Preferred Provider Plan Essential Qualified

DURAND-ARKANSAW SCHOOL DISTRICT
Group No.: *30203*

Group Health Benefit Summary

This Benefit Summary provides important information about reimbursement rules that apply to your health insurance benefits. It also identifies what Optional Eligibility and Optional Benefit Provisions, if any, apply to your coverage. Many of the terms used below are explained in Section 4 of your Certificate of Coverage (Certificate). Your Certificate describes your benefits and the exclusions and limitations that apply to them. We encourage you to keep it handy for your reference.

Group Effective Date: *07/01/2017* **Benefit Period**: *January* through *December*
Network: *Trust Preferred*

Basic Reimbursement Factors of Your Health Plan

All Covered Health Care Services	Services Received from Network Providers	Services Received from Non-Network Providers
Deductible You Pay (Embedded)	$3,000 individual/$6,000 family	$6,000 individual/$12,000 family
Coinsurance You Pay	0%	20%
Maximum Out-of-Pocket Limit ([Embedded][Non-Embedded]) Maximum amount of deductible, coinsurance, and Network copayments you are required to pay under this plan.	$3,000 individual/$6,000 family	$8,000 individual/$16,000 family

To qualify as a health savings account (HSA) qualified high deductible health plan, the deductible amounts must be equal to or greater than the lowest amounts allowed by the Internal Revenue Service (IRS). The deductible amounts and maximum out-of-pocket limits will be adjusted each year, at the beginning of the Benefit Period, to reflect the updated amounts published by the IRS that became effective on January 1 of that year. If a group fails to adopt the new minimum deductible amounts, the plan will no longer be HSA-qualified.

The Network and Non-Network maximum out-of-pocket limits accumulate separately and are not transferrable. There is one exception: Deductible, coinsurance, and copayment amounts you pay for prescription drugs, whether you obtain the drugs from a participating or non-participating pharmacy, are applied to the Network deductible and maximum out-of-pocket limit.

If you believe the services you require are not available from a 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 a Network provider maximizes your benefits. You can find a Network provider by clicking on Find a Doctor at weatrust.com. If you go to a provider outside this Network, you will likely have higher out-of-pocket costs. For more information, please see Reimbursement Notifications for Non-Network Providers below and view your Certificate at weatrust.com.

Prescription Drug Reimbursement Information (After Deductible Has Been Met)

	Value Drugs	Tier 1	Tier 2	Tier 3
Cost-Sharing Per Prescription Fill	$0	$0	$0	$0

As required by 2013 Wisconsin Act 186, copayments for oral chemotherapy medication will not exceed $100 per 30-day supply.

Reimbursement Information for Preventive Services

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

The Trust covers 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 a Network provider, your services are not subject to a deductible, coinsurance, or copayment. When you seek recommended preventive services from a Non-Network provider, your services are subject to deductible, coinsurance, and/or copayment. For colorectal cancer screening, the Trust follows the guidelines issued by the U.S. Preventive Services Task Force.

Reimbursement Information for Other Covered Services (After Applicable Deductible Has Been Met)

Other Covered Services	Member Pays for Services Received from Network Providers	Member Pays for Services Received from Non-Network Providers
Physician Services		
Primary Care Office Visits	0%	20%
Specialty Care Office Visits	0%	20%
Urgent Care	0%	0%
Convenient Care Clinic Services	0%	20%
E-visits	0%	100%
Routine Maternity Care	0%	20%
Laboratory and Radiology	0%	20%
Specialty Drugs (including injections)	0%	20%
Inpatient Services	0%	20%
Outpatient Services	0%	20%
Inpatient Facility Services		
Hospitalization	0%	20%
Surgery, Anesthesia, and Related Supplies	0%	20%
Maternity and Newborn Services	0%	20%
Advanced Imaging and Laboratory Services	0%	20%
Mental Health and Substance Abuse Services	0%	20%
Skilled Nursing Facility (limited to 30 days per confinement)	0%	20%
Skilled Rehabilitation Facility (limited to 60 days per Benefit Period)	0%	20%
Outpatient Facility Services		
Surgery and Related Services	0%	20%
Non-Emergency Advanced Imaging	0%	20%
Other Diagnostic Tests	0%	20%
Emergency Room (exceptions may apply, so please see your Certificate)	0%	0%

Reimbursement Information for Other Covered Services (After Applicable Deductible Has Been Met) (*continued*)

Other Covered Services	Member Pays for Services Received from Network Providers	Member Pays for Services Received from Non-Network Providers
Other Services		
Aural Therapy (limited to 30 visits per Benefit Period)	0%	20%
Cardiac Rehabilitation (limited to 36 visits per Benefit Period)	0%	20%
Chiropractic Treatment	0%	20%
Congenital Heart Disease Surgery (Non-Network services are limited to $35,000 per Benefit Period)	0%	20%
Dental Services	0%	20%
Durable Medical Equipment (DME) and Supplies	0%	20%
Extraction/Replacement of Natural Teeth	No Coverage	No Coverage
Hearing Aids	0%	20%
Home Health Care (limited to 60 visits per Benefit Period)	0%	20%
Hospice Care	0%	20%
Kidney Disease Treatment	0%	20%
Outpatient Mental Health and Substance Abuse Services	0%	20%
Pulmonary Rehabilitation (limited to 20 visits per Benefit Period)	0%	20%
Temporomandibular Disorder (TMD) Treatment	0%	20%
Therapy – Physical, Speech, and Occupational (limited to 20 visits per type of service per Benefit Period)	0%	20%
Transplants (Non-Network services are limited to $35,000 per Benefit Period)	0%	20%
Vision Exam (limited to one routine vision exam per Benefit Period) (Deductible does not apply)	0%	0%
Vision – Non-Routine Services	0%	20%

Preauthorization – Certain services require preauthorization. You will find a list of the services that require preauthorization on our website at weatrust.com. We will impose a penalty of 50% of the maximum allowable fee before deductible, coinsurance, and copayments are applied, up to $500 per covered service, for failure to preauthorize. This penalty does not apply to your maximum out-of-pocket limit.

Penalty for Failure to Timely Notify Us of Any Hospital Admission for Emergency or Childbirth – 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 Non-Network Providers

Reimbursement for Non-Network providers is limited to our maximum allowable fee, as described in Section 4 of your Certificate. The percentage of the Medicare-allowable fee is 150%. The percentage of the contracted Network fee is 50%. You are responsible for the difference between the Non-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

Enhanced Vision Examination Benefit

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 benefit 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 the Trust's web site at weatrust.com.

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