School District of Whitefish Bay

Medical Summary for 7/1/17		
Benefit Summary	**Network Benefit**	**Non-Network Benefit**
Deductible		
Single Deductible	$250	$500
Family Deductible	$500	$1,000
Coinsurance		
Coinsurance	10%	30%
Out-of-Pocket *(Includes Deductible)*		
Single	$875	$2,375
Family	$1,750	$4,750
Office Visits		
General	$10 then 10% coinsurance	$25 then 30% coinsurance
Specialist	$10 then 10% coinsurance	$25 then 30% coinsurance
Preventive Care		
Preventive Care Services	100%	$25 / 70%
Routine Exams	100%	$25 / 70%
Immunizations	100%	$25 / 70%
Inpatient		
Hospital Services	Deductible / Coinsurance	Deductible / Coinsurance
Outpatient		
Hospital Services	Deductible / Coinsurance	Deductible / Coinsurance
Emergency Room		
ER Services	$200 then 10% coinsurance	$200 then 10% coinsurance
Urgent Care		
UC Services	$75 then 10% coinsurance	$75 then 10% coinsurance
Prescription Drugs (Retail)		
Generic (Tier 1)	$10	N/A
Formulary (Tier 2)	$25	N/A
Non-Formulary (Tier 3)	$50	N/A
Specialtiy (Tier 4)	10%	30%

Preferred Provider Plan Essential Health

WHITEFISH BAY SCHOOL DISTRICT
Group No.: 30783

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*
Network: *Trust Preferred*

Benefit Period: *July* through *June*

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	$250 individual/$500 family	$500 individual/$1,000 family
Coinsurance You Pay	10%	30%
Maximum Out-of-Pocket Maximum amount of deductible, coinsurance, and Network copayments, including pharmacy cost-sharing, you are required to pay under this plan.	$875 individual/$1,750 family	$2,375 individual/$4,750 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	$25	$50

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 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 10%	Deductible, then 30%
Cardiac Rehabilitation	Deductible, then 10%	Deductible, then 30%
Chiropractic Treatment*	$10 Copay, Deductible, then 10%	$25 Copay, Deductible, then 30%
Congenital Heart Disease Surgery (Non-Network services are limited to $35,000 per Benefit Period)	Deductible, then 10%	Deductible, then 30%
Dental Services	Deductible, then 10%	Deductible, then 30%
Durable Medical Equipment (DME) and Supplies	Deductible, then 10%	Deductible, then 30%
Extraction/Replacement of Natural Teeth (limited to $1,500 per Benefit Period)	Deductible, then 10%	Deductible, then 30%
Hearing Aids	Deductible, then 10%	Deductible, then 30%
Home Health Care	Deductible, then 10%	Deductible, then 30%
Hospice Care	Deductible, then 10%	Deductible, then 30%
Kidney Disease Treatment	Deductible, then 10%	Deductible, then 30%
Outpatient Mental Health and Substance Abuse Services *	$10 Copay, Deductible, then 10%	$25 Copay, Deductible, then 30%
Pulmonary Rehabilitation	Deductible, then 10%	Deductible, then 30%
Temporomandibular Disorder (TMD) Treatment	Deductible, then 10%	Deductible, then 30%
Therapy – Physical, Speech, and Occupational*	$10 Copay, Deductible, then 10%	$25 Copay, Deductible, then 30%
Transplants (Non-Network services are limited to $35,000,per Benefit Period)	Deductible, then 10%	Deductible, then 30%
Vision Exam	No Coverage	No Coverage
Vision – Non-Routine Services	Deductible, then 10%	Deductible, then 30%

*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.