Human Resources Committee

Mike Harris, Chairman
James Carius Community Room
101 S. Capitol Street
Pekin, Illinois 61554
Tuesday, July 22, 2025
Immediately following Finance Committee meeting

I. Roll Call

II. Approve the minutes of the June 17, 2025 meeting and the June 25, 2025 in-place meeting

III. Public Comment

IV. Unfinished Business

V. New Business

A. Discussion: Elected Official Salaries for County Clerk and Treasurer

HR-25-13 B. Recommend to Approve Termination of the Carle Health Plus, Inc., Preferred Provider Organization Agreement

HR-25-14 C. Recommend to Approve Aetna Health Insurance Agreement

HR-25-15 D. Recommend to Approve Updates to Health Insurance Summary of Benefits and Coverage

E. Executive Session – 5 ILCS 120/2(c)(2) – Collective Bargaining or Salary Schedules

VI. Reports and Communications

VII. Recess

Members: Chairman Mike Harris, Max Schneider, Joe Woodrow, Deene Milam, Eric Schmidgall, Kim Joesting, Russ Crawford, Dave Mingus, Nancy Proehl, Eric Stahl, Aaron Phillips

Minutes pending committee approval

HUMAN RESOURCES COMMITTEE
James Carius Conference Room
Tuesday, June 17, 2025 – 4:19 p.m.

Committee Members Present: Chairman Mike Harris, Max Schneider, Eric Schmidgall, Kim Joesting, Russ Crawford, Joe Woodrow, Nancy Proehl, Deene Milam, Eric Stahl, Aaron Phillips

Committee Members Absent: Dave Mingus

Others Attending: Mike Deluhery, County Administrator

MOTION **MOTION BY MEMBER WOODROW, SECOND BY MEMBER STAHL** to approve the minutes from the May 20, 2025 meeting.

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

MOTION **MOTION BY MEMBER SCHMIDGALL, SECOND BY MEMBER JOESTING** to move the Committee into Executive Session under 5 ILCS 120/2(c)(2) – Collective Bargaining or Salary Schedules at 4:19 p.m.

On voice vote, **MOTION CARRIED UNANIMOUSLY**

Chairman Harris moved the Committee out of Executive Session at 4:44 p.m.

RECESS Chairman Harris recessed the meeting at 4:44 p.m.

(transcribed by S. Gullette)

Minutes pending committee approval

IN-PLACE HUMAN RESOURCES COMMITTEE
James Carius Conference Room
Wednesday, June 25, 2025 – 6:29 p.m.

Committee Members Present: Chairman Mike Harris, Max Schneider, Eric Schmidgall, Kim Joesting, Russ Crawford, Joe Woodrow, Deene Milam, Aaron Phillips, Dave Mingus

Committee Members Absent: Nancy Proehl, Eric Stahl

Others Attending: Mike Deluhery, County Administrator

MOTION **MOTION BY MEMBER CRAWFORD, SECOND BY MEMBER SCHNEIDER** to move the Committee into Executive Session under 5 ILCS 120/2(c)(2) – Collective Bargaining or Salary Schedules at 6:30 p.m.

On voice vote, **MOTION CARRIED UNANIMOUSLY**

Chairman Harris moved the Committee out of Executive Session at 6:32 p.m.

HR-25-08 **MOTION BY MEMBER CRAWFORD, SECOND BY MEMBER MINGUS** to recommend to approve the Collective Bargaining Agreement between Tazewell County and the Teamsters, Chauffeurs, and Helpers Local Union No. 627 on behalf of the Administrative and Support Staff Employees Unit

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

RECESS Chairman Harris recessed the meeting at 6:33 p.m.

(transcribed by S. Gullette)

Countywide Elected Officals Salaries - Comparison to other Counties

Treasurer

	2026	2025	2024	2023
Peoria	118,060	118,060	118,060	116,560
McLean	118,235	114,981	111,821	111,297
Rock Island	102,000	102,000	100,000	100,000
Kendall	116,460	113,619	110,848	108,145
Tazewell	99,197	96,308	93,503	90,780
LaSalle	77,322	75,436	73,596	71,801
Kankakee	78,233	75,954	73,742	71,594
Macon	94,276	92,655	91,061	89,495
Dekalb	109,100	107,000	104,900	102,800

County Clerk

	2026	2025	2024	2023
Peoria	118,060	118,060	118,060	116,560
McLean	118,235	114,981	111,821	111,297
Rock Island	102,000	102,000	100,000	100,000
Kendall	116,460	113,619	110,848	108,145
Tazewell	101,069	98,125	95,267	92,492
LaSalle	77,322	75,436	73,596	71,801
Kankakee	80,580	78,233	75,954	73,742
Macon	94,276	92,655	91,061	89,495
Dekalb	109,100	107,000	104,900	102,800

Countywide Elected Officials' Salaries - Historical Increases

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
FY25 - FY28 (Auditor, Circuit Clerk, Coroner, Board Chairman)							3% (except Corner 11.97%)	3%	3%	3%
FY23 - FY26 (County Clerk, Treasurer)					3%	3%	3%	3%		
FY21 - FY24 (Auditor, Circuit Clerk, Coroner, Board Chairman)			0%	0%	1.30%	5.90%				
FY19 - FY22 (County Clerk, Treasurer, Sheriff)	0%	0%	1.30%	5.90%						
Liquor Commissioner (Board Chairman)	$50	$50	$50	$50	$50	$50	3%	3%	3%	3%
Non-Union	1.50%	3% (2% base, 1% merit)	2%	5% (3% base, 2% merit)	3.5% + Longevity Inc. (5.83% Ave.)	4% + Performance Incentive (2 % base, 2% merit, 1.5%-3.5% PIP)	4% (2% base, 2% merit)			

Countywide Elected Officials Salaries

(As of July 18, 2025)

Office	Current Salaries	State Stipends	Total	Authority
State's Attorney	$ 219,326	$ -	$ 219,326	Set by the State with cost of living adjustments typically effective July 1st. Salary as of 7/1/25 increase.
Sheriff	175,460	6,500	181,960	State Statute requires at least 80% of State's Attorney, with cost of living adjustments typically effective July 1st. Salary as of 7/1/25 increase
Circuit Clerk	106,933	6,500	113,433	Set by County Board
County Clerk	98,125	6,500	104,625	Set by County Board
Treasurer	96,308	6,500	102,808	Set by County Board
Coroner	95,000	6,500	101,500	Set by County Board
Auditor	60,958	6,500	67,458	Set by County Board
County Board Chairman	35,251	-	35,251	Set by County Board and includes $2,934 liquor commissioner compensation

COMMITTEE REPORT

HR-25-13

Mr. Chairman and Members of the Tazewell County Board:

Your Human Resources Committee has considered the following RESOLUTION and recommends that it be adopted by the Board:

R E S O L U T I O N

WHEREAS, the Human Resources Committee recommends to the County Board to terminate the physician hospital organization agreement ("Agreement") with Health Plus, Inc effective September 1, 2025.; and

WHEREAS, the County entered into the Agreement with an effective June 1, 2022 and the amended Agreement has an expiration date of December 31, 2026; and

WHEREAS, the Agreement provides discounts for in-network services, with the primary hospital system being the Carle Health network; and

WHEREAS, members of the Insurance Review Committee and employees have expressed a desire to have broader in-network providers; and

WHEREAS, Health Plus, Inc. has conveyed their willingness to accept the Agreement being terminated effective September 1, 2025; and

WHEREAS, the County's Health Insurance consultant The Wyman Group has presented an option that will significantly expand the County's in-network providers, potentially reduce costs, and will be able to continue to work with the County's third-party administrator Consociate Health.

THEREFORE BE IT RESOLVED that the County Board approves terminating the agreement and authorizes the County Board Chairman or County Administrator to provide notification to Health Plus, Inc.

BE IT FURTHER RESOLVED that the County Clerk notifies the County Board Office, the Human Resources Department, and the Auditor of this action.

PASSED THIS 30th DAY OF JULY, 2025.

ATTEST:

_____ _____

County Clerk County Board Chairman

COMMITTEE REPORT

HR-25-14

Mr. Chairman and Members of the Tazewell County Board:

Your Human Resources Committee has considered the following RESOLUTION and recommends that it be adopted by the Board:

R E S O L U T I O N

WHEREAS, the County's Human Resources Committee recommends to the County Board to approve the Aetna Signature Administrators PPO Managed Care Services Agreement; and

WHEREAS, the Aetna Network will make available to Tazewell County plan particpants a nation-wide network of healthcare providers and facilities allowing for more care options; and

WHEREAS, the agreement with Aetna maintains the current level of coverage and benefits for plan participants; and

WHEREAS, the agreement is for an initial term of one year and then automatically renews for consecutive one-year terms; and

WHEREAS, this contract is not conducive to competitive bidding due to the requirement that the managed services provider selected must have a relationship with Consociate, our current TPA (third party administrator) under contract; and

WHEREAS, the service fee is $16.25 per employee per month.

THEREFORE BE IT RESOLVED that the County Board approve the agreement.

BE IT FURTHER RESOLVED that the County Board authorizes the County Board Chairman to sign all documents relating to this agreement.

BE IT FURTHER RESOLVED that the County Clerk notifies the County Board Office, Human Resources Department, and the Auditor of this action in order that this action.

PASSED THIS 30th DAY OF JULY, 2025.

ATTEST:

_____ _____

County Clerk County Board Chairman

Aetna Signature Administrators® PPO

Managed Care Services Agreement

This **Aetna Signature Administrators® PPO Managed Care Services Agreement** (the "Agreement") is entered into, between Aetna Life Insurance Company, on behalf of itself and its applicable affiliates ("Aetna") and Tazewell County, a self-funded plan sponsor ("Customer") (together, the "Parties") as of the Effective Date shown below.

TPA: Consociate Health

EFFECTIVE DATE: August 01, 2025

1. **TERM**

This Agreement begins on the Effective Date, continues for an initial term of one (1) year, and then automatically renews for consecutive one (1) year terms. The Agreement may be terminated by either Party, for any reason or no reason at all, with at least ninety (90) days advance written notice to the other Party. Additional termination provisions are included in the Agreement.

2. DEFINITIONS

2.1. Applicable Law. All applicable Federal and states laws, regulations and governmental directives related to this Agreement, including, but not limited to, ERISA, ACA, HIPAA and applicable federal and state privacy laws and regulations.

2.2. Aetna/TPA Agreement. The Network Administration, Coordination and Oversight Agreement between Aetna and TPA, which enables Customer to contract directly with Aetna for the ASA Program, as further described in this Agreement.

2.3. Customer/TPA Agreement. The administrative services agreement between Customer and TPA, through which Customer contracts with TPA to obtain third party claims administration and related services.

2.4. ASA Program. The Aetna Signature Administrators(s) program, which offers health care provider network, risk assumption, medical/case management and/or other services to Customer, as further described in this Agreement.

2.5. Provider Contract Rates. The contract rates and terms negotiated by Aetna and Participating Providers with respect to the Participating Providers' network participation with the ASA Program.

2.6. Covered Services. Those health care and related services for which a Member is entitled to receive coverage under the Plan, and that are rendered by Participating Providers in accordance with this Agreement.

2.7. Member. A person covered by or enrolled in the Plan. Member includes the subscriber and any of the subscriber's eligible dependents.

2.8. Participating Provider. A health care provider that participates as an in-network provider for the ASA Program.

2.9. Plan. Customer's self-funded health benefits plan(s).

2.10. Services. The Services provided by Aetna to Customer under the ASA Program.

2.11. Service Fees. The service fees payable by Customer to Aetna in exchange for the ASA Program.

2.12. Stop Loss Policy. The separate stop loss policy: (a) in effect between Customer and a stop loss carrier specifically approved by Aetna; and (b) in relation to which a portion of the financial risk for the Plan is

borne by Aetna through a reinsurance agreement between Aetna and such stop loss carrier.

3. ASA PROGRAM ACCESS

3.1. Customer understands that access to the ASA Program is subject to the following rules and agrees to the following:

3.1.1. Customer/TPA Agreement. Customer will maintain, throughout the term of this Agreement, a Customer/TPA Agreement with TPA and will comply with the terms of that agreement.

3.1.2. Utilization Management/Case Management. Customer understands that TPA may be subject to an agreement with an Aetna affiliate to obtain a range of utilization management and/or case management services that may be provided to the Plan. Consistent with that contract, Customer agrees that it may not use any third party other than TPA to perform utilization management and/or case management services for Plan in-network claims, except as specifically agreed in advance, in writing, by Aetna. Customer understands that Aetna reserves the right to perform case management with respect to any Member.

3.1.3. Stop Loss. Customer agrees to maintain an in-force Stop Loss Policy throughout the term of this Agreement.

3.1.4. Claim and Clinical Policies. Customer acknowledges that, consistent with the Aetna/TPA Agreement, access to the ASA Program is subject to the application of certain Aetna claim and clinical policies, including, but not limited to, Aetna's Clinical Policy Bulletins (CPBs) as amended from time to time.

3.1.5. Pharmacy Rebates. Customer acknowledges and agrees that rebates for pharmaceuticals that are administered and paid through the plan rather than the participant's pharmacy benefit portion of the plan will be retained by Aetna as compensation for the services provided under this Agreement. Aetna will disclose to Customer, on an annual basis the rebates collected and attributable to your plan (without reduction by any portion that may be retained by Aetna). Aetna will provide Customer all information concerning the rebates collected that is necessary for you to comply with any applicable reporting requirements. Customer hereby grants Aetna the authority to enter into necessary agreements on its behalf to engage CVS Caremark for the exclusive provision of manufacturer rebate services for your plan.[1]

4. SERVICE FEES AND PAYMENT OBLIGATIONS

4.1. Service Fee Amounts.

4.1.1. As of the Effective Date, the Service Fees are:
$16.25 per employee per month

4.2. Service Fee Increases. After each annual period that this Agreement is in effect, Aetna may increase the Service Fees by providing Customer (via TPA) with written notice of the new Service Fees, at least ninety (90) days prior to the start of any annual renewal period; no amendment to this Agreement shall be required and increases will automatically take effect upon the renewal date, unless this Agreement is terminated prior to the renewal date.

[1] CVS Caremark and its affiliates may contract with pharmaceutical companies for the provision of services, such as care management, program administration, adverse event and other data reporting, and fulfillment services. CVS Caremark may receive compensation for such services. CVS Caremark and its affiliates may receive administrative fees from pharmaceutical companies of up to six percent of the wholesale acquisition cost of the products dispensed. CVS Caremark affiliated pharmacies may contract with pharmaceutical companies for the purchase of products and these contracts may provide for prompt pay discounts and other concurrent or retrospective purchase discounts on products purchased for pharmacy dispensing inventories. For clarity, the discounts, fees and other compensation described in this paragraph are independent of the manufacturer rebates.

4.3. Service Fees Upon Termination. Upon termination, Service Fees will be charged for an additional three (3) months to cover twelve (12) months of runout processing.

4.4. Customer Obligation to Make Payment. Funding of claims from Participating Providers, Service Fees and any applicable Stop Loss Policy premiums is the obligation of Customer. Although claims processing and fee/premium remittance functions may be delegated by Customer to its contracted TPA, in the event that TPA does not forward payment to Participating Providers and/or fails to remit Service Fees and applicable Stop Loss Policy premiums to Aetna, in a timely manner, Aetna may demand and collect such payments/amounts directly from Customer.

5. MEMBER ELIGIBILITY

5.1. Eligibility Information. Customer agrees to supply TPA, electronically, with all industry-standard information regarding the eligibility of Members. Customer agrees that Aetna will not be responsible in any way for any delay or error caused by: (i) Customer's failure to furnish complete and accurate eligibility information to TPA; or (ii) TPA's failure to correctly administer accurate eligibility information, in a timely manner.

5.2. Retroactive Member Terminations. Customer understands and agrees that, while Aetna will use commercially reasonable efforts to cooperate with Customer in making retroactive adjustments to Customer's bills for terminated Members, a maximum of three (3) month's credit for Member terminations will be provided.

6. FUNDING OF CLAIMS

6.1. Participating Provider Claims. Customer agrees to promptly fund claims for Covered Services, in accordance with Applicable Law, the terms of the Customer/TPA Agreement, and the Provider Contract Rates.

6.2. Provider Contract Rate Application. Customer understands and agrees that no rates other than the Provider Contract Rates may be applied to claims for Covered Services and that no reductions or administrative fees of any kind (e.g., reasonable and customary adjustments) shall be applied to or against the Provider Contract Rates. Customer understands that retroactive adjustments are occasionally made to the Provider Contract Rates (e.g., because the federal government does not issue cost of living data in sufficient time for an adjustment to be made on a timely basis, or because contract negotiations were not completed by the end of the prior rate period). Customer's obligation to fund amounts related to such adjustments will survive the termination of this Agreement.

6.3. Participating Provider Contract Requirements. Customer specifically understands that certain network participation agreements with Participating Providers may be negotiated on a case-by- case basis and may include special requirements (e.g., limits on retrospective audits or precertification requirements; unique arbitration provisions). Customer shall cooperate fully with TPA's administration of claims in accordance with the applicable Participating Provider's network agreement, including any specially negotiated terms in that contract. Customer understands that the Provider Contract Rates may include, but are not limited to, various methodologies, such as value based contracting terms, risk share components and/or other similar arrangements. Customer understands that Customer's or TPA's failure to comply with the terms of a Participating Provider agreement (including, but not limited to timely claim payment provisions) may result in the loss of the discount/Provider Contract Rate offered by the Participating Provider.

7. PLAN INFORMATION AND BENEFIT REQUIREMENTS

7.1. Plan Information. Customer will provide or instruct TPA to provide Aetna with: (i) all Plan documents within (15) days of Aetna's request; and (ii) reasonably necessary information requested by Aetna regarding administration of the Plan. Customer agrees that Aetna will not be responsible in any way for any delay or

error caused by Customer's or TPA's failure to furnish correct Plan documents or relevant information regarding Plan administration in a timely manner.

7.2. Plan Design. Customer agrees that the Plan will utilize a preferred provider organization (PPO) benefit model, with no primary care physician referrals required, and that it will contain a minimum twenty percent (20%) coinsurance differential between in-network (preferred) and out-of-network (non-preferred) benefits. (For purposes of illustration, if the out-of-network benefits have a 70/30% coinsurance, then the in-network coinsurance shall be at least 90/10%). If a Plan utilizes copayments, then the differentials for in-network versus out-of-network benefits shall be actuarially comparable to the coinsurance differentials set forth above. A minimum of 80% of the membership under the Plan must access the Aetna network. Customer's Plans utilizing Network Providers must provide that Member and Plan responsibility for all Covered Services shall be based on a percentage of the negotiated contract rate between Aetna and the applicable Participating Provider (after deductible or copayments) and not on any other basis (such as a percentage of usual and customary charges or a percentage of Medicare allowable amounts.) ASA may not be offered alongside a reference-based pricing plan option. For purposes of clarification the term "referenced based pricing" includes, but is not limited to, plan coverage set at a percentage of Medicare allowable charges or other pricing reference point (e.g., FairHealth database). Plans may not require member coinsurance amounts greater than 30% of the contract rate and Member coinsurance amounts will be based on the Provider Contract Rate.

8. NETWORK

8.1. Participating Provider Network. Aetna will make available to Customer its network of Participating Providers for the ASA Program. Customer understands that Aetna has no obligation to make any specific health care provider(s) available to Members. Customer acknowledges that Aetna does not provide medical care or treatment and that Participating Providers are solely responsible for the care and treatment they provide; that Participating Providers are not employees or agents of Aetna; and that Aetna is not responsible for clinical outcomes.

8.2. Aetna Institutes of Excellence™. Customer agrees that Aetna's network of participating facilities for transplant and transplant-related services (known, as of the Effective Date, as the Institutes of Excellence® transplant network) will be included with the Plan and utilized as the primary transplant network for the Plan.

8.3. Aetna Gene-based, Cellular and other Innovative Therapies™ ("GCIT" and "GCIT Network"). Aetna's network of participating facilities specifically contracted for GCIT services will be included with Plan and will be utilized as the primary GCIT network for the Plan. The Plan shall require that GCIT services are performed at a facility within the GCIT Network and will only be covered at the Aetna GCIT network rate or up to 100% of average wholesale acquisition price (in situations where a GCIT facility could not be used).

9. TERMINATION

9.1. Customer understands and agrees that Aetna may terminate Customer's access to the Services (and, thereby, this Agreement) under the following circumstances:

a. If Customer fails to respond within five (5) business days of written notice by Aetna or TPA to provide funds for the payment of claims to Participating Providers, Aetna shall have the right to suspend Services until the requested funds have been provided; Aetna may terminate the Agreement immediately upon transmission of notice to Customer by mail, facsimile transmission or other means of communication (including electronic mail).

b. If Customer fails to pay Service Fees within thirty (30) calendar days of written notice of unpaid Service Fees by Aetna or if TPA fails to forward payment to Aetna, Aetna shall have the right to suspend Services until the Service Fees have been paid; Aetna may terminate this Agreement immediately upon

transmission of notice to Customer by mail, facsimile transmission or other means of communication (including electronic mail).

In the event of the termination of the Aetna/TPA Agreement, Customer/TPA Agreement or the Stop Loss Policy, for any reason, this Agreement shall terminate automatically. Unless the Agreement is terminated by Aetna due to Customer's breach of its provisions, Aetna will continue to perform Services for benefits under the Plan that were incurred prior to but not processed as of the termination date, and which were received by Aetna not more than twelve (12) months following the termination date, subject to Customer's continued compliance with this Agreement.

10. CONFIDENTIALITY

Without limiting any obligations contained in the Agreement, Customer understands and agrees that Aetna's data, procedures, materials, lists, systems and other non-publicly available information are confidential and proprietary to Aetna, and Customer agrees that it will not provide any Confidential Information to any third party without Aetna's prior written consent. Customer further agrees that it will not use the Confidential Information or portions thereof, for any purpose other than to perform its obligations under this Agreement. Aetna's confidentiality obligations with respect to the information of Plan members ("Members") are set forth in the Business Associate Agreement between Aetna and TPA. Confidential Information does not include Provider Contract Rates, Participating Provider agreements or Service Fees.

11. AETNA NOT CLAIMS FIDUCIARY

Customer agrees that, under no circumstances shall Aetna or any of its affiliates be considered the "appropriate named fiduciary" for purposes of reviewing denied claims under the terms of the Plan and that none of its Plan materials or other communications to Members shall contradict this provision.

12. INDEPENDENT CONTRACTORS

Aetna and Customer are independent contractors and not employees or agents of each other. Customer understands and acknowledges that Aetna is neither the insurer nor third party administrator of the Plan and that, under no circumstances, is Aetna responsible for making or confirming eligibility decisions or coverage determinations, or for funding provider claims or other charges. Therefore, Customer hereby agrees to indemnify and hold harmless Aetna and its affiliates from and against that portion of any and all claims, liabilities, causes of action, judgments, damages, losses, costs and expenses (including, but not limited to, reasonable attorneys' fees and costs) (collectively, "Claims") arising directly from: (a) Customer's breach of its obligations under this Agreement including, but not limited to, Customer's failure to provide timely, accurate eligibility information regarding a Member to TPA and/or a Participating Provider; and/or (b) the funding, administration, processing, determination or denial of a claim under a Plan. Aetna agrees to discharge its obligations under this Services Agreement with that level of reasonable care which a similarly situated provider of network and related services would exercise under similar circumstances and agrees to indemnify and hold harmless Customer from and against that portion of any Claims arising directly from Aetna's failure to provide the Services in accordance with that standard of care.

13. MISCELLANEOUS

13.1. Subject to the terms of the separate Stop Loss Policy, this Agreement constitutes the entire understanding between the parties and supersedes any and all prior or contemporaneous oral or written communications or proposals not expressly included herein. This Agreement may be amended only upon the mutual written agreement of Aetna and Customer or as required (in Aetna's determination) by Applicable Law. To the extent not preempted by Federal law, this Agreement shall be governed by the laws of the State of Connecticut. This Agreement may not be assigned or delegated, in whole or in part, by Customer. In the event that any provision of this Program Agreement is deemed unenforceable, such provision shall be severed and the remaining provisions shall continue to apply in full force and effect. By executing this

Agreement, Customer acknowledges and agrees that it has had the opportunity to review the Agreement with the counsel of its choice and intends to be legally bound by the same. The waiver by either Party of a breach or violation of any provision of this Agreement will not operate as or be construed to be a waiver of any subsequent breach of this Agreement. Other than as expressly set forth in this Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, but not limited to, Members. Headings in the Agreement are for convenience only and do not affect the meaning of the Agreement.

13.2. Dispute Resolution. Aetna will provide an internal mechanism under which Customer can raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Customer will exhaust Aetna's internal mechanism before instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held during this process will be treated as settlement negotiations and will be inadmissible into evidence in any court proceeding, except to prove the existence of a binding settlement agreement.

13.3. Arbitration. Any controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity thereof, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration in Hartford, CT, administered by the American Arbitration Association ("AAA") and conducted by a sole arbitrator in accordance with the AAA's Commercial Arbitration Rules ("Rules"). The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16, to the exclusion of state laws inconsistent therewith or that would produce a different result, and judgment on the award rendered by the arbitrator may be entered by any court having jurisdiction thereof. Except as may be required by law or to the extent necessary in connection with a judicial challenge, or enforcement of an award, neither a party nor the arbitrator may disclose the existence, content, record or results of an arbitration. Fourteen (14) calendar days before the hearing, the parties will exchange and provide to the arbitrator (a) a list of witnesses they intend to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (b) pre-marked copies of all exhibits they intend to use at the hearing. Depositions for discovery purposes shall not be permitted. The arbitrator may award only monetary relief and is not empowered to award damages other than compensatory damages.

13.4. Insurance. Each Party agrees to maintain industry standard insurance coverage or a comparable program of self-insurance.

13.5. Limitation of Liability. A Party's liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party's actual damages. NEITHER PARTY WILL BE LIABLE TO THE OTHER FOR ANY CONSEQUENTIAL, INCIDENTAL, OR PUNITIVE DAMAGES WHATSOEVER. This section will survive the termination of this Agreement.

13.6. Notices. Notices required to terminate or non-renew the Agreement must be sent by U.S. mail or nationally recognized courier, return receipt requested, to the applicable Party's most currently updated address. Any other notices required under this Agreement may be sent by letter, electronic mail or other generally accepted media, to the applicable Party's last updated address.

13.7. Use of Name. Customer agrees that Aetna may make lawful references to Customer in informing health care providers as to the organizations and plans for which Services are to be provided.

13.8. Compliance. Customer agrees that it shall, throughout the term of this Agreement, operate and administer the Plan and perform its obligations hereunder in compliance with Applicable Law. Aetna agrees that it shall, throughout the term of this Agreement, operate in material compliance with Applicable Law related to the performance of its obligations under this Agreement.

IN WITNESS WHEREOF, the undersigned Parties have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

TAZEWELL COUNTY	**AETNA LIFE INSURANCE COMPANY**
By:_____	By:_____
Printed Name:_____	Printed Name:_____
Title:_____	Title:_____
Date:_____	Date:_____

COMMITTEE REPORT

HR-25-15

Mr. Chairman and Members of the Tazewell County Board:

Your Human Resources Committee has considered the following RESOLUTION and recommends that it be adopted by the Board:

R E S O L U T I O N

WHEREAS, the County's Human Resources Committee recommends to approve updates to the County's Health Plan as provided in the attached Summary of Benefits and Coverage documents; and

WHEREAS, the current Health Plan does not cover out-of-network costs when a plan participant resides within a 40-mile local radius, except in limited circumstances; and

WHEREAS, with the approval of the Aetna program, the County will have a significantly expanded national list of in-network providers; and

WHEREAS, the Aetna plan requires differentiation between in-network and out-of-network; and

WHEREAS, the Aetna plan will allow for removing the lack of out-of-network coverage within the 40-mile radius requirement and replacing it with the out-of-network coverage provided in the attached Summary of Benefits and Coverage, with most out-of-network services having a 40% coinsurance unless provided otherwise; and

WHEREAS, the change will be effective September 1, 2025.

THEREFORE BE IT RESOLVED that the County Board approves the recommendations and directs Consociate to incorporate the changes into the Health Plan.

BE IT FURTHER RESOLVED that the County Clerk notifies the County Board Office, the Human Resources Department and Consociate of this action in order that this resolution be fully implemented.

PASSED THIS 30th DAY OF July, 2025.

ATTEST:

_____ _____

County Clerk County Board Chairman

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.consociatehealth.com or call 1-800-798-2422 to request a copy.

Important Questions	Answers	Why This Matters:
What is the Calendar Year overall deductible?	For network providers/out-of-network providers combined: $500 Individual $1,000 Family	Generally, you must pay all of the costs from providers up to the calendar year 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. Preventive care, emergency room, network charges where copayments apply, and prescription drug copayments 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. 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 Calendar Year out-of-pocket limit for this plan?	For network providers/out-of-network providers combined: $1,300 Individual $2,600 Family	The out-of-pocket limit is the most you could pay in a calendar 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, balance-billed charges, copayments, dental/vision, penalties for failure to obtain preauthorization, ineligible 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.consociate.com or call 1-800-798-2422 for a list of network providers. You can also see ~~www.healthpluspeoria.com~~ or call ~~1-309-671-8358~~. aetna.com/asa (*~~If you are outside of the network service area, please contact MultiPlan (www.multiplan.com) for a PHCS-Out of Area Provider.~~*)	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. ~~*Out-of-network benefits are not available unless you are outside of the network area or unless the treatment is not offered at the Network facility.*~~
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
The plan includes services at BJC HealthCare Center of Excellence Network (BJC COE). For Services at BJC COE, the deductible and out of pocket expenses will be waived.				
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment	40% ~~20%~~ coinsurance	Telemedicine with Walmart Virtual Care: Call 1-855-636-3669. Chiropractic Care covered at 20% coinsurance for Network Providers. ~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~
	Specialist visit	$25 copayment	40% ~~20%~~ coinsurance	
	Preventive care/screening/ immunization	No Charge	~~No Charge~~ 40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Office: 20% coinsurance Outpatient: 10% coinsurance	40% ~~20%~~ coinsurance	Imaging: Preauthorization is required for Advanced Radiology including Nuclear Medicine and Nuclear Cardiology, or benefits could be reduced. ~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~
	Imaging (CT/PET scans, MRIs)	Facility: 10% coinsurance Physician: 20% coinsurance	40% ~~20%~~ coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Smithrx.com or 1-844-454-5201.	Generic drugs	Retail 30-day: $12 copayment 90-day: $24 copayment	Not Covered	Covers up to a 30-day supply (retail); 90-day supply (retail and mail order). Retirees and/or Retiree's spouses eligible for Medicare are not covered by the Drug Program.
	Preferred brand drugs	Retail 30-day: $30 copayment 90-day: $60 copayment		
	Non-preferred brand drugs	Retail 30-day: $50 copayment 90-day: $100 copayment		
	Specialty drugs	$50 copayment	Not Covered	Covers up to a 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% ~~20%~~ coinsurance	Preauthorization is required or benefits could be reduced. ~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~
	Physician/surgeon fees	20% coinsurance	40% ~~20%~~ coinsurance	
If you need immediate medical attention	Emergency room care	Facility: $300 copayment; After Facility copayment, other providers for emergency services: 10% coinsurance after In Network Deductible		Preauthorization is required if admitted. Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	40% ~~20%~~ coinsurance	None
	Urgent care	$75 copayment	~~$75 copayment~~ 40% ~~20%~~	None

* For more information about limitations and exceptions, see the plan or policy document at www.consociatehealth.com.

~~*Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.*~~

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			coinsurance	
If you have a hospital stay	Inpatient or Outpatient treatment - Facility	10% coinsurance	40% ~~20%~~ coinsurance	Preauthorization is required or benefits could be reduced. ~~*Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.*~~
	Inpatient or Outpatient: Services, Physician Charges, Surgery Services, Hospital care	20% coinsurance	40% ~~20%~~ coinsurance	
If you need behavioral health services, or substance use services	Office Visit	$25 copayment	40% ~~20%~~ coinsurance	~~*Out-of-network benefits* are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~
	Outpatient services	20% coinsurance	40% ~~20%~~ coinsurance	
	Inpatient services, Residential, and Partial Day Services	10% coinsurance	40% ~~20%~~ coinsurance	Preauthorization is required or benefits could be reduced. ~~*Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.*~~
If you are pregnant	Office visits	$25 copayment for initial visit	40% ~~20%~~ coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization is required for some maternity hospital stays. Pregnancy is covered for a dependent daughter. ~~*Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.*~~
	Routine Prenatal and Postnatal services	No charge, deductible does not apply	~~No charge, deductible does not apply~~ 40% coinsurance	
	Non-Routine Prenatal Services, Delivery, and all Inpatient Care	Facility: 10% coinsurance All other: 20% coinsurance	40% ~~20%~~ coinsurance	
If you need help recovering or have other special health needs (*Out-of-network benefits* are not available unless you are outside of the network area or treatment is not offered at the Network facility.)	Home health care	20% coinsurance	40% ~~20%~~ coinsurance	None
	Rehabilitation services	20% coinsurance	40% ~~20%~~ coinsurance	None
	Habilitation services	20% coinsurance	40% ~~20%~~ coinsurance	
	Skilled nursing care	20% coinsurance	40% ~~20%~~ coinsurance	Preauthorization is required or benefits could be reduced.
	Durable medical equipment	20% coinsurance	40% ~~20%~~ coinsurance	None
	Hospice services	20% coinsurance	40% ~~20%~~ coinsurance	Preauthorization is required for inpatient services.
If your child needs dental or eye care	Children's eye exam	Not Covered		Employee vision benefit only
	Children's glasses	Not Covered		None

* For more information about limitations and exceptions, see the plan or policy document at www.consociatehealth.com.

~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~				
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not Covered		Covered only if Dental coverage is elected

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
- Dental care (Adult)
- Glasses/Hearing Aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-network prescription drugs
- Routine eye care
- 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
- Infertility

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 Health: 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 or the U.S. Department of Health and Human Services at 1-877-267-2323 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 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: Consociate Health: 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

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 1-800-798-2422

[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	$500
Specialist copayment	$25
Hospital (facility) coinsurance	10%
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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$48
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
Total Example Cost	$12,700
The total Peg would pay is	$1,408

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	$25
Hospital (facility) coinsurance	10%
Other coinsurance	20%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$962
Coinsurance	$246
Total Example Cost	$7,400
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,763

Mia's Simple Fracture

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

The plan's overall deductible	$500
Specialist & ER copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	20%

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500

* For more information about limitations and exceptions, see the plan or policy document at www.consociatehealth.com.

Total Example Cost	$1,900
Copayments	$200
Coinsurance	$146

Total Example Cost	$1,900
What isn't covered	
Limits or exclusions	$0

Total Example Cost	$1,900
The total Mia would pay is	$846

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

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.consociatehealth.com or call 1-800-798-2422 to request a copy.

Important Questions	Answers	Why This Matters:
What is the Calendar Year overall deductible?	For network providers/out-of-network providers combined: $1,000 Individual $2,000 Family	Generally, you must pay all of the costs from providers up to the calendar year 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. Preventive care, benefits where copayments apply, and prescription drug copayments 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. 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 Calendar Year out-of-pocket limit for this plan?	For network providers/out-of-network providers combined: $2,000 Individual $4,000 Family	The out-of-pocket limit is the most you could pay in a calendar 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, balance-billed charges, copayments, penalties for failure to obtain preauthorization, ineligible 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.consociate.com or call 1-800-798-2422 for a list of network providers. You can also see ~~www.healthpluspeoria.com~~ or call ~~1-309-671-8358~~. aetna.com/asa ~~(*If you are outside of the network service area, please contact MultiPlan (www.multiplan.com) for a PHCS-Out of Area Provider.*)~~	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. ~~*Out-of-network benefits are not available unless you are outside of the network area or unless the treatment is not offered at the Network facility.*~~
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
The plan includes services at BJC HealthCare Center of Excellence Network (BJC COE). For Services at BJC COE, the deductible and out of pocket expenses will be waived.				
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment	40% ~~20%~~ coinsurance	Telemedicine with Walmart Virtual Care: Call 1-855-636-3669. Chiropractic Care covered at 20% coinsurance for Network Providers. ~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~
	Specialist visit	$25 copayment	40% ~~20%~~ coinsurance	
	Preventive care/screening/ immunization	No Charge	No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Office: 20% coinsurance Outpatient: 10% coinsurance	40% ~~20%~~ coinsurance	I maging: Preauthorization is required for Advanced Radiology including Nuclear Medicine and Nuclear Cardiology, or benefits could be reduced. ~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~
	Imaging (CT/PET scans, MRIs)	Office: 20% coinsurance Outpatient: 10% coinsurance	40% ~~20%~~ coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at SmithRx.com or 1-844-454-5201.	Generic drugs	Retail 30-day: $12 copayment 90-day: $24 copayment	Not Covered	Covers up to a 30-day supply (retail); 90-day supply (retail and mail order). Retirees and/or Retiree's spouses eligibile for Medicare are not covered byt the Drug Program.
	Preferred brand drugs	Retail 30-day: $30 copayment 90-day: $60 copayment		
	Non-preferred brand drugs	Retail 30-day: $50 copayment 90-day: $100 copayment		
	Specialty drugs	$50 copayment	Not Covered	Covers up to a 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% ~~20%~~ coinsurance	Preauthorization is required or benefits could be reduced. ~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~
	Physician/surgeon fees	20% coinsurance	40% ~~20%~~ coinsurance	
If you need immediate medical attention	Emergency room care	Facility: $300 copayment; After Facility copayment, other providers for emergency services: 10% coinsurance after In Network Deductible		Preauthorization is required if admitted. Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	40% ~~20%~~ coinsurance	None
	Urgent care	$75 copayment	~~$75 copayment~~ 40%	None

* For more information about limitations and exceptions, see the plan or policy document at www.consociatehealth.com.

~~*Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.*~~

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			coinsurance	
If you have a hospital stay	Inpatient or Outpatient treatment - Facility	10% coinsurance	40% ~~20%~~ coinsurance	Preauthorization is required or benefits could be reduced. ~~*Out-of-network benefits* are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~
	Inpatient or Outpatient: Services, Physician Charges, Surgery Services, Hospital care	20% coinsurance	40% ~~20%~~ coinsurance	
If you need behavioral health services, or substance use services	Office Visit	$25 copayment	40% ~~20%~~ coinsurance	~~*Out-of-network benefits* are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~
	Outpatient services	Facility: 10% coinsurance Physician: 20% coinsurance	40% ~~20%~~ coinsurance	
	Inpatient services, Residential, and Partial Day Services	10% coinsurance	40% ~~20%~~ coinsurance	Preauthorization is required or benefits could be reduced. ~~*Out-of-network benefits* are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~
If you are pregnant	Office visits	$25 copayment for initial visit	40% ~~20%~~ coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization is required for some maternity hospital stays~~. *Out-of-network benefits* are not available unless you are outside of the network area or treatment is not offered at the Network facility. Pregnancy is covered for a dependent daughter.~~
	Routine Prenatal and Postnatal services	No charge, deductible does not apply		
	Non-Routine Prenatal Services, Delivery, and all Inpatient Care	Facility: 10% coinsurance All other: 20% coinsurance	40% ~~20%~~ coinsurance	
If you need help recovering or have other special health needs (*Out-of-network benefits* are not available unless you are outside of the network area or treatment is not offered at the Network facility.)	Home health care	20% coinsurance	40% ~~20%~~ coinsurance	None
	Rehabilitation services	20% coinsurance	40% ~~20%~~ coinsurance	None
	Habilitation services	20% coinsurance	40% ~~20%~~ coinsurance	
	Skilled nursing care	20% coinsurance	40% ~~20%~~ coinsurance	Preauthorization is required or benefits could be reduced.
	Durable medical equipment	20% coinsurance	40% ~~20%~~ coinsurance	None
	Hospice services	20% coinsurance	40% ~~20%~~ coinsurance	Preauthorization is required for inpatient services.
If your child needs dental or eye care	Children's eye exam	Not Covered		Employee vision benefit only
	Children's glasses	Not Covered		None

* For more information about limitations and exceptions, see the plan or policy document at www.consociatehealth.com.

~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~				
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not Covered		Covered only if Dental coverage is elected

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
- Dental care (Adult)
- Hearing Aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Routine foot care, except for diabetics
- 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
- Infertility

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 Health: 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 or the U.S. Department of Health and Human Services at 1-877-267-2323 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 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: Consociate Health: 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

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 1-800-798-2422

[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	$1,000
Specialist copayment	$0
Hospital (facility) coinsurance	10%
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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,000**

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

The plan's overall deductible	$1,000
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	20%

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	$900
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

The plan's overall deductible	$1,000
Specialist & ER copayment	$325
Hospital (facility) coinsurance	10%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

* For more information about limitations and exceptions, see the plan or policy document at www.consociatehealth.com.

Total Example Cost	$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000

Total Example Cost	$2,800
Copayments	$325
Coinsurance	$200
What isn't covered	

Total Example Cost	$2,800
Limits or exclusions	$0
The total Mia would pay is	$1,525

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

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.consociatehealth.com or call 1-800-798-2422 to request a copy.

Important Questions	Answers	Why This Matters:
What is the Calendar Year overall deductible?	*Effective 1/1/2024 – 12/31/2024:* For network providers/out-of-network providers combined: *$3,200 Individual $6,400 Family* *Effective 1/1/2025 – 12/31/2025* For network providers/out-of-network providers combined: *$3,300 Individual $6,600 Family*	Generally, you must pay all of the costs from providers up to the calendar year 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. Preventive care is 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. 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 Calendar Year out-of-pocket limit for this plan?	For network providers/out-of-network providers combined: $6,000 Individual $8,000 Family	The out-of-pocket limit is the most you could pay in a calendar 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, balance-billed charges, penalties for failure to obtain preauthorization, ineligible 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.consociate.com or call 1-800-798-2422 for a list of network providers. You can also see ~~www.healthpluspeoria.com~~ or call ~~1-309-671-8358~~. aetna.com/asa *(~~If you are outside of the network service area, please contact MultiPlan (www.multiplan.com) for a PHCS-Out of Area Provider.~~)*	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. ~~*Out-of-network benefits are not available unless you are outside of the network area or unless the treatment is not offered at the Network facility.*~~
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
The plan includes services at BJC HealthCare Center of Excellence Network (BJC COE). Services at BJC COE will be covered 100% after deductible.				
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% ~~20%~~ coinsurance	Telemedicine with Walmart Virtual Care: Call 1-855-636-3669. Chiropractic Care covered at 20% coinsurance for Network Providers. ~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~
	Specialist visit	20% coinsurance	40% ~~20%~~ coinsurance	
	Preventive care/screening/ immunization	No Charge	~~No Charge~~ 40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% ~~20%~~ coinsurance	Imaging: Preauthorization is required for Advanced Radiology including Nuclear Medicine and Nuclear Cardiology, or benefits could be reduced. ~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% ~~20%~~ coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Smithrx.com or 1-844-454-5201.	Generic drugs	20% coinsurance	Not Covered	Covers up to a 30-day supply (retail); 90-day supply (retail and mail order). Retirees and/or Retiree's spouses eligible for Medicare are not covered by the Drug Program.
	Preferred brand drugs	20% coinsurance		
	Non-preferred brand drugs	20% coinsurance		
	Specialty drugs	20% coinsurance	Not Covered	Covers up to a 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% ~~20%~~ coinsurance	Preauthorization is required or benefits could be reduced. ~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~
	Physician/surgeon fees	20% coinsurance	40% ~~20%~~ coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance		Preauthorization is required if admitted.
	Emergency medical transportation	20% coinsurance		None

~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	20% coinsurance	40% ~~20%~~ coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% ~~20%~~ coinsurance	Preauthorization is required or benefits could be reduced. ~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~
	Physician Charges, Surgery Services, Hospital care	20% coinsurance	40% ~~20%~~ coinsurance	
If you need behavioral health services, or substance use services	Office Visit	20% coinsurance	40% ~~20%~~ coinsurance	~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~
	Outpatient services	20% coinsurance	40% ~~20%~~ coinsurance	
	Inpatient services, Residential, and Partial Day Services	20% coinsurance	40% ~~20%~~ coinsurance	Preauthorization is required or benefits could be reduced. ~~Non-Network Hospital benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~
If you are pregnant	Office visits	20% coinsurance	40% ~~20%~~ coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization is required for some maternity hospital stays. Pregnancy is covered for a dependent daughter. ~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~
	Childbirth/delivery professional services	20% coinsurance	40% ~~20%~~ coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% ~~20%~~ coinsurance	
If you need help recovering or have other special health needs (*Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.)*	Home health care	20% coinsurance	40% ~~20%~~ coinsurance	None
	Rehabilitation services	20% coinsurance	40% ~~20%~~ coinsurance	None
	Habilitation services	20% coinsurance	40% ~~20%~~ coinsurance	
	Skilled nursing care	20% coinsurance	40% ~~20%~~ coinsurance	Preauthorization is required or benefits could be reduced.
	Durable medical equipment	20% coinsurance	40% ~~20%~~ coinsurance	None
	Hospice services	20% coinsurance	40% ~~20%~~ coinsurance	Preauthorization is required for inpatient services.
If your child needs dental or eye care	Children's eye exam	Not Covered		Employee vision benefit only
	Children's glasses	Not Covered		None

* For more information about limitations and exceptions, see the plan or policy document at www.consociatehealth.com.

~~Out-of-network benefits are not available unless you are outside of the network area or treatment is not offered at the Network facility.~~

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not Covered		Covered only if Dental coverage is elected

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
- Dental care (Adult)
- Hearing Aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Routine foot care, except for diabetics
- 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
- Infertility

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 Health: 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 or the U.S. Department of Health and Human Services at 1-877-267-2323 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 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: Consociate Health: 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

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 1-800-798-2422

[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

* For more information about limitations and exceptions, see the plan or policy document at www.consociatehealth.com.

[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	$3,300
Specialist coinsurance	20%
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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,300
Copayments	$0
Coinsurance	$1,880
Total Example Cost	$12,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,240

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

The plan's overall deductible	$3,300
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$3,300
Copayments	$0
Coinsurance	$460
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$3,780

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

The plan's overall deductible	$3,300
Specialist & ER coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

* For more information about limitations and exceptions, see the plan or policy document at www.consociatehealth.com.

Total Example Cost	$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800

Total Example Cost	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	

Total Example Cost	$2,800
Limits or exclusions	$0
The total Mia would pay is	$2,800

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