

A The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit our website at www.weatrust.com or call us at 1-800-279-4000. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-800-279-4000 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$3,000/individual or \$6,000 /family for Network providers. \$6,000/person or \$12,000 family for non-network providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and routine vision exams are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Network providers \$3,000 individual / \$6,000 family; for non-network providers \$9,000 individual / \$18,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, non-network copays, penalties for failure to satisfy preauthorization or hospital admission notification requirements, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.weatrust.com or call 1-800-279-4000 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some

		services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	0% <u>coinsurance</u>	30% <u>coinsurance</u>	_____none_____
	<u>Specialist</u> visit	0% <u>coinsurance</u>	30% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for genetic testing. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Imaging</u> (CT/PET scans, MRIs)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.weaktrust.com	Value Drugs (subset of Tier 1)	\$0 <u>copay</u> .		Covers a 30-day supply (retail subscription); 90 day supply under the Home Delivery Program or from participating pharmacies under the 90-Day Retail Benefit.
	Tier 1 (Most generic, some brand and some over-the-counter drugs)	\$0 <u>copay</u> .		See www.weaktrust.com for list of drugs that are excluded or require <u>preauthorization</u> . Failure to <u>preauthorize</u> may result in <u>claim</u> denial or penalty of 50% up to \$500.
	Tier 2 (Preferred brand and some generic drugs)	\$0 <u>copay</u> .		
	Tier 3 (Non-preferred brand and some generic drugs)	\$0 <u>copay</u> .		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for certain outpatient surgeries. See our website www.weaktrust.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	0% coinsurance	30% coinsurance	for a list of services that require preauthorization. Non-compliance may result in <u>claim denial</u> or penalty of 50% up to \$500. *See Sections 5 & 6.
If you need immediate medical attention	Emergency room care	0% coinsurance		_____none_____
	Emergency medical transportation	0% coinsurance		_____none_____
	Urgent care	0% coinsurance		_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	Preauthorization required for elective or planned hospital stays. Non-compliance may result in <u>claim denial</u> or penalty of 50% up to \$500.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	Notification required for emergency admissions and childbirth. Non-compliance penalty of up to \$250/service may apply. *See Sections 5 & 6.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	30% coinsurance	Preauthorization required for ECT, all partial hospitalization and intensive outpatient services, and all elective or planned inpatient admissions to a hospital or residential treatment facility. See our website www.weaktrust.com for a list of other services that require preauthorization. Non-compliance may result in <u>claim denial</u> or penalty of 50% up to \$500. Notification required for emergency admissions. Non-compliance penalty of up to \$250/service may apply. *See Sections 5 & 6.
	Inpatient services	0% coinsurance	30% coinsurance	
If you are pregnant	Office visits	0% coinsurance	30% coinsurance	Cost-sharing does not apply for <u>Network preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	Notification required. Non-compliance penalty of up to \$250/service may apply.
	Childbirth/delivery facility services	0% coinsurance	30% coinsurance	Notification required. Non-compliance penalty of up to \$250/service may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for all services except evaluations. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Habilitation services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for all services except evaluations. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 days per confinement. <u>Preauthorization</u> required. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for certain <u>DME</u> services. See our website www.weatrust.com for a list of services that require <u>preauthorization</u> . Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500. *See Sections 5 & 6.
If your child needs dental or eye care	<u>Hospice services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	_____none_____
	Children's eye exam	No Charge	No Charge	Limited to one exam per Benefit Period.
	Children's glasses	Not covered	Not covered	<u>Excluded service</u>
	Children's dental check-up	Not covered	Not covered	<u>Excluded service</u>

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u>.)	
• Acupuncture • Bariatric Surgery • Children's glasses • Children's Dental Check-up	• Cosmetic Surgery • Dental Care (Adult) • Infertility Treatment • Long-Term Care • Non-emergency care when traveling outside the U.S.
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Chiropractic Care	• Hearing Aids • Routine Eye Care (Adult), limited to one eye exam each Benefit Period

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or oci.wi.gov; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the WEA Insurance Corporation at 1-800-279-4000 or www.weatrust.com; the Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or oci.wi.gov; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of Network pre-natal care and a hospital delivery)

- The plan's overall deductible \$3,000
- Specialist copay \$0
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,731
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$3,000
- Specialist copay \$0
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,389
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$998
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$221
The total Joe would pay is	\$1,220

Mia's Simple Fracture
(Network emergency room visit and follow up care)

- The plan's overall deductible \$3,000
- Specialist copay \$0
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,925
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,925
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,925

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit our website at www.weatrust.com or call us at 1-800-279-4000. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other undefined terms see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-800-279-4000 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$3,000/individual or \$6,000 /family for Network providers. \$6,000/person or \$12,000 family for non-network providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and routine vision exams are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Network providers \$3,000 individual / \$6,000 family; for non-network providers \$8,000 individual / \$16,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, non-network copays, penalties for failure to satisfy preauthorization or hospital admission notification requirements, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.weatrust.com or call 1-800-279-4000 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some

			services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.		You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	0% <u>coinsurance</u>	20% <u>coinsurance</u>	_____none_____ You may have to pay for services that aren't <u>preventive</u>. Ask your <u>provider</u> if the services you need are <u>preventive</u>. Then check what your <u>plan</u> will pay.
	Specialist visit	0% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Preventive</u> care/ <u>screening</u> /immunization	No charge	20% <u>coinsurance</u>	
If you have a test	<u>Diagnostic</u> test (x-ray, blood work)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Preauthorization required for genetic testing. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Preauthorization required. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.wwatrust.com	Value Drugs (subset of Tier 1)	\$0 <u>copay</u> .		Covers a 30-day supply (retail subscription); 90 day supply under the Home Delivery Program or from participating pharmacies under the 90-Day Retail Benefit. See www.wwatrust.com for list of drugs that are excluded or require <u>preauthorization</u>. Failure to <u>preauthorize</u> may result in <u>claim</u> denial or penalty of 50% up to \$500.
	Tier 1 (Most generic, some brand and some over-the-counter drugs)	\$0 <u>copay</u> .		
	Tier 2 (Preferred brand and some generic drugs)	\$0 <u>copay</u> .		
	Tier 3 (Non-preferred brand and some generic drugs)	\$0 <u>copay</u> .		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Preauthorization required for certain outpatient surgeries. See our website www.wwatrust.com

* For more information about limitations and exceptions, see the plan or policy document at www.wwatrust.com.

Boyceville Community School District (\$3,000-\$6,000 Trust Preferred) #32240

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	0% coinsurance	20% coinsurance	for a list of services that require preauthorization. Non-compliance may result in claim denial or penalty of 50% up to \$500. *See Sections 5 & 6.
If you need immediate medical attention	Emergency room care	0% coinsurance		_____none_____
	Emergency medical transportation	0% coinsurance		_____none_____
	Urgent care	0% coinsurance		_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Preauthorization required for elective or planned hospital stays. Non-compliance may result in claim denial or penalty of 50% up to \$500.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	Notification required for emergency admissions and childbirth. Non-compliance penalty of up to \$250/service may apply. *See Sections 5 & 6.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	20% coinsurance	Preauthorization required for ECT, all partial hospitalization and intensive outpatient services, and all elective or planned inpatient admissions to a hospital or residential treatment facility. See our website www.weatrust.com for a list of other services that require preauthorization. Non-compliance may result in claim denial or penalty of 50% up to \$500. Notification required for emergency admissions. Non-compliance penalty of up to \$250/service may apply. *See Sections 5 & 6.
	Inpatient services	0% coinsurance	20% coinsurance	
If you are pregnant	Office visits	0% coinsurance	20% coinsurance	Cost-sharing does not apply for <u>Network preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	Notification required. Non-compliance penalty of up to \$250/service may apply.
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	Notification required. Non-compliance penalty of up to \$250/service may apply.

* For more information about limitations and exceptions, see the plan or policy document at www.weatrust.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required for all services except evaluations. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Habilitation services</u>	0% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required for all services except evaluations. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 60 days per confinement. <u>Preauthorization</u> required. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required for certain DME services. See our website www.hearttrust.com for a list of services that require <u>preauthorization</u> . Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500. *See Sections 5 & 6.
	<u>Hospice services</u>	0% <u>coinsurance</u>	20% <u>coinsurance</u>	_____none_____
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Limited to one exam per Benefit Period.
	Children's glasses	Not covered	Not covered	<u>Excluded service</u>
	Children's dental check-up	Not covered	Not covered	<u>Excluded service</u>

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Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)	
• Acupuncture • Bariatric Surgery • Children's glasses • Children's Dental Check-up	• Cosmetic Surgery • Dental Care (Adult) • Infertility Treatment • Long-Term Care • Non-emergency care when traveling outside the U.S.
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Chiropractic Care	• Hearing Aids • Routine Eye Care (Adult), limited to one eye exam each Benefit Period

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or oci.wi.gov; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the WEA Insurance Corporation at 1-800-279-4000 or www.weatrust.com; the Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or oci.wi.gov; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of Network pre-natal care and a hospital delivery)

- The plan's overall deductible **\$3,000**
- Specialist copay **\$0**
- Hospital (facility) coinsurance **0%**
- Other coinsurance **0%**

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,731
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible **\$3,000**
- Specialist copay **\$0**
- Hospital (facility) coinsurance **0%**
- Other coinsurance **0%**

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,389
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$998
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$221
The total Joe would pay is	\$1,220

Mia's Simple Fracture

(Network emergency room visit and follow up care)

- The plan's overall deductible **\$3,000**
- Specialist copay **\$0**
- Hospital (facility) coinsurance **0%**
- Other coinsurance **0%**

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,925
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,925
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,925

The plan would be responsible for the other costs of these EXAMPLE covered services.

A The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.** This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit our website at www.weatrust.com or call us at 1-800-279-4000. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-800-279-4000 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$6,550/individual or \$13,100 /family for Network providers. \$13,100/person or \$26,200 family for non-network providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and routine vision exams are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Network providers \$6,550 individual / \$13,100 family; for non-network providers \$15,000 individual / \$30,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, non-network copays, penalties for failure to satisfy preauthorization or hospital admission notification requirements, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.weatrust.com or call 1-800-279-4000 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some

		services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	0% <u>coinsurance</u>	30% <u>coinsurance</u>	_____none_____
	<u>Specialist</u> visit	0% <u>coinsurance</u>	30% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for genetic testing. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Imaging</u> (CT/PET scans, MRIs)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.weatrust.com	Value Drugs (subset of Tier 1)	\$0 <u>copay</u> .		Covers a 30-day supply (retail subscription); 90 day supply under the Home Delivery Program or from participating pharmacies under the 90-Day Retail Benefit. See www.weatrust.com for list of drugs that are excluded or require <u>preauthorization</u> . Failure to <u>preauthorize</u> may result in <u>claim</u> denial or penalty of 50% up to \$500.
	Tier 1 (Most generic, some brand and some over-the-counter drugs)	\$0 <u>copay</u> .		
	Tier 2 (Preferred brand and some generic drugs)	\$0 <u>copay</u> .		
	Tier 3 (Non-preferred brand and some generic drugs)	\$0 <u>copay</u> .		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for certain outpatient surgeries. See our website www.weatrust.com

* For more information about limitations and exceptions, see the plan or policy document at www.weatrust.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	0% coinsurance	30% coinsurance	for a list of services that require preauthorization. Non-compliance may result in <u>claim denial</u> or penalty of 50% up to \$500. *See Sections 5 & 6.
If you need immediate medical attention	Emergency room care	0% coinsurance		_____none_____
	Emergency medical transportation	0% coinsurance		_____none_____
	Urgent care	0% coinsurance		_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	Preauthorization required for elective or planned hospital stays. Non-compliance may result in <u>claim denial</u> or penalty of 50% up to \$500.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	Notification required for emergency admissions and childbirth. Non-compliance penalty of up to \$250/service may apply. *See Sections 5 & 6.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	30% coinsurance	Preauthorization required for ECT, all partial hospitalization and intensive outpatient services, and all elective or planned inpatient admissions to a hospital or residential treatment facility. See our website www.weatrust.com for a list of other services that require preauthorization. Non-compliance may result in <u>claim denial</u> or penalty of 50% up to \$500. Notification required for emergency admissions. Non-compliance penalty of up to \$250/service may apply. *See Sections 5 & 6.
	Inpatient services	0% coinsurance	30% coinsurance	
If you are pregnant	Office visits	0% coinsurance	30% coinsurance	Cost-sharing does not apply for <u>Network preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	Notification required. Non-compliance penalty of up to \$250/service may apply.
	Childbirth/delivery facility services	0% coinsurance	30% coinsurance	Notification required. Non-compliance penalty of up to \$250/service may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for all services except evaluations. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Habilitation services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for all services except evaluations. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 days per confinement. <u>Preauthorization</u> required. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for certain <u>DME</u> services. See our website www.weatrust.com for a list of services that require <u>preauthorization</u> . Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500. *See Sections 5 & 6.
	<u>Hospice services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	_____none_____
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Limited to one exam per Benefit Period.
	Children's glasses	Not covered	Not covered	<u>Excluded service</u>
	Children's dental check-up	Not covered	Not covered	<u>Excluded service</u>

* For more information about limitations and exceptions, see the plan or policy document at www.weatrust.com.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)	
• Acupuncture • Bariatric Surgery • Children's glasses • Children's Dental Check-up	• Cosmetic Surgery • Dental Care (Adult) • Infertility Treatment • Long-Term Care • Non-emergency care when traveling outside the U.S. • Private Duty Nursing • Routine Foot Care • Weight Loss Programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Chiropractic Care	• Hearing Aids • Routine Eye Care (Adult), limited to one eye exam each Benefit Period

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or oci.wi.gov; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the WEA Insurance Corporation at 1-800-279-4000 or www.weatrust.com; the Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or oci.wi.gov; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of Network pre-natal care and a hospital delivery)

- The plan's overall deductible \$6,550
- Specialist copay \$0
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,731
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$6,550
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,610

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$6,550
- Specialist copay \$0
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	\$7,389
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$998
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$221
The total Joe would pay is	\$1,220

Mia's Simple Fracture
(Network emergency room visit and follow up care)

- The plan's overall deductible \$6,550
- Specialist copay \$0
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	\$1,925
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,925
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,925

A The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit our website at www.weatrust.com or call us at 1-800-279-4000. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other undefined terms see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-800-279-4000 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$6,550/individual or \$13,100 /family for Network providers. \$13,100/person or \$26,200 family for non-network providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and routine vision exams are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Network providers \$6,550 individual / \$13,100 family; for non-network providers \$15,000 individual / \$30,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, non-network copays, penalties for failure to satisfy preauthorization or hospital admission notification requirements, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.weatrust.com or call 1-800-279-4000 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some

			services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a specialist?	No.		You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% <u>coinsurance</u>	20% <u>coinsurance</u>	_____none_____
	Specialist visit	0% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Preventive care/screening/immunization	No charge	20% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay.
If you have a test	Diagnostic test (x-ray, blood work)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Preauthorization required for genetic testing. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Preauthorization required. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.wwatrust.com	Value Drugs (subset of Tier 1)	\$0 <u>copay</u> .		Covers a 30-day supply (retail subscription); 90 day supply under the Home Delivery Program or from participating pharmacies under the 90-Day Retail Benefit.
	Tier 1 (Most generic, some brand and some over-the-counter drugs)	\$0 <u>copay</u> .		See www.wwatrust.com for list of drugs that are excluded or require <u>preauthorization</u> . Failure to <u>preauthorize</u> may result in <u>claim</u> denial or penalty of 50% up to \$500.
	Tier 2 (Preferred brand and some generic drugs)	\$0 <u>copay</u> .		
	Tier 3 (Non-preferred brand and some generic drugs)	\$0 <u>copay</u> .		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Preauthorization required for certain outpatient surgeries. See our website www.wwatrust.com

* For more information about limitations and exceptions, see the plan or policy document at www.wwatrust.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	0% coinsurance	20% coinsurance	for a list of services that require preauthorization. Non-compliance may result in <u>claim denial</u> or penalty of 50% up to \$500. *See Sections 5 & 6.
If you need immediate medical attention	Emergency room care	0% coinsurance		_____none_____
	Emergency medical transportation	0% coinsurance		_____none_____
	Urgent care	0% coinsurance		_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Preauthorization required for elective or planned hospital stays. Non-compliance may result in claim denial or penalty of 50% up to \$500.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	Notification required for emergency admissions and childbirth. Non-compliance penalty of up to \$250/service may apply. *See Sections 5 & 6.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	20% coinsurance	Preauthorization required for ECT, all partial hospitalization and intensive outpatient services, and all elective or planned inpatient admissions to a hospital or residential treatment facility. See our website www.weatrust.com for a list of other services that require preauthorization. Non-compliance may result in <u>claim denial</u> or penalty of 50% up to \$500. Notification required for emergency admissions. Non-compliance penalty of up to \$250/service may apply. *See Sections 5 & 6.
	Inpatient services	0% coinsurance	20% coinsurance	
If you are pregnant	Office visits	0% coinsurance	20% coinsurance	Cost-sharing does not apply for <u>Network preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	Notification required. Non-compliance penalty of up to \$250/service may apply.
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	Notification required. Non-compliance penalty of up to \$250/service may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required for all services except evaluations. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Habilitation services</u>	0% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required for all services except evaluations. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 60 days per confinement. <u>Preauthorization</u> required. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required for certain <u>DME</u> services. See our website www.weatrust.com for a list of services that require <u>preauthorization</u> . Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500. *See Sections 5 & 6.
If your child needs dental or eye care	<u>Hospice services</u>	0% <u>coinsurance</u>	20% <u>coinsurance</u>	_____none_____
	Children's eye exam	No Charge	No Charge	Limited to one exam per Benefit Period.
	Children's glasses	Not covered	Not covered	<u>Excluded service</u>
	Children's dental check-up	Not covered	Not covered	<u>Excluded service</u>

* For more information about limitations and exceptions, see the plan or policy document at www.weatrust.com.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)	
• Acupuncture • Bariatric Surgery • Children's glasses • Children's Dental Check-up	• Cosmetic Surgery • Dental Care (Adult) • Infertility Treatment • Long-Term Care • Non-emergency care when traveling outside the U.S.
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Chiropractic Care	• Hearing Aids • Routine Eye Care (Adult), limited to one eye exam each Benefit Period

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or oci.wi.gov; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the WEA Insurance Corporation at 1-800-279-4000 or www.weatrust.com; the Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or oci.wi.gov; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.weatrust.com.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of Network pre-natal care and a hospital delivery)

- The plan's overall deductible \$6,550
- Specialist copay \$0
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,731
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$6,550
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,610

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$6,550
- Specialist copay \$0
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,389
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$998
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$221
The total Joe would pay is	\$1,220

Mia's Simple Fracture

(Network emergency room visit and follow up care)

- The plan's overall deductible \$6,550
- Specialist copay \$0
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,925
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,925
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,925

The plan would be responsible for the other costs of these EXAMPLE covered services.