Preferred Provider Plan Essential Qualified

Maple Dale-Indian Hill School District
Group No.: 30471

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: 07/01/2022 **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 (Embedded)	$3,000 single/ $6,000 family	$6,000 single/ $12,000 family
Coinsurance You Pay	0%	30%
Maximum Out-of-Pocket Limit (Embedded) Maximum amount of **Deductible**, **Coinsurance**, and in-network **Copayments You** are required to play under this **Plan**.	$3,000 single/ $6,000 family	$9,000 single/ $18,000 family

To qualify as a health savings account (HSA) qualified high deductible health plan, the **Deductible** amounts must be equal to or greater than the lowest amounts allowed by the Internal Revenue Service (IRS). The **Deductible** amounts and **Maximum Out-of-Pocket Limits** will be adjusted each year, at the beginning of the **Benefit Period**, to reflect the updated amounts published by the IRS that became effective on January 1 of that year. If a group fails to adopt the new minimum **Deductible** amounts, the plan will no longer be HSA-qualified.

The In-Network and Out-of-Network **Maximum Out-of-Pocket Limits** accumulate separately and are not transferrable. There is one exception: **Deductible**, **Coinsurance**, and **Copayment** amounts **You** pay for **Prescription Drugs**, whether you obtain the drugs from an **In-Network** or **Out-of-Network** pharmacy, are applied to the **In-Network Deductible** and **Maximum Out-of-Pocket Limit**.

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 (After Deductible Has Been Met)

	Value Drugs	Tier 1	Tier 2	Tier 3	
Cost-Sharing Amount Per Prescription Fill	0%	0%	0%	0%	

Certain preventive prescription drugs are not subject to a deductible if Preventive Prescription Drug Benefit is chosen. You will find the list of preventive prescription drugs on our website, weatrust.com. 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%	30%
Tobacco Cessation Screening and Brief Interventions	0%	30%
Other Preventive Services Including Immunizations, Screenings, and Certain Counseling Services (see **weatrust.com** Members section for details)	0%	30%

Reimbursement Information for Other Covered Services (After Deductible Has Been Met)

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	0%	30%
Specialty Care Office Visits	0%	30%
Urgent Care	0%	0%
Walk-In Retail Clinic Services	0%	30%
Virtual Visits	0%	100%
Maternity Care	0%	30%
Laboratory and Radiology	0%	30%
Specialty Drugs (including injections)	0%	30%
Inpatient Services	0%	30%
Outpatient Services	0%	30%

Reimbursement Information for Other Covered Services, **Continued** (After Deductible Has Been Met)

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
INPATIENT FACILITY SERVICES		
Hospitalization	0%	30%
Surgery, Anesthesia, and Related Supplies	0%	30%
Maternity and Newborn Services	0%	30%
Advanced Imaging and Laboratory Services	0%	30%
Behavioral Health and Substance Abuse Disorder Services	0%	30%
Skilled Nursing Facility (limited to 30 Days per Confinement)	0%	30%
Skilled Rehabilitation Facility (limited to 60 Days per Benefit Period)	0%	30%
OUTPATIENT FACILITY SERVICES		
Surgery and Related Services	0%	30%
Non-Emergency Advanced Imaging	0%	30%
Other Diagnostic Tests	0%	30%
Emergency Room (exceptions may apply, so please see **Your Certificate**)	0%	0%
OTHER SERVICES		
Aural Therapy (limited to 30 visits per **Benefit Period**)	0%	30%
Cardiac Rehabilitation (limited to 36 Visits per Benefit Period)	0%	30%
Chiropractic Treatment	0%	30%
Congenital Heart Disease Surgery (**Out-of-Network** services are limited to $35,000 per **Benefit Period**)	0%	30%
Dental Services (Limited Services Only)	0%	30%
Durable Medical Equipment (DME) and Supplies	0%	30%
Extraction/Replacement of Natural Teeth	No Coverage	No Coverage
Hearing Aids	0%	30%
Home Health Care (limited to 60 Visits per Benefit Period)	0%	30%
Hospice Care	0%	30%
Kidney Disease Treatment	0%	30%
Outpatient Behavioral Health and Substance Abuse Services	0%	30%

Reimbursement Information for Other Covered Services, **Continued** (After Deductible Has Been Met)

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
OTHER SERVICES, continued		
Pulmonary Rehabilitation (limited to 20 Visits per Benefit Period)	0%	30%
Temporomandibular Disorder (TMD) Treatment	0%	30%
Therapy – Physical, Speech, and Occupational (limited to 20 Visits per Benefit Period)	0%	30%
Transplants (**Out-of-Network** services are limited to $35,000 per **Benefit Period**)	0%	30%
Vision Exam	No Coverage	No Coverage
Vision – Non-Routine Services	0%	30%

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

Optional Benefit Provisions that Apply

Preventative Prescription Drug 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*.

WEA trust

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