Preferred Provider Plan Essential Qualified

SHELL LAKE SCHOOL DISTRICT
Group No.: 30667

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) 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 (limited to $1,500 per Benefit Period)	0%	20%
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
Disabled Employee Continuation—Limited Duration

Waiver of Premium Benefit

Optional Benefit Provisions that Apply

Extraction/Replacement of Natural Teeth
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.

Underwritten by WEA Insurance Corporation
P.O. Box 7338, Madison, WI 53707 Voice/TTY: (608) 276-4000 or (800) 279-4000
weatrust.com

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.cciio.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 provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

⚠ 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% coinsurance	20% coinsurance	——————none——————
	Specialist visit	0% coinsurance	20% coinsurance	
	Preventive care/screening/ immunization	No charge	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	20% coinsurance	Preauthorization required for genetic testing. Non-compliance may result in claim denial or penalty of 50% up to $500.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	Preauthorization required. Non-compliance may result in claim 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.www.weatrust.com	Value Drugs (subset of Tier 1)	$0 copay.		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 preauthorization. Failure to preauthorize may result in claim denial or penalty of 50% up to $500.
	Tier 1 (Most generic, some brand and some over-the-counter drugs)	$0 copay.		
	Tier 2 (Preferred brand and some generic drugs)	$0 copay.		
	Tier 3 (Non-preferred brand and some generic drugs)	$0 copay.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	Preauthorization 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	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. Notification required for emergency admissions and childbirth. Non-compliance penalty of up to $250/service may apply. *See Sections 5 & 6.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	
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 Network preventive services. 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	Home health care	0% coinsurance	20% coinsurance	Limited to 60 visits/Benefit Period. Preauthorization required. Non-compliance may result in claim denial or penalty of 50% up to $500.
	Rehabilitation services	0% coinsurance	20% coinsurance	Physical, occupational, speech therapy - Limited to 20 visits/Benefit Period Period for each. Preauthorization required for all services except evaluations. Non-compliance may result in claim denial or penalty of 50% up to $500. Cardiac rehab – 36 visits/Benefit Period Pulmonary rehab – 20 visits/Benefit Period Skilled Rehab Facility – 60 visits/Benefit Period.
	Habilitation services	0% coinsurance	20% coinsurance	Physical, occupational, speech therapy - Limited to 20 visits/Benefit Period Period for each. Preauthorization required for all services except evaluations. Non-compliance may result in claim denial or penalty of 50% up to $500.
	Skilled nursing care	0% coinsurance	20% coinsurance	Limited to 30 days per confinement. Preauthorization required. Non-compliance may result in claim denial or penalty of 50% up to $500.
	Durable medical equipment	0% coinsurance	20% coinsurance	Preauthorization required for certain DME services. See our website www.weatrust.com 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.
	Hospice services	0% coinsurance	20% coinsurance	————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	Excluded service
	Children's dental check-up	Not covered	Not covered	Excluded service

* 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	• Cosmetic Surgery	• Private Duty Nursing
• Bariatric Surgery	• Dental Care (Adult)	• Routine Foot Care
• Children's glasses	• Infertility Treatment	• Weight Loss Programs
• Children's Dental Check-up	• 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.

* 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	$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**

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**

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**

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.