Preferred Provider Plan Essential Health

DANE COUNTY
Group No.: *38180*
Eligible Class: *Active*

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 Benefit Provisions, if any, apply to your coverage. Many of the terms used below are explained in Section 4 of your policy. Your policy describes your benefits and the exclusions and limitations that apply to them. We encourage you to keep it handy for reference.

Group Effective Date: *01/01/2016* **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	$100 individual/$200 family	$200 individual/$400 family
Coinsurance You Pay	0%	0%
Maximum Out-of-Pocket Maximum amount of deductible, coinsurance, and Network copayments you are required to pay under this plan.	$250 individual/$500 family	$500 individual/$1,000 family
Maximum Out-of-Pocket for Prescription Drug Cost-Sharing	$500 individual/$1,500 family	Not Applicable

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 policy'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 policy at weatrust.com.

Prescription Drug Reimbursement Information

	Value Drugs	**Tier 1**	**Tier 2**	**Tier 3**
Cost-Sharing Per Prescription Fill	$0	$10	$20	$40

Prescription drugs covered under this drug plan are not subject to a deductible. Prescription drugs for the treatment of infertility are limited to $2,000 per lifetime per member and subject to 50% coinsurance and do not count towards your prescription drug Maximum Out-of-Pocket limit. 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%	$10 Copay, Deductible, then 0%
Tobacco Cessation Screening and Brief Interventions	0%	Deductible, then 0%
Other Preventive Services Including Immunizations, Screenings, and Certain Counseling Services (see weatrust.com Members section for details)	0%	Deductible, then 0%

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 SERVICES		
Primary Care Office Visits*	$5 Copay, Deductible, then 0%	$10 Copay, Deductible, then 0%
Specialty Care Office Visits*	$5 Copay, Deductible, then 0%	$10 Copay, Deductible, then 0%
Urgent Care	$10 Copay, Deductible, then 0%	$10 Copay, Deductible, then 0%
Convenient Care Clinic Services*	$5 Copay, Deductible, then 0%	$10 Copay, Deductible, then 0%
E-visits	$5 Copay	100%
Routine Maternity Care	Deductible, then 0%	Deductible, then 0%
Laboratory and Radiology	Deductible, then 0%	Deductible, then 0%
Specialty Drugs (including injections)	Deductible, then 0%	Deductible, then 0%
Inpatient Services	Deductible, then 0%	Deductible, then 0%
Outpatient Services	Deductible, then 0%	Deductible, then 0%
INPATIENT FACILITY SERVICES		
Hospitalization	Deductible, then 0%	Deductible, then 0%
Surgery, Anesthesia, and Related Supplies	Deductible, then 0%	Deductible, then 0%
Maternity and Newborn Services	Deductible, then 0%	Deductible, then 0%
Advanced Imaging and Laboratory Services	Deductible, then 0%	Deductible, then 0%
Mental Health and Substance Abuse Services	Deductible, then 0%	Deductible, then 0%
Skilled Nursing Facility (limited to 120 days per confinement)	Deductible, then 0%	Deductible, then 0%
Skilled Rehabilitation Facility (limited to 90 days per benefit period)	Deductible, then 0%	Deductible, then 0%
OUTPATIENT FACILITY SERVICES		
Surgery and Related Services	Deductible, then 0%	Deductible, then 0%
Non-Emergency Advanced Imaging	Deductible, then 0%	Deductible, then 0%
Other Diagnostic Tests	Deductible, then 0%	Deductible, then 0%
Emergency Room (exceptions may apply, so please see your policy)	$50 Copay, Deductible, then 0%	$50 Copay, Deductible, then 0%

*Office visit copayments are waived for members less than 18 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 0%
Cardiac Rehabilitation	Deductible, then 0%	Deductible, then 0%
Chiropractic Treatment*	$5 Copay, Deductible, then 0%	$10 Copay, Deductible, then 0%
Congenital Heart Disease Surgery (non-network services are limited to $35,000 per Benefit Period)	Deductible, then 0%	Deductible, then 0%
Dental Services	Deductible, then 0%	Deductible, then 0%
Durable Medical Equipment, (DME) and Supplies	Deductible, then 0%	Deductible, then 50%
Extraction Replacement of Natural Teeth	No Coverage	No Coverage
Hearing Aids	Deductible, then 0%	Deductible, then 0%
Home Health Care	Deductible, then 0%	Deductible, then 20%
Hospice Care	Deductible, then 0%	Deductible, then 0%
Kidney Disease Treatment	Deductible, then 0%	Deductible, then 0%
Outpatient Mental Health and Substance Abuse Services*	$5 Copay, Deductible, then 0%	$10 Copay, Deductible, then 0%
Pulmonary Rehabilitation	Deductible, then 0%	Deductible, then 0%
Temporomandibular Disorder (TMD) Treatment	Deductible, then 0%	Deductible, then 0%
Therapy - Physical, Speech, and Occupational* (limited to 50 visits per type of service per Benefit Period)	$5 Copay, Deductible, then 0%	$10 Copay, Deductible, then 20%
Transplants (non-network services are limited to $35,000 per Benefit Period)	Deductible, then 0%	Deductible, then 0%
Vision Exam (limited to one routine vision exam per Benefit Period)*	$5 Copay, Deductible, then 0%	$10 Copay, Deductible, then 0%
Vision — Non-Routine Services	Deductible, then 0%	Deductible, then 0%

*Office visit copayments are waived for members less than 18 years of age.

Preauthorization – Certain services require preauthorization. You will find a list of the services that require preauthorization on our Web site 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: 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 policy. The percentage of the Medicare-allowable fee is 125%. 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

Domestic Partner Coverage
Expanded Eligibility Options:
Retired Employee Continuation
Surviving Dependent Continuation—Limited Duration

Optional Benefit Provisions that Apply

Value Choice Drug Plan
Vision Examination Benefit
Enhanced DME Benefits
Drug Plan Amendment for Medicare Part D Eligible Individuals
Dane County Amendment

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 provider 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.

WEA TRUST

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