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 1-800-615-7020. 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 1-800-615-7020.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Tier 2**: **$0** individual/ **$0** family per Plan year **Tier 3: $4,000** individual/ **$8,000** family per Plan year Family Deductible is Embedded	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. All services at the Onsite Clinic, Direct-Bundled Contracted providers, and utilizing Alithias. 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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Tier 2 Providers: Maximum out-of-pocket limit**: **Medical and RX**: **(including copays)**: **$4,000** Individual/**$8,000** Family **Tier 3 Providers: Maximum out-of-pocket limit Medical and RX (including copays)**: **$8,000** Individual/**$16,000** Family Family OOP Max is Embedded	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, amounts over the allowed amount, balanced billed charges, 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. See www.prairieontheweb.com for a list of network providers. Click "Members" than "My Prairie Online" Member Login	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
		On-site Clinic / Alithias / /Direct Bundled Contracts (Tier 1)	In Network Providers (Tier 2)	Non-Network Providers (Tier 3)	
If you visit a health care provider's office or clinic	A Primary care visit to treat an injury or illness	0% coinsurance no copayment	Office visit; $35 copayment/ Chiropractic; $35 copayment	Office visit, 30% coinsurance after deductible Chiropractic; 30% coinsurance after deductible	Chiropractic Care limited to maximum of 24 visits per Plan year. Maintenance excluded.
	Specialist visit	0% coinsurance no copayment	Office visit, $75 copayment	Office visit, 30% coinsurance, after deductible	None
	Preventive care/screening/ immunization	0% coinsurance no copayment	0% coinsurance no copayment	0% coinsurance no copayment	You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work, also including Ultrasounds, EKG and Echocardiograms)	0% coinsurance no copayment	Lab: $50 copayment per date of test; Diagnostic tests: $250 copayment per test	Lab: 30% coinsurance, after deductible; Diagnostic Tests: 30% coinsurance, after deductible per test	Pre-certification is required for PET Scans
	Imaging (CT/PET scans, MRIs)	0% coinsurance no copayment	$250 copayment	30% coinsurance, after deductible	

* 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
		On-site Clinic / Alithias / /Direct Bundled Contracts (Tier 1)	In Network Providers (Tier 2)	Non-Network Providers (Tier 3)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** please contact **ScoutRx at 1-833-233-1818.**	Generic drugs (Tier 1)	Preventive: $0 Retail and Mail Order: 1-30-day supply: $10 copayment 84-90-day supply: $20 copayment	Not covered	Not covered	Medications dispensed at a ProAct participating Retail Pharmacy or Mail Order Pharmacy are limited to: Retail Pharmacy 1-30- or 84-90-Days Supply. Mail Order Pharmacy 1-30- or 84-90-Day Supply 31-to-83-day supplies are excluded from coverage at retail and mail order. If you or your doctor requests a brand name drug when a generic equivalent exists, you will pay the difference between the non-preferred brand and generic medication.
	Preferred brand drugs (Tier 2)	Retail and Mail Order: 1-30-day supply: $50 copayment 84-90-day supply: $100 copayment	Not covered	Not covered	
	Non-preferred brand drugs (Tier 3)	Retail and Mail Order: 1-30-day supply: $100 copayment 84-90-day supply: $200 copayment	Not covered	Not covered	
	Specialty drugs (Tier 4)	**Non-Formulary for Brand Specialty:**atp@scoutrxconsulting.com or text ScoutRx for assistance at 1-833-233-1818	**Non-Formulary for Brand Specialty:**atp@scoutrxconsulting.com or text ScoutRx for assistance at 1-833-233-1818	**Non-Formulary for Brand Specialty:**atp@scoutrxconsulting.com or text ScoutRx for assistance at 1-833-233-1818	

Common Medical Event	Services You May Need	What You Will Pay			*Limitations, Exceptions, & Other Important Information
		On-site Clinic / Alithias / /Direct Bundled Contracts (Tier 1)	In Network Providers (Tier 2)	Non-Network Providers (Tier 3)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance no copayment	$300 copayment	30% coinsurance, after deductible	Pre-certification is required for Outpatient surgeries. copayment includes all facility and services charges.
	Physician/surgeon fees	0% coinsurance no copayment	All covered physician services / supplies included in the facility $300 copayment	30% coinsurance, after deductible	
If you need immediate medical attention	Emergency room care	Not Applicable	$300 copayment	$300 copayment	copayment is per visit. copayment is waived if admitted. Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if am Out-of-Network Provider is used. Ground, water and air ambulance included. Ambulance: Must meet medical necessity requirements.
	Emergency medical transportation	Not Applicable	$300 copayment	30% coinsurance, after deductible	
	Urgent care	Not Applicable	$100 copayment	30% coinsurance, after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	$1,500 copayment /day not to exceed $3,000	30% coinsurance, after deductible	Pre-certification is required for Inpatient stays. copayment, includes all facility services/supplies
	Physician/surgeon fees	Not Applicable	All covered physician services/supplies included in the facility $1,500 copayment	30% coinsurance, after deductible	

* 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
		On-site Clinic / Alithias / /Direct Bundled Contracts (Tier 1)	In Network Providers (Tier 2)	Non-Network Providers (Tier 3)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance no copayment	Physicians; $35 copayment Outpatient facility: $300 copayment / per day	30% coinsurance, after deductible	Pre-certification is required for Inpatient Hospitalization. copayment, includes all facility/physician services/supplies.
	Inpatient services	Not Applicable	$1,500 copayment /day not to exceed $3,000	30% coinsurance, after deductible	
If you are pregnant	Office visits	Not Applicable	Office visit; $35 copayment	Office visit, 30% coinsurance after deductible	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Pre-certification is required for Inpatient Hospitalization. Dependent pregnancy is covered; however, applicable copay costs will be required for all services performed.
	Childbirth/delivery professional services	Not Applicable	All covered physician services/supplies included in the facility $1,500 copayment	30% coinsurance, after deductible	
	Childbirth/delivery facility services	Not Applicable	$1,500 copayment /day not to exceed $3,000	30% coinsurance, after deductible	
If you need help recovering or have other special health needs	Home health care • Home Care Visits • Home Dialysis • Home Infusion Therapy • Other Home Care Services/Supplies	Not Applicable	$35 copayment $75 copayment $75 copayment $35 copayment	30% coinsurance, after deductible	Limited to a maximum of 60 visits per Plan year. In and Out-of-Network combined.
	Rehabilitation services	0% coinsurance no copayment	$35 copayment per type of covered	30% coinsurance, after deductible	Benefit Maximum(s) are for In- and

Common Medical Event	Services You May Need	What You Will Pay			*Limitations, Exceptions, & Other Important Information
		On-site Clinic / Alithias / /Direct Bundled Contracts (Tier 1)	In Network Providers (Tier 2)	Non-Network Providers (Tier 3)	
			service		Out-of-Network visits combined, and for office and outpatient visits combined. **Physical & Occupational Therapy**: 40 visits per Plan year **Speech Therapy**: 20 visits per Plan year **Cardiac Rehabilitation**: 36 visits per Plan year **Pulmonary Rehabilitation**: 20 visits per Plan year
	Habilitation services	Not Covered	Not Covered	Not Covered	
	Skilled nursing care	Not Applicable	$1,500 copayment /day not to exceed $3,000	30% coinsurance, after deductible	Limited to a maximum of 30 visits per Plan year. In and Out-of-Network combined
	Durable medical equipment, including Orthotics (Custom Molded only) and Prosthetics.	0% coinsurance no copayment	$100 copayment per day of service.	30% coinsurance, after deductible	Pre-certification is required for purchases over $500 and/or any Medical Equipment Rental. Custom molded limited to 1 pair every 3 years
	Hospice services (Home Care or Inpatient Hospice)	Not Applicable	$35 copayment per day / per admission	30% coinsurance, after deductible	
If your child needs dental or eye care	Children's eye exam	0% coinsurance no copayment	0% coinsurance no copayment	30% coinsurance, after deductible	1 Routine Vision Exam will be covered per Plan year, including the refraction.
	Children's glasses	Not Covered	Not covered	Not covered	None
	Children's dental check-up	Not Covered	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.)

- Acupuncture
- Dental care (Pediatric)
- Cosmetic surgery

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

• Dental care (Adult) • Glasses for a child • Routine foot care	• Infertility treatment • Weight loss programs	• Dental Check-up • Long-term care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic Care (Limited to maximum of 24 visits per Plan Year) • Private-duty nursing $50,000 maximum per Plan year. $100,000 maximum/Lifetime	• Hearing aids 1 Item(s)/ear every 3 years for children 18 years of age or under. • Routine eye care (Adult) 1 Routine Vision Exam will be covered pe Plan year, including the refraction.	• Non-emergency care when traveling outside the U.S.

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. 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. A list of states with Consumer Assistance Programs is available at 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, kwiijigo holne' 1-800-615-7020.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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** **$0**
- **Specialist copayment** **$75**
- **Hospital (facility) copayment** **$1,500**
- **Other copayment** **Based on services**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$3,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,660***

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$75**
- **Hospital (facility) copayment** **$1,500**
- **Other copayment** **Based on services**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$75**
- **Hospital (facility) copayment** **$1,500**
- **Other copayment** **Based on services**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

***The above examples are based on services provided by Tier 2 Contracted Providers**
Member will pay less when services are rendered by Tier 1 Contracted Providers
Member will pay more when services are rendered by Tier 3 Non-Contracted providers

The plan would be responsible for the other costs of these EXAMPLE covered services.