SUMMARY OF BENEFITS

General Limits

Payment for any of the expenses listed below is subject to all Plan Exclusions, limitations and provisions. All coverage figures, if applicable, are after the out-of-pocket Deductible has been satisfied.

See the Utilization Management section for more information regarding Pre-Certification and/or Notification requirements.

Network and Non-Network Provider Arrangement

The Plan contracts with medical Provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical Provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Participants use a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:
    a. In the event a Covered Person utilizes a Network Provider for inpatient/outpatient services/procedures, but the Network Provider uses a Non-Network Provider for services including, but not limited to, anesthesia, interpretation of laboratory tests, or x-rays, then charges of the Non-Network Provider will be paid as though the services were provided by a Network Provider and will fall under the applicable plan Tier.
    b. The Tier 2 Network Provider level of benefits is payable for any Participant who cannot access Tier SBL because they reside outside the Network service area. The Network service area is defined as 50 miles from the Sarah Bush Lincoln Health Center in Mattoon, IL and/or Sarah Bush Lincoln Fayette County Hospital in Vandalia, IL and is measured from zip code to zip code.
    c. In the event services are not available from a Network Provider (Tier SBL, Tier 1 or Tier 2), then charges of a Non-Network Provider may be paid as though the services were provided by a Tier 2 Provider.

2. If the charge billed by a Non-Network Provider for any covered service is higher than the Maximum Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously–given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.

3. To receive benefit consideration, Participants must submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.

4. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

Balance Billing

In the event that a claim submitted by a Network or Non-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator, although the Plan has no control over any Provider's actions, including balance billing.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Participant is responsible for any applicable payment of Coinsurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Choice of Providers

The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other health care Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Third Party Administrator. The delivery of medical and other health care services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges exceed the Maximum Allowable Charge or services that are not Medically Necessary, and may include a patient medical billing records review and/or audit of the patient's medical charts and records. Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

Transition of Care. If a Participant is under the care of a Non-Network Provider at the time of joining the Plan, there are a limited number of medical conditions that may qualify for transition of care. If transitional care is appropriate, specific treatment by a Non-Network Provider may be covered at the Network level of benefits for a limited period of time. The Third Party Administrator will review and approve or deny such requests.

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 Home Tier, Preferred Tier, or PPO Tier**
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	$600	$1,200	$2,500	$4,000
Family	$1,200	$2,400	$5,000	$8,000
Maximum Out-of-Pocket (includes Deductibles, Co-Insurance, Co-Payments, and Prescription Drug Co-Payments)				
Individual	$1,500	$2,500	$7,500	$15,000
Family	$3,000	$5,000	$15,000	$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 outpatient surgeries
Anesthesia	100%	100%	75%	50%	
Bariatric Surgery	$250 copay	$250 copay	75%	50%	Preauthorization required
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%	Preauthorization required
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 equipment over $500
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
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
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
Outpatient Treatment	100%	100%	75%	50%	
Infertility Testing and Treatment	100%	100%	75%	50%	Preauthorization required. Lifetime Max of 6 attempts
Injections	100%	100%	75%	50%	Preauthorization required
Mastectomy Bra	100%	100%	75%	50%	1 per occurrence
Newborn Care	100%	100%	75%	50%	

	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 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
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	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)*
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
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.					
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
Temporomandibular Joint (TMJ) Treatment	100%	100%	75%	50%	
Therapy					
ABA Therapy for Autism	100%	100%	75%	50%	Preauthorization is required. 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%	Preauthorization required. 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)*
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%	

Preauthorization is required for all hospitalizations*/observations* (except for bariatric surgery performed at SBL), transplant services (including evaluations), Inpatient rehabilitations stays, substance abuse treatment (inpatient, residential and partial day program), mental health* (inpatient, residential and partial day programs), skilled nursing, home health care*, hospice*, PET*/SPECT*/MRI* and CT* Scans, Chemotherapy* and Radiation*, Therapy Services including Physical*, Speech*, Occupational*, and Cardiac Therapy*, Durable Medical Equipment over $500/Claim, and Pre-natal*/Maternity Care*. Please contact American Health Holdings (AHH) at 1-866-345-3509 for all Preauthorization items. AHH contact information and preauthorization listing will also be included on your ID card.

*No pre-cert required at Tier SBL except for Bariatric Surgery performed at SBL..

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) Visits @ FCH Only: - 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 – 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 $2,500 Individual/$5,000 Family. This is combined with medical.

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 ($7,500 Individual / $15,000 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.

For weight loss drugs, including but not limited to Wegovy and Saxenda, such drugs must be purchased at Prairie Medical Pharmacy at the Non-Formulary copay and will be limited to a 30-day supply. A Medication Therapy Management visit is required when taking these medications. For remote workers that can't access Prairie Medical, exceptions may be made. For medications, including but not limited to, Ozempic, the Pharmacy Benefit Manager will use an ala carte method prior authorization to determine use. If primary diagnosis is diabetes, regular copays will apply.

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 Home Tier, Preferred Tier, or PPO Tier**
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	$3,000	$3,200	$3,500	$6,000
Family	$6,000	$6,400	$7,000	$12,000
Maximum Out-of-Pocket (includes Deductibles, Co-Insurance, Co-Payments, and Prescription Drug Co-Payments)				
Individual	$3,000	$4,000	$7,500	$15,000
Family	$6,000	$8,000	$15,000	$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 is required for outpatient surgeries
Anesthesia	100%	90%	75%	50%	
Bariatric Surgery	100%	90%	75%	50%	Preauthorization required
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%	Preauthorization required
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 equipment over $500
Gender Reassignment Surgery	Not Available	90%	75%	50%	Preauthorization is required
Glaucoma, Cataract Surgery and Lenses (one set)	100%	90%	75%	50%	Preauthorization required
Hearing Aids	**Not Covered**				
Home Health Care	100%	90%	75%	50%	Preauthorization required.
Hospice					
Inpatient	100%	90%	75%	50%	Preauthorization required
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
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
Outpatient Emergency Services (includes all services performed in Emergency Room)	100%	100%	100%	100%	Preauthorization within 48 hours

	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.					
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
Temporomandibular Joint (TMJ) Treatment	100%	90%	75%	50%	
Therapy					
ABA Therapy for Autism	100%	90%	75%	50%	Preauthorization is required. 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%	Preauthorization required. 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)*
Transplants					
Recipient Expenses	Not Available	90%	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	90%	75%	50%	
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%	

Preauthorization is required for all hospitalizations*/observations* (except for bariatric surgery performed at SBL), transplant services (including evaluations), Inpatient rehabilitations stays, substance abuse treatment (inpatient, residential and partial day program), mental health* (inpatient, residential and partial day programs), skilled nursing, home health care*, hospice*, PET*/SPECT*/MRI* and CT* Scans, Chemotherapy* and Radiation*, Therapy Services including Physical*, Speech*, Occupational*, and Cardiac Therapy*, Durable Medical Equipment over $500/Claim, and Pre-natal*/Maternity Care*. Please contact American Health Holdings (AHH) at 1-866-345-3509 for all Preauthorization items. AHH contact information and preauthorization listing will also be included on your ID card.

*No pre-cert required at Tier SBL except for Bariatric Surgery performed at SBL..

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) Visits @ FCH Only: - 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.

For weight loss drugs, including but not limited to Wegovy and Saxenda, such drugs must be purchased at Prairie Medical Pharmacy at the Non-Formulary copay and will be limited to a 30-day supply. A Medication Therapy Management visit is required when taking these medications. For remote workers that can't access Prairie Medical, exceptions may be made. For medications, including but not limited to, Ozempic, the Pharmacy Benefit Manager will use an ala carte method prior authorization to determine use. If primary diagnosis is diabetes, regular copays will apply

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