


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, contact Prairie States Enterprises at 800-615-7020. 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 <https://www.healthcare.gov/sbc-glossary/> or call 800-615-7020 for a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">network providers</a> : <b>\$2,500</b> Individual / <b>\$5,000</b> Family; For <a href="#">out-of-network</a> providers <b>\$5,000</b> Individual / <b>\$10,000</b> Family Does not apply to preventive care. BSD contributes \$1,500 HSA dollars/individual BSD contributes \$3,000 HSA dollars/family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> when rendered by <a href="#">network providers</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> <b>\$5,000</b> Individual / <b>\$10,000</b> Family; For <a href="#">out-of-network</a> providers there is no maximum. Includes the <a href="#">deductible</a> , <a href="#">coinsurance</a> and <a href="#">copayments</a>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, amounts over usual and customary fees, pre-certification penalties, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. The Alliance and Trilogy: <a href="http://www.the-alliance.org">www.the-alliance.org</a> or <a href="http://www.trilogycares.com">www.trilogycares.com</a> or call Customer Service at 1-800-223-4139 Out-of-area: First Health Network <a href="http://www.firsthealth.com">www.firsthealth.com</a> or call 1-800-226-5116	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	This <a href="#">plan</a> will allow you to see a <a href="#">specialist</a> of your choice without a <a href="#">referral</a> .

 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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	<a href="#">Deductible</a> , then \$20 <a href="#">copayment</a> , then 5% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	BHS will waive co-pay for services provided to any individual covered under the Beloit School District health plan, except emergency room co-pay
	<a href="#">Specialist</a> visit	<a href="#">Deductible</a> , then \$20 <a href="#">copayment</a> , then 5% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	BHS will waive co-pay for services provided to any individual covered under the Beloit School District health plan, except emergency room co-pay
	<a href="#">Preventive care/screening/immunization</a>	<a href="#">Deductible</a> waived, 0% <a href="#">coinsurance</a> , no <a href="#">copayment</a>	No Coverage	<a href="#">Well Child Care</a> examinations and routine related lab. Includes state-mandated immunizations <a href="#">Routine Physical Examinations</a> applies to covered persons age 7 and over. <a href="#">Routine Mammograms</a> limited to one per plan year beginning at age 40. <a href="#">Routine PSA Testing</a> limited to one per plan year beginning at age 40. <a href="#">Routine Pap Smear</a> limited to one per plan year. <a href="#">Routine Colonoscopy</a> limited to 1 every 5 years. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	<a href="#">Deductible</a> then 5% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	<a href="#">Deductible</a> then 5% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	Imaging Requires <a href="#">Preauthorization</a> . Failure to do so will result in a 25% Penalty up to \$250.

\* For more information about limitations and exceptions, see the [plan](#) or policy document by calling your Human Resources Dept or Prairie States.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available from at <a href="http://www.flexscripts.com">http://www.flexscripts.com</a> or 1-800-603-7796</p>	Generic drugs (Tier 1)	<u>Deductible</u> then: \$7 <u>copayment</u> Retail 34-day supply \$14 <u>copayment</u> Retail 35-68-day supply \$21 <u>copayment</u> Retail 69-102-day supply \$21 <u>copayment</u> Mail Order up to 102-day supply	Not Covered	Specialty Drugs over \$1,500 for a 30-day supply require additional Plan Authorization by contacting the Pharmacy Benefit Administrator at 1.800-603.7796
	Preferred brand drugs (Tier 2)	<u>Deductible</u> then: \$16 <u>copayment</u> Retail 34-day supply \$32 <u>copayment</u> Retail 35-68-day supply \$48 <u>copayment</u> Retail 69-102-day supply \$48 <u>copayment</u> Mail Order up to 102-day supply	Not Covered	
	Non-preferred brand drugs (Tier 3)	<u>Deductible</u> then: 50% <u>copayment</u> Retail 34-day supply 50% <u>copayment</u> Retail 35-68-day supply 50% <u>copayment</u> Retail 69-102-day supply 50% <u>copayment</u> Mail Order up to 102-day supply	Not Covered	
	<a href="#">Specialty drugs</a> (Tier 4)	Call FlexScripts	Not Covered	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	<u>Deductible</u> then 5% <u>coinsurance</u>	<u>Deductible</u> , then 30% <u>coinsurance</u>	<p><u>Preauthorization</u> is required. If you don't receive <u>Preauthorization</u>, benefits will be reduced by 25% up to a maximum of \$250.</p>
	Physician/surgeon fees	<u>Deductible</u> then 5% <u>coinsurance</u>	<u>Deductible</u> , then 30% <u>coinsurance</u>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document by calling your Human Resources Dept or Prairie States.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	<a href="#">Deductible</a> then \$75 <a href="#">copayment</a> then 5% <a href="#">coinsurance</a>	<a href="#">Deductible</a> then \$75 <a href="#">copayment</a> then 5% <a href="#">coinsurance</a>	<a href="#">Copayment</a> is waived if admitted. Copayment shall apply regardless if deductible is met
	<a href="#">Emergency medical transportation</a>	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>	<a href="#">Deductible</a> 20% <a href="#">coinsurance</a>	If medically necessary the out of network ambulance charge will be paid at the in-network benefit level
	<a href="#">Urgent care</a>	<a href="#">Deductible</a> then \$30 <a href="#">copayment</a> then 5% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	<a href="#">Deductible</a> then 5% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't receive <a href="#">Preauthorization</a> , benefits will be reduced by 25% up to a maximum of \$250.
	Physician/surgeon fees	<a href="#">Deductible</a> then 5% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<a href="#">Deductible</a> then \$20 <a href="#">copayment</a> then 5% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	BHS will waive <a href="#">copayment</a> for services provided to any individual covered under the Beloit School District health plan, except emergency room <a href="#">copayment</a> . <a href="#">Preauthorization</a> is required for inpatient hospitalizations. If you don't receive <a href="#">Preauthorization</a> , benefits will be reduced by 25% up to a maximum of \$250.
	Inpatient services	<a href="#">Deductible</a> then 5% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	<a href="#">Deductible</a> then \$20 <a href="#">copayment</a> then 5% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> and <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Dependent pregnancy covered.
	Childbirth/delivery professional services	<a href="#">Deductible</a> then 5% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	<a href="#">Deductible</a> then 5% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document by calling your Human Resources Dept or Prairie States.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	Limited to 40 visits per plan year. <a href="#">Preauthorization</a> is required. If you don't receive <a href="#">Preauthorization</a> , benefits will be reduced by 25% up to a maximum of \$250.
	<a href="#">Rehabilitation services</a>	<a href="#">Deductible</a> then \$20 <a href="#">copayment</a> then 5% <a href="#">coinsurance</a> for Occupation/Physical/Speech Therapy. <a href="#">Deductible</a> then 5% <a href="#">coinsurance</a> for all other covered Rehabilitation services.	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	Occupational/Physical/Speech Therapy <a href="#">Preauthorization</a> is required. If you don't receive <a href="#">Preauthorization</a> , benefits will be reduced by 25% up to a maximum of \$250.
	<a href="#">Habilitation services</a>	Covered	Covered	Covered.
	<a href="#">Skilled nursing care</a>	<a href="#">Deductible</a> then 5% <a href="#">coinsurance</a> first 30 days than 20% <a href="#">coinsurance</a> next 90 days	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	Skilled Nursing Inpatient maximum 120 visits per plan year. <a href="#">Preauthorization</a> is required. If you don't receive <a href="#">Preauthorization</a> , benefits will be reduced by 25% up to a maximum of \$250.
	<a href="#">Durable medical equipment</a>	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't receive <a href="#">Preauthorization</a> , benefits will be reduced by 25% up to a maximum of \$250.
	<a href="#">Hospice services</a>	<a href="#">Deductible</a> then 5% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 30% <a href="#">coinsurance</a>	Inpatient Hospice <a href="#">Preauthorization</a> is required. If you don't receive <a href="#">Preauthorization</a> , benefits will be reduced by 25% up to a maximum of \$250.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

\* For more information about limitations and exceptions, see the [plan](#) or policy document by calling your Human Resources Dept or Prairie States.

## 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
- Routine Dental Care (Adult & Child)
- Habilitation Services
- Bariatric Surgery and/or weight loss programs
- Infertility Treatment
- Holistic Medicine
- Cosmetic Surgery
- Long-Term Care

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Oral Surgery
- Contraception Services
- Autism Spectrum Disorder
- Chiropractic Care
- Cochlear Implants

**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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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](http://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 on how 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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). A list of states with Consumer Assistance Programs is available at [www.HealthCare.gov](http://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 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](#).

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-615-7020.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-615-7020.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-615-7020.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-800-615-7020.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

\* For more information about limitations and exceptions, see the [plan](#) or policy document by calling your Human Resources Dept or Prairie States.



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](#) \$2500
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 5%
- Other [coinsurance](#) 20%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$500
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,070</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$2500
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 5%
- Other [coinsurance](#) 20%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles*</a>	\$2,500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$20
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,840</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$2500
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 5%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles*</a>	\$2,500
<a href="#">Copayments</a>	\$80
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,580</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.