Preferred Provider Plan Essential Health

The School District of North Fond du Lac
Group No.: 30503

Group Health Benefit Summary

This Benefit Summary provides important information about reimbursement rules that apply to your health plan 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. You may view your Certificate and any applicable amendments on our website, weatrust.com. If you prefer to receive a paper copy, please call our customer service department. We encourage you to keep your Benefits Summary and Certificate handy for your reference.

Group Effective Date: 01/01/2020 **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	$2,000 individual/ $4,000 family	$4,000 individual/ $8,000 family
Coinsurance You Pay	0%	20%
Maximum Out-of-Pocket Limit Maximum amount of deductible, coinsurance, and Network copayments you are required to pay under this plan.	$4,850 individual/ $9,700 family	$6,000 individual/ $12,000 family
Maximum Out-of-Pocket Limit for Prescription Drug Cost-Sharing	$2,000 individual/ $4,000 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 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%	$50 Copay, Deductible, then 20%
Tobacco Cessation Screening and Brief Interventions	0%	Deductible, then 20%
Other Preventive Services Including Immunizations, Screenings, and Certain Counseling Services (see **weatrust.com** Members section for details)	0%	Deductible, then 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

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*	$25 Copay, Deductible, then 0%	$50 Copay, Deductible, then 20%
Specialty Care Office Visits*	$50 Copay, Deductible, then 0%	$100 Copay, Deductible, then 20%
Urgent Care	$75 Copay, Deductible, then 0%	$75 Copay, Deductible, then 0%
Convenient Care Clinic Services*	$0 Copay	$50 Copay, Deductible, then 20%
E-visits	$0 Copay	100%
Maternity Care	Deductible, then 0%	Deductible, then 20%
Laboratory and Radiology	Deductible, then 0%	Deductible, then 20%
Specialty Drugs (including injections)	Deductible, then 0%	Deductible, then 20%
Inpatient Services	Deductible, then 0%	Deductible, then 20%
Outpatient Services	Deductible, then 0%	Deductible, then 20%
INPATIENT FACILITY SERVICES		
Hospitalization	Deductible, then 0%	Deductible, then 20%
Surgery, Anesthesia, and Related Supplies	Deductible, then 0%	Deductible, then 20%
Maternity and Newborn Services	Deductible, then 0%	Deductible, then 20%
Advanced Imaging and Laboratory Services	Deductible, then 0%	Deductible, then 20%
Mental Health and Substance Abuse Services	Deductible, then 0%	Deductible, then 20%
Skilled Nursing Facility (limited to 30 Days per Confinement)	Deductible, then 0%	Deductible, then 20%
Skilled Rehabilitation Facility (limited to 60 Days per Benefit Period)	Deductible, then 0%	Deductible, then 20%
OUTPATIENT FACILITY SERVICES		
Surgery and Related Services	Deductible, then 0%	Deductible, then 20%
Non-Emergency Advanced Imaging	Deductible, then 0%	Deductible, then 20%
Other Diagnostic Tests	Deductible, then 0%	Deductible, then 20%
Emergency Room (exceptions may apply, so please see your Certificate)	$200 Copay, Deductible, then 0%	$200 Copay, Deductible, then 0%

*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 0%	Deductible, then 20%
Cardiac Rehabilitation (limited to 36 Visits per Benefit Period)	Deductible, then 0%	Deductible, then 20%
Chiropractic Treatment*	$25 Copay, Deductible, then 0%	$50 Copay, Deductible, then 20%
Congenital Heart Disease Surgery (Non-Network services are limited to $35,000 per Benefit Period)	Deductible, then 0%	Deductible, then 20%
Dental Services (Limited Services Only)	Deductible, then 0%	Deductible, then 20%
Durable Medical Equipment (DME) and Supplies	Deductible, then 0%	Deductible, then 20%
Extraction/Replacement of Natural Teeth (limited to $1,500 per Benefit Period)	Deductible, then 0%	Deductible, then 20%
Hearing Aids	Deductible, then 0%	Deductible, then 20%
Home Health Care (limited to 60 Visits per Benefit Period)	Deductible, then 0%	Deductible, then 20%
Hospice Care	Deductible, then 0%	Deductible, then 20%
Kidney Disease Treatment	Deductible, then 0%	Deductible, then 20%
Outpatient Mental Health and Substance Abuse Services*	$25 Copay, Deductible, then 0%	$50 Copay, Deductible, then 20%
Pulmonary Rehabilitation (limited to 20 Visits per Benefit Period)	Deductible, then 0%	Deductible, then 20%
Temporomandibular Disorder (TMD) Treatment	Deductible, then 0%	Deductible, then 20%
Therapy – Physical, Speech, and Occupational* (limited to 20 Visits per Benefit Period)	$25 Copay, Deductible, then 0%	$50 Copay, Deductible, then 20%
Transplants (Non-Network services are limited to $35,000 per Benefit Period)	Deductible, then 0%	Deductible, then 20%
Vision Exam (limited to one routine vision exam per Benefit Period)	0%	0%
Vision – Non-Routine Services	Deductible, then 0%	Deductible, then 20%

*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

Optional Benefit Provisions that Apply

Value Choice Drug Plan
Extraction/Replacement of Teeth
Enhanced Vision Exam 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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