Preferred Provider Plan Essential Health

Group: PORT WASHINGTON-SAUKVILLE SCHOOL DISTRICT

Group No.: 30603

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.

Employer: PORT WASHINGTON-SAUKVILLE SCHOOL DISTRICT
Effective Date: 07/01/2014 **Benefit Period:** July through June
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	$500 individual/$1,000 family	$1,000 individual/$2,000 family
Coinsurance You Pay	0%	20%
Maximum Out-of-Pocket Limit Maximum amount of deductible, coinsurance, and copayments you are required to pay under this plan	$1,500 individual/$3,000 family	$3,000 individual/$6,000 family

The deductible, coinsurance, and copayments applied to your Network and non-network maximum out-of-pocket limits accumulate separately and are not transferable.

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 the Find a Doctor tab 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 under the Forms tab.

Prescription Drug Reimbursement Information

	Value Tier	**Tier One**	**Tier Two**	**Tier Three**
Cost-Sharing Per Prescription Fill	$0	$10	$30	$60

Prescription drugs covered under this drug plan are not subject to a deductible. Coinsurance and copayments under this drug plan do not apply to your maximum out-of-pocket limit.

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%	$25 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 SERVICES		
Primary Care Office Visits	$25 Copay, then 0%	$25 Copay, Deductible, then 20%
Specialty Care Office Visits	$50 Copay, then 0%	$100 Copay, Deductible, then 20%
Urgent Care	$50 Copay, Deductible, then 0%	$50 Copay, Deductible, then 0%
Convenient Care Clinic Services	$25 Copay, then 0%	$25 Copay, Deductible, then 20%
Routine 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 and Outpatient Services (copayments are waived for members less than 6 years of age)	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 60 days per confinement)	Deductible, then 0%	Deductible, then 20%
Skilled Rehabilitation Facility	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 policy)	$150 Copay, Deductible, then 0%	$150 Copay, Deductible, then 0%

Laboratory, ultrasounds and x-rays performed on the same day as a Network Office Visit are not subject to deductible, coinsurance, or copayment amounts.

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	Deductible, then 0%	Deductible, then 20%
Chiropractic Treatment	$25 Copay, then 0%	$25 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	Deductible, then 0%	Deductible, then 20%
Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Deductible, then 0%	Deductible, then 20%
Extraction/Replacement of Natural Teeth	No Coverage	No Coverage
Hearing Aids	Deductible, then 0%	Deductible, then 20%
Home Health Care	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, then 0%	$25 Copay, Deductible, then 20%
Pulmonary Rehabilitation	Deductible, then 0%	Deductible, then 20%
Temporomandibular Disorder (TMD) Treatment	Deductible, then 0%	Deductible, then 20%
Therapy - Physical, Speech, and Occupational	$25 Copay, then 0%	$25 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)	$25 Copay, Deductible, then 0%	$25 Copay, Deductible, then 20%
Vision Correction (limited to one pair of lenses and one pair of frames per Benefit Period)	No Coverage	No Coverage
Vision — Non-Routine Services	Deductible, then 0%	Deductible, then 20%

Copayments for chiropractic treatment, outpatient mental health and substance abuse services, therapies, and vision exam 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 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 Benefit Provisions that Apply

Value Choice Drug Plan
Vision Correction Excluded
Enhanced Benefits

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

Underwritten by WEA Insurance Corporation
P.O. Box 7338, Madison, WI 53707 Voice/TTY: (608) 276-4000 or (800) 279-4000
weatrust.com