The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit our website at www.weatrust.com or call us at 1-800-279-4000. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-279-4000 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000**/individual or **$4,000**/family for Network providers per Benefit Period. **$4,000**/individual or **$8,000**/family for Non-Network providers per Benefit Period.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. The following services are covered before you meet your deductible: prescription drugs, routine vision exams, preventive care, e-visits, and convenience care clinic services, when performed by a Network provider.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Network providers **$4,000**/individual and **$8,000**/family per Benefit Period. For Non-Network providers **$10,000**/individual and **$20,000**/family per Benefit Period. Pharmacy cost-sharing applies to a separate out-of-pocket limit of **$4,000**/individual and **$8,000**/family per Benefit Period	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, non-network copays, penalties for failure to satisfy	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
	preauthorization or hospital admission notification requirements, and health care this plan doesn't cover.	
Will you pay less if you use a network provider?	Yes. See www.weatrust.com **or call 1-800-279-4000** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**$30** copay/visit	**$60** copay/visit then **20%** coinsurance	none
	Specialist visit	**$60** copay/visit	**$120** copay/visit then **20%** coinsurance	none
	Preventive care/screening/ immunization	No charge	**$60** copay/visit then **20%** coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	**0%** coinsurance	**20%** coinsurance	Preauthorization required for genetic testing. Non-compliance may result in claim denial or penalty of 50% up to $500.
	Imaging (CT/PET scans, MRIs)	**$100** copay/visit	**$200** copay/visit then **20%** coinsurance	Preauthorization required. Non-compliance may result in claim denial or penalty of 50% up to $500.

* For more information about limitations and exceptions, see the plan or policy document at www.weatrust.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.www.weatrust.com	Value Drugs (subset of Tier 1)	**No Charge** (Preferred Pharmacy) **$10** copay/prescription. (Non-Preferred Pharmacy)	Not Covered	Covers 30-day supply for retail purchase. 90-day Home Delivery may only be subject to two copayments instead of three. See www.weatrust.com for list of drugs that are excluded or require preauthorization. Failure to preauthorize may result in claim denial or penalty of 50% up to $500. Deductible does not apply. Cost-sharing applies to a separate maximum out-of-pocket limit.
	Tier 1 (Most generic, some brand and some over-the-counter drugs)	**$20** copay/prescription. (Preferred Pharmacy) **$50** copay/prescription. (Non-Preferred Pharmacy)	Not Covered	
	Tier 2 (Preferred brand and some generic drugs)	**$75** copay/prescription. (Preferred Pharmacy) **$105** copay/prescription. (Non-Preferred Pharmacy)	Not Covered	
	Tier 3 (Non-preferred brand and some generic drugs)	**$100** copay/prescription. (Preferred Pharmacy) **$130** copay/prescription. (Non-Preferred Pharmacy)	Not Covered	
	Tier 4 (Specialty Drugs)	**20%** coinsurance up to **$250** per fill. (Preferred/Non-Preferred Pharmacy)	Not Covered	See www.weatrust.com for list of drugs that are excluded or require preauthorization. Failure to preauthorize may result in claim denial or penalty of 50% up to $500. Deductible does not apply. Cost-sharing applies to a separate maximum out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**0%** coinsurance	**20%** coinsurance	Preauthorization required for certain outpatient surgeries. See our website www.weatrust.com for a list of services that require preauthorization. Non-compliance may result
	Physician/surgeon fees	**0%** coinsurance	**20%** coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at www.weatrust.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				in claim denial or penalty of 50% up to $500. *See Sections 5 & 6.
If you need immediate medical attention	Emergency room care	**$300** copay/visit		Copay waived if admitted as inpatient for at least 24 hours.
	Emergency medical transportation	**0%** coinsurance		——————none——————
	Urgent care	**$100** copay/visit		——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	**0%** coinsurance	**20%** coinsurance	Preauthorization required for elective or planned hospital stays. Non-compliance may result in claim denial or penalty of 50% up to $500. Notification required for emergency admissions and childbirth. Non-compliance penalty of up to $250/service may apply. *See Sections 5 & 6.
	Physician/surgeon fees	**0%** coinsurance	**20%** coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**$30** copay/visit	**$60** copay/visit then **20%** coinsurance	Preauthorization required for ECT, all partial hospitalization and intensive outpatient services, and all elective or planned inpatient admissions to a hospital or residential treatment facility. See our website www.weatrust.com for a list of other services that require preauthorization. Non-compliance may result in claim denial or penalty of 50% up to $500. Notification required for emergency admissions. Non-compliance penalty of up to $250/service may apply. *See Sections 5 & 6.
	Inpatient services	**0%** coinsurance	**20%** coinsurance	
If you are pregnant	Office visits	**0%** coinsurance	**20%** coinsurance	Cost-sharing does not apply for Network preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	**0%** coinsurance	**20%** coinsurance	Notification required. Non-compliance penalty of up to $250/service may apply.
	Childbirth/delivery facility services	**0%** coinsurance	**20%** coinsurance	Notification required. Non-compliance penalty of up to $250/service may apply.

* For more information about limitations and exceptions, see the plan or policy document at www.weatrust.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	**0%** coinsurance	**20%** coinsurance	Preauthorization required. Non-compliance may result in claim denial or penalty of 50% up to $500.
	Rehabilitation services	**$30** copay/visit for physical, occupational, and speech therapy. **0%** coinsurance for cardiac and pulmonary rehab, and skilled rehab facility services.	**$60** copay/visit then **20%** coinsurance for physical, occupational, and speech therapy. **20%** coinsurance for cardiac and pulmonary rehab, and skilled rehab facility services.	Preauthorization required. for all services except evaluations. Non-compliance may result in claim denial or penalty of 50% up to $500
	Habilitation services	**$30** copay/visit.	**$60** copay/visit then **20%** coinsurance.	Preauthorization required. for all services except evaluations. Non-compliance may result in claim denial or penalty of 50% up to $500
	Skilled nursing care	**0%** coinsurance	**20%** coinsurance	Limited to **60** days per confinement. Preauthorization required. Non-compliance may result in claim denial or penalty of 50% up to $500.
	Durable medical equipment	**0%** coinsurance	**20%** coinsurance	Preauthorization required for certain DME services. See our website www.weatrust.com for a list of services that require preauthorization. Non-compliance may result in claim denial or penalty of 50% up to $500. *See Sections 5 and 6.
	Hospice services	**0%** coinsurance	**20%** coinsurance	——————none——————
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Limited to one exam per Benefit Period
	Children's glasses	Not Covered	Not Covered	Excluded service
	Children's dental check-up	Not Covered	Not Covered	Excluded service

* For more information about limitations and exceptions, see the plan or policy document at www.weatrust.com.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Bariatric Surgery • Children's glasses • Children's Dental Check-up	• Cosmetic Surgery • Dental Care (Adult) • Infertility Treatment • Long-Term Care • Non-emergency care when traveling outside the U.S.	• Private Duty Nursing • Routine Foot Care • Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic Care	• Hearing Aids	• Routine Eye Care (Adult), limited to one eye exam each Benefit Period

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or oci.wi.gov; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the WEA Insurance Corporation at 1-800-279-4000 or www.weatrust.com; the Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or oci.wi.gov; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.weatrust.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of Network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$60
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,687**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$11
Coinsurance	$0
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$2,072**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$60
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,601**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$499
Coinsurance	$0
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$2,677**

Mia's Simple Fracture
(Network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$60
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$425
Coinsurance	$0
What isn't covered	
Limits or exclusions	$364
The total Mia would pay is	**$2,789**

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.umr.com or by calling 1-800-207-3172. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.umr.com or call 1-800-207-3172 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** person / **$4,000** family In-network **$4,000** person / **$8,000** family Out-of-network	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	**$4,000** person / **$8,000** family In-network **$10,000** person / **$20,000** family Out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Penalties, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.umr.com or call 1-800-207-3172 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment costs shown in this chart are applied before the deductible; coinsurance costs are applied after your deductible has been met, as applicable.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 Copay per visit	$60 Copay per visit; 20% Coinsurance	None
	Specialist visit	$60 Copay per visit	$120 Copay per visit; 20% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	$60 Copay per visit PCP; $120 Copay per visit Specialist. 20% Coinsurance for Preventive care; 20% Coinsurance for Preventive screenings. No charge; Deductible Waived Immunizations	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge office setting; $100 Copay per day outpatient setting	20% Coinsurance office setting; $200 Copay per day; 20% Coinsurance outpatient setting	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.carmark.com	Generic drugs (Tier 1)	$20 for a 30-day supply, retail; $60 for a 31–90-day supply, retail; $40 for up to a 90-day supply, mail order	$20 for a 30-day supply, retail; $60 for a 31–90-day supply, retail; $40 for up to a 90-day supply, mail order	Deductible waived Separate prescription drug out of pocket maximum: $4,000 person / $8,000 family. *This is in addition to the medical maximum out-of-pocket shown on page 1.* Covered prescriptions on the Value Priced Generic Drug List have no copay. If you choose a non-preferred drug when a generic is available, you will pay the cost difference between the two plus the non-preferred copay. However, if your physician indicates dispense as written (DAW) on prescription, then only the non-preferred copay will apply *Specialty prescriptions can only be obtained through a CVS Pharmacy or by CVS Caremark mail order to a maximum 30-day supply.
	Preferred brand drugs (Tier 2)	$75 for a 30-day supply, retail; $225 for a 31–90-day supply, retail; $150 for up to a 90-day supply, mail order	$75 for a 30-day supply, retail; $225 for a 31–90-day supply, retail; $150 for up to a 90-day supply, mail order	
	Non-preferred brand drugs (Tier 3)	$100 for a 30-day supply, retail; $300 for a 31–90-day supply, retail; $200 for up to a 90-day supply, mail order	$100 for a 30-day supply, retail; $300 for a 31–90-day supply, retail; $200 for up to a 90-day supply, mail order	
	Specialty drugs (Tier 4)	20% to a $250 maximum for up to a 30-day supply*	20% to a $250 maximum for up to a 30-day supply*	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% Coinsurance	None
	Physician/surgeon fees	No charge	20% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need immediate medical attention	Emergency room care	$300 Copay per visit	$300 Copay per visit	In-network deductible applies to Out-of-network benefits; Copay may be waived if admitted
	Emergency medical transportation	No charge	No charge	In-network deductible applies to Out-of-network benefits
	Urgent care	$100 Copay per visit	$100 Copay per visit	In-network deductible applies to Out-of-network benefits
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% up to $250 of the total cost of the service for Out-of-network.
	Physician/surgeon fee	No charge	20% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$30 Copay per office visit; No charge other outpatient services	$60 Copay per visit; 20% Coinsurance office visits 20% Coinsurance other outpatient services	None
	Inpatient services	No charge	20% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% up to $250 of the total cost of the service for Out-of-network.
If you are pregnant	Office visits	No charge; Deductible Waived	20% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	20% Coinsurance	
	Childbirth/delivery facility services	No charge	20% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% Coinsurance	None
	Rehabilitation services	$30 Copay per visit	$60 Copay per visit; 20% Coinsurance	Preauthorization is required.
	Habilitation services	$30 Copay per visit	$60 Copay per visit; 20% Coinsurance	
	Skilled nursing care	No charge	20% Coinsurance	60 Maximum days per admission/confinement; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% up to $250 of the total cost of the service for Out-of-network.
	Durable medical equipment	No charge	20% Coinsurance	Preauthorization is required for DME in excess of $1,000 for rentals or for purchases. If you don't get preauthorization, benefits could be reduced by 25% up to $250 per occurrence for Out-of-network.
	Hospice service	No charge	20% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge; Deductible Waived	No charge; Deductible Waived	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Dental care (Adult)	• Private-duty nursing
• Bariatric surgery	• Infertility treatment	• Routine foot care
• Cosmetic surgery	• Long-term care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult)
• Hearing aids		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this plan Provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan Meet the Minimum Value Standard? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

This is only a summary. It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist copayment	$60
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$2,070**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist copayment	$60
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$900
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist copayment	$60
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$2,000
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,510**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Jt. School District No. 1 Elkhart Lake

Health Plan Options
July 1, 2022

April 8, 2022

WEA trust

		Renewal Rates / All 3 HPPN		
Health Plan		Essential PPO		
Deductible (Single/Family)				
Network		$2,000/$4,000		
Non-Network		$4,000/$8,000		
Coinsurance				
Network		100%		
Non-Network		80%		
Maximum Out-of-Pocket (Single/Family)				
Excludes Medical Copayments		No		
Excludes Pharmacy Copayments		Yes		
Network		$4,000/$8,000		
Non-Network		$10,000/$20,000		
Copayments		Primary	Specialty	
Network Office Visit		$30	$60	then ded/coins
Non-Network Office Visit		$60	$120	then ded/coins
Network Convenient Care/Telehealth Office Visit		$0		copay only
Urgent Care		$100		then ded/coins
Emergency Room		$300		then ded/coins
Advanced Imaging Copay		$100/$200		then ded/coins
Maximum Out-of-Pocket Medical Copay		$0/$0		
Pharmacy		HPPN Pref 0/20/75/100		
Drug Plan		non-Pref 10/50/105/130		
Maximum Out-of-Pocket Pharmacy Copay		$4,000/$5,600		
Includes Erectile Dysfunction Benefits		No		
Specialty Pharmacy Coinsurance		Yes		
Optional Benefits				
Vision Benefit		Enhanced Vision No Cost Sharing		
Extraction/Replacement of Teeth		No Extraction Coverage		
Waiver of Plan Contribution		No		
Vitality		Elevate - Employee Only		
Premium Rates	Current Subscribers			
Single	7	$940.06		
Family	17	$2,127.74		
Single Medicare	-	$0.00		
Family Medicare	-	$0.00		
Single Medicare w/o Drug	-	$236.90		
Family Medicare w/o Drug	-	$473.79		
Special Medicare (1 over/1 under) one Rx	-	$1,176.95		
Monthly Contribution	24	$42,751.96		
		10.4%		

The rates include the following commission: This calculation includes standard commission

The rates in this chart are renewal options for illustrative purposes and are not a contract for coverage. The pricing assumes a single plan design per employee segment with the Trust as the sole carrier. These rates are subject to change and contain no guarantee. Moreover, this information is intended only for the use of the individual or entity to which it is addressed. It may contain information that is privileged, confidential, and prohibited from disclosure under law. If the reader of this message is not the intended recipient, you are notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

Ann Bleckel Haack

Signature

* Emailed 4/12/22

GHT
WCA Group Health Trust

*Emailed 8/16/22

ELKHART LAKE – GLENBEULAH SCHOOL DISTRICT
MEDICAL/RX PROPOSAL
(Effective 10/01/2022 – 6/30/2023)

	Proposed Benefits		
Network	UHC Choice Plus		
Plan Type	PPO		
Accumulation Type	Embedded		
Benefit Accumulator	Calendar Year		
	In-Network	***Out-of-Network***	
Deductible (Single/Family)	$2,000/$4,000	$4,000/$8,000	
Coinsurance	100%	80%	
Total Maximum Out-of-Pocket (Deductible, Coinsurance, & Medical Copays)	$4,000/$8,000	$10,000/$20,000	
Medical Benefits			
Inpatient Hospital	Deductible/100%	Deductible/80%	
Outpatient Hospital	Deductible/100%	Deductible/80%	
Office Visit	$30 Copay/Deductible/100%	$60 Copay/ Deductible/80%	
Specialist Office Visit	$60 Copay/Deductible/100%	$120 Copay/ Deductible/80%	
Preventive Exam	100%/Deductible Waived	$60 Copay/ Deductible/80%	
Convenient Care/ Retail Clinic	100%/Deductible Waived	$60 Copay/ Deductible/80%	
Manipulation	$30 Copay/Deductible/100%	$60 Copay/ Deductible/80%	
Phys/Occ/Sp/Resp Therapy	$30 Copay/Deductible/100%	$60 Copay/ Deductible/80%	
Urgent Care	$100 Copay/PPO Deductible/100%		
Emergency Room Care	$300 Copay/PPO Deductible/100%		
Mental Health/Subst. Abuse: Office Visit Inpatient Outpatient	 $30 Copay/Deductible/100% Deductible/100% Deductible/100%	 $60 Copay/Deductible/80% Deductible/80% Deductible/80%	
High Tech Imaging Coverage	$100/Deductible/100%	$200/Deductible/80%	
Oral Surgery	Deductible/100%	Deductible/80%	
All Other Covered Medical Services	Deductible/100%	Deductible/80%	
Teladoc Benefits	100%/Deductible Waived		
Pharmacy Benefits			
Drug Plan Formulary	Generic	Preferred	Non-Preferred
Retail, 30 Days	$20	$75	$100
Retail, 31-90 Days	$60	$225	$300
Mail Order, 90 Days	$40	$150	$200
Specialty, 30 Days	20% (maximum $250)	20% (maximum $250)	20% (maximum $250)
	Value Price Generics: $0		
	Mandatory Generic: Yes		
	Rx Max Out-of-Pocket: $4,000/$8,000		
Value Adds	**UHC Hearing Program, Maternity Management, Vision Exam, Hearing Exam, Real Appeal, Live Well Reward$**		

By: Elkhart Lake – Glenbeulah School District

Signature: [signature]
Print Name: ADAM ENGEBRETSON
Title: DISTRICT ADMINISTRATOR
Date: 8/3/2022

By: WCA Group Health Trust

Signature: [signature]
Print Name: Michael Lamont
Title: Chief Operating Officer
Date: 07.13.2022