This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.prairieontheweb.com or by calling 1-800-615-7020.

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.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible
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
Is there an out–of–pocket limit on my expenses?	Yes. 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 during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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.
Is there an overall annual limit on what the plan pays?	No for Essential Health Benefits	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. The Alliance, www.the-alliance.org Out-of-area: First Health Network www.firsthealth.com or call 1-800-226-5116	If you use an in-network doctor or other health care provider, this plan will pay some or all the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
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 0%	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 0%	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
	Other practitioner office visit	Deductible, then $20 co-pay, then 0%	Deductible then 30%	Chiropractic – Limited to the lesser of 25 visits or $1,000. 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%	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	Deductible then 5%	Deductible then 30%	Requires pre-certification. Failure to do so will result in a 25% Penalty up to $250.
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	$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 seeing a listing of these pharmacies, go to: www.restat.com/members/resources/pharmacies
	Preferred brand drugs	$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	You are required to obtain medications from one of the Align pharmacies. To seeing a listing of these pharmacies, go to: www.restat.com/members/resources/pharmacies
	Non-preferred brand drugs	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	You are required to obtain medications from one of the Align pharmacies. To seeing a listing of these pharmacies, go to: www.restat.com/members/resources/pharmacies
	Specialty drugs	Call Restat for further information	No Coverage	You are required to obtain medications from one of the Align pharmacies. To seeing a listing of these pharmacies, go to: www.restat.com/members/resources/pharmacies
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	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	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$75 co-pay, then Deductible, then 0%	$75 co-pay, then Deductible then 0%	----------none----------
	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 0%	Deductible then 30%	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 5%	Deductible then 30%	Inpatient Hospitalization requires pre-certification. Failure to do so will result in a 25% Penalty up to $250 per occurrence
	Physician/surgeon fee	Deductible then 5%	Deductible then 30%	Inpatient Hospitalization requires pre-certification. Failure to do so will result in a 25% Penalty up to $250 per occurrence
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then $20 co-pay, then 0%	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
	Mental/Behavioral health inpatient services	Deductible then 5%	Deductible then 30%	Inpatient Hospitalization requires pre-certification. Failure to do so will result in a 25% Penalty up to $250 per occurrence
	Substance use disorder outpatient services	Deductible, then $20 co-pay, then 0%	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
	Substance use disorder inpatient services	Deductible then 5%	Deductible then 30%	Inpatient Hospitalization requires pre-certification. Failure to do so will result in a 25% Penalty up to $250 per occurrence
If you are pregnant	Prenatal and postnatal care	Deductible then 5%	Deductible then 30%	Dependent Pregnancy Covered.
	Delivery and all inpatient services	Deductible then 5%	Deductible then 30%	Dependent Pregnancy Covered.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
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	Habilitation services Not Covered
	Skilled nursing care	Deductible then 0% 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 service	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	*Eye exam*	Not Coverage	Not Coverage	----------none----------
	Glasses	Not Coverage	Not Coverage	----------none----------
	Dental check-up	Not Coverage	Not Coverage	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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 **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

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

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-893-9163. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Prairie States Enterprises at 1-877-893-9163 or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." This health coverage does meet the minimum value standard for the benefits it provides.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,640
- **Patient pays** $ 2,900

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,500
Copays	$10
Coinsurance	$240
Limits or exclusions	$150
Total	**$2,900**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,420
- **Patient pays** $ 2,980

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,500
Copays	$250
Coinsurance	$150
Limits or exclusions	$80
Total	**$2,980**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-615-7020 or visit us at www.prairieontheweb.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** to request a copy.

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