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 1-800-615-7020. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-844-915-7020.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	There are no deductibles	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?	N/A. This Plan has no deductibles.	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?	**In-Network Providers: Maximum out-of-pocket limit: Medical and RX: (including copays):** $5,000 Individual**/$7,500 Family** **Out-of-Network Providers: Maximum out-of-pocket limit Medical and RX (including copays)** for all other providers: $8,000 Individual/$12,000 Family	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. The Family Maximum out-of-pocket limit is Embedded. ****HRA: A Prairie States Health Reimbursement Account will automatically reimburse**: · Individuals for covered expenses in excess of $3,000 ($2,000 maximum HRA), OR · $2,000 if a Family spends $5,500 of covered expenses first · Reimbursements will automatically occur quarterly · Reminder: HPS pays the providers directly. Plan members are able to use the HRA reimbursement to pay HPS
What is not included in the out-of-pocket limit?	Premiums, amounts over the allowed amount, balanced billed charges, 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 1-844-915-7020 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	You can see the specialist you choose without a referral .

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		MASD Clinic Direct Contracted Providers Collaborative Care Doctor on Demand ($0 Options) (You will pay the least)	HPS and First Health (In-Network) (RBP) Out-Of-Network (Out-of-Network) You will pay less for In-Network and the most for Out-of-Network. Out-of-Network Providers will be repriced and you may be Balance Billed.	
If you visit a health care provider's office or clinic	A Primary care visit to treat an injury or illness	No copayment	**In-Network:** $50 copayment/office visit until MASD Clinic opens and $100 copayment/office visit after MASD Clinic opens; Chiropractic, $25 copayment/office visit **Out-of-Network:** $200 copayment/office visit; Chiropractic $50 copayment/office visit.	Chiropractic Care limited to maximum of 26 visits per Plan Year.
	Doctor on Demand	No copayment	Not Applicable	
	Specialist visit	No copayment	**In-Network:** $150 copayment/office visit **Out-of-Network:** $300 copayment/office visit	None

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		MASD Clinic Direct Contracted Providers Collaborative Care Doctor on Demand ($0 Options) (You will pay the least)	HPS and First Health (In-Network) (RBP) Out-Of-Network (Out-of-Network) You will pay less for In-Network and the most for Out-of-Network. Out-of-Network Providers will be repriced and you may be Balance Billed.	
	Preventive care/screening/ immunization	No copayment No Cost for ACA required list of Preventive services	**In-Network:** no copayment No Cost for ACA required list of Preventive services **Out-of-Network** Copays are relative to covered services performed. Preventive Care services will be covered at 100% for non-Network Providers if there is no Network Provider who can provide a required preventive service. Other Preventive Care services may be covered based upon ACA Guidelines	You may have to pay for services that are not 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)	No copayment	**In-Network:** Lab: $50 maximum copayment per lab; X-ray: $100 copayment **Out-of-Network:** Lab: maximum $100 copayment per lab; X-ray: $200 copayment	Genetics: $1000 per lab. Pre-certification required. If you don't receive pre-certification, benefits will be reduced by $250.

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		MASD Clinic Direct Contracted Providers Collaborative Care Doctor on Demand ($0 Options) (You will pay the least)	HPS and First Health (In-Network) (RBP) Out-Of-Network (Out-of-Network) You will pay less for In-Network and the most for Out-of-Network. Out-of-Network Providers will be repriced and you may be Balance Billed.	
	Imaging (CT/PET scans, MRIs)	No copayment	**In-Network:** $500 copayment per MRI.CT.PET **Out-of-Network:** $1,000 copayment per MRI, CT, PET	Pre-certification is required for MRIs and PET Scans. If you don't receive pre-certification, benefits will be reduced by $250.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** please contact Ventegra: Customer Care Team Phone Number: (877) -867-0943. Customer Service Team Email Address: customercareteam@ventegra.com	Generic drugs (Tier 1)	Retail and Mail Order: $5 copayment	Not Covered	Retail Pharmacy 1-91 Day Supply. Mail Order Pharmacy 1-91 Day Supply. 1-91 day supplies are covered at retail and mail order. If you or your doctor requests a brand name drug when a generic equivalent exists, you will pay the difference between the non-preferred brand and generic medication.
	Preferred brand drugs (Tier 2)	Retail and Mail Order: $50 copayment	Not Covered	
	Non-preferred brand drugs (Tier 3)	Retail and Mail Order: $100 copayment	Not Covered	
	Specialty drugs (Tier 4)	Not Covered Please call ReScrybe @ 1-866-401-1883	Not Covered Please call ReScrybe @ 1-866-401-1883	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No copayment	**In-Network:** $500 copayment **Out-of-Network:** $1,000 copayment	Pre-certification is required for Outpatient surgeries. If you don't receive pre-certification, benefits will be reduced by $250.

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		MASD Clinic Direct Contracted Providers Collaborative Care Doctor on Demand ($0 Options) (You will pay the least)	HPS and First Health (In-Network) (RBP) Out-Of-Network (Out-of-Network) You will pay less for In-Network and the most for Out-of-Network. Out-of-Network Providers will be repriced and you may be Balance Billed.	
	Physician/surgeon fees	No copayment	Not Applicable	All covered physician services/supplies included in the facility fee copay.
If you need immediate medical attention	Emergency room care	Not Applicable	**In-Network:** $500 copayment **Out-of-Network:** $500 copayment	Pre-certification required within 48 hours after Emergency. If you don't receive pre-certification, benefits will be reduced by $250. Ground, water and air ambulance included. Must meet medical necessity requirements.
	Emergency medical transportation	Not Applicable	**In-Network:** $500 copayment **Out-of-Network:** $500 copayment	
	Urgent care	Not Applicable	**In-Network:** $150 copayment **Out-of-Network** $150 copayment	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	**In-Network:** $1,000 copayment/day not to exceed $3,000 per Plan Year **Out-of-Network:** $2,000 copayment/day not to exceed $6,000 per Plan Year	Pre-certification is required for Inpatient stays. If you don't receive pre-certification, benefits will be reduced by $250. Facility supplies and covered services included in the Copay.

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		MASD Clinic Direct Contracted Providers Collaborative Care Doctor on Demand ($0 Options) (You will pay the least)	HPS and First Health (In-Network) (RBP) Out-Of-Network (Out-of-Network) You will pay less for In-Network and the most for Out-of-Network. Out-of-Network Providers will be repriced and you may be Balance Billed.	
	Physician/surgeon fees	Not Applicable	Not Applicable	All covered services/supplies included in the facility fee copay.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No copayment	**In-Network: Physician** $50 copayment/office visit. **Outpatient facility services:** $50 copay per day **Out-of-Network: Physician:** $100 copayment/office visit. **Outpatient facility services:** $100 copayment per day	Inpatient: Pre-certification is required. If you don't receive pre-certification, benefits will be reduced by $250. All covered services/supplies included in the facility fee copay.
	Inpatient services	Not Applicable	**In-Network: Physician:** Not Applicable. **Inpatient:** $1,000 copayment per day not to exceed $3,000 Facility and Services Included **Out-of-Network: Physician:** Not Applicable **Inpatient:** $2,000 copayment per day not to exceed $6,000 Facility and Services Included.	

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		MASD Clinic Direct Contracted Providers Collaborative Care Doctor on Demand ($0 Options) (You will pay the least)	HPS and First Health (In-Network) (RBP) Out-Of-Network (Out-of-Network) You will pay less for In-Network and the most for Out-of-Network. Out-of-Network Providers will be repriced and you may be Balance Billed.	
If you are pregnant	Office visits	Not Applicable	**In-Network:** No copayment/office visit (for Employees and Spouses only) **Out-of-Network:** No copayment/office visit (for Employees and Spouses only)	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). **Dependent pregnancy is covered; however, applicable copay costs will be required for all services performed.**
	Childbirth/delivery professional services	Not Applicable	**In-Network:** No copayment (for Employees and Spouses only) **Out-of-Network:** No copayment (for Employees and Spouses only)	
	Childbirth/delivery facility services	Not Applicable	**In-Network:** $1,000 copayment per day not to exceed $3,000 **Out-of-Network:** $2,000 copayment per day not to exceed $6,000	
If you need help recovering or have other special health needs	Home health care	Not Applicable	**In-Network:** $50 copayment per day **Out-of-Network:** $100 copayment per day	Pre-certification is required. If you don't receive pre-certification, benefits will be reduced by $250. Must meet medical necessity requirements.

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		MASD Clinic Direct Contracted Providers Collaborative Care Doctor on Demand ($0 Options) (You will pay the least)	HPS and First Health (In-Network) (RBP) Out-Of-Network (Out-of-Network) You will pay less for In-Network and the most for Out-of-Network. Out-of-Network Providers will be repriced and you may be Balance Billed.	
	Rehabilitation services	No copayment	**In-Network:** $50 copayment per visit, per type of covered service **Out-of-Network:** $100 copayment per visit, per type of covered service	Pre-certification is required for all Therapy, with the exception of $0 Physical Therapy option. If you don't receive pre-certification, benefits will be reduced by $250.
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	Not Applicable	**In-Network:** $500 copayment/admit **Out-of-Network:** $1,000 copayment/admit	Pre-certification is required. If you don't receive pre-certification, benefits will be reduced by $250. Must meet medical necessity requirements.
	Durable medical equipment	No copayment	**In-Network:** $100 copayment per order date **Out-of-Network:** $200 copayment per order date	Pre-certification is required for ALL rentals and Purchases over $500. If you don't receive pre-certification, benefits will be reduced by $250. Foot orthotics Limited to 1 custom molded pair every 3 Plan Years. Compression socks limited to 3 pairs per Plan Year.

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		MASD Clinic Direct Contracted Providers Collaborative Care Doctor on Demand ($0 Options) (You will pay the least)	HPS and First Health (In-Network) (RBP) Out-Of-Network (Out-of-Network) You will pay less for In-Network and the most for Out-of-Network. Out-of-Network Providers will be repriced and you may be Balance Billed.	
				Mastectomy Bras limited to 2 per Plan Year.
	Hospice services	Not Applicable	**In-Network:** $50 copayment per day (Home Care); $100 copayment per day (Inpatient Hospice) **Out-of-Network:** $50 copayment per day (Home Care); $100 copayment per day (Inpatient Hospice)	Pre-certification is required. If you don't receive pre-certification, benefits will be reduced by $250.
If your child needs dental or eye care	Children's eye exam	No copayment	No copayment	Limited to 1 eye exam with refraction per Plan Year, in-and-out of network.
	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.)

- Bariatric Surgery
- Cosmetic surgery
- Dental Care (Adult)
- Infertility treatment (diagnosis only)
- Long-term care
- Private Duty Nursing
- Routine foot care
- Weight loss programs

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

- Chiropractic Care (Limited to maximum of 24 visits per Plan Year)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult and Children) (Limited to 1 per plan year)
- Routine Hearing Exam (Adult and Children) (Limited to 1 exam per pan year)

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 1-800-615-7020.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-615-7020.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-615-7020.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-615-7020.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible $0**
- **Specialist copayment $150**
- **Hospital (facility) copayment $1,000**
- **Other copayment $100**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$2,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,960****

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible $0**
- **Specialist copayment $150**
- **Hospital (facility) copayment $1,000**
- **Other copayment $100**

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	$0
Copayments	$2,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible $0**
- **Specialist copayment $150**
- **Hospital (facility) copayment $1,000**
- **Other copayment $100**

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	$0
Copayments	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

****This example is assuming the member is the Employee or Spouse.**

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