Preferred Provider Plan Essential Health

SUPERIOR SCHOOL DISTRICT
Group No.: *32325*

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**: *July* through *June*
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	$750 individual/$1,500 family	$1,500 individual/$3,000 family
Coinsurance You Pay	20%	40%
Maximum Out-of-Pocket Maximum amount of deductible, coinsurance, and Network copayments, including pharmacy cost-sharing, you are required to pay under this plan.	$3,500 individual/$7,000 family	$5,000 individual/$10,000 family

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

	Value Drugs	Tier 1	Tier 2	Tier 3
Cost-Sharing Per Prescription Fill	$0	$10	$40	$80

Prescription drugs covered under this drug plan are not subject to a deductible. 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%	Deductible, then 40%
Tobacco Cessation Screening and Brief Interventions	0%	Deductible, then 40%
Other Preventive Services Including Immunizations, Screenings, and Certain Counseling Services (see **weatrust.com** Members section for details)	0%	Deductible, then 40%

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

Other Covered Services	Member Pays for Services Received from Network Providers	Member Pays for Services Received from Non-Network Providers
Physician/Practitioner Services		
Primary Care Office Visits*	Deductible, then 20%	Deductible, then 40%
Specialty Care Office Visits*	Deductible, then 20%	Deductible, then 40%
Urgent Care	Deductible, then 20%	Deductible, then 20%
Convenient Care Clinic Services*	$0 Copay	Deductible, then 40%
E-visits	$0 Copay	100%
Routine Maternity Care	Deductible, then 20%	Deductible, then 40%
Laboratory and Radiology	Deductible, then 20%	Deductible, then 40%
Specialty Drugs (including injections)	Deductible, then 20%	Deductible, then 40%
Inpatient Services	Deductible, then 20%	Deductible, then 40%
Outpatient Services	Deductible, then 20%	Deductible, then 40%
Inpatient Facility Services		
Hospitalization	Deductible then 20%	Deductible, then 40%
Surgery, Anesthesia, and Related Supplies	Deductible, then 20%	Deductible, then 40%
Maternity and Newborn Services	Deductible, then 20%	Deductible, then 40%
Advanced Imaging and Laboratory Services	Deductible, then 20%	Deductible, then 40%
Mental Health and Substance Abuse Services	Deductible, then 20%	Deductible, then 40%
Skilled Nursing Facility (limited to 30 days per confinement)	Deductible, then 20%	Deductible, then 40%
Skilled Rehabilitation Facility (limited to 60 days per Benefit Period)	Deductible, then 20%	Deductible, then 40%
Outpatient Facility Services		
Surgery and Related Services	Deductible, then 20%	Deductible, then 40%
Non-Emergency Advanced Imaging	Deductible, then 20%	Deductible, then 40%
Other Diagnostic Tests	Deductible, then 20%	Deductible, then 40%
Emergency Room (exceptions may apply, so please see your Certificate)	Deductible, then 20%	Deductible, then 20%

*Office visit copayments are waived for members under 6 years of age.

Reimbursement Information for Other Covered Services (*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)	Deductible, then 20%	Deductible, then 40%
Cardiac Rehabilitation (limited to 36 visits per Benefit Period)	Deductible, then 20%	Deductible, then 40%
Chiropractic Treatment*	Deductible, then 20%	Deductible, then 40%
Congenital Heart Disease Surgery (Non-Network services are limited to $35,000 per Benefit Period)	Deductible, then 20%	Deductible, then 40%
Dental Services	Deductible, then 20%	Deductible, then 40%
Durable Medical Equipment (DME) and Supplies	Deductible, then 20%	Deductible, then 40%
Extraction/Replacement of Natural Teeth	No Coverage	No Coverage
Hearing Aids	Deductible, then 20%	Deductible, then 40%
Home Health Care (limited to 60 visits per Benefit Period)	Deductible, then 20%	Deductible, then 40%
Hospice Care	Deductible, then 20%	Deductible, then 40%
Kidney Disease Treatment	Deductible, then 20%	Deductible, then 40%
Outpatient Mental Health and Substance Abuse Services *	Deductible, then 20%	Deductible, then 40%
Pulmonary Rehabilitation (limited to 20 visits per Benefit Period)	Deductible, then 20%	Deductible, then 40%
Temporomandibular Disorder (TMD) Treatment	Deductible, then 20%	Deductible, then 40%
Therapy – Physical, Speech, and Occupational* (limited to 20 visits per type of service per Benefit Period)	Deductible, then 20%	Deductible, then 40%
Transplants (Non-Network services are limited to $35,000,per Benefit Period)	Deductible, then 20%	Deductible, then 40%
Vision Exam (limited to one routine vision exam per Benefit Period)	0%	0%
Vision – Non-Routine Services	Deductible, then 20%	Deductible, then 40%

*Office visit copayments are waived for members less than 6 years of age.

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 an 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
- Surviving Dependent Continuation—Limited Duration

Optional Benefit Provisions that Apply

Value Choice Drug Plan
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