



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:
Effective Date: **Benefit Period:** through
Network:

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		
Coinsurance You Pay		
<p>Maximum Out-of-Pocket Limit Maximum amount of deductible, coinsurance, and copayments you are required to pay under this plan</p> <p><i>The deductible, coinsurance, and copayments applied to your Network and non-network maximum out-of-pocket limits accumulate separately and are not transferable.</i></p> <p><i>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.</i></p>		

	Tier One	Tier Two	Tier Three
Cost-Sharing Per Prescription Fill			

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%	
Tobacco Cessation Screening and Brief Interventions	0%	
Other Preventive Services Including Immunizations, Screenings, and Certain Counseling Services	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 Specialty Care Office Visits Urgent Care Convenient Care Clinic Services Routine Maternity Care Laboratory and Radiology Specialty Drugs (including injections) Inpatient and Outpatient Services		
INPATIENT FACILITY SERVICES Hospitalization Surgery, Anesthesia, and Related Supplies Maternity and Newborn Services Advanced Imaging and Laboratory Services Mental Health and Substance Abuse Services Skilled Nursing Facility Skilled Rehabilitation Facility		
OUTPATIENT FACILITY SERVICES Surgery and Related Services Non-Emergency Advanced Imaging Other Diagnostic Tests Emergency Room (exceptions may apply, so please see your policy)		

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		
Cardiac Rehabilitation		
Chiropractic Treatment		
Congenital Heart Disease Surgery		
Dental Services		
Durable Medical Equipment, Prosthetics, Orthotics and Supplies		
Hearing Aids		
Home Health Care		
Hospice Care		
Kidney Disease Treatment		
Outpatient Mental Health and Substance Abuse Services		
Pulmonary Rehabilitation		
Temporomandibular Disorder (TMD) Treatment		
Therapy - Physical, Speech, and Occupational		
Transplants		
Vision Exam (limited to one routine vision exam per Benefit Period)		
Vision Correction (limited to one pair of lenses and one pair of frames per Benefit Period)		
Vision — Non-Routine Services		

Reimbursement Notifications For Non-Network Providers

Optional Benefit Provisions that Apply



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