Summary of Benefits – Medical – Effective January 1, 2024

The following benefits are per Participant per Calendar Year.
All benefits are subject to the Maximum Allowable Charge.

TRADITIONAL PPO - SUMMARY OF BENEFITS				
All Essential Health Benefits		Unlimited		
	Tier SBL: In-Network Sarah Bush Lincoln Health Center	**Tier 1: In-Network Partner Vendors**	**Tier 2: In-Network Aetna**	**Tier 3: Out-of-Network Providers**
Definition	**SBL and FCH owned/billed providers & facilities Hospital-based providers**	**Partner Vendors and Visiting Specialists**	**Aetna, Oral Surgeons**	**Any provider not covered in Tier SBL, Tier 1, or Tier 2**
Providers	**See end of Schedule of Benefits for Providers identified under each applicable Tier**			
Please Note	• **All Services with the ability to be performed at Sarah Bush Lincoln will be required to be performed at SBL, SBLFCH (including Dr. Darmadi, Dr. Dossett, Senior Renewal), Effingham Surgical Partners, LLC., or Family Care Associates.** • **For members who reside within a 50-mile radius of either SBL or SBLFCH, if available services are performed at a different provider, then the claim will be treated as Out-of-Network.** **EMERGENCY SERVICES ARE EXEMPT FROM THIS PROVISION.**			
Deductible				
Individual	$800	$1,500	$3,000	$5,000
Family	$1,600	$3,000	$6,000	$10,000
Maximum Out-of-Pocket (includes Deductibles, Co-Insurance, Co-Payments, and Prescription Drug Co-Payments)				
Individual	$2,000	$3,000	$8,000	$15,000
Family	$4,000	$6,000	$16,000	$30,000
Coinsurance Level (unless otherwise specified)				
Individual and Family	100%	100%	75%	50%

All Deductible and Out of Pocket Tiers comingle with each other.

The following table identifies what does and does not apply toward the In-Network and Out-of-Network Out-of-Pocket Maximums:

Plan Features	**Applies to the In-Network Out-of-Pocket Maximum?**	**Applies to the Out-of-Network Out-of-Pocket Maximum?**
Payments toward the annual Deductible	Yes	Yes
Coinsurance payments, **even those for covered services available in the Prescription Drug Benefits section, except for those covered health services identified in the Summary of Benefits that do not apply to the Out-of-Pocket Maximum**	Yes	Yes
Copayments	Yes	Yes
Charges for non-covered services	No	No
The amounts of any Pre-Certification penalties	No	No
Charges that exceed Allowable Expenses	No	No

	Tier SBL	Tier 1	Tier 2	Tier 3	**Limits** *(All charges subject to Medical Necessity and appropriateness)*
Plan Coverage applies after deductible has been met unless otherwise stated. Coverage for all benefits is subject to medical necessity and appropriateness of care. Even if listed below, if treatment is not deemed medically necessary or appropriate, no coverage will apply.					
Allergy Services					
Office Visit	Primary Care: $25 copay Specialist: $40 copay	Primary Care: $25 copay Specialist: $40 copay	75%	50%	
Injections	100%	100%	75%	50%	
Serum	100%	100%	75%	50%	
Ground Ambulance	Not Available	75%	75%	75%	Applies to Tier 2 Deductible and Out-of-Pocket
Air Ambulance	Not Available	75%	75%	75%	Applies to Tier 2 Deductible and Out-of-Pocket. Inter-facility Air transport must be pre-certified through Sentinel Air Medical Alliance at 1-877-542-8828
Ambulatory Surgical Center	$250 copay	$250 copay	75%	50%	Preauthorization is required for certain outpatient procedures.
Anesthesia	100%	100%	75%	50%	
Bariatric Surgery	$250 copay	$250 copay	75%	50%	Preauthorization required. *Note: Charges for related Bariatric Treatment such as lab work and Office Visits will be covered as billed.*
Birthing Center	Not Available	Not Available	75%	50%	Preauthorization required for some maternity stays
Blood & Plasma	100%	100%	75%	50%	
Cardiac Rehabilitation	100%	100%	75%	50%	
Chiropractic Care	Not Available	100%	75%	50%	Limited to 20 visits per calendar year
Clinical Trials (Routine Patient Costs)	100%	100%	75%	50%	Preauthorization required
Cochlear Implants	Not Available	100%	75%	50%	
Dialysis	100% Inpatient when billed by SBL	100%	75%	50%	Preauthorization required
Durable Medical Equipment	100%	100%	75%	50%	Preauthorization required for electric/motorized scooters or wheelchairs, and for pneumatic compression devices
Gender Reassignment Surgery	Not Available	$250 copay	75%	50%	Preauthorization is required
Glaucoma, Cataract Surgery and Lenses (one set)	$250 copay	$250 copay	75%	50%	Preauthorization required if performed inpatient.
Hearing Aids	**Not Covered**				
Home Health Care	100%	100%	75%	50%	Preauthorization required.
Hospice					
Inpatient	$250 copay per admission	$250 copay per admission	75%	50%	Preauthorization required for inpatient services.
Outpatient	100%	100%	75%	50%	
Family Bereavement Counseling	100%	100%	75%	50%	Limit of 6 visits
Hospital					
Inpatient Treatment	$250 copay per admission	$250 copay per admission	75%	50%	Preauthorization required for inpatient services and for certain outpatient procedures.
Outpatient Treatment	100%	100%	75%	50%	
Infertility Testing and Treatment	100%	100%	75%	50%	Lifetime Max of 6 attempts
Injections	100%	100%	75%	50%	Preauthorization required
Mastectomy Bra	100%	100%	75%	50%	1 per occurrence

	Tier SBL	Tier 1	Tier 2	Tier 3	**Limits** *(All charges subject to Medical Necessity and appropriateness)*
Plan Coverage applies after deductible has been met unless otherwise stated. Coverage for all benefits is subject to medical necessity and appropriateness of care. Even if listed below, if treatment is not deemed medically necessary or appropriate, no coverage will apply.					
Newborn Care	100%	100%	75%	50%	
Outpatient Diagnostic X-Ray and Lab	100%	100%	75%	50%	Preauthorization required for all high-tech imaging
Outpatient Emergency Services (includes all services performed in Emergency Room)	$300 copay then covered 100%	$300 copay then covered 100%	$300 copay then covered 100%	$300 copay then covered 100%	If admitted, $300 copay is waived. Preauthorization within 48 hours
Physician Services					
Primary Care Office Visits (includes OB/Gyn)	$25 copay	$25 copay	75%	50%	Includes walk-in visits and virtual visits. Coverage for obesity/morbid obesity is covered at Tier SBL and Tier 1 the same as any other illness.
Specialist Office Visits	$40 copay	$40 copay	75%	50%	
Physician Inpatient/Outpatient	100%	100%	75%	50%	
Labs, X-Rays	100%	100%	75%	50%	
Imaging (CT/PET/MRI)	100%	100%	75%	50%	Preauthorization required
Pregnancy Services					
Routine Prenatal and Postnatal Services	Office Visit: $25 copay Other Services: 100%	100%	75%	50%	Preauthorization required for some maternity hospital stays. Covered for Dependent Daughter
Non-Routine Prenatal Services, Delivery and all Inpatient Care	100%	100%	75%	50%	
Breast Pump	100% Deductible waived	100% Deductible waived	100% Deductible waived	*100% Deductible waived	*Limited to 1 per pregnancy. When purchased at a retailer such as Target or Amazon, the plan will reimburse up to $350 per breast pump per pregnancy.
Pre-natal screening as defined under Women's Preventative Services of the Patient Protection and Affordable Care Act of 2010	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Preventative Care – Adult and Child					
Routine Physical Exam, including school and sport physicals for children	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Mammograms, including 3D	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	Medically necessary Mammograms also payable the same as preventative Mammograms, and the ACA age limits do not apply.
Pap Smears	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Annual Hearing Exam	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Routine Digital Rectal Exams/Prostate Specific Antigen Test	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Colorectal Cancer Screens	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	Including Cologuard

	Tier SBL	Tier 1	Tier 2	Tier 3	**Limits** *(All charges subject to Medical Necessity and appropriateness)*
Plan Coverage applies after deductible has been met unless otherwise stated. Coverage for all benefits is subject to medical necessity and appropriateness of care. Even if listed below, if treatment is not deemed medically necessary or appropriate, no coverage will apply.					
Outpatient Gastric Scopes	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	Includes routine and medically necessary Colonoscopy, Sigmoidoscopy, Endoscopy, etc. (Includes scopes with polyp removal). The ACA age limits do not apply.
Routine Immunizations	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Private Duty Nursing	Not Available	75%	75%	50%	Limited to 70 visits per calendar year
Prosthetics, Orthotics, Supplies, Surgical Dressings	100%	100%	75%	50%	Limited to 2 foot orthotic devices or 1 pair of foot orthotic devices per calendar year (not limited to diabetes only)
Psychiatric Services					
Residential Treatment	Not Available	100%	75%	50%	Preauthorization required
Inpatient Treatment	$250 copay per admission	$250 copay per admission	75%	50%	
Partial Day Program	Not Available	100%	75%	50%	
Office Visits/Therapy	$25 copay	$25 copay	75%	50%	
Routine Foot Care	100%	100%	75%	50%	Covered for diabetics only
Second Surgical Opinions	100%	100%	75%	50%	
Skilled Nursing Facility	Not available	75%	75%	50%	Preauthorization required. Limit of 180 days per calendar year.
Sleep Disorders	100%	100%	75%	50%	
Substance Abuse					
Residential Treatment	Not Available	100%	75%	50%	Preauthorization required
Inpatient Treatment	Not Available	$250 copay per admission	75%	50%	
Partial Day Program	Not Available	100%	75%	50%	
Office Visits/Therapy	Not Available	$25 copay	75%	50%	
Outpatient Physician	Not Available	100%	75%	50%	
Surgery	$250 copay	$250 copay	75%	50%	Preauthorization required for inpatient services and for certain outpatient procedures.
Temporomandibular Joint (TMJ) Treatment	100%	100%	75%	50%	
Therapy					
ABA Therapy for Autism	100%	100%	75%	50%	Therapy for autism does not count toward any other therapy limits.
Chemotherapy/Radiation	100%	100%	75%	50%	Preauthorization required
Occupational Therapy	$25 copay	$25 copay	75%	50%	Limited to 60 visits per therapy type per calendar year. Limit not applicable for Autism treatment.
Physical Therapy	$25 copay	$25 copay	75%	50%	
Speech Therapy	$25 copay	$25 copay	75%	50%	
Respiratory Therapy	100%	100%	75%	50%	
Vision Therapy	100%	100%	75%	50%	Limited to treatment of Autism

	Tier SBL	Tier 1	Tier 2	Tier 3	**Limits** *(All charges subject to Medical Necessity and appropriateness)*
Plan Coverage applies after deductible has been met unless otherwise stated. Coverage for all benefits is subject to medical necessity and appropriateness of care. Even if listed below, if treatment is not deemed medically necessary or appropriate, no coverage will apply.					
Transplants					
Recipient Expenses	Not Available	$250 copay	75%	50%	Preauthorization required. Centers of Excellence must be utilized. Travel & Lodging benefit available when traveling more than 50 miles to where transplant is performed: (1) Lodging limited to $50/day; (2) Travel & Lodging combined limited to $10,000 maximum per transplant
Donor Expenses	Not available	$250 copay	75%	50%	
Urgent Care[1]	Not Available	$25 copay	75%	50%	
Walk-In Clinics[1]	$25 copay	$25 copay	75%	50%	
Wigs	100%	100%	75%	50%	Following chemotherapy/radiation, burns or surgery, and diagnosis of alopecia. Limit of $300 per calendar year.
All Other Covered Services	100%	100%	75%	50%	

Pre-authorization is required for inpatient admissions*; outpatient/physician surgeries; PET Scans; capsule endoscopy; genetic testing (including BRCA); sleep studies; chemotherapy; radiation; oncology/transplant related injections; infusion treatments; hyperbaric oxygen; home health care; DME (limited to electric/motorized scooters or wheelchairs and pneumatic compression devices); obesity*/bariatrics*; robotics*.

*Services at SBL are exempt from pre-certification on these items.

Provider Network Tiers				
	Tier SBL	**Tier 1**	**Tier 2**	**Tier 3**
Definition	SBL and FCH owned/billed providers and facilities; Hospital-based providers	Partner Vendors and Visiting Specialists	Aetna Network	Out of Network Providers
Add'l Info	Providers Billed under SBL/FCH Tax ID#	BJC; STL Children's Hospital Wash-U Physicians Effingham Surg Partners Family Care Associates Advanced Ophthalmology Dermatology & Mohs Surgery Institute VitalSkin Dermatology Renal Care Assoc Senior Renewal (FCH) Dr. M. Darmadi (FCH) Dr. B. Dossett (FCH) <u>Visits @ FCH Only:</u> - Dr. Dy - Dr. Comstock - Dr. Miller - C. Birdsall - Prairie Cardiology	Other Participating Aetna Providers	Non-Aetna Providers

- All Services with the ability to be performed at Sarah Bush Lincoln will be required to be performed at SBL, SBLFCH (including Dr. Darmadi, Dr. Dossett, Senior Renewal), Effingham Surgical Partners, LLC., or Family Care Associates.
- For members who reside within a 50-mile radius of either SBL or SBLFCH, if available services are performed at a different provider, then the claim will be treated as Out-of-Network.

EMERGENCY SERVICES ARE EXEMPT FROM THIS PROVISION.

Prescription Drug Benefits – Traditional PPO Plan

For Prescriptions filled through the Prairie Medical Center Pharmacy, the maximum individual and/or family out-of-pocket expenses will be reached at $2,000 Individual/$4,000 Family. This is combined with medical. Deductible is waived for Prescription Drug Benefits under the Traditional PPO Plan.

When prescriptions are filled outside the Prairie Medical Center Pharmacy and the individual and/or family out-of-pocket expenses reach the Tier 2 out-of-pocket maximum ($8,000 Individual / $16,000 Family), the Plan will pay 100% of the Allowable Expense for the remainder of the Calendar Year. No family member will be charged more than the individual out-of-pocket maximum.

Copays for prescriptions filled at Prairie Medical Center will not apply after the Tier 1 out-of-pocket maximum has been reached. All other prescription copays will continue until the Tier 2 out-of-pocket maximum has been reached.

Weight loss medications without diabetic indication will not be covered under the Plan. Diabetic medications, including, but not limited to Ozempic and Mounjaro, will require prior authorization.

Covered Prescription Drug Expenses:	**You Pay at Prairie Medical Center Pharmacy**	**You Pay at all other pharmacies**	**Limits**
	Retail Pharmacy Option: Covers up to 30-day supply		
Copayment per prescription or refill, for generic	$10	$20	See Prescription Drug Benefits section
Copayment per prescription or refill, for formulary name brands	$35	$50	
Copayment per prescription or refill, for non-formulary name brands	$60	$75	
Preventive Medications			
When purchased at Prairie Medical Center Pharmacy, medications on the Standard Plus Preventive Medications List are covered at a $0 copay for generics and diabetic medications and supplies. Brand name drugs will be subject to applicable copays.			
Specialty Drugs: Limited to 30- day supply – Only available at Prairie Medical			
Copayment per prescription or refill	50%, $200 Maximum		Must be filled through Prairie Medical Center Pharmacy. See Prescription Drug Benefits section.
Covered Prescription Drug Expenses:	**You Pay at Prairie Medical Center Pharmacy**	**You Pay at all other pharmacies**	**Limits**
Retail Pharmacy Option: Covers 31 to 60-day supply - Only available at Prairie Medical			
Copayment per prescription or refill, for generic	$20		See Prescription Drug Benefits section
Copayment per prescription or refill, for formulary name brands	$70		
Copayment per prescription or refill, for non-formulary name brands	$120		
Covered Prescription Drug Expenses:	**You Pay at Prairie Medical Center Pharmacy**	**You Pay at all other pharmacies**	**Limits**
Retail Pharmacy Option: Covers 61 to 90-day supply – Only available at Prairie Medical			
Copayment per prescription or refill, for generic	$30		See Prescription Drug Benefits section
Copayment per prescription or refill, for formulary name brands	$105		
Copayment per prescription or refill, for non-formulary name brands	$180		

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) WITH OPTIONAL HEALTH SAVINGS ACCOUNT (HSA) – SUMMARY OF BENEFITS				
	Tier SBL: In-Network Sarah Bush Lincoln Health Center	**Tier 1: In-Network Partner Vendors**	**Tier 2: In-Network**	**Tier 3: Out-of-Network Providers**
Definitions	**SBL and FCH owned/billed providers & facilities Hospital-based providers**	**Partner Vendors and Visiting Specialists**	**Aetna, Oral Surgeons**	**Any provider not covered in Tier SBL, Tier 1, or Tier 2**
Providers	**See end of Schedule of Benefits for Providers identified under each applicable Tier**			
Please Note	• **All Services with the ability to be performed at Sarah Bush Lincoln will be required to be performed at SBL, SBLFCH (including Dr. Darmadi, Dr. Dossett, Senior Renewal), Effingham Surgical Partners, LLC., or Family Care Associates.** • **For members who reside within a 50-mile radius of either SBL or SBLFCH, if available services are performed at a different provider, then the claim will be treated as Out-of-Network.** **EMERGENCY SERVICES ARE EXEMPT FROM THIS PROVISION.**			
Deductible (The Family Deductible is an embedded deductible. If one individual in the family has claims, the plan will start paying on that member after the individual deductible is met.)				
Individual	$3,200	$3,500	$4,000	$6,000
Family	$6,400	$7,000	$8,000	$12,000
Maximum Out-of-Pocket (includes Deductibles, Co-Insurance, Co-Payments, and Prescription Drug Co-Payments)				
Individual	$3,200	$4,500	$8,000	$15,000
Family	$6,400	$9,000	$16,000	$30,000
Coinsurance Level (unless otherwise specified) after satisfaction of the Deductible				
Individual and Family	100%	90%	75%	50%

The following table identifies what does and does not apply toward the In-Network and Out-of-Network Out-of-Pocket Maximums:

Plan Features	**Applies to the In-Network Out-of-Pocket Maximum?**	**Applies to the Out-of-Network Out-of-Pocket Maximum?**
Payments toward the annual Deductible	Yes	Yes
Coinsurance payments, **even those for covered services available in the Prescription Drug Benefits section, except for those covered health services identified in the Summary of Benefits that do not apply to the Out-of-Pocket Maximum**	Yes	Yes
Copayments for Prescription Drugs apply after deductible and apply to the Preferred Tier 1 Deductible and Out-of-Pocket	Yes, to Tier 1	No
Charges for non-covered services	No	No
The amounts of any Pre-Certification penalties	No	No
Charges that exceed Allowable Expenses	No	No

Notes regarding Deductible and Out-of-Pocket: All Deductible and Out-of-pocket Tiers comingle with each other.

	Tier SBL	Tier 1	Tier 2	Tier 3	**Limits** *(All charges subject to Medical Necessity and appropriateness)*
Plan Coverage applies after deductible has been met unless otherwise stated. Coverage for all benefits is subject to medical necessity and appropriateness of care. Even if listed below, if treatment is not deemed medically necessary or appropriate, no coverage will apply.					
Allergy Services					
Office Visit	100%	90%	75%	50%	
Injections	100%	90%	75%	50%	
Serum	100%	90%	75%	50%	
Ground Ambulance	Not Available	75%	75%	75%	Applies to Tier 2 Deductible and Out-of-Pocket
Air Ambulance	Not Available	75%	75%	75%	Applies to Tier 2 Deductible and Out-of-Pocket. Inter-facility Air transport must be pre-certified through Sentinel Air Medical Alliance at 1-877-542-8828
Ambulatory Surgical Center	100%	90%	75%	50%	Preauthorization required for certain outpatient procedures.
Anesthesia	100%	90%	75%	50%	
Bariatric Surgery	100%	90%	75%	50%	Preauthorization required. *Note: Charges for related Bariatric Treatment such as lab work and Office Visits will be covered as billed.*
Birthing Center	Not Available	Not Available	75%	50%	Preauthorization required for some maternity stays
Blood & Plasma	100%	90%	75%	50%	
Cardiac Rehabilitation	100%	90%	75%	50%	
Chiropractic Care	Not Available	90%	75%	50%	Limited to 20 visits per calendar year
Clinical Trials (Routine Patient Costs)	100%	90%	75%	50%	Preauthorization required
Cochlear Implants	Not Available	90%	75%	50%	
Dialysis	100% Inpatient when billed by SBL	90%	75%	50%	Preauthorization required
		90%			
Durable Medical Equipment	100%	90%	75%	50%	Preauthorization required for electric/motorized scooters or wheelchairs, and for pneumatic compression devices
Gender Reassignment Surgery	Not Available	90%	75%	50%	Preauthorization is required
Glaucoma, Cataract Surgery and Lenses (one set)	100%	90%	75%	50%	Preauthorization required if performed as inpatient.
Hearing Aids	**Not Covered**				
Home Health Care	100%	90%	75%	50%	Preauthorization required.
Hospice					
Inpatient	100%	90%	75%	50%	Preauthorization required for inpatient services.
Outpatient	100%	90%	75%	50%	
Family Bereavement Counseling	100%	90%	75%	50%	Limit of 6 visits
Hospital					
Inpatient Treatment	100%	90%	75%	50%	Preauthorization required for inpatient services and for certain outpatient procedures.
Outpatient Treatment	100%	90%	75%	50%	
Infertility Testing and Treatment	100%	90%	75%	50%	Preauthorization required. Lifetime Max of 6-attempts
Injections	100%	90%	75%	50%	Preauthorization required
Mastectomy Bra	100%	90%	75%	50%	1 per occurrence
Newborn Care	100%	90%	75%	50%	
Outpatient Diagnostic X-Ray and Lab	100%	90%	75%	50%	Preauthorization required for all high-tech imaging

	Tier SBL	Tier 1	Tier 2	Tier 3	**Limits** *(All charges subject to Medical Necessity and appropriateness)*
Plan Coverage applies after deductible has been met unless otherwise stated. Coverage for all benefits is subject to medical necessity and appropriateness of care. Even if listed below, if treatment is not deemed medically necessary or appropriate, no coverage will apply.					
Outpatient Emergency Services (includes all services performed in Emergency Room)	100%	100%	100%	100%	Preauthorization within 48 hours
Physician Services					
Primary Care Office Visits (includes OB/Gyn)	100%	90%	75%	50%	Includes Walk-in Visits
Specialist Office Visits	100%	90%	75%	50%	
Physician Inpatient/Outpatient	100%	90%	75%	50%	
Labs, X-Rays	100%	90%	75%	50%	
Imaging (CT/PET/MRI)	100%	90%	75%	50%	Preauthorization required
Pregnancy Services					
Routine Prenatal and Postnatal Services	100%	90%	75%	50%	Preauthorization required for some maternity hospital stays. Covered for Dependent Daughter
Non-Routine Prenatal Services, Delivery and all Inpatient Care	100%	90%	75%	50%	
Breast Pump	100% Deductible waived	100% Deductible waived	100% Deductible waived	Not covered	Limited to 1 per pregnancy. When purchased at a retailer such as Target or Amazon, the plan will reimburse up to $350 per breast pump per pregnancy.
Pre-natal screening as defined under Women's Preventative Services of the Patient Protection and Affordable Care Act of 2010	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Preventative Care – Adult and Child					
Routine Physical Exam, including school and sport physicals for children	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Mammograms, including 3D	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	Medically necessary Mammograms also payable the same as preventative Mammograms, and the ACA age limits do not apply.
Pap Smears	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Annual Hearing Exam	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Routine Digital Rectal Exams/Prostate Specific Antigen Test	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Colorectal Cancer Screens	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	Including Cologuard

	Tier SBL	Tier 1	Tier 2	Tier 3	**Limits** *(All charges subject to Medical Necessity and appropriateness)*
Plan Coverage applies after deductible has been met unless otherwise stated. Coverage for all benefits is subject to medical necessity and appropriateness of care. Even if listed below, if treatment is not deemed medically necessary or appropriate, no coverage will apply.					
Outpatient Gastric Scopes	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	Includes routine and medically necessary Colonoscopy, Sigmoidoscopy, Endoscopy, etc. (Includes scopes with polyp removal). The ACA age limits do not apply.
Routine Immunizations	100% Deductible waived	100% Deductible waived	100% Deductible waived	50%	
Private Duty Nursing	Not Available	90%	75%	50%	Limited to 70 visits per calendar year
Prosthetics, Orthotics, Supplies, Surgical Dressings	100%	90%	75%	50%	Limited to 2 foot orthotic devices or 1 pair of foot orthotic devices per calendar year (not limited to diabetes only)
Psychiatric Services					
Residential Treatment	Not Available	90%	75%	50%	Preauthorization required
Inpatient Treatment	100%	90%	75%	50%	
Partial Day Program	Not Available	90%	75%	50%	
Office Visits/Therapy	100%	90%	75%	50%	
Routine Foot Care	100%	90%	75%	50%	Covered for diabetics only
Second Surgical Opinions	100%	90%	75%	50%	
Skilled Nursing Facility	Not available	75%	75%	50%	Preauthorization required. Limit of 180 days per calendar year.
Sleep Disorders	100%	90%	75%	50%	
Substance Abuse					
Residential Treatment	Not Available	90%	75%	50%	Preauthorization required
Inpatient Treatment	Not Available	90%	75%	50%	
Partial Day Program	Not Available	90%	75%	50%	
Office Visits/Therapy	Not Available	90%	75%	50%	
Outpatient Physician	Not Available	90%	75%	50%	
Surgery	100%	90%	75%	50%	Preauthorization required for inpatient services and for certain outpatient procedures.
Temporomandibular Joint (TMJ) Treatment	100%	90%	75%	50%	
Therapy					
ABA Therapy for Autism	100%	90%	75%	50%	Therapy for autism does not count toward any other therapy limits.
Chemotherapy/Radiation	100%	90%	75%	50%	Preauthorization required
Occupational Therapy	100%	90%	75%	50%	Limited to 60 visits per therapy type per calendar year. Limit not applicable for Autism treatment.
Physical Therapy	100%	90%	75%	50%	
Speech Therapy	100%	90%	75%	50%	
Respiratory Therapy	100%	90%	75%	50%	
Vision Therapy	100%	90%	75%	50%	Limited to treatment of Autism

	Tier SBL	Tier 1	Tier 2	Tier 3	Limits *(All charges subject to Medical Necessity and appropriateness)*
Plan Coverage applies after deductible has been met unless otherwise stated. Coverage for all benefits is subject to medical necessity and appropriateness of care. Even if listed below, if treatment is not deemed medically necessary or appropriate, no coverage will apply.					
Transplants					
Recipient Expenses	Not Available	90%	75%	50%	Preauthorization required. Centers of Excellence must be utilized.
Donor Expenses	Not available	90%	75%	50%	Travel & Lodging benefit available when traveling more than 50 miles to where transplant is performed: (1) Lodging limited to $50/day; (2) Travel & Lodging combined limited to $10,000 maximum per transplant
Urgent Care[1]	Not Available	90%	75%	50%	
Walk-In Clinics[1]	100%	90%	75%	50%	
Wigs	100%	90%	75%	50%	Following chemotherapy/radiation, burns or surgery, and diagnosis of alopecia. Limit of $300 per calendar year.
All Other Covered Services	100%	90%	75%	50%	

Pre-authorization is required for inpatient admissions*; outpatient/physician surgeries; PET Scans; capsule endoscopy; genetic testing (including BRCA); sleep studies; chemotherapy; radiation; oncology/transplant related injections; infusion treatments; hyperbaric oxygen; home health care; DME (limited to electric/motorized scooters or wheelchairs and pneumatic compression devices); obesity*/bariatrics*; robotics*.

*Services at SBL are exempt from pre-certification on these items.

Provider Network Tiers				
	Tier SBL	**Tier 1**	**Tier 2**	**Tier 3**
Definition	SBL and FCH owned/billed providers and facilities; Hospital-based providers	Partner Vendors and Visiting Specialists	Aetna Network	Out of Network Providers
Add'l Info	Providers Billed under SBL/FCH Tax ID#	BJC; STL Children's Hospital Wash-U Physicians Effingham Surg Partners Family Care Associates Advanced Ophthalmology Dermatology & Mohs Surgery Institute VitalSkin Dermatology Renal Care Assoc Senior Renewal (FCH) Dr. M. Darmadi (FCH) Dr. B. Dossett (FCH) <u>Visits @ FCH Only:</u> - Dr. Dy - Dr. Comstock - Dr. Miller - C. Birdsall - Prairie Cardiology	Other Participating Aetna Providers	Non-Aetna Providers

- All Services with the ability to be performed at Sarah Bush Lincoln will be required to be performed at SBL, SBLFCH (including Dr. Darmadi, Dr. Dossett, Senior Renewal), Effingham Surgical Partners, LLC., or Family Care Associates.
- For members who reside within a 50-mile radius of either SBL or SBLFCH, if available services are performed at a different provider, then the claim will be treated as Out-of-Network.

EMERGENCY SERVICES ARE EXEMPT FROM THIS PROVISION.

Prescription Drug Benefits - HDHP

Copays for prescriptions apply after the Deductible and apply to the Preferred Tier 1 Deductible and Out-of-Pocket.

Weight loss medications without diabetic indication will not be covered under the Plan. Diabetic medications, including, but not limited to Ozempic and Mounjaro, will require prior authorization.

Covered Prescription Drug Expenses through OptumRx:	**Prairie Medical Center Pharmacy**	**Other Participating Pharmacies**
Copayment per prescription or refill, for generic	After deductible is met: 100% 100% 100%	After deductible is met: $20 for 30-day supply
Copayment per prescription or refill, for formulary name brands (Preferred Brand Name)	After deductible is met: 100% 100% 100%	After deductible is met: $50 for 30-day supply
Copayment per prescription or refill, for non-formulary name brands (Non-Preferred Brand Name)	After deductible is met: 100% 100% 100%	After deductible is met: $75 for 30-day supply

DENTAL BENEFITS

Calendar Year Deductible – Does not apply to Class 1 or Class 4	
Individual	$75
Family	$225
Maximum Benefit per Calendar Year per person: $1,500 (applies to * below, combined)	
Services	**Plan Pays**
Class 1* Diagnostic, Preventive and Miscellaneous	100% Coinsurance
Class 2* Restorative, General, Endodontic, Periodontic, and Oral Surgery	80% Coinsurance
Class 3* Crowns, Inlays/Onlays and Prosthodontic	50% Coinsurance
Class 4 Orthodontic Services, including Invisalign **Lifetime Maximum $1,500 per person**	50% Coinsurance

The Deductible amount listed above is the amount each Participant must pay each Calendar Year toward Covered Expenses. Once the Deductible is satisfied, additional Covered Expenses will be reimbursed according to the percentages set forth above, subject to the limitations and Exclusions set forth in this section.