
 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/>.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network \$2,500 Individual \$5,000 Family. Non-Network \$5,000 individual \$10,000 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 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network \$5,000 Individual \$10,000 Family. Non-Network has no maximum. Includes the deductible, coinsurance, and copays.	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-billed charges, co-payments, amounts over usual and customary fee's, pre-certification penalties 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. The Alliance, www.the-alliance.org Out-of-area: First Health Network www.firsthealth.com or call 1-800-226-5116	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](#) 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 provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then \$20 co-pay, then 5%	Deductible then 30%	BHS will waive co-pay for services provided to any individual covered under Beloit School District health plan outside of the clinic at any BHS facility except emergency room co-pay
	Specialist visit	Deductible, then \$20 co-pay, then 5%	Deductible then 30%	BHS will waive co-pay for services provided to any individual covered under Beloit School District health plan outside of the clinic at any BHS facility except emergency room co-pay
	Preventive care/screening/immunization	0% Deductible waived no co-pay	No Coverage	Well Child Care examinations and routine related lab. Includes state-mandated immunizations Routine Physical Examinations applies to covered persons age 7 and over. Routine Mammograms limited to one per calendar year beginning at age 35. Routine PSA Testing limited to one per calendar year beginning at age 40. Routine Pap Smear limited to one per calendar year. Routine Colonoscopy limited to 1 every 5 years.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 5%	Deductible then 30%	Imaging Requires pre-certification. Failure to do so will result in a 25% Penalty up to \$250.
	Imaging (CT/PET scans, MRIs)	Deductible then 5%	Deductible then 30%	

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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.restat.com/members/resources/pharmacies or 1-800-248-1062	Generic drugs (Tier 1)	\$7 co-pay Retail 34 day supply \$14 co-pay Retail 35-68 day supply \$21 co-pay Retail 69-102 day supply \$21 co-pay Mail Order up to 102 day supply	No Coverage	You are required to obtain medications from one of the Align pharmacies. To see a listing of these pharmacies, go to: www.restat.com/members/resources/pharmacies
	Preferred brand drugs (Tier 2)	\$16 co-pay Retail 34 day supply \$32 co-pay Retail 35-68 day supply \$48 co-pay Retail 69-102 day supply \$48 co-pay Mail Order up to 102 day supply	No Coverage	
	Non-preferred brand drugs (Tier 3)	50% co-pay Retail 34 day supply 50% co-pay Retail 35-68 day supply 50% co-pay Retail 69-102 day supply 50% co-pay Mail Order up to 102 day supply	No Coverage	
	Specialty drugs (Tier 4)	Call Restat for further information	No Coverage	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	30% Coinsurance	Pre-certification required.
	Physician/surgeon fees	No Charge	30% Coinsurance	Pre-certification required.
If you need immediate medical attention	Emergency room care	\$75 co-pay, then Deductible, then 5%	\$75 co-pay, then Deductible then 5%	If medically necessary the out of network ambulance charge will be paid at the in-network benefit level
	Emergency medical transportation	Deductible then 20%	Deductible then 20%	
	Urgent care	Deductible, then \$30 co-pay, then 5%	Deductible then 30%	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 5%	Deductible then 30%	Outpatient Surgery requires pre-certification. Failure to do so will result in a 25% Penalty up to \$250.
	Physician/surgeon fees	Deductible then 5%	Deductible then 30%	Outpatient Surgery requires pre-certification. Failure to do so will result in a 25% Penalty up to \$250.

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 mental health, behavioral health, or substance abuse services	Outpatient services	Deductible, then \$20 co-pay, then 5%	Deductible then 30%	BHS will waive co-pay for services provided to any individual covered under Beloit School District health plan outside of the clinic at any BHS facility except for emergency room co-pay Inpatient Hospitalization requires pre-certification. Failure to do so will result in a 25% Penalty up to \$250 per occurrence
	Inpatient services	Deductible then 5%	Deductible then 30%	
If you are pregnant	Office visits	Deductible, then \$20 co-pay, then 5%	Deductible then 30%	Dependent Pregnancy Covered.
	Childbirth/delivery professional services	Deductible then 5%	Deductible then 30%	
	Childbirth/delivery facility services	Deductible then 5%	Deductible then 30%	
If you need help recovering or have other special health needs	Home health care	Deductible then 5%	Deductible then 30%	40 visits per calendar year; pre-certification required. Failure to do so will result in a 25% Penalty up to \$250
	Rehabilitation services	Deductible then 5%	Deductible then 30%	Occupational/Physical/Speech Therapy, pre-certification required. Failure to do so will result in a 25% Penalty up to \$250
	Habilitation services	Not Coverage	Not Coverage	
	Skilled nursing care	Deductible then 5% first 30 days then 20% next 90 days	Deductible then 30%	Skilled Nursing Inpatient maximum 120 days per year. Requires pre-certification. Failure to do so will result in a 25% Penalty up to \$250 per occurrence
	Durable medical equipment	Deductible then 20%	Deductible then 30%	Requires pre-certification. Failure to do so will result in no coverage.
	Hospice services	Deductible then 5%	Deductible then 30%	Inpatient Hospice requires pre-certification. Failure to do so will result in a 25% Penalty up to \$250
If your child needs dental or eye care	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

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](#).)

- Cosmetic surgery
- Routine Dental care (Adult & Child)
- Habilitation services
- Holistic Medicine
- Acupuncture
- Long Term Care
- Weight loss programs and/or bariatric surgery
- Infertility Treatment

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

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

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. 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](#). 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. Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#).].

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 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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

—————*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](#) \$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*)

Total Example Cost	\$12,731
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2500
Copayments	\$68
Coinsurance	\$620
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,248

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*)

Total Example Cost	\$7,389
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$599
Coinsurance	\$93
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$3,247

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*)

Total Example Cost	\$1,925
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,850
Copayments	\$75
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,925