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?	**$2,000**/individual or $**4,000** /family for Network providers. **$4,000**/person or **$8,000** 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. The following services are covered before you meet your deductible: prescription drugs; e-visits and convenience care clinic services when performed by a Network provider; and preventive care.	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 **$6,000** individual / **$12,000** family. Pharmacy cost-sharing applies to a separate out-of-pocket limit of **$2,000** individual / **$4,000** 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	$10 copay/visit	$25 copay/visit then 20% coinsurance	——————none——————
	Specialist visit	$10 copay/visit	$25 copay/visit then 20% coinsurance	
	Preventive care/screening/ immunization	No Charge	$25 copay/visit then 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 copay/test	$0 copay/test then 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)	No Charge		Covers 30-day supply for retail purchase. 90-day Home Delivery may only be subject to two copayments instead of three. 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. Cost-sharing applies to a separate maximum out-of-pocket limit.
	Tier 1 (Most generic, some brand and some over-the-counter drugs)	$5 copay. Deductible does not apply.		
	Tier 2 (Preferred brand and some generic drugs)	$20 copay. Deductible does not apply.		
	Tier 3 (Non-preferred brand and some generic drugs)	$40 copay. Deductible does not apply.		

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

	Tier 4 (Specialty Drugs)	NA Covered specialty drugs are placed in one of the above tiers as indicated on our website, www.weatrust.com.		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. Cost-sharing applies to a separate maximum out-of-pocket limit.
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 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.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay/visit		Copay waived if admitted as inpatient for at least 24 hours.
	Emergency medical transportation	0% coinsurance		——————none——————
	Urgent care	$25 copay/visit		——————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	$10 copay/visit	$25 copay/visit then 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

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

				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.
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	$10 copay for physical, occupational, and speech therapy 0% coinsurance for cardiac and pulmonary rehab.	$25 copay/visit then 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	$10 copay	$25 copay then 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————————

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

If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Excluded service
	Children's glasses	Not Covered	Not Covered	Excluded service
	Children's dental check-up	Not Covered	Not Covered	Excluded service

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 Eye Exam
- 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 Eye Care (Adult)
- 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

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.

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	**$2,000**
Specialist copay	**$10**
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	$2,000
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,080**

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

The plan's overall deductible	**$2,000**
Specialist copay	**$10**
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	**$7,554**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$918
Copayments	$510
Coinsurance	$0
What isn't covered	
Limits or exclusions	$221
The total Joe would pay is	**$1,650**

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

The plan's overall deductible	**$2,000**
Specialist copay	**$10**
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	$1,715
Copayments	$210
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.