Elkhart Lake-Glenbeulah School District

**WEA Trust** - Health Insurance Exhibit (7/1/2021)

*Medical*

## Single:

| | *Plan 1* | *Plan 2* |
|---|---|---|
| | Per Month | Per Month |
| | $915.40 | $851.50 |
| | x 12 months | x 12 months |
| Total cost per year: | $10,984.80 | $10,218.00 |
| Less District contribution per year for 100% FTE employee: | $9,000.00 | $9,000.00 |
| Employee portion per year for 100% FTE employee: | $1,984.80 | $1,218.00 |
| Monthly cost for 100% FTE employee: | $165.40 | $101.50 |
| Approximate employee deduction per paycheck for 100% FTE: | $82.70 | $50.75 |

## Family:

| | *Plan 1* | *Plan 2* |
|---|---|---|
| | Per Month | Per Month |
| | $2,072.04 | $1,927.30 |
| | x 12 months | x 12 months |
| Total cost per year: | $24,864.48 | $23,127.60 |
| Less district contribution per year for 100% FTE employee: | $20,000.00 | $20,000.00 |
| Employee portion per year for 100% FTE employee: | $4,864.48 | $3,127.60 |
| Monthly cost for 100% FTE employee: | $405.37 | $260.63 |
| Approximate employee deduction per paycheck for 100% FTE: | $202.69 | $130.32 |

Elkhart Lake-Glenbeulah School District

**WEA Trust** - Health Insurance Exhibit (7/1/2020)

Annual Premium + Total Medical Out of Pocket

## *Medical*

### Single:

| | *Plan 1* | *Plan 2* |
|---|---|---|
| | Per Month | Per Month |
| | $915.40 | $851.50 |
| | x 12 months | x 12 months |
| Total cost per year: | $10,984.80 | $10,218.00 |
| Less District contribution per year for 100% FTE employee: | $9,000.00 | $9,000.00 |
| Employee portion per year for 100% FTE employee: | $1,984.80 | $1,218.00 |
| *Maximum Annual Employee Liability for Medical: | $4,000.00 | $4,000.00 |
| ***Total Annual Employee Cost at Maximum Liability:*** | ***$5,984.80*** | ***$5,218.00*** |

### Family:

| | *Plan 1* | *Plan 2* |
|---|---|---|
| | Per Month | Per Month |
| | $2,072.04 | $1,927.30 |
| | x 12 months | x 12 months |
| Total cost per year: | $24,864.48 | $23,127.60 |
| Less district contribution per year for 100% FTE employee: | $20,000.00 | $20,000.00 |
| Employee portion per year for 100% FTE employee: | $4,864.48 | $3,127.60 |
| *Maximum Annual Family Liability for Medical: | $8,000.00 | $8,000.00 |
| ***Total Annual Family Cost at Maximum Liability:*** | ***$12,864.48*** | ***$11,127.60*** |

*Only includes medical out of pocket. Prescription drug expense would be in addition to this amount

# Preferred Provider Plan Essential Health

Jt. School District No. 1 Elkhart Lake
Group No.: 38362

## 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 defined in **Your Certificate** of Coverage (**Certificate**) and explained in Section 2: General Provisions That Apply to All Benefits. **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 Benefit Summary** and **Certificate** handy for **Your** reference.

**Group Effective Date:** 07/01/2021
**Benefit Period:** January through December
**Network:** Trust Preferred

### Basic Reimbursement Factors of Your Health Plan

| All Covered Health Care Services | Services Received from In-Network Providers | Services Received from Out-of-Network Providers |
|---|---|---|
| **Deductible You Pay** | $1,000 single/<br>$2,000 family | $2,000 single/<br>$4,000 family |
| **Coinsurance You Pay** | 0% | 20% |
| **Maximum Out-of-Pocket Limit** Maximum amount of **Deductible**, and **Coinsurance**, and in- network **Copayments You** are required to pay under this Plan. | $4,000 single /<br>$8,000 family | $9,000 single/<br>$18,000 family |
| **Maximum Out-of-Pocket Limit for Prescription Drug Cost-Sharing Amounts** | $4,000 single / $8,000 family | |

If **You** believe the services **You** require are not available from an **In-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 an **In-Network Provider** maximizes **Your** benefits. **You** can find an **In-Network Provider** by clicking on *Find a Doctor* at *weatrust.com*. If **You** go to an **Out-of-Network Provider, You** will likely have higher out-of-pocket costs. For more information, please see the Reimbursement Notifications for **Out-of-Network Providers** section below and view **Your Certificate** at *weatrust.com*.

### Prescription Drug Reimbursement Information

| | Value Drugs | Tier 1 | Tier 2 | Tier 3 | |
|---|---|---|---|---|---|
| **Cost-Sharing Amount Per Prescription Fill** | $0 | $20 | $60 | $100 | |

Prescription Drugs covered under this drug plan are not subject to a **Deductible. You** will be charged 2 **Cost- Sharing Amounts** for a 90-day supply through **Our** Home Delivery Program. As required by Wis. Stat. § 632.867, copayments for oral chemotherapy medication will not exceed $100 per 30-day supply.

## Reimbursement Information for Preventive Services

We cover 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 an **In-Network Provider**, **Your** services are not subject to a **Deductible**, **Coinsurance**, or **Copayment**. When **You** seek recommended preventive services from an **Out-of-Network Provider**, **Your** services are subject to a **Deductible**, **Coinsurance**, and/or **Copayment**. For colorectal cancer screening, **We** follow the guidelines issued by the U.S. Preventive Services Task Force.

| Preventive Services | Member Pays for Services Received from In-Network Providers | Member Pays for Services Received from Out-of-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% |

## Reimbursement Information for Other Covered Services

Please Note: Unless otherwise specified, **You** must pay a **Cost-Sharing Amount** for each service or item you receive, even if you get multiple services or items at the same time or on the same day.

| Other Covered Services | Member Pays for Services Received from In-Network Providers | Member Pays for Services Received from Out-of-Network Providers |
|---|---|---|
| PHYSICIAN/PRACTITIONER SERVICES | | |
| Primary Care Office Visits* | $30 Copay, Deductible, then 0% | $50 Copay, Deductible, then 20% |
| Specialty Care Office Visits* | $60 Copay, Deductible, then 0% | $100 Copay, Deductible, then 20% |
| Urgent Care | $100 Copay, Deductible, then 0% | $100 Copay, Deductible, then 0% |
| Walk-In Retail Clinic Services* | $0 Copay | $50 Copay, Deductible, then 20% |
| Virtual 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% |
| Behavioral Health and Substance Abuse Disorder 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% |

*Copayments are waived for **Members** under 6 years of age.

## Reimbursement Information for Other Covered Services (*continued*)

**Please Note:** Unless otherwise specified, **You** must pay a **Cost-Sharing Amount** for each service or item you receive, even if you get multiple services or items at the same time or on the same day.

| Other Covered Services | Member Pays for Services Received from In-Network Providers | Member Pays for Services Received from Out-of-Network Providers |
|---|---|---|
| OUTPATIENT FACILITY SERVICES | | |
| Surgery and Related Services | Deductible, then 0% | Deductible, then 20% |
| Non-Emergency Advanced Imaging | $100 Copay, Deductible, then 0% | $200 Copay, Deductible, then 20% |
| Other Diagnostic Tests | Deductible, then 0% | Deductible, then 20% |
| Emergency Room (exceptions may apply, so please see Your Certificate) | $300 Copay, Deductible, then 0% | $300 Copay, Deductible, then 0% |
| 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* | $30 Copay, Deductible, then 0% | $50 Copay, Deductible, then 20% |
| Congenital Heart Disease Surgery (Out-of-Network services are limited to $35,000 per BenefitPeriod) | 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 Behavioral Health and Substance Abuse Services * | $30 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 type of service per Benefit Period) | $30 Copay, Deductible, then 0% | $50 Copay, Deductible, then 20% |
| Transplants (Out-of-Network services are limited to $35,000 perBenefit 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. **For DME, the Cost-Sharing Amount applies per DME item, per claim. Depending on the DME item, this could result in a one-time Cost-Sharing Amount payment, or multiple Cost-Sharing Amount payments made over the span of a rental period.

## Prior Authorization and Hospital Admission Notification Requirements

Certain services require **Prior Authorization**. **You** will find a list of the services that require **Prior Authorization** 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 get **Prior Authorization**. This penalty does not apply to**Your Maximum Out-of-Pocket Limit**.

**You** will be charged a penalty if **You** fail to timely notify **Us** of any **Hospital** admission for an emergency or childbirth. The penalty will equal 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 Out-of-Network Providers

Reimbursement for **Out-of-Network Providers** is limited to **Our Maximum Allowable Fee**, as described in Section 2: General Provisions That Apply to All Benefits of **Your** Certificate. The percentage of the Medicare-allowable fee is 150%. The percentage of the contracted in-network fee is 50%. **You** are responsible for the difference between the **Out-of-Network Provider's** charge and **Our Maximum Allowable Fee**.

## Optional Eligibility Provisions that Apply

Expanded Eligibility Options:

Retired Employee Continuation—Limited Duration
Surviving Dependent Continuation—Limited Duration

## Optional Benefit Provisions that Apply

Value Choice Drug Plan
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 our website at *weatrust.com*.

Underwritten by WEA Insurance Corporation
45 Nob Hill Road, Madison, WI 53713-3959
Voice/TTY: (608) 276-4000 or (800) 279-4000
weatrust.com

# Preferred Provider Plan Essential Health

Jt. School District No. 1 Elkhart Lake
Group No.: 38362

## 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 defined in **Your Certificate** of Coverage (**Certificate**) and explained in Section 2: General Provisions That Apply to All Benefits. **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 Benefit Summary** and **Certificate** handy for **Your** reference.

**Group Effective Date:** 07/01/2021
**Benefit Period:** January through December
**Network:** Trust Preferred

### Basic Reimbursement Factors of Your Health Plan

| All Covered Health Care Services | Services Received from In-Network Providers | Services Received from Out-of-Network Providers |
|---|---|---|
| **Deductible You Pay** | $2,000 single/<br>$4,000 family | $4,000 single/<br>$8,000 family |
| **Coinsurance You Pay** | 0% | 20% |
| **Maximum Out-of-Pocket Limit** Maximum amount of **Deductible**, and **Coinsurance**, and in- network **Copayments You** are required to pay under this **Plan**. | $4,000 single /<br>$8,000 family | $10,000 single/<br>$20,000 family |
| **Maximum Out-of-Pocket Limit for Prescription Drug Cost-Sharing Amounts** | $4,000 single / $8,000 family | |

If **You** believe the services **You** require are not available from an **In-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 an **In-Network Provider** maximizes **Your** benefits. **You** can find an **In-Network Provider** by clicking on *Find a Doctor* at *weatrust.com*. If **You** go to an **Out-of-Network Provider**, **You** will likely have higher out-of-pocket costs. For more information, please see the Reimbursement Notifications for **Out-of-Network Providers** section below and view **Your Certificate** at *weatrust.com*.

### Prescription Drug Reimbursement Information

| | Value Drugs | Tier 1 | Tier 2 | Tier 3 | |
|---|---|---|---|---|---|
| **Cost-Sharing Amount Per Prescription Fill** | $0 | $20 | $60 | $100 | |

Prescription Drugs covered under this drug plan are not subject to a **Deductible**. **You** will be charged 2 **Cost- Sharing Amounts** for a 90-day supply through **Our** Home Delivery Program. As required by Wis. Stat. § 632.867, copayments for oral chemotherapy medication will not exceed $100 per 30-day supply.

## Reimbursement Information for Preventive Services

We cover 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 an **In-Network Provider**, **Your** services are not subject to a **Deductible**, **Coinsurance**, or **Copayment**. When **You** seek recommended preventive services from an **Out-of-Network Provider**, **Your** services are subject to a **Deductible**, **Coinsurance**, and/or **Copayment**. For colorectal cancer screening, **We** follow the guidelines issued by the U.S. Preventive Services Task Force.

| Preventive Services | Member Pays for Services Received from In-Network Providers | Member Pays for Services Received from Out-of-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% |

## Reimbursement Information for Other Covered Services

Please Note: Unless otherwise specified, **You** must pay a **Cost-Sharing Amount** for each service or item you receive, even if you get multiple services or items at the same time or on the same day.

| Other Covered Services | Member Pays for Services Received from In-Network Providers | Member Pays for Services Received from Out-of-Network Providers |
|---|---|---|
| PHYSICIAN/PRACTITIONER SERVICES | | |
| Primary Care Office Visits* | $30 Copay, Deductible, then 0% | $50 Copay, Deductible, then 20% |
| Specialty Care Office Visits* | $60 Copay, Deductible, then 0% | $100 Copay, Deductible, then 20% |
| Urgent Care | $100 Copay, Deductible, then 0% | $100 Copay, Deductible, then 0% |
| Walk-In Retail Clinic Services* | $0 Copay | $50 Copay, Deductible, then 20% |
| Virtual 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% |
| Behavioral Health and Substance Abuse Disorder 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% |

*Copayments are waived for **Members** under 6 years of age.

## Reimbursement Information for Other Covered Services (*continued*)

**Please Note:** Unless otherwise specified, **You** must pay a **Cost-Sharing Amount** for each service or item you receive, even if you get multiple services or items at the same time or on the same day.

| Other Covered Services | Member Pays for Services Received from In-Network Providers | Member Pays for Services Received from Out-of-Network Providers |
|---|---|---|
| OUTPATIENT FACILITY SERVICES | | |
| Surgery and Related Services | Deductible, then 0% | Deductible, then 20% |
| Non-Emergency Advanced Imaging | $100 Copay, Deductible, then 0% | $200 Copay, Deductible, then 20% |
| Other Diagnostic Tests | Deductible, then 0% | Deductible, then 20% |
| Emergency Room (exceptions may apply, so please see Your Certificate) | $300 Copay, Deductible, then 0% | $300 Copay, Deductible, then 0% |
| 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* | $30 Copay, Deductible, then 0% | $50 Copay, Deductible, then 20% |
| Congenital Heart Disease Surgery (Out-of-Network services are limited to $35,000 per BenefitPeriod) | 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 Behavioral Health and Substance Abuse Services * | $30 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 type of service per Benefit Period) | $30 Copay, Deductible, then 0% | $50 Copay, Deductible, then 20% |
| Transplants (Out-of-Network services are limited to $35,000 perBenefit 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% |

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## Prior Authorization and Hospital Admission Notification Requirements

Certain services require **Prior Authorization**. **You** will find a list of the services that require **Prior Authorization** 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 get **Prior Authorization**. This penalty does not apply to**Your Maximum Out-of-Pocket Limit.**

**You** will be charged a penalty if **You** fail to timely notify **Us** of any **Hospital** admission for an emergency or childbirth. The penalty will equal 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 Out-of-Network Providers

Reimbursement for **Out-of-Network Providers** is limited to **Our Maximum Allowable Fee**, as described in Section 2: General Provisions That Apply to All Benefits of **Your** Certificate. The percentage of the Medicare-allowable fee is 150%. The percentage of the contracted in-network fee is 50%. **You** are responsible for the difference between the **Out-of-Network Provider's** charge and **Our Maximum Allowable Fee.**

## Optional Eligibility Provisions that Apply

Expanded Eligibility Options:

Retired Employee Continuation—Limited Duration
Surviving Dependent Continuation—Limited Duration

## Optional Benefit Provisions that Apply

Value Choice Drug Plan
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 our website at *weatrust.com.*

Underwritten by WEA Insurance Corporation
45 Nob Hill Road, Madison, WI 53713-3959
Voice/TTY: (608) 276-4000 or (800) 279-4000
weatrust.com