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 the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
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 40. 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 http://www.flexscripts.com or 1-800-603-7796	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	
	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 FlexScripts	No Coverage	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 5%	30% Coinsurance	Pre-certification required.
	Physician/surgeon fees	Deductible then 5%	30% Coinsurance	Pre-certification required.
If you need immediate medical attention	Emergency room care	Deductible, then $75 co-pay, then 5%	Deductible, then $75 co-pay, then 5%	Co-pay is waived if admitted.
	Emergency medical transportation	Deductible then 20%	Deductible then 20%	If medically necessary the out of network ambulance charge will be paid at the in-network benefit level
	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.

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)	
	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.
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 20%	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	$20 co-pay then Deductible then 5% for Occupation/ Physical/Speech Therapy. Deductible then 5% for all other covered Rehabilitation services	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 than 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

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)	
	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, kwiijigo 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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2500
Copayments	$68
Coinsurance	$620
What isn't covered	
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$599
Coinsurance	$93
What isn't covered	
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**

In this example, Mia would pay:

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

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