



IMPORTANT NOTE: The following information is a general description of a covered person's benefits arranged by type of coverage (example: medical, dental, vision). It is not intended to be an all-inclusive benefit description and cannot be considered a guarantee of benefits. Please note any limitations that apply to specific benefits or diagnoses. Not all restrictions or limitations are listed.

The benefits available are conditional on the patient's employment status, plan eligibility, payment of contributions, and amount of benefits remaining, plan provisions, and plan exclusions. The benefits quoted are not guaranteed. Final determination as to benefits payable will be made at the time a claim is submitted for payment, and subject to review of the necessary medical records and other information.

INFORMATION LISTED IS IN EFFECT AS OF 1/1/23

REQUIRED PRE-CERTIFICATION LIST:

- | | |
|---|--|
| Inpatient Stay, > 23 Hours of Observation | Outpatient Surgical Procedures |
| Durable Medical Equipment | Orthotics |
| Abdominal CT scan w and w/out dye | MRI Brain w and w/out dye |
| MRI Lumbar Spine w/o dye | MRI Lower Extremity w/o dye |
| PET Scans | Radiation Therapy |
| Chemotherapy | Physical Therapy |
| Speech Therapy | Occupational Therapy |
| Cardiac Rehabilitation | IV Therapy in Office |
| IV Therapy at Home | Home Health Care |
| Hospice | Skilled Nursing Facility |
| Varicose Vein Treatments | Extended Care Facility |
| Pain Management Procedure in Office | Pain Management Procedure at Facility |
| Genetic Testing | Hyperbaric Oxygen treatment |
| Dialysis | |

*Outpatient Pre-Certification Authorizations expire 60 days from notification. If an extension is needed, please contact Prairie States Health Management

***The penalty for non-compliance is: a 25% reduction in benefits otherwise payable for services up to a maximum penalty of \$2,000.**

***Inpatient admissions, and extended days not pre-certified will result in all charges not being covered under the Plan.**

***All costs incurred as a result of a non-precertified inpatient admission will be self-pay.**

| MAJOR MEDICAL BENEFITS | |
|---|---|
| Plan: 107CCNA, 107HTVA, 107TACA, 107TCHA, 107TCFA, 107CSRA | SELF FUNDED – GRANDFATHERED |
| PREFERRED NETWORK | CHS – Community Healthcare Systems |
| Wrap PPOs Available (out of network): | SAGAMORE - in state of Indiana PHCS - in state of Illinois GLOBAL |

| | PREFERRED NETWORK | WRAP PPO | OUT OF NETWORK |
|--|--------------------------|-----------------|-----------------------|
| ANNUAL MAXIMUM | Unlimited | Unlimited | unlimited |
| INDIVIDUAL DEDUCTIBLE | \$275 | \$275 | \$275 |
| FAMILY DEDUCTIBLE | \$825 | \$825 | \$825 |
| OUT OF POCKET MAXIMUM PER PATIENT | \$7500 | \$22,500 | \$22,500 |

DEDUCTIBLE MAY BE SATISFIED WITH BOTH IN AND OUT OF NETWORK SERVICES (ONE DEDUCTIBLE TO SATISFY)

UPON THE OUT OF POCKET AMOUNTS BEING REACHED, THE PLAN WILL PAY AT 100% ON PAYABLE CLAIMS

CODES: 'A'nnual, 'L'ifetime, 'W'EEKLY, "D'AILY, 'O'CCURRENCE, '\$' DOLLARS, 'U'NITS, 'C'OPAY, 'V'ISITS, 'M'AX CHARGE;

*After Deductible Met; + Does not apply to out-of-pocket, P = pre-certification or authorization required.

Prairie States Enterprises, Inc. • P.O. Box 23 • Sheboygan, WI 53082-0023
Voice (920)451-7020 • Toll-Free (800)615-7020 • Fax (920)451-7023



| Service | Preferred Network CHS | Wrap PPO & OUT NETWORK | Limits |
|--|-------------------------|-------------------------|--|
| Acupuncture | NOT COVERED | NOT COVERED | |
| Allergy Injections | 75%* | 50%* | |
| Ambulance - Air | 80%* | 80%* | |
| Ambulance – Ground | 80%* | 80%* | |
| Anesthesia - Inpatient | 80%* | 50%* | |
| Anesthesia – Outpatient | 80%* | 50%* | |
| Birth Control – injections/sterilization/IUD | 85%* | 50%* | |
| Breast Pump | 100% UP TO \$250 MAX | 100% UP TO \$250 MAX | Deductible waived 1 per Lifetime |
| Cardiac Rehabilitation | 80%* | 50%* | Pre-Cert |
| Chemotherapy | 80%* | 50%* | Pre-Cert See note 2 below |
| Chiropractic (manipulation, modalities, PTY, x-rays, DME) | 85%* | 50%* | 25 Visits per Year |
| CT- Done In Hspt (TCH-SMM-STC) | 80%* | 50%* | Pre-Cert See note 3 below |
| CT- Done In Physician Office | 60%* | 50%* | Pre-Cert See note 3 below |
| Dialysis | 80%* | 50%* | Pre-cert see note 5 below |
| Diet Instruction | 80%* | 50%* | Plan allows 3 visit per lifetime, for condition of Diabetes, hyperlipemia, hypertension |
| Doctor Office Visit - PCP | 85%* | 50%* | |
| Doctor Office Visit - Specialist | 85%* | 50%* | |
| Durable Medical Equipment (DME) (1 ST PAIR Lenses Post Cataract) | 80%* | 80%* | Pre-Cert |
| Emergency Room – Facility | 80%* | 80%* | \$50 co-pay |
| Emergency Room – Physician | 80%* | 80%* | |
| Epidurals – Hospital | 85%* | 50%* | Pre-Cert |
| Epidurals-Physician | 85%* | 50%* | Pre-Cert |
| Freestanding Surgical Center | NOT COVERED | NOT COVERED | |
| Hearing Aids | NOT COVERED | NOT COVERED | |
| Home Health Care (RN visit) | 80%* | 80%* | 40 visits per year Pre-Cert |
| Home IV Therapy | 85%* | 50%* | Pre-Cert |
| Hospice Care | 100%* | 100%* | Pre-Cert |
| Hospital Inpatient (semi-private room) | \$100 co-pay, 100%* | 50%* | Pre-Cert |
| Hospital Outpatient Diagnostic | 80%* | 50%* | |
| Hospital Outpatient Surgery | \$50co-pay, 90%* | 50%* | Pre-Cert |
| Injections | 85%* | 50%* | |
| Infertility – diagnostic only | 80%* | 50%* | \$1500 yearly max \$3000 lifetime max |
| IV-therapy in office | 85%* | 50%* | Pre-Cert |
| Laboratory – Inpatient | 100%* | 50%* | |
| Laboratory – Outpatient | 80%* | 50%* | |
| Mammogram | 80%* | 50%* | |
| Maternity – Global Fee | 85%* | 50%* | Pre-Cert |
| Maternity - Office Visit | 85%* | 50%* | 1 ST office visit |
| Maternity – genetic test | 80%* | 50%* | Pre-Cert |



| Service | Preferred Network CHS | Wrap PPO & OUT NETWORK | Limits |
|---|--|--|--|
| (materniT21) | | | |
| Mental Health Benefit (substance abuse) - Outpatient and Inpatient | ComPsych | ComPsych | Call Perspectives EAP before any treatment at 1-800-456-6327 |
| MRI- Done In Hspt (TCH, SMM, STC) | 80%* | 50%* | Pre-Cert See note 3 below |
| MRI - Done In Physician Office | 60%* | 50%* | Pre-cert See note 3 below |
| Occupational Therapy (licensed OT) | 80%* | 50%* | Pre-Cert |
| Oral surgery (Removal of impacted wisdom teeth) | 50%* | 50%* | See note 4 below |
| Orthotics (foot) | 80%* | 80%* | Pre-Cert See note 1 below |
| P.E.T. Done In Hspt (TCH, SMM, STC) | 80%* | 50%* | Pre-Cert See note 3 below |
| P.E.T. Done In Physician Office | 60%* | 50%* | Pre-Cert See note 3 below |
| Physical Therapy (licensed PT) | 80%* | 50%* | Pre-Cert |
| Physician Visit – inpatient or consultation | 85%* | 50%* | |
| Podiatry – physician | 85%* | 50%* | DME=Pre-Cert See note 1 below |
| Prescription Plan (EHIM) | EHIM | EHIM | 1-800-311-3446 |
| Radiation Therapy | 80%* | 50%* | Pre-Cert |
| Radiology | 80%* | 50%* | |
| Routine Preventative Office Visit Well Baby Visit Pap PSA, Mammogram, etc. Immunizations Colonoscopy >45 yrs old (no pre-cert) | \$10 copay 100% \$10 copay 100% 100% no deductible 80% 100% no deductible 85% | \$20 copay 100% \$20 copay 100% 50% after deductible 50% 50% after deductible 50% | No Deductible No Deductible After Deductible After Deductible |
| Skilled Nursing Care / Extended Care | \$100 Co-pay, 100%* | 50%* | 120 Days Max Pre-Cert |
| SNF-Custodial care | NOT COVERED | NOT COVERED | |
| Sleep Study – Hospital | 80%* | 50%* | |
| Sleep Study – physician office | 80%* | 50%* | |
| Speech Therapy (licensed ST) | 80%* | 50%* | Pre-Cert Developmental delays not covered |
| Surgeon – Inpatient | 85%* | 50%* | Pre-Cert |
| Surgeon – Outpatient (In the physician's office) | 85%* | 50%* | |
| Surgeon – Outpatient (not in physician's office) | 85%* | 50%* | Pre-Cert |
| TMJ | SEND PRE-DETERMINATION | SEND PRE-DETERMINATION | \$1000 Lifetime Max |
| Urgent Care | 80% | 80% | |
| Varicose Vein Treatment | 85%* | 50%* | Pre-Cert |
| Wig After Chemotherapy/Radiation | 80%* | 80%* | 1 per Lifetime UP TO \$500 MAX |

CODES: 'A'nnual, 'L'ifetime, 'W'weekly, "D'aily, 'O'ccurrence, '\$' Dollars, 'U'nits, 'C'opay, 'V'isits, 'M'ax Charge;
*After Deductible Met; + Does not apply to out-of-pocket, P = pre-certification or authorization required.



1. Routine foot care including: removal of corns and calluses; clipping of the nails; removal of toenails; treatment of weak, strained, flat, unstable, unbalanced feet, and chronic foot strain is not covered under the medical plan.
 2. Pre-cert is required. Chemotherapy drugs must be FDA approved for diagnosis. Off label use is not covered.
 3. As of 01/01/2010 the following diagnostic tests require pre-certification: MRI lumbar spine w/o dye, MRI joint of lower extremity w/o dye, MRI brain w/o and w/dye, CT-scan abdominal w/o and w/dye, and all PET-scan. If pre-cert not completed prior to testing, services will be penalized 25%. This penalty will apply to any facility where testing is performed.
 4. Medical plan will consider removal of full, partial and tissue impacted wisdom teeth 1st then service will be considered under the dental plan, if dental plan is active.
No charge will be covered under medical benefits for dental and oral procedures involving orthodontic care of the teeth, periodontal disease, and preparing the mouth for the fitting of or continued use of dentures.
 5. Effective January 1, 2015, outpatient Renal Dialysis Services are sent to Dialysis PPO. The 1st 40 renal dialysis visits, cumulative and not subject to annual reset are paid at the applicable deductible and coinsurance as listed in the Schedule of Benefits of the allowable amount. Additional visits are paid at 150% of the Medicare allowable amount, adjusted for the geographical wage index.
- Please contact Prairie States Enterprises for **pre-certification at 1-800-615-7020**. Refer back to required pre-cert list. Pre-certification must be obtained prior to covered person entering a medical care facility on non-emergency basis. Penalty for non compliance is denial of services.
 - CHS: Community Healthcare Systems. Physicians/hospitals not in Community Healthcare Systems network, but contracted with Sagamore for Indiana Providers and PHCS for Illinois Providers – benefit percentage is 50%. Facility claims are paid at different benefit percentages depending on availability of services at Community Healthcare Systems.
 - With prior approved referral on file with PSE and if service is not available in the Community Healthcare Systems network, the following facilities can be covered at network level. University of Chicago (U of C)*, Advocate Hope Children's Hospital, Ann & Robert H Lurie Children's Hospital of Chicago, Northwestern Memorial Hospital and Rush University Medical Center.

*U of C includes University of Chicago Hospitals, Comer Children's Hospital and Research Center, and University of Chicago Practice plan
 - Preferred network, wrap PPO network and out of network deductibles accumulate to **ONE** \$275 deductible.
 - Wrap PPO/Out of network services will apply to a separate \$22,500 out of pocket maximum.
 - Submit all mental health claims to Com-Psych * P.O. Box 8379, Chicago IL 60680 * phone 800-344-9754
 - Timely filing is one year from date of service.
 - Plan Year is January 1st to December 31st
 - Send all other claims to: Prairie States Enterprises, P.O. Box 23, Sheboygan WI 53082-0023.
 - All electronic claims may be submitted to: WEBMD/Envoy – Electronic Payer ID Number 36373.
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