	Single	Family
	$2,000	$4,000
Rates	Current	Renewal
Employee 14	$1,072.10	$1,104.26
Family 47	$2,426.16	$2,498.94
Annual Δ% from Current		3.00%
Monthly Totals	$129,038.92	$132,909.82
Annual Totals	$1,548,467.04	$1,594,917.84
Annual Δ$ from Current		$46,451

While every effort is made to illustrate the carriers' various benefits, discrepancies or errors are possible. In the event of an error, the actual product brochure furnished by the insurance carrier and approved by the Commissioner of Insurance will prevail. The master contract and policyholder certificates are more detailed and should be used for the determination of benefits. All plans will comply with state and/or federal requirements with regard to nervous and mental benefits.

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PB
3/30/2022

Preferred Provider Plan Essential Health

ʼhool District of Wild Rose
Group No.: 30791

Group Health Benefit Summary

This **Benefit Summary** provides important information about reimbursement rules that apply to **Your** health plan benefits. It also identifies what Optional Eligibility and Optional Benefit Provisions, if any, apply to **Your** coverage. Many of the terms used below are defined in **Your Certificate** of Coverage (**Certificate**) and explained in Section 2: General Provisions That Apply to All Benefits. **Your Certificate** describes **Your** benefits and the exclusions and limitations that apply to them. **You** may view **Your Certificate** and any applicable amendments on **Our** website, *weatrust.com*. If **You** prefer to receive a paper copy, please call **Our Customer Service Department**. **We** encourage **You** to keep **Your Benefit Summary** and **Certificate** handy for **Your** reference.

Group Effective Date: 07/01/2021 **Benefit Period:** January through December
Network: Trust Preferred

Basic Reimbursement Factors of Your Health Plan

All Covered Health Care Services	Services Received from In-Network Providers	Services Received from Out-of-Network Providers
Deductible You Pay	$1,000 single/ $2,000 family	$2,000 single/ $4,000 family
Coinsurance You Pay	0%	20%
Maximum Out-of-Pocket Limit Maximum amount of **Deductible, Coinsurance,** and In-Network **Copayments You** are required to play under this **Plan.**	$2,000 single/ $4,000 family	$4,000 single/ $8,000 family
Maximum Out-of-Pocket Limit for Prescription Drug Cost-Sharing Amounts	$2,000 single/ $4,000 family	

If **You** believe the services **You** require are not available from an **In-Network Provider**, call **Our** Customer Service Department and discuss the application of the **Certificate's** reimbursement rules to **Your** medical situation

Selecting a Provider: With a preferred provider plan, using an **In-Network Provider** maximizes **Your** benefits. **You** can find an **In-Network Provider** by clicking on *Find a Doctor* at *weatrust.com*. If **You** go to an **Out-of-Network Provider, You** will likely have higher out-of-pocket costs. For more information, please see the Reimbursement Notifications for **Out-of-Network Providers** section below and view **Your Certificate** at *weatrust.com*.

Prescription Drug Reimbursement Information

	Value Drugs	Tier 1	Tier 2	Tier 3	Tier 4
Cost-Sharing Amount Per Prescription Fill	$0	$10	$40	50%	20%

Prescription Drugs under this drug plan are not subject to a deductible. Your Tier 3 cost-sharing is subject to a $75 minimum copayment and a $150 maximum copayment per fill. Your Tier 4 cost-sharing is subject to a $250 maximum copayment per fill. You will be charged 2 **Cost-Sharing Amounts** for a 90-day supply through **Our** Home Delivery Program. As required by 2013 Wisconsin ʼt 186, copayments for oral chemotherapy medication will not exceed $100 per 30-day supply.

Reimbursement Information for Preventive Services

We cover preventive services recommended by the U.S. Preventive Services Task Force and other entities as required by federal regulations. When **You** seek recommended preventive services from an **In-Network Provider, Your** services are not subject to a **Deductible, Coinsurance,** or **Copayment.** When **You** seek recommended preventive services from an **Out-of-Network Provider, Your** services are subject to a **Deductible, Coinsurance,** and/or **Copayment.** For colorectal cancer screening, **We** follow the guidelines issued by the U.S. Preventive Services Task Force.

Preventive Services	**Member Pays for Services Received from In-Network Providers**	**Member Pays for Services Received from Out-of-Network Providers**
Preventive Office Visits	0%	$60 Copay, Deductible, then 20%
Tobacco Cessation Screening and Brief Interventions	0%	Deductible, then 20%
Other Preventive Services Including Immunizations, Screenings, and Certain Counseling Services (see ***weatrust.com*** *Members section* for details)	0%	Deductible, then 20%

Reimbursement Information for Other Covered Services

Please Note: Unless otherwise specified, **You** must pay a **Cost-Sharing Amount** for each service or item you receive, even if you get multiple services or items at the same time or on the same day.

Other Covered Services	**Member Pays for Services Received from In-Network Providers**	**Member Pays for Services Received from Out-of-Network Providers**
PHYSICIAN/PRACTITIONER SERVICES		
Primary Care Office Visits*	$30 Copay, Deductible, then 0%	$60 Copay, Deductible, then 20%
Specialty Care Office Visits*	$60 Copay, Deductible, then 0%	$120 Copay, Deductible, then 20%
Urgent Care	$100 Copay, Deductible, then 0%	$100 Copay, Deductible, then 0%
Walk-in Retail Clinic Services *	$0 Copay	$60 Copay, Deductible, then 20%
Virtual Visits*	$0 Copay	100%
Maternity Care	Deductible, then 0%	Deductible, then 20%
Laboratory and Radiology	Deductible, then 0%	Deductible, then 20%
Specialty Drugs (including injections)	Deductible, then 0%	Deductible, then 20%
Inpatient Services	Deductible, then 0%	Deductible, then 20%
Outpatient Services	Deductible, then 0%	Deductible, then 20%
INPATIENT FACILITY SERVICES		
Hospitalization	Deductible, then 0%	Deductible, then 20%
Surgery, Anesthesia, and Related Supplies	Deductible, then 0%	Deductible, then 20%
Other Covered Services	**Member Pays for Services Received from In-Network Providers**	**Member Pays for Services Received from Out-of-Network Providers**
Maternity and Newborn Services	Deductible, then 0%	Deductible, then 20%
Advanced Imaging and Laboratory Services	Deductible, then 0%	Deductible, then 20%
Mental Health and Substance Abuse Services	Deductible, then 0%	Deductible, then 20%
Skilled Nursing Facility (limited to 30 Days per Confinement)	Deductible, then 0%	Deductible, then 20%
Skilled Rehabilitation Facility (limited to 60 Days per Benefit Period)	Deductible, then 0%	Deductible, then 20%

***Copayments** are waived for **Members** under 6 years of age.

Reimbursement Information for Other Covered Services (*continued*)

Please Note: Unless otherwise specified, **You** must pay a **Cost-Sharing Amount** for each service or item you receive, even if you get multiple services or items at the same time or on the same day.

OUTPATIENT FACILITY SERVICES	Member Pays for Services Received from In-Network Providers	Member Pays for Services Received from Out-of-Network Providers
OUTPATIENT FACILITY SERVICES		
Surgery and Related Services	Deductible, then 0%	Deductible, then 20%
Non-Emergency Advanced Imaging	$100 Copay, Deductible, then 0%	$200 Copay, Deductible, then 20%
Other Diagnostic Tests	Deductible, then 0%	Deductible, then 20%
Emergency Room (exceptions may apply, so please see your Certificate)	$300 Copay, Deductible, then 0%	$300 Copay, Deductible, then 0%
OTHER SERVICES		
Aural Therapy (limited to 30 visits per Benefit Period)	Deductible, then 0%	Deductible, then 20%
Cardiac Rehabilitation (limited to 36 Visits per Benefit Period)	Deductible, then 0%	Deductible, then 20%
Chiropractic Treatment*	$30 Copay, Deductible, then 0%	$60 Copay, Deductible, then 20%
Congenital Heart Disease Surgery (**Out-of-Network** services are limited to $35,000 per **Benefit Period**)	Deductible, then 0%	Deductible, then 20%
Dental Services (Limited Services Only)	Deductible, then 0%	Deductible, then 20%
Durable Medical Equipment (DME) and Supplies**	Deductible, then 0%	Deductible, then 20%
Extraction/Replacement of Natural Teeth	No Coverage	No Coverage
Hearing Aids	Deductible, then 0%	Deductible, then 20%
Home Health Care (limited to 60 Visits per Benefit Period)	Deductible, then 0%	Deductible, then 20%
Hospice Care	Deductible, then 0%	Deductible, then 20%
Kidney Disease Treatment	Deductible, then 0%	Deductible, then 20%
Outpatient Behavioral Health and Substance Abuse Services *	$30 Copay, Deductible, then 0%	$60 Copay, Deductible, then 20%
Pulmonary Rehabilitation (limited to 20 Visits per Benefit Period)	Deductible, then 0%	Deductible, then 20%
Temporomandibular Disorder (TMD) Treatment	Deductible, then 0%	Deductible, then 20%
Therapy – Physical, Speech, and Occupational* (limited to 20 Visits per Benefit Period)	$30 Copay, Deductible, then 0%	$60 Copay, Deductible, then 20%
Transplants (**Out-of-Network** services are limited to $35,000 per **Benefit Period**)	Deductible, then 0%	Deductible, then 20%
Vision Exam	No Coverage	No Coverage
Vision – Non-Routine Services	Deductible, then 0%	Deductible, then 20%

***Copayments** are waived for **Members** less than 6 years of age.**For DME, the **Cost-Sharing Amount** applies per DME item, per claim. Depending on the DME item, this could result in a one-time **Cost-Sharing Amount** payment, or multiple **Cost-Sharing Amount** payments made over the span of a rental period.

Prior Authorization and Hospital Admission Notification Requirements

Certain services require **Prior Authorization**. You will find a list of the services that require **Prior Authorization** on **Our** website at weatrust.com. **We** will impose a penalty of 50% of the **Maximum Allowable Fee** before **Deductible, Coinsurance**, and **Copaymer** are applied, up to $500 per covered service, for failure to get **Prior Authorization**. This penalty does not apply to **Your Maximun Out-of-Pocket Limit**.

You will be charged a penalty if **You** fail to timely notify **Us** of any **Hospital** admission for an emergency or childbirth. The penalty will equal 50% of **Covered Services** up to a maximum of $250. This penalty does not apply to **Your Maximum Out-of-Pocket Limit**.

Reimbursement Notifications for Out-of-Network Providers

Reimbursement for **Out-of-Network Providers** is limited to **Our Maximum Allowable Fee**, as described in Section 2: General Provisions That Apply to All Benefits of **Your** Certificate. The percentage of the Medicare-allowable fee is 150%. The percentage of the contracted in-network fee is 50%. **You** are responsible for the difference between the **Out-of-Network Provider's** charge and **Our Maximum Allowable Fee**.

Optional Eligibility Provisions that Apply

Expanded Eligibility Options:

Retired Employee Continuation—Limited Duration

Optional Benefit Provisions that Apply

Value Choice Drug Plan
Drug Plan Amendment for Medicare Part D Eligible Individuals

NOTICE: LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED

You should be aware that when you elect to utilize the services of a non-participating provider for a covered service, benefit payments to such non-participating providers are not based upon the amount billed. The basis of your ber payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE, AND COPAYMENT AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill enrollees for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payment for covered services with no additional billing to the enrollee other than copayment, coinsurance, and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling (800) 279-4000 or visiting our website at *weatrust.com*.

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