Insurance Review Committee

Tammy Rich-Stimson, Chairman
McKenzie Building - Jury Room
11 S. 4th Street
Pekin, IL 61554
Thursday, February 27, 2025 – 3:00 p.m.

I. Roll Call

II. Approve the minutes of the September 12, 2024 meeting

III. New Business

Discussion:

A. 2024 Consociate Annual Claim Cost Review
B. In/Out of Network charges explanation
C. Carle Health Physician Name Change
D. Smith Rx Specialty Pharmacy Change Information
E. Multi-Plan and Wrap Network
F. 2025 Wellness Programs

a. Wellness Coverage
b. Health fair Planning
c. Incentives

IV. Unfinished Business

V. Recess

Members: Chairman Tammy Rich-Stimson, Nick Graff, Jon Hopkins, Dave Mingus, Janet Johnson, Scott Moon, Irvin Johnson, Trent Strunk, Ryan Tarby Jake Tucker, Mark Chism

Minutes pending Committee approval

Insurance Review Committee Meeting

McKenzie Building – Jury Room
Thursday, September 12, 2024 – 3:00 p.m.

Committee Members Present:	Chairman Zimmerman, Mark Chism, Tammy Rich-Stimson, Janet Johnson, Irvin Johnson, Trent Strunk
Committee Members Absent:	Sam Goddard, Dave Mingus, Scott Moon, Ryan Tarby, Jake Tucker
Others Attending:	Mike Deluhery, County Administrator, Sue Webster, Human Resources Director, Roger Workheiser, Kim Atkins

DISCUSSION **2025 Plans Overview**

Human Resources Director Sue Webster provided the members with a handout listing all health plan vendors with contact information. She stated that all vendors are staying the same. She stated that they have prepared a Tazewell County benefit booklet with descriptions of all benefits.

MOTION **MOTION BY MEMBER STRUNK, SECOND BY MEMBER CHISM** to approve the minutes of the July 24, 2024 meeting.

On voice vote, **MOTION CARRIED UNANIMOUSLY.**

DISCUSSION **2025 Plan Premiums**

Human Resources Director Sue Webster provided the members with a handout with the 2025 health care premiums for non-union employees, P.B.P.A. deputies, control room operators, judicial clerks, F.O.P. correction officers, probation officers, and teamsters ASSEU. She stated that they are currently budgeting a 4% increase.

Chairman David Zimmerman questioned how premiums are determined and Director Webster stated that the amount of claims, stop loss charges, and that they look at the national average. She stated that the national average is going up 10%-12%.

Payroll Administrator Teresa Melvin questioned if the County follows ACA guidelines, and Director Webster stated that it is calculated on the high deductible healthcare plan. She stated that it cannot be more than $186 a month.

Administrator Mike Deluhery stated that the total premium for FY25 for employee health only is the same on all sheets which is a budgeted increase of 4%. He stated that the 4% is then split based on the contract.

DISCUSSION **LegalShield Program**

Human Resources Director Sue Webster provided the members with a handout for the LegalShield program. She stated that this is a benefit that the County currently has and it is a voluntary program. She stated that currently there are 13 participants. She stated that currently, employees pay $8.95 per month, and it will be increased to $12.95 for the basic plan. She stated that the family plan will be $22.95. She stated that an employee can enroll in this program at any time. Payroll Administrator Teresa Melvin requested that employees send a copy of the form to her and to LegalShield.

DISCUSSION **Stop Loss Renewal**

Human Resources Director Sue Webster stated that we are up for renewal. She stated that it is through Pareto, which we currently have. She stated that we also get the Cancer Care program free of charge. She stated that it went up 10%.

DISCUSSION **Claims Review**

Human Resources Director Sue Webster provided the members with a handout that showed a colored graph of the claims year to date in 2024. She stated that total claims are almost $3,000,000.

Member Irvin Johnson questioned how the insurance reserve money is built back up. Administrator Deluhery stated that the funds come from premiums shared by the employer and the employee.

Member Strunk stated that in a prior year, when premiums were increased, the stop loss account was still climbing, but none of our premiums were going down. He questioned how much in that stop loss account would be needed for our premiums to decrease.

Administrator Deluhery stated that we have to look at the big picture and the reality that insurance costs will continue to trend upward. He stated that the goal is to protect the fund balance to make it so we do not have to make any dramatic increases.

Human Resources Director Sue Webster stated that when you look at healthcare costs, the more employees that are added and more claims are received, the more costs that are put into the plan.

Human Resources Director Sue Webster stated that there is a stop loss deductible per person limit of $125,000 per incident. She stated that once a person gets to the $125,000 limit, the stop loss starts paying the claims. She stated that the stop loss carrier charges the County a rate per employee and an aggregate rate per employee. He stated that they also charge a deductible and administration fees.

Member Strunk questioned how much the County pays for each employee's health insurance plan. Administrator Deluhery stated that we have $870,000 budgeted for the yearly premiums. Director Webster stated that only includes the medical insurance.

DISCUSSION **Health Fair update**

Human Resources Director Sue Webster stated that the health fair is starting on October 8th at the Carle Health Pekin Hospital starting at 6:10 a.m. She stated that this is free for all full and part-time employees, county board members, and retired employees who are on the medical plan. She stated that everyone in the next week will receive an email with instructions on how to register for the online portal. She stated that you will schedule your appointment through the online portal. She stated that your results can be sent directly to your primary care physician.

Chairman Zimmerman recessed the meeting at 3:29 p.m.

(transcribed by S. Gullette)

Tazewell County

Group ID: C2312TC

Date Range: Transaction Date: 1/1/2024 through 12/31/2024 (366 days) (Paid Data)

Included Prescription Payments from Adjudication System

Excluded Prescription Details from PBM

Claim Summary for Overall

Date Range	1/1/2024 1/31/2024	2/1/2024 2/29/2024	3/1/2024 3/31/2024	4/1/2024 4/30/2024	5/1/2024 5/31/2024	6/1/2024 6/30/2024	7/1/2024 7/31/2024	8/1/2024 8/31/2024	9/1/2024 9/30/2024	10/1/2024 10/31/2024	11/1/2024 11/30/2024	12/1/2024 12/31/2024	Average/ Total
Total Charges	$102,667.59	$107,076.93	$1,105,259.88	$760,055.53	$1,901,675.03	$567,232.55	$1,011,569.44	$622,660.38	$1,872,334.51	$1,481,079.76	$962,139.12	$499,626.40	$10,993,377.12
Discount Amount	$0.00	$0.00	$482,525.85	$307,677.86	$642,009.05	$88,118.99	$469,657.04	$242,654.34	$653,623.80	$295,268.07	$381,715.70	$161,079.50	$3,724,330.20
Employee Responsibility	$0.00	$6,541.33	$72,089.26	$43,706.67	$66,309.78	$18,793.82	$31,603.48	$32,791.05	$20,814.38	$23,697.05	$20,782.29	$13,582.49	$350,711.60
Other Insurance	$0.00	$0.00	$1,009.48	$421.99	$7,191.01	$2,130.66	$1,120.21	$10,000.84	$9,095.46	$6,655.00	$18,754.36	$6,274.41	$62,653.42
Plan Payment	$102,142.83	$92,149.75	$459,904.91	$322,210.49	$985,314.60	$209,639.69	$570,427.82	$239,829.54	$932,822.48	$556,409.02	$452,190.57	$186,738.50	$5,109,780.20
% of Charges	99.49 %	86.06 %	41.61 %	42.39 %	51.81 %	36.96 %	56.39 %	38.52 %	49.82 %	37.57 %	47.00 %	37.38 %	52.08 %
Spec Stop Loss Reimb	$0.00	$0.00	$0.00	$0.00	$341,944.67	$0.00	$0.00	$115,593.90	$386,876.68	$0.00	$0.00	$0.00	$844,415.25
Claims Cost - Total	$102,142.83	$92,149.75	$459,904.91	$322,210.49	$643,369.93	$209,639.69	$570,427.82	$124,235.64	$545,945.80	$556,409.02	$452,190.57	$186,738.50	$4,265,364.95
Employee	$101,371.08	$86,025.05	$346,206.47	$234,434.05	$338,923.43	$152,338.54	$274,380.14	$277,772.86	$275,883.60	$371,066.54	$291,316.69	$136,403.70	$2,886,122.15
Spouse	$771.75	$2,212.39	$57,940.54	$24,003.87	$104,757.62	$17,132.38	$133,301.70	$206,952.39	$204,194.59	$114,271.53	$52,503.07	$29,217.99	$947,259.82
Dependent	$0.00	$3,912.31	$55,757.90	$63,772.57	$541,633.55	$40,168.77	$162,745.98	($244,895.71)	$452,744.29	$71,070.95	$108,370.81	$21,116.81	$1,276,398.23
Total Employees	265	267	264	266	269	267	265	265	269	267	268	267	267
Employee Only	177	177	175	179	182	180	179	179	179	177	178	177	178
Employee Plus Spouse	20	20	20	19	19	19	19	18	21	21	21	21	20
Employee Plus Children	23	24	24	24	24	24	24	25	26	26	26	27	25
Family	45	46	45	44	44	44	43	43	43	43	43	42	44
Cost Per Employee	$385.44	$345.13	$1,742.06	$1,211.32	$3,662.88	$785.17	$2,152.56	$905.02	$3,467.74	$2,083.93	$1,687.28	$699.40	$1,593.99
Claims Processed	62	140	1,265	970	1,663	665	881	1,426	1,094	1,126	1,052	549	10,893
Average Claim Cost	$1,647.47	$658.21	$363.56	$332.18	$386.87	$315.25	$647.48	$87.12	$499.04	$494.15	$429.84	$340.14	$516.77
Services Processed	142	326	2,002	1,646	2,776	1,073	1,312	2,278	1,841	1,828	1,974	914	18,112
Average Service Cost	$719.32	$282.67	$229.72	$195.75	$231.76	$195.38	$434.78	$54.54	$296.55	$304.38	$229.07	$204.31	$281.52

Total Cost Summary for Overall

Date Range	1/1/2024 1/31/2024	2/1/2024 2/29/2024	3/1/2024 3/31/2024	4/1/2024 4/30/2024	5/1/2024 5/31/2024	6/1/2024 6/30/2024	7/1/2024 7/31/2024	8/1/2024 8/31/2024	9/1/2024 9/30/2024	10/1/2024 10/31/2024	11/1/2024 11/30/2024	12/1/2024 12/31/2024	Average/ Total
Plan Payment	$102,142.83	$92,149.75	$459,904.91	$322,210.49	$985,314.60	$209,639.69	$570,427.82	$239,829.54	$932,822.48	$556,409.02	$452,190.57	$186,738.50	$5,109,780.20
Medical Plan Payment	$2,039.20	$2,682.75	$356,403.45	$275,055.85	$831,995.25	$106,652.75	$472,678.24	$125,222.34	$809,035.92	$423,925.91	$379,104.03	$128,404.37	$3,913,200.06
Dental Plan Payment	$0.00	$18,556.61	$21,454.34	$20,307.80	$22,917.00	$26,596.23	$6,622.49	$28,430.27	$21,698.76	$15,612.56	$21,448.62	$11,303.83	$214,948.51
Vision Plan Payment	$0.00	$0.00	$0.00	$0.00	$57.20	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$57.20
Rx Plan Payment	$100,103.63	$70,910.39	$82,047.12	$26,846.84	$130,345.15	$76,390.71	$91,127.09	$86,176.93	$102,087.80	$116,870.55	$51,637.92	$47,030.30	$981,574.43
Other Expenses	$70,740.81	$71,732.89	$70,101.94	$71,090.31	$70,788.87	$71,847.35	$71,314.80	$70,344.07	$71,975.11	$76,771.49	$77,747.64	$78,374.17	$872,829.45
Administration Fees	$5,962.50	$6,030.00	$5,872.50	$6,007.50	$6,007.50	$6,097.50	$6,030.00	$6,007.50	$6,097.50	$5,962.50	$6,075.00	$6,575.00	$72,725.00
Dental Administration Fees	$803.25	$812.25	$803.25	$803.25	$803.25	$801.00	$801.00	$810.00	$805.50	$789.75	$805.50	$805.50	$9,643.50
Other Premium	$331.25	$335.00	$326.25	$333.75	$333.75	$338.75	$335.00	$333.75	$338.75	$331.25	$337.50	$337.50	$4,012.50
PPO Access Fees	$795.00	$804.00	$783.00	$801.00	$801.00	$813.00	$804.00	$801.00	$813.00	$795.00	$810.00	$810.00	$9,630.00
Precert Fees	$636.00	$643.20	$626.40	$640.80	$640.80	$650.40	$643.20	$640.80	$650.40	$636.00	$648.00	$648.00	$7,704.00
Stop Loss Premium	$61,285.31	$62,180.94	$60,763.04	$61,569.51	$61,268.07	$62,198.20	$61,763.60	$60,816.52	$62,321.46	$67,329.49	$68,126.64	$68,253.17	$757,875.95
Telemedicine Fees	$927.50	$927.50	$927.50	$934.50	$934.50	$948.50	$938.00	$934.50	$948.50	$927.50	$945.00	$945.00	$11,238.50

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 Out-of-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 "Out-of-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 Out-of-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 Network Provider refers a Participant to an Out-of-Network Provider for services, then charges of the Out-of-Network Provider will be paid as though the services were provided by a Network Provider.
    b. The Network Provider level of benefits is payable for any Participant who cannot access Network Providers because they reside outside the Network service area. The Network service area is defined as a 40-mile radius from the Employee's primary residence.
    c. The services are not available at a Network Provider. The Network Provider level of benefits will be payable.
    d. The Network Provider level of benefits is payable when a Participant receives Emergency care either Out-of-Area or at an Out-of-Network Hospital for an Accidental Bodily Injury or Emergency.

2. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-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 may need to submit claims for services provided by out of-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.

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.

Direct PPO Contract Unity Point

NOTE: Carle Health will replace UnityPoint Health as the parent organization of UnityPoint Health – Central Illinois.

Hospital services in Tazewell, Peoria, Woodford, Mclean, Sangamon, and Fulton counties must be received from Methodist Medical Center, Pekin Hospital, Hopedale Hospital, Memorial Medical Center, Proctor Hospital or Ann & Robert H Lurie Children's Hospital of Chicago. ***However, this provision may be waived if the services are not available from a designated facility, if***

transportation of the patient to a designated facility would jeopardize the patient's health, if the Employee's primary residence is outside a 40-mile radius from the Network service area, or if authorized by the Plan Administrator.

If you are in the Network service area and chose to see an Out-of-network provider, there are no benefits for any services provided.

If you are outside of the Network service area, please contact MultiPlan (www.multiplan.com) for a PHCS-Out of Area Provider.

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.

Pursuant to Illinois law, in the event that a Participant receives services from an Out-of-Network Provider due to a moral objection raised by Network Provider(s) under the Health Care Right of Conscience Act, the Network Provider level of benefits is payable.

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on that information, the Participant's Coinsurance, Copayment, Deductible, and Out-of-pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

Balance Billing

In the event that a claim submitted by a Network or Out-of-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.

Network Provider Information

The Network Providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any Network Provider.

A current list of Network Providers is available, without charge, through the Third Party Administrator's website (located at www.consociatehealth.com). If the Participant does not have access to a computer at his or her home, he or she may access this website at his or her place of employment. If he or she has any questions about how to do

this, he or she should contact the Human Relations Department. The Network Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a Network Provider before receiving services. Please refer to the Participant identification card for the Network website address.

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.

No Surprises Act – Emergency Services and Surprise Bills

For Out-of-Network claims subject to the No Surprises Act ("NSA"), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan's Covered Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by an Out-of-Network Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
- Covered Out-of-Network air ambulance services.

All other sections of the Plan remain unchanged.

Continuity of Care

In the event a Participant is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner, and that the Participant has rights to elect continued transitional care from the Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2. is undergoing a course of institutional or Inpatient care from a specific Provider,
3. is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,

4. is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5. is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, although Plan benefits will be processed as if the termination had not occurred and the law requires the Provider to continue to accept the previously-contracted amount, the contract itself will have terminated, and thus the Plan may be unable to protect the Participant if the Provider pursues a balance bill.

Transition of Care

If a Participant is under the care of an Out-of-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 an Out-of-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.

Second Amendment to the Agreement

This Second Amendment to the Physician Hospital Organization Agreement ("Second Amendment"), effective as of the date of the last signature below (the "Effective Date"), is made by and between Carle Health Physician Partners, Inc., formerly Health Plus, Inc. ("CHPP") and Tazewell County Employees ("Organization"). Unless the context of the sentence would provide a different interpretation, Carle and Organization may be collectively referred to herein as the "Parties" and individually as a "Party."

RECITALS

WHEREAS, Tazewell County Employees has a Physician Hospital Organization Agreement ("Agreement") with Health Plus Inc. ("HP"), with an effective date of June 1, 2022.

WHEREAS, CHPP has assumed the operations of HP effective January 1, 2025.

WHEREAS, Tazewell County Employees and CHPP desire to update the Agreement to reflect the current relationship between the Parties;

NOW THEREFORE, in consideration of the covenants contained herein, it is mutually agreed by and between the parties as follows:

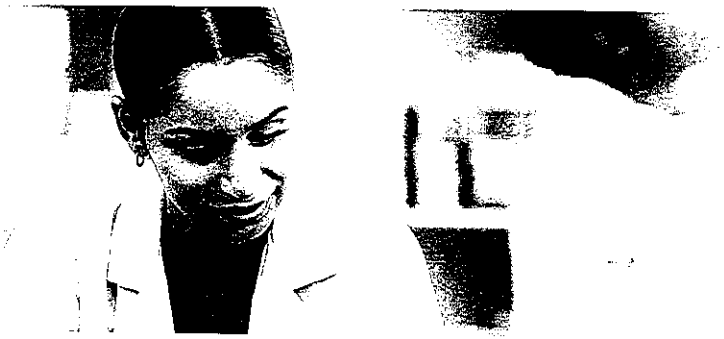
1. As of January 1, 2025 ("Transfer Date"), HP hereby assigns to CHPP its rights and obligations under the Agreement. CHPP hereby assumes the rights from and agrees to perform all obligations of HP under the Agreement. The Parties agree that as of the Transfer Date, CHPP is to be substituted for HP under the Agreement and all references in the Agreement to HP shall refer to CHPP.

2. Except as amended and supplemented hereby, all of the terms of the Agreement shall remain and continue in full force and effect and are hereby confirmed in all respects.

3. This Amendment may be executed in any number of counterparts, each of which shall be an original and all of which together shall constitute one and the same document, and is binding on all parties notwithstanding that each of the parties may have signed different counterparts. Facsimiles or scanned copies of signatures or electronic images of signatures shall be considered original signatures.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment the day and year as written below.

Carle Health Physician Partners	**Tazewell County Employees**
By: _____	By: _____
Print: _____	Print: _____
Title: _____	Title: _____
Date: _____	Date: _____



We're here for you

We are dedicated to improving specialty pharmacy care, one patient at a time, through educational, clinical, financial and service excellence.

Questions about specialty pharmacy services?

Please contact us.

ADDRESS:

310 Integrity Dr. Suite 105
Madison, WI 53717
855-213-0070 | costcoSP@lumicera.com
lumicera.com/costco-specialty-pharmacy

HOURS:

Monday – Thursday: 8 a.m. – 7 p.m. CT
Friday: 8 a.m. – 6 p.m. CT

PICK UP HOURS:

Monday – Friday: 8 a.m. – 4:30 p.m. CT
closed for lunch break daily from 2 - 2:30 p.m. CT

Costco partners with Lumicera Health Services to help patients with their specialty medications.

COSTCO PHARMACY

Welcome to Costco Specialty Pharmacy

Greater Confidence, Support and Savings for Specialty Drugs

Health care touches us all.

We know that specialty drugs can be complicated. That's why we provide you with the highest level of custom care. To make sure you have the guidance, clarity, and peace of mind to manage your condition well and live a healthier, happier life. Our experienced pharmacists and care team understand your chronic condition and the drug used to treat it. We also work with your doctor to make sure your prescription use is safe and effective.

OUR SERVICES INCLUDE:

Pre-therapy screening

We work to keep you safe. We will review your lab reports to make sure they are within normal limits before you begin therapy. If there are any concerns, we'll contact your doctor.

Drug delivery

Most specialty drugs require special packaging, handling and shipping. We make this process easy by delivering directly to you. We'll track the shipment and let you know when your drug will arrive.

Drug and condition support

You'll receive a care plan with goals to help you through every treatment step and our pharmacists will teach you how to properly use your drugs. We also provide support in managing side effects or reactions with other drugs you may be taking.

Refill reminders

We'll remind you about refills by phone or text before you run out of your prescription.

Connecting with your doctor

As part of your care team, we have access to your medical records and lab results. This allows us to directly talk with your doctor to make sure your drugs match their instructions.

Easier to fill (and refill) your specialty prescription

Getting your specialty drugs shouldn't be a hassle. We make it fast and easy. We are a complete source for your specialty drugs and supplies. That means no more trips to the pharmacy and no more waiting in line. Everything you need comes in your shipment.

Ordering refills is easy too. You can easily order refills online, by text message, or by calling us.

Costco Specialty Pharmacy partners with Lumicera Health Services to provide an exceptional experience for patients receiving specialty medications. Together the specialty pharmacy team works with your providers and nurses to optimize care and coordinate treatment.

Prior authorization and financial assistance

We will work with your provider's office to coordinate prior authorization to get you the medication you need quicker. We will work with all available financial resources and programs to assist getting the medication for you at a cost you can afford.

Why choose Costco Specialty Pharmacy?

MORE SERVICE AND SUPPORT

You can count on us for service and support. We want to help improve your health and give you peace of mind. We offer a personalized support program, delivered by our chronic condition experts, that provides you with the best care.

OUR EXPERTS ARE HERE FOR YOU.

We're here to answer your questions and offer assistance whenever you need it.

Just give us a call.

Getting started

Call us today at 855-213-0070 to start your therapy.

Specialty Pharmacy Information

SmithRx does not own or operate any pharmacy, allowing us to work flexibly with a broad network of pharmacies nationwide, including specialty pharmacies. This model allows us to focus on quality of service and cost-effectiveness, as we are not incentivized to drive utilization through any specific provider. We have strong specialty pharmacy partners, requiring no additional management, oversight, or resources from the broker, client or the TPA. Moreover, in most cases, you also have the flexibility to include your preferred specialty pharmacy provider.

Our Specialty Pharmacy Partners

Our contracted specialty providers have proven track records and service all states in the U.S. They also offer comprehensive therapy management programs and support teams. Our current specialty pharmacy partners are:

Costco Specialty Pharmacy is a preferred specialty partner due to their exceptional customer service, competitive pricing, and member experience. Members get access to a convenient online portal to manage their refills, in addition to a dedicated care coordinator to answer their questions.

Senderra is a preferred specialty pharmacy partner due to their exceptional customer service, discount rates, and support programs.

Member Support

Enrollment Assistance and Customer Service

Costco Speciality Pharmacy

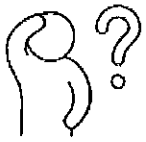
New Patient Enrollment Process

Members can create an account on the Costco Pharmacy Member Portal (Smithrx.com/specialty). Once enrolled, Members can log into the portal to request refills, manage their prescriptions and track orders. Prescribers can be directed to send prescriptions via fax or e-scribe.

Ongoing Customer Service

Patients: 855-213-0070
Prescribers: 855-213-0070
Fax: 855-213-0125

Senderra Speciality Pharmacy



New Patient Enrollment Process

For enrollment assistance patients can call: 888-777-5547. Prescribers can visit https://senderrarx.com/prescribers/forms and fill out the appropriate forms for the appropriate department. Prescribers can submit prescriptions via fax or e-scribe.

Ongoing Customer Service

Patients: 888-777-5547
Prescribers: 855-460-7928
Fax: 888-777-5645

SmithRx Member Support

In addition, SmithRx's member support teams are always ready to answer questions from your members and help them obtain needed prescriptions. Additionally, our specialty partners have teams of pharmacists, nurses, patient care coordinators, and reimbursement specialists that can help. Members receive ongoing support, counseling, and education for the duration of their treatment.

https://www.healthpluspeoria.org

Health PLUS+

HOME | PROVIDER LOCATOR | HOSPITAL LOCATOR | FOR PROVIDERS | CONTACT US

Health PLUS+

This website is your resource for information on our providers and important forms and documents. Backed by the expansive Carle Health provider network, we're here to meet all of your health and wellness needs.

Health PLUS+

HOME | PROVIDER LOCATOR | HOSPITAL LOCATOR | FOR PROVIDERS | CONTACT US

Find a Provider in Health Plus

Select Physician or Medical Group by Name

Search by First Letter

Letter: A

Search

Search By Name

Search By Group

Search By Specialty

Search By City

Search By Zip Code

Search By Specialty and City

Search By Specialty and Zip Code

Health PLUS+

HOME | PROVIDER LOCATOR | HOSPITAL LOCATOR | FOR PROVIDERS | CONTACT US

Find a Provider in Health Plus

Select Physician or Medical Group by Name

Search by First Letter

Search By Name

First Name:

Last Name:

Search

Search By Group

Search By Specialty

Search By City

Search By Zip Code

Search By Specialty and City

Search By Specialty and Zip Code

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Search

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Search By Name

Search By Group

Search By Specialty

Specialty:

Select a Specialty

Search

- Select a Specialty
- Addiction Recovery
- Adult Hematology
- Advanced Heart Failure and Transplant
- Allergy & Immunology
- Allergy/Immunology
- Ambulatory
- Ambulatory Surgical Treatment Center
- Anatomic Pathology and Clinical Pathology
- Anesthesiology
- Anesthesiology x
- Anethesiology
- Audiologist
- Audiology
- Autism Diagnostics and Behavioral Evaluations
- Bariatric Surgery
- Bariatrics
- Cadiovasular Disease
- Cardiac Electrophysiology
- Cardiac Event Monitoring

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Search By Specialty and City

Search By Specialty and Zip Code

Specialty:

Select a Specialty

Zip Code:

Search

https://www.claritev.com

MULTIPLAN IS NOW CLARITEV | Looking for the MultiPlan Provider Search? Click "Find a Provider" below.

Click to find Provider

claritev™

MEMBERS | PROVIDERS | PAYORS **Find a Provider**

SERVICES ▾ MARKETS ▾ COMPANY ▾ CAREERS ▾ KNOWLEDGEHUB INVESTORS

On a mission to improve affordability, transparency and quality in and across the U.S. healthcare system.

Learn more

Providing purpose-built solutions for all key stakeholders

Claritev provides tech-enabled solutions and services fueled by multiple data sources from over 40 years of claims repricing experience. Today, we utilize world-class technology and AI solutions to power a robust enterprise platform that delivers meaningful insights to drive affordability in healthcare, brings price transparency and optimizes networks and benefit plan design.

WE ANALYZE | WE IDENTIFY | WE PROCESS | WE ELIMINATE

MultiPlan

Español

Find a doctor or facility

Welcome to the MultiPlan Provider Search. Search for a doctor, hospital, lab or other healthcare provider or facility.

Choose a network

PHCS Network

- ○ PHCS *(Logo on front of card)*
- ○ PHCS *(Logo on back of card)*
- ○ PHCS Out of Area
- ○ PHCS Extended PPO
- ○ PHCS Limited Benefit Plan
- ○ PHCS Practitioner Only
- ○ PHCS Hospital Only
- ○ PHCS Practitioner & Ancillary
- ○ PHCS Preventive Services Only
- ○ PHCS Specific Services
- ○ PHCS Healthy Directions
- ○ PHCS For Value-Driven Health Plans

MultiPlan Network

- ○ MultiPlan Limited Benefit Plan
- ○ MultiPlan Practitioner Only
- ○ MultiPlan PPO
- ○ MultiPlan Practitioner & Ancillary
- ○ MultiPlan Preventive Services Only
- ○ MultiPlan Specific Services
- ○ MultiPlan Medicare Advantage
- ○ *I don't see any of these statements on my ID Card*

Other Network

- ○ HealthEOS
- ○ ValuePoint
- ○ Beech Street AK, NV and/or UT
- ○ Beech Street All Other States
- ○ AMN, RAN, and/or HMN
- ○ First Choice Health Network

○ I don't see any of these / No network *(Click here to do a general search of our MultiPlan network if you are unsure which network your plan uses)*

Select and Search >

MultiPlan

Español

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Welcome to the MultiPlan Provider Search. Search for a doctor, hospital, lab or other healthcare provider or facility.

Search

PHCS Network for out of area/extended PPO access

Searching in the Network:

PHCS

Change network or restart search >

☐ Remember my network

Search by name, specialty, facility type, NPI # or license #

City/County & State or Zip

Search >

I'm not a robot

reCAPTCHA

Privacy - Terms

Need assistance?

For Translator services only, please call 866-981-7427 and hold for a representative.
For TTY/TTD service, please call 866-918-7427.

Report an accessibility barrier

Please note, we work hard to ensure our data is accurate, but provider information changes frequently. Also, finding a provider on this site is not a guarantee of benefits coverage.

Before you receive care, you should contact:

- The provider to verify new patient status, location, network participation, and services currently being offered.
- Your health plan to verify your benefits.

MultiPlan.

Español

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Searching in the Network:

PHCS

Change network or restart search >

☐ Remember my network

Search by name, specialty, facility type, NPI # or license #

Galesburg, IL 61401, USA

Search >

Select one or enter 4 or more characters for more options

Popular Facility Types

- Hospital
- Laboratory
- Physical Therapy
- Radiology
- Urgent Care

Popular Specialty Names

- Family Practice
- Internal Medicine
- Nurse Practitioner
- Obstetrics and Gynecology
- Pediatrics

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MultiPlan.

Español

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☐ Remember my network

Hospital

Galesburg, IL 61401, USA

Search >

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- Your health plan to verify your benefits.

Provider information contained in this Directory was last updated earlier today and therefore may have changed. Please report any data inaccuracies in this listing to MultiPlan at 866-814-7427 or msaprovidersearchdqrpt@multiplan.com. Before scheduling your appointment or receiving services, check with the provider to confirm participation in the network, location, and if the provider is accepting new patients.

Search

PHCS Network for out of area/extended PPO access

Searching in the Network:

PHCS

Change network or restart search >

☐ Remember my network

Hospital

Galesburg, IL 61401, USA

Search >

Illinois requires that we display the following notice in our provider listings:

The provider network is built broadly and includes providers that meet network credentialing criteria as established by MultiPlan, Inc., which includes but is not limited to, verifying appropriate licensure, education and training, board certification, work history, DEA licensure, accreditation/certification status, review of sanctions and a review of an acceptable history of professional liability claims. The network includes providers in specialties that are recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the American Board of Oral and Maxillofacial Surgery (ABOMS), the American Board of Podiatric Surgery (ABPS), the American Board of Pain Medicine (ABPM), or that have completed a training program recognized by the American Council on Graduate Medical Education (ACGME). Providers not meeting MultiPlan established criteria are subject to rejection or termination from network participation.

Under Section 355b of Illinois Code, insurers will accommodate a reasonable request by a covered person, including a request made by a covered child's guardian, to receive claims-related information by alternate means or at an alternate location if the information could endanger the covered person/child. Insurers may require the request in writing, with a statement that such information could endanger the person making the request. Upon acceptance of the request, the insurer will not disclose identifying information (including address and telephone number) of the covered person/child, the health care provider, or the nature of the services provided, without the consent of the person making the request.

A person or guardian wishing to make such a request should contact their insurer for specific confidentiality protocols.

For your information, the phone number for the Illinois Domestic Violence Helpline is (877) TO END DV; (877) 863-6338; (877) 863-6339 (TTY).

To report any data inaccuracies, in addition to the contact information mentioned above, you may also contact the Illinois Department of Consumer Health Insurance at (877) 527-9431.

Directory information last updated earlier today.

2 results for ' Hospital ' near 61401

Printer Friendly Email Results Sort by Distance (approx.)

View National/Regional Providers

Refine Results

Apply Filter Reset Filter

— Location

Within 20 Miles

OSF Saint Mary Medical Center
General, 141 Beds
Telemedicine Services Available: Yes
Services: Lactation Consultant, STD Test Kits, STD Test Kits Lab, Abortion - Medical (Surgical), Abortion - Prescription Based
3333 N Seminary St
Galesburg, IL 61401
309-344-3161
2.40 Miles

OSF Holy Family Medical Center
General, 91 Beds
Telemedicine Services Available: No
Services: Lactation Consultant
1000 W Harlem Ave
Monmouth, IL 61462
309-734-3141
15.18 Miles

Search

PHCS Network for out of area/extended PPO access

Searching in the Network:

PHCS

Change network or restart search >

☐ Remember my network

Family Practice

Galesburg, IL 61401, USA

Search >

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Directory information last updated earlier today.

13 results for ' Family Practice ' near 61401

Printer Friendly | Email Results | Sort by Distance (approx.)

View National/Regional Providers

Refine Results

Apply Filter | Reset Filter

— Location

Within 20 Miles

— New Patient Status

Pratt, Timothy, Allen,M.D.
Family Practice
Gender: Male
Telemedicine Services Available: Yes
695 N Kellogg St
Galesburg, IL 61401
309-343-5114
View all locations
0.32 Miles

Carrier, Jeremy, Ryan,M.D.
Family Practice
Gender: Male
Telemedicine Services Available: Yes
1000 W Harlem Ave
Monmouth, IL 61462
309-734-1414
View all locations
0.32 Miles

Watring, John, Anthony,D.O.
Emergency Medicine, Family Practice
Gender: Male
695 N Kellogg St
Galesburg, IL 61401
309-343-8131
0.32 Miles