East Peoria Community High School/TMCSEA Health and Dental Plan
Summary of Benefits Effective July 1, 2019

MEDICAL SUMMARY OF BENEFITS – Grandfathered Plan	In-Network	Out-of-Network
INDIVIDUAL DEDUCTIBLE: Per Individual, per calendar year. Deductible amounts combine for In and Out-of-Network.	$300	$300
FAMILY DEDUCTIBLE: All individual deductible amounts will satisfy the Family deductible, but no one participant will be required to pay more than the Individual deductible amount.	$900	$900
OUT-OF-POCKET MAXIMUM INCLUDES: Annual medical deductible and coinsurance. It does not include copays or prescription drug benefits or organ transplants performed at a Non-Center of Excellence Facility. Out-of-Pocket amounts combine for In and Out-of-Network. All Individual out-of-pocket amounts will satisfy the Family out-of-pocket, but no one participant will be required to pay more than the Individual out-of-pocket amount.	$1,000 (Individual) $3,000 (Family)	$10,000 (Individual) $10,000 (Family)
CHOICE OF PRIMARY PROVIDER NETWORK: OSF Health Care–Direct Access Network (OSF-DAN) ***or*** UnityPoint Health Plus+ **WRAP & TRAVEL NETWORK:** PHCS		
THIRD PARTY ADMINISTRATOR: Consociate Health 2828 North Monroe Avenue, Decatur IL 62526 Phone: 800-798-2422 | Fax: 217-423-4575 | Website: www.consociatehealth.com		
PRECERTIFICATION NOTIFICATION REQUIREMENTS: 72 hours advanced precertification for all scheduled inpatient admissions, overnight hospital stays, and dialysis required. Within 2 Business days following the admission for Urgent/ Emergency Inpatient admissions.		
COVERED MEDICAL EXPENSES	**PLAN PAYS**	
*** Deductible must be met before benefits are paid where noted.**	**In-Network**	**Out-of-Network**
PREVENTATIVE CARE:		
Routine/Preventive Adult and Child Care - office visits, labs, x-rays, vision/hearing screening, immunizations, child flu/pneumonia immunizations	100% Coinsurance	Not Covered
Routine/Preventative Pap smear, Mammogram, PSA Testing, breast feeding support and supplies, adult care flu/pneumonia immunizations	100% Coinsurance	60% Coinsurance, after deductible*
Routine/Preventative Adult Care Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings (including related services)	80% Coinsurance, after deductible*	60% Coinsurance, after deductible*
Contraceptive Methods - devices (e.g. IUD or diaphragms), injections, implant insertion/removal, emergency contraceptives and condoms; sterilization - tubal ligation and vasectomy (excludes birth control pills/patches, spermicides -see Prescription Drug Benefits)	100% Coinsurance	60% Coinsurance, after deductible*
PHYSICIAN SERVICES:		
Professional office visits include primary care, specialist care, inpatient hospital visits, inpatient surgery and anesthesia, outpatient hospital and ambulatory surgical center visits, mental health and chemical dependency therapy visits and behavioral health residential services, chiropractic exams, manipulations, chiropractic labs and x-rays	80% Coinsurance, after deductible*	60% Coinsurance, after deductible*
High Tech diagnostic services, labs and x-rays at a physician's office, qualified practitioner pathology and radiology, skilled nursing facility (81-day calendar year limit), home health care (80 visit per year limit), outpatient private duty nursing ($12,000 per year limit), outpatient surgery and anesthesia	80% Coinsurance	60% Coinsurance
INPATIENT FACILITY SERVICES: Hospital Room and Board, ancillary facility services, partial hospitalization. Precertification Required on inpatient stays.	80% Coinsurance	60% Coinsurance, after deductible*
OUTPATIENT HOSPITAL and AMBULATORY SURGICAL CENTER FACILITY SERVICES:		
Outpatient Hospital and Ambulatory Surgical Center facility services, surgical and non-surgical services and ancillary services	80% Coinsurance	60% Coinsurance
Outpatient Hospital and Ambulatory Surgical Center High Tech diagnostic services, labs and x-rays, outpatient occupational, speech, physical, cognitive therapy, hospice care, cardiac rehab phase I and II	80% Coinsurance	60% Coinsurance, after deductible*
EMERGENCY ROOM FACILITY, Ancillary Services – Emergent & Non-Emergent, Urgent Care Facility – Facility, ancillary services and qualified practitioner services.	80% Coinsurance	
EMERGENCY MEDICAL TRANSPORTATION	80% Coinsurance, after deductible*	
OTHER COVERED SERVICES: includes respiratory and pulmonary therapy, chemotherapy, radiation, durable medical equipment, prosthetics	80% Coinsurance, after deductible*	60% Coinsurance, after deductible*
PRESCRIPTION DRUG BENEFITS: Retail and Mail order up to a 90-day supply 2 times copay for 31-90 day supply. Specialty drugs are limited to a 30-day supply per fill - $10 Copay Over-the-counter Program - $0 copay	**30 Day Supply** Generic $5 Preferred Brand $10 Non-Preferred Brand $40	**30 Day Supply:** Generic $5 Preferred Brand $10 Non-Preferred Brand $40

This is an informational summary. All benefits coverages will be paid according to the EPCHS/TMCSEA Health and Dental Plan

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DENTAL SUMMARY OF BENEFITS		
CALENDAR YEAR DEDUCTIBLE All Individual deductible amounts will satisfy the Family deductible, but no one participant will be required to pay more than the Individual deductible amount	**Individual** **$50**	**Family** **$150**
INDIVIDUAL MAXIMUM BENEFIT Preventative, Basic Major, Restorative and Prosthodontic Services	**$1,500 per Calendar Year**	
COVERED DENTAL EXPENSES	**PLAN PAYS**	
PREVENTATIVE SERVICES • **Routine Exams and Cleanings** • **X-rays** • **Fluoride Treatments (to age 16)** • **Space Maintainers (to age 14)** • **Sealants** • **Emergency Evaluation and Palliative (Emergency) Treatment**	**Covered Expense is payable at 100%, not subject to Deductible**	
BASIC SERVICES • **Fillings** • **Extractions** • **Stainless Steel Crowns** • **Oral Surgery** • **Drug Injections/General Anesthesia/IV sedation** • **Periodontal Evaluations/Maintenance** • **Periodontal Scaling/Root Planing/ Site Therapy** • **Endodontics/Root Canals** • **Harmful Habit Appliance** • **Occlusal Guards** • **Maintenance/Repairs of Bridges and Partial and Complete Dentures** • **Tissue Conditioning** • **Pulpotomies on Primary Teeth** • **Full Mouth Debridement**	**Covered Expense is payable at 80%, not subject to Deductible**	
MAJOR RESTORITIVE AND PROSTHODONTIC SERVICES • **Crowns and their maintenance/repairs** • **Inlays or Onlays and their maintenance/repairs** • **Post/Core Build-ups for Crowns** • **Gold Foil Fillings and their maintenance/repairs** • **Occlusal Adjustments when done in conjunction with periodontal surgery** • **Denture/Bridgework**	**After Deductible, Covered Expense is payable at 50%**	
ORTHODONTIA SERVICES **Individual Lifetime Maximum Benefit for Orthodontic Services is $1,500 per covered person. Child orthodontia – Covers children to age 19**	**Covered Expenses is payable at 50%, not subject to Deductible**	

FILING CLAIMS
Generally, your health care provider will submit your claim to us for processing. You will not have to initially complete any claim forms from us. After we receive a claim, we may need additional information from you. We will let you know by letter if we need additional information such as accident details, signed authorization to obtain medical information, Subrogation forms. If your provider will not file your claim, please contact us at 800-798-2422, and we will assist you in getting your claim filed.

On Line Tools: View your claim information securely on line, anywhere, anytime with Consociate Health at www.consociatehealth.com

Still need assistance?
Call Consociate Health:
800-798-2422

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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 your Human Resources Department. 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 www.consociate.com or call 1-800-798-2422 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network Providers: **$300** per individual / **$900** per family. For Out-of-Network Providers: **$300** per individual / **$900** per family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain Preventive care and primary care services are covered before you meet your deductible. Prescription drugs purchased with the drug card require a copayment but are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible..
Are there other deductibles for specific services?	No, there are no other specific deductibles.	You don't have to meet other deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$1,000** Person / **$3,000** Family; Out-of-Network: **$10,000** Person/**$10,000** 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.
What is not included in the out-of-pocket limit?	Premiums, copays, prescription drug benefits, Out-of-Network transplant expenses, balance-billed charges, penalties for failure to obtain preauthorization, 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. You may choose either **UnityPoint Health Plus+** or **OSF-Direct Access Network** to be your network. For a list of preferred providers, see www.consociatehealth.com or call 1-800-798-2422.	This plan uses provider networks. 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.

All coinsurance costs shown in this chart are after your deductible has been met, unless otherwise noted.

Do you need a referral to see a specialist?	No. You do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

All coinsurance costs shown in this chart are after your deductible has been met, unless otherwise noted.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network PPO Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible	40% coinsurance after deductible	None
	Specialist visit	20% coinsurance after deductible	40% coinsurance after deductible	
	Routine/Preventive Adult and Child Care - office visits, labs, x-rays, vision/hearing screening, immunizations, child flu/pneumonia immunizations, immunization	No Charge	Not Covered	None
	Routine/Preventative Pap smear, Mammogram, PSA Testing, breast feeding support and supplies, adult care flu/pneumonia immunizations	No Charge	40% coinsurance after deductible	
	Routine/Preventative Adult Care Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings (including related services)	20% coinsurance after deductible	40% coinsurance after deductible	

All coinsurance costs shown in this chart are after your deductible has been met, unless otherwise noted.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network PPO Provider	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs) at a physicians office.	20% coinsurance. No deductible.	40% coinsurance. No deductible.	None
	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs) at an in-patient or out-patient facility.	20% coinsurance. No deductible.	40% coinsurance after deductible	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.castiarx.com	Generic drugs (Tier 1)	$5 Copay per 30-day supply (retail); $10 Copay per 90-day supply (mail order or retail)	$5 Copay per 30-day supply (retail); $10 Copay per 90-day supply (mail order or retail)	Deductible does not apply
	Preferred brand drugs (Tier 2)	$10 Copay per 30-day supply (retail); $20 Copay per 90-day supply (mail order or retail)	$10 Copay per 30-day supply (retail); $20 Copay per 90-day supply (mail order or retail)	
	Non-preferred brand drugs (Tier 3)	$40 Copay per 30-day supply (retail); $80 Copay per 90-day supply (mail order or retail)	$40 Copay per 30-day supply (retail); $80 Copay per 90-day supply (mail order or retail)	
	Specialty drugs (Tier 4)	$10 Copay per 30 day supply;	$10 Copay per 30 day supply;	Preauthorization is required for some Specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance. No deductible.	40% coinsurance. No deductible.	None
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	20% coinsurance. No deductible.		For Physician/Profession fees at Emergency Room, you pay 20% coinsurance AFTER deductible
	Emergency medical transportation	20% coinsurance after deductible		None
	Urgent care	20% coinsurance. No deductible.	20% coinsurance. No deductible.	None

All coinsurance costs shown in this chart are after your deductible has been met, unless otherwise noted.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network PPO Provider	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance. No deductible.	40% coinsurance after deductible	Preauthorization is required or the first $200 of covered expense will not be covered.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance. No deductible.	None
	Inpatient services	20% coinsurance. No deductible.	40% coinsurance after deductible	Preauthorization is required or the first $200 of covered expense will not be covered.
If you are pregnant	Office visits	20% coinsurance after deductible	40% coinsurance after deductible	None
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Depending on the type of services, a coinsurance or deductible may apply
	Childbirth/delivery facility services	20% coinsurance. No deductible.	40% coinsurance after deductible	Preauthorization is required if inpatient stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery or the first $200 of covered expense will not be covered.
If you need help recovering or have other special health needs	Home health care	20% coinsurance. No deductible. .	40% coinsurance. No deductible .	Home Health Care Services limited to 80 visits per calendar year. Outpatient private duty nursing covered up to $12,000 per person per calendar year.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Respiratory and pulmonary therapy, chemotherapy
	Habilitation services	20% coinsurance. No deductible.	40% coinsurance after deductible	Occupational, speech, physical, cognitive therapy, cardiac rehab

All coinsurance costs shown in this chart are after your deductible has been met, unless otherwise noted.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network PPO Provider	Out-of-Network Provider (You will pay the most)	
				phase I and II
	Skilled nursing care	20% coinsurance. No deductible.	40% coinsurance. No deductible.	Short term non-custodial care limited to 81 days per calendar year
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	None
	Hospice services	20% coinsurance. No deductible.	40% coinsurance after deductible	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Routine Vision Screening Only
	Children's glasses	Not Covered	Not Covered	Excluded service
	Children's dental check-up	As covered under dental plan	As covered under dental plan	See Dental Plan

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Custom Molded Orthotics
- Dental Care – Covered under dental plan
- Jaw Joint/TMJ
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside of the U.S.
- 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
- Hearing Aids-Limited to cochlear/auditory brain stem implants
- Routine Vision/Hearing (Adult/Child) screening only
- Infertility – Diagnosis Only

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: Consociate – 1-800-798-2422. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the U.S. Department of Health and Human Services at 1-877-267-232 x 61565 or www.cciio.cms.gov. 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

 All **coinsurance** costs shown in this chart are after your **deductible** has been met, unless otherwise noted.

provide complete information 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: Consociate – 1-800-798-2422. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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. Contact Consociate, and you will be referred to a translator, if available:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-798-2422.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-798-2422.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-798-2422.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-798-2422.]

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	**$300**
Specialist copayment	**N/A**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$700
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,000**

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

The plan's overall deductible	**$500**
Specialist copayment	**N/A**
Hospital (facility) coinsurance	**20%**
Prescription copayment	**$10**

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	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$200
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,000**

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

The plan's overall deductible	**$300**
Specialist copayment	**N/A**
Hospital (facility) coinsurance	**20%**
Other emergency room copayment	**N/A**

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	**$2,400**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$420
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$720**

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