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 833-493-9163. 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 833-493-9163 for a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers: **$3,500** Individual / **$7,000** Family ($3,500 per Individual in Family Coverage) for out- of-network providers **$7,000** Individual / **$14,000** Family ($7,000 per Individual in Family Coverage)	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 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?	For network providers **$6,750** Individual / **$13,500** Family ($6,750 per Individual in Family Coverage); for out- of-network providers **$8,750** Individual / **$17,500** Family ($8,750 per Individual in Family Coverage)	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-billing charges, 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. See www.prairieontheweb.com or call 833-493-9163 for a list of network providers.	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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	This plan will allow you to see a specialist of your choice 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	0% coinsurance after deductible	20% coinsurance after deductible	Chiropractic care is limited to 12 visits per year; Preauthorization is required after the visit limit is exhausted; a penalty may apply for non-compliance.
	Specialist visit	0% coinsurance after deductible	20% coinsurance after deductible	
	Preventive care/screening/ immunization	No Charge	20% coinsurance after deductible	You may have to pay for services that aren't 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)	0% coinsurance after deductible	20% coinsurance after deductible	Preauthorization is required for PET Scans; a penalty may apply for non-compliance.
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	20% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** s available from TrueScripts at www.truescripts.com	Generic Drugs (Tier 1)	**Trigs Pharmacies and Mail Order Pharmacies**: 1-30 Day: Deductible, then $20 copayment/ prescription. 31-90 Day: Deductible, then $50 copayment/ prescription **All Other Pharmacies**: 1-30 Day: Deductible, then $30 copayment/ prescription. 31-90 Day: Not Applicable		DED and OOP are Rx and Medical Combined. Individual Deductible = $3,500 Individual OOP = $6,750 Family Deductible = $7,000 Family OOP = $13,500 ACA Preventive Care Drugs are available at no cost. Specialty drugs are limited to a max 30 day supply and require a prior authorization. The specialty drug formulary changes from time to time. To see if your prescription is covered under the plan, as well as the level of coverage,
	Preferred Brand Drugs (Tier 2)	**Trigs Pharmacies and Mail Order Pharmacies**: 1-30 Day: Deductible, then $40 copayment/ prescription. 31-90 Day: Deductible, then $100 copayment/ prescription **All Other Pharmacies**: 1-30 Day:		

* 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)	
		Deductible, then $60 copayment/ prescription. 31-90 Day: Not Applicable		please contact TrueScripts at 844-257-1955.
	Non-Preferred Brand Drugs (Tier 3)	**Trigs Pharmacies and Mail Order Pharmacies**: 1-30 Day: Deductible, then $100 copayment/ prescription. 31-90 Day: Deductible, then $250 copayment/ prescription **All Other Pharmacies**: 1-30 Day: Deductible, then $150 copayment/ prescription. 31-90 Day: Not Applicable		
	Specialty Drugs (Tier 4)	1 – 30 Day: Deductible, then 25% coinsurance to a maximum $300/prescription 31 – 90 Day: Not Applicable		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	20% coinsurance after deductible	Preauthorization is required for outpatient surgeries; a penalty may apply for non-compliance.
	Physician/surgeon fees	0% coinsurance after deductible	20% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	0% coinsurance after deductible	Network Benefits Apply	
	Emergency medical transportation	0% coinsurance after deductible	Network Benefits Apply	
	Urgent care	0% coinsurance after deductible	20% coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	20% coinsurance after deductible	Preauthorization is required for inpatient hospitalizations; a penalty may apply for non-compliance.
	Physician/surgeon fees	0% coinsurance after deductible	20% coinsurance after deductible	

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	Benefits are based on the setting in which covered services are received.		Preauthorization is required for inpatient hospitalizations; a penalty may apply for non-compliance.
	Inpatient services			
If you are pregnant	Office visits	0% coinsurance after deductible	20% coinsurance after deductible	Preauthorization is required for inpatient hospitalizations; a penalty may apply for non-compliance. Cost sharing does not apply to preventive services from a participating provider. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance after deductible	20% coinsurance after deductible	
	Childbirth/delivery facility services	0% coinsurance after deductible	20% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	20% coinsurance after deductible	Limited to 40 visits per calendar year. Preauthorization is required; a penalty may apply for non-compliance.
	Rehabilitation services	0% coinsurance after deductible	20% coinsurance after deductible	Preauthorization is required; a penalty may apply for non-compliance.
	Habilitation services	0% coinsurance after deductible	20% coinsurance after deductible	
	Skilled nursing care	0% coinsurance after deductible	20% coinsurance after deductible	Limited to 30 days per admission. Preauthorization is required; a penalty may apply for non-compliance.
	Durable medical equipment	0% coinsurance after deductible	20% coinsurance after deductible	Preauthorization is required on all rentals and purchases greater than $2,500; a penalty may apply for non-compliance.
	Hospice services	0% coinsurance after deductible	20% coinsurance after deductible	Bereavement counseling is covered if received within 12 months. Preauthorization is required; a penalty may apply for non-compliance.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one exam per calendar.
	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.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Infertility Treatment (Diagnosis Covered)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine foot care
- Weight loss programs (unless covered by the ACA)

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

- Chiropractic Care
- Hearing Aids
- Routine eye care

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 1-833-493-9163.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-493-9163.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-833-493-9163.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-493-9163.

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

* 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	**$3500**
Specialist copayment	**N/A**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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)*
Prescription drugs

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,570**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$3500**
Specialist copayment	**N/A**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$3,500
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,820**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$3500**
Specialist copayment	**N/A**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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