Human Resources Committee

Mike Harris, Chairman
James Carius Community Room
101 S. Capitol Street
Pekin, Illinois 61554
Tuesday, September 22, 2026
Immediately following Finance Committee meeting

I. Roll Call

II. Approve the minutes of the August 18, 2026 meeting and August 26, 2026 in-place meeting

III. Public Comment

IV. New Business

HR-26-05 A. Recommend to approve renewal of VSP agreement for optical services

HR-26-07 B. Recommend to approve changes to the health insurance plan

HR-26-08 C. Recommend to approve a change to the Qualified High Deductible PPO Health Plan

HR-26-09 D. Recommend to approve renewal agreement with ParetoHealth as stop loss carrier

HR-26-10 E. Recommend to approve non-renewal of TPA Administrative Services Agreement with Consociate, Inc., DBA Consociate Health

HR-26-11 F. Recommend to approve Third Party Administrator Agreement with Allied Administrators

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

V. Unfinished Business

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, Eugene Glueck

Minutes pending committee approval

HUMAN RESOURCES COMMITTEE
James Carius Community Room
Tuesday, August 18, 2026 – 3:56 p.m.

Committee Members Present: Chairman Mike Harris, Russ Crawford, Eric Schmidgall, Nancy Proehl, Kim Joesting, Eric Stahl, Joe Woodrow, Dave Mingus, Deene Milam, Eugene Glueck

Committee Members Absent: Vice Chairman Max Schneider

Others Attending: Mindy Darcy, County Administrator

MOTION **MOTION BY MEMBER WOODROW, SECOND BY MEMBER GLUECK** to approve the minutes from the July 21, 2026 meeting

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

HR-26-06 **MOTION BY MEMBER CRAWFORD, SECOND BY MEMBER STAHL** to recommend to approve Agreement with Thrive Wellness, Inc., and participation in the FY26 Health Fair

Human Resources Director Roger Workheiser stated that each year they have a health fair for the County employees. He stated that this year they are using Thrive Wellness, who the County utilized last year. He stated that the health fair will take place on October 6, 7, 9, and 16. He stated that last year 116 people participated, however, 496 people were eligible. He stated that this is open to all employees, board members, retirees, and spouses who are on the insurance plan.

Member Crawford questioned where the health fair is taking place. Director Workheiser stated that on October 6th it will take place in the Justice Center Community Room. He stated that on October 7th, October 9th, and October 16th it will take place in the McKenzie Building Jury Room. He stated that all three dates will go from 7:00 a.m. to 10:00 a.m. He stated that on October 16th, it will also go from 1:30 p.m. to 2:30 p.m. for the second and third shift employees. He stated that once he receives the flyer from Thrive Wellness, he will send it out for people to register.

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

MOTION **MOTION BY MEMBER MINGUS, SECOND BY MEMBER JOESTING** to move the Committee into Executive Session under 5 ILCS 120/2(c)(2) – Collective Bargaining or Salary Schedules at 4:02 p.m.

On voice vote, **MOTION CARRIED UNANIMOUSLY**

Chairman Harris moved the Committee out of Executive Session at 4:16 p.m.

RECESS Chairman Harris recessed the meeting at 4:17 p.m.

(transcribed by S. Gullette)

Minutes pending committee approval

IN-PLACE HUMAN RESOURCES COMMITTEE
James Carius Community Room
Wednesday, August 26, 2026 – 6:34 p.m.

Committee Members Present: Chairman Mike Harris, Russ Crawford, Nancy Proehl, Eric Stahl, Dave Mingus, Eric Schmidgall, Kim Joesting, Joe Woodrow, Deene Milam, Eugene Glueck

Committee Members Absent: Vice Chairman Max Schneider

Others Attending: Mindy Darcy, County Administrator

HR-26-06 MOTION BY MEMBER CRAWFORD, SECOND BY MEMBER SCHMIDGALL to recommend to approve Agreement with Thrive Wellness, Inc. and participation in the FY26 Health Fair

Administrator Mindy Darcy stated that this matter was previously discussed at the committee meeting last week. She stated that the revision includes spouses of employees and retirees who are enrolled in the County's insurance plan, allowing them to attend the health fair.

On voice vote, MOTION CARRIED UNANIMOUSLY.

RECESS Chairman Harris recessed the meeting at 6:35 p.m.

(transcribed by S. Gullette)

COMMITTEE REPORT

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 a renewal of the agreement with VSP for vision insurance; and

WHEREAS, the County currently offers employees vision insurance through VSP; and

WHEREAS, the Wyman Group serves as the County's consultant for Tazewell County's health, dental and vision benefit plan offerings and providers; and

WHEREAS, the Wyman Group is recommending renewing with VSP under their VSP Choice plan which offers employees added benefits over the existing plan; and

WHEREAS, the changes include an increase in frame and contact allowance and coverage for non-prescription blue light glasses or sunglasses; and

WHEREAS, this change will have no premium rate increase to either employees or the County; and

WHEREAS, the four-year agreement will be effective on December 1, 2026.

THEREFORE BE IT RESOLVED by the County Board this recommendation be approved.

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

PASSED THIS 30th DAY OF SEPTEMBER, 2026.

ATTEST:

_____ _____

Tazewell County Clerk Tazewell County Board Chairman

VISION SERVICE PLAN OF ILLINOIS, NFP
3333 QUALITY DRIVE
RANCHO CORDOVA, CALIFORNIA 95670
(800) 852-7600

CLIENT VISION CARE POLICY

Client Name	**TAZEWELL COUNTY**
Policy Number	**40152172**
State of Delivery	**ILLINOIS**
Effective Date	**DECEMBER 1, 2026**
Policy Period	**FORTY-EIGHT (48) MONTHS**

In consideration of the statements and agreements contained in the Client Application, if applicable, and in consideration of payment by the Client of the premiums as herein provided, VISION SERVICE PLAN OF ILLINOIS, NFP ("VSP") agrees to insure certain individuals under this Client Vision Care Policy ("Policy") for the benefits provided herein, subject to the exceptions, limitations and exclusions hereinafter set forth. This Policy is delivered in and governed by the laws of the state of delivery and is subject to the terms and conditions recited on the subsequent pages hereof, including any Exhibits or state-specific Addenda, which are a part of this Policy.

Dave Plevyak, Chief Insurance Officer

I.

TERM, RENEWAL AND TERMINATION

1.01. **Term**: This Policy shall commence on the Effective Date noted on the front page of this Policy, and shall remain in effect for the Policy Period, also noted on the front page of this Policy.

1.02. **Renewal**:

(a) VSP shall issue written renewal notice to Client at least sixty (60) days before the end of the Policy Period. If Client fails to accept the renewal terms and/or rates in writing prior to the end of the Policy Period, this Policy shall terminate at 11:59 p.m. on the last day of the Policy Period.

(b) If Client wishes to renew the Policy but acceptance of the renewal cannot be formalized before the end of the Policy Period, or if the parties continue to negotiate renewal terms after the Policy Period, Client may submit a written request to have the Policy renew on a temporary month- to- month basis under the expired contract terms, not to exceed six months, until Client's acceptance of the renewal is formalized in writing and a new Policy is issued. Once renewal is accepted, VSP reserves the right to bill Client retroactively at the renewal premium for the temporary month-to-month renewal period. During the temporary month to month period, either party may terminate the Policy by providing thirty (30) days advance written notice to other party.

1.03. **Termination**:

(a) This Policy may be terminated by either the Client or VSP upon expiration of a Policy Period as set forth in paragraph 1.02.

(b) This Policy may also be terminated by VSP immediately upon written notice, if Client fails to:

(i) Pay premiums by the dates defined in paragraph 3.04.

(ii) Report a material change in accordance with paragraph 3.03.

(c) If Client terminates this Policy as of any date other than the end of the Policy Period, such termination will be treated by VSP as a breach by Client.

(d) If this Policy is terminated under paragraph 1.03(b) or (c), coverage is terminated and VSP is released from all obligations of this Policy, effective as of the termination date (except for preexisting obligations specifically set forth in Section 1.03 (e), below). Client will remain liable to VSP for the lesser amount of any deficit incurred by VSP or the payments which Client would have paid for the remaining term of this Policy, not to exceed one year. A deficit incurred by VSP will be calculated by subtracting the cost of incurred and outstanding claims, as calculated on an incurred

date basis with a claim run-out not to exceed six months from the date of termination, from the net premiums received by VSP from Client. Net premiums shall mean premiums paid by Client minus any applicable retention amounts and/or broker commissions. Client shall also be responsible for any legal and/or collection fees incurred by VSP to collect amounts due under this Policy.

(e) If this Policy is terminated for any cause as stated in this section 1.03, VSP is not required to pay for services provided after such termination date, except for any outstanding, unexpired benefit that is authorized before termination, or any other claim obligations that arose prior to termination.

II.

OBLIGATIONS OF VSP

2.01. **Coverage of Covered Person**: VSP will enroll for coverage, as directed by Client, each eligible Enrollee and his/her Eligible Dependents (if dependent coverage is provided), all of whom shall be referred to upon enrollment as "Covered Persons." To institute coverage, VSP may require Client to complete, sign and forward to VSP a Client Application along with information regarding Enrollees and Eligible Dependents, and all applicable premiums.

Following the enrollment of the Covered Persons, VSP will provide Client with an Evidence of Coverage for distribution to Covered Persons by Client. Such Evidence of Coverage and Member Benefit Summaries will summarize the terms and conditions set forth in this Policy.

2.02. **Administration of Plan Benefits**: Through VSP Preferred Providers (or through other licensed vision care providers where a Covered Person is eligible for, and chooses to receive Plan Benefits from, an Open Access Provider) VSP shall provide Covered Persons such Plan Benefits listed in the Schedule of Benefits (Exhibit A(s)) and when purchased by Client, the Additional Benefit Rider (Schedule C(s)) attached hereto, subject to any limitations, exclusions, or Copayments therein stated. VSP Preferred Providers have agreed to accept payments for services with no additional billing to the Covered Person other than Copayments, applicable tax, co-insurance and any amounts for non-covered services and/or materials. Notwithstanding any other provision, no references to services shall be operative unless and to the extent that services are specifically set forth in the Schedule of Benefits, and when purchased by Client, the Additional Benefit Rider. Retail chains may not offer all Plan Benefits. Covered Person may contact VSP Preferred Provider for information describing vision care services and vision care materials offered.

A Benefit Authorization must be obtained before a Covered Person can use Plan Benefits from a VSP Preferred Provider. When a Covered Person seeks Plan Benefits from a VSP Preferred Provider, the Covered Person must schedule an appointment and identify himself/herself as a VSP Covered Person so the VSP Preferred Provider can obtain a Benefit Authorization from VSP. VSP shall provide a Benefit Authorization to the VSP Preferred Provider to authorize the administration of Plan Benefits to the Covered Person. Each Benefit Authorization will contain an expiration date and must be used by the Covered Person to obtain Plan Benefits prior to the date the Benefit Authorization expires. VSP shall issue Benefit Authorizations in accordance with the latest eligibility information furnished by Client and the Covered Person's past service utilization, if any. Any Benefit Authorization so issued by VSP shall constitute a certification to the VSP Preferred Provider that payment will be made to VSP Preferred Provider, irrespective of a later loss of eligibility of the Covered Person, as long as Plan Benefits are utilized prior to the Benefit Authorization expiration date.

VSP shall pay or deny claims for Plan Benefits provided to Covered Persons, less any applicable Copayment, within a reasonable time but not more than thirty (30) calendar days after VSP receives a completed claim, unless special circumstances require additional time. In such cases, VSP may obtain an extension of fifteen (15) calendar days by providing notice to the claimant of the reasons for the extension.

2.03. Open Access Provider Services: When Covered Persons elect to utilize the services of an Open Access Provider, benefit payments for services from such Open Access Provider will be determined according to the Plan's Open Access Provider benefit fee schedule if Open Access Provider reimbursement is available. COVERED PERSONS MAY BE LIABLE FOR MORE THAN THE COPAYMENT. The Open Access Provider may bill Covered Persons for that Provider's standard rates, regardless of the amount of VSP's Plan Benefits. If Covered Person is eligible for and obtains Plan Benefits from an Open Access Provider, Covered Person remains liable for the provider's full fee. Covered Person will be reimbursed by VSP in accordance with the Open Access Provider reimbursement schedule shown on the attached Schedule of Benefits (Exhibit A (s)) and Additional Benefit Rider (Schedule C(s)) (if purchased by Client), less any applicable Copayments.

2.04. Information to Covered Persons: Upon request, VSP shall make available to Covered Persons necessary information describing Plan Benefits and instructions for use. A copy of this Policy shall be provided to Client and will be made available at the offices of VSP for any Covered Persons. Covered Persons may obtain information on VSP's Preferred Providers through VSP's website at , VSP's Customer Care toll-free number (1-800-877-7195), or by written request. If Client supplies email addresses of Covered Persons to VSP, VSP may use the email addresses to communicate information to Covered Persons about their vision benefits.

2.05. Confidentiality and Non-Disclosure Agreements VSP and Client have delivered, or will deliver, upon execution and delivery of this Policy, certain information about the properties and operations of their respective businesses. VSP and Client, therefore, agree as follows:

a) Definition of Confidential Information. For purposes of this Policy, "Confidential Information" means any data and/or information, in any form, disclosed by the disclosing Party ("Discloser") to the receiving Party ("Recipient") either before or after the Effective Date, which relates to Discloser and/or its Affiliates, and solely by way of illustration and not in limitation shall include the following information: (i) current or future product(s), services, methodologies, plans, designs, costs, prices, customer or doctor names and addresses, finances or financial information (including budgets), marketing plans or strategies (including e-commerce development plans), business plans, matters, opportunities or offerings, equipment and other purchase matters, strategic matters, research, development, know-how and/or personnel, (ii) is

identified as confidential at the time of disclosure, (iii) given the nature of the information disclosed and the circumstances surrounding its disclosure, reasonably ought to be treated as Confidential Information by a person in the same industry as Discloser, or (iv) by law must be protected as Confidential Information. Recipient acknowledges that the Confidential Information is proprietary to Discloser and has been developed and obtained through great efforts by Discloser. Confidential Information shall not, however, include information that (A) at the time of disclosure is, or subsequently becomes, available to the public or the industry through no fault or breach on the part of Recipient; (B) Recipient can demonstrate to have had rightfully in its possession prior to disclosure by Discloser; (C) is independently developed by Recipient without the use of any Confidential Information; or (D) Recipient rightfully obtains from a third party who has the right to transfer or disclose it. Confidential Information shall also be deemed to include any and all confidential information defined as Confidential Matters hereunder, the treatment of which shall be as set forth in Paragraph 2.05 of this Policy.

b) Non-Disclosure and Non-Use of Confidential Information. Recipient shall not, directly or indirectly, without the prior written approval of Discloser in each instance or unless otherwise expressly permitted herein, use for its own benefit, publish or otherwise disclose to others, or authorize the use by others for their benefit, or to the detriment of Discloser, any of Discloser's Confidential Information. Recipient shall carefully restrict access to Discloser's Confidential Information to only those of its and its Affiliates' officers, directors, employees, agents and representatives (collectively, "Representatives") who (i) clearly require such access in order to enable to perform their respective obligations under this Policy (ii) who are bound by confidentiality obligations that protect third party information which are at least as restrictive and protective as those contained in this Policy, and (iii) are not (or do not work for) direct competitors of Discloser. Recipient shall not use, copy, distribute and/or remove any of Discloser's Confidential Information from Recipient's premises except to the extent necessary or appropriate to carry out its respective obligations under the Policy, without the prior consent of Discloser. Recipient and its Representatives will employ all security measures used for their own proprietary information of similar nature but in no event using less than a reasonable degree of care. Recipient agrees to advise and require its Representatives of their obligations to keep such information confidential and shall each be liable for any acts and omissions of their Representatives related thereto.

c) Return or Destruction of Confidential Information. The Receiving Party, including its Personnel, its employees and/or agents shall upon request of Discloser (i) immediately return to Discloser's designated representative any and all documents or other information and materials in whatever form which contain Discloser's Confidential Information, or as permitted by Discloser, (ii) destroy all copies thereof, and certify to Discloser in writing that all copies of such documents or other information and materials have been destroyed; provided, however, that the Receiving Party may retain one set of

such documents and other information and materials for archival purposes only, subject to the continuing confidentiality and security obligations set forth under this Policy. Recipient may disclose Discloser's Confidential Information if and to the extent required by a judicial or governmental request, requirement or order; provided that Recipient will take reasonable steps to give

Discloser sufficient prior notice (to the extent that sufficient time is available) of such request, requirement or order for Discloser to contest, limit and/or protect such disclosure.

d) Injunctive Relief. The Parties understand and acknowledge that any disclosure or misappropriation of any Confidential Information in violation of this Policy may cause irreparable harm, for which monetary damages alone may not be an adequate remedy and, therefore, agrees that Discloser shall have the right to apply to a court of competent jurisdiction for an order immediately restraining any such further disclosure or misappropriation and for other equitable relief, without objection and without the requirement of posting a bond or other form of security. Such right of each Party is in addition to the remedies otherwise available under this Policy or otherwise at law or equity.

e) Survival: The obligations laid down in this Section 2.05 shall continue and survive beyond the termination of this Policy.

2.06. Urgent Vision Care: When vision care is necessary for Urgent Conditions, Covered Persons may obtain Plan Benefits by contacting a VSP Preferred Provider or Open Access Provider, if Open Access benefits are available. Services for conditions of a medical nature are covered by VSP only under supplemental eyecare plans. If Client purchased one of these plans, such coverage will be evidenced in an Additional Benefit Rider (Schedule C). If Client has not purchased one of these plans, Covered Persons are not covered by VSP for such services and should contact a physician under Covered Persons' medical insurance plan for care.

For situations of a non-medical nature, such as lost, broken or stolen glasses, Covered Person should call VSP's Customer Care toll-free number (1-800-877-7195) for assistance. Reimbursement and eligibility are subject to the terms of this Policy.

2.07. Coordination of Benefits: Unless otherwise agreed to by Client and VSP, the following rules governing coordination of benefits shall apply. When VSP is the primary insurer, it will pay benefits according to the terms of this Policy, subject to any applicable state or federal codes, statutes or regulations. When VSP is the secondary insurer, it will coordinate those vision care services and materials that were considered by the primary insurer as allowable expenses. VSP will pay the lesser of:

a) The normal Plan Benefit, in the absence of other coverage, or

b) The remaining balance up to Covered Person's Plan Benefits, not to exceed the billed amount.

III.

OBLIGATIONS OF CLIENT

3.01. **Identification of Eligible Enrollees**: An Enrollee is eligible for coverage under this Policy if he/she satisfies the enrollment criteria specified by the Client, and in accordance with applicable state and federal law. Client shall provide VSP with required eligibility information, in a mutually agreed upon timeframe, format and medium, to identify all Enrollees who are eligible for coverage under this Policy.

3.02. **Retroactive Eligibility Terminations**: Retroactive eligibility changes are limited to the month in which notification is received by VSP, plus two prior months. VSP may refuse retroactive termination of a Covered Person if Plan Benefits have been obtained by, or authorized for, the Covered Person after the effective date of the requested termination.

3.03. **Change of Client Composition**: Client's percentage of Enrollees covered under the Policy as well as Client's contribution and eligibility requirements are factors used to determine rates and are considered material to VSP's obligations under this Policy. During the term of this Policy and in accordance with section 1.03, Client must provide VSP with written notification of any changes that will significantly impact utilization of the benefits and such changes must be agreed upon by VSP. Nothing in this section shall limit Client's ability to add Enrollees or Eligible Dependents under the terms of this Policy. For purposes of this paragraph, Client may not reduce membership by more than fifty percent (50%) over a twenty-four (24) month period without VSP's written consent.

3.04. **Payment of Premiums**: Upon receipt of VSP's billing statement, Client shall remit to VSP the premiums as set forth in Exhibit B. The premiums set forth in Exhibit B shall remain in effect for the term of this Policy unless the Client requests a change in the Schedule of Benefits and/or Additional Benefits Rider (if purchased by Client), or there is a material change in Policy terms or conditions, provided any such change is mutually agreed upon in writing by VSP. Client premium payments are due upon receipt of VSP's billing statement and shall become delinquent after thirty-one (31) days. If the premium payment remains unpaid the coverage may be cancelled and the Client will be responsible for payment for all Plan Benefits provided to Covered Persons. Client shall also be responsible for any legal and/or collection fees incurred by VSP to collect amounts due under this Policy.

3.05. **Distribution of Required Materials:** Client shall provide to Enrollees any materials required by any regulatory authority, within the timeframe required under applicable law.

3.06. Communication Materials: Communication materials created by Client which relate to this Vision Care Policy may be submitted to VSP for review and approval. VSP's review of such materials shall be limited to approving the accuracy of Plan Benefits and shall not encompass or constitute certification that Client's materials meet any applicable legal or regulatory requirements including, but not limited to, ERISA requirements. In the event of any dispute between the communication materials and this Policy, the provisions of this Policy shall prevail.

3.07. Converting to an Administrative Services Program In the event Client wishes to convert its method of funding from a fully insured Risk Program to a self insured Administrative Services Program, Client shall establish an appropriate level of reserves as determined by VSP, prior to conversion. Upon conversion to an Administrative Services Program, all claims for vision care begun on and after the effective date of conversion will be paid through the Administrative Services Program.

V.
OBLIGATIONS OF COVERED PERSONS UNDER THE POLICY

4.01. **General**: This Policy provides coverage for Client's Enrollees. If Client offers dependent coverage, this Policy will also cover Enrollees' Eligible Dependents. This Policy may be amended or terminated by agreement between VSP and Client without the consent or concurrence of Covered Persons. This Policy with any and all Exhibits and/or attachments constitutes the entire obligation of VSP to Covered Persons.

4.02. **Copayments for Services Received**: Any Copayments required under this Policy shall be the personal responsibility of the Covered Person receiving Plan Benefits. Copayments are to be paid at the time services are rendered or materials ordered. Amounts which exceed Plan allowances, annual maximum benefits or any other stated Plan limitations are not considered Copayments but are also the responsibility of the Covered Person.

4.03. **Obtaining Services from VSP Preferred Providers**: To utilize Plan Benefits, Covered Persons must select a VSP Preferred Provider, schedule an appointment and inform the doctor's office that they are Covered Persons of VSP. The VSP Preferred Provider will contact VSP to obtain a Benefit Authorization. If a Covered Person receives Plan Benefits from a VSP Preferred Provider without a Benefit Authorization, any services or materials received from the doctor will be treated as benefits from an Open Access Provider. Retail chains may not offer all Plan Benefits. Covered Person may contact VSP Preferred Provider for information describing vision care services and vision care materials offered.

4.04. **Open Access Provider Benefits**: If required by state law, or if purchased by Client, this Policy provides Plan Benefits for services and materials received from Open Access Providers. Covered Persons may submit requests for reimbursement to VSP and VSP will pay available Plan Benefits to Covered Persons. VSP may deny any claims received after three hundred sixty-five (365) calendar days from the date services are rendered and/or materials provided.

4.05. **Complaints and Grievances:** Complaints and grievances may be submitted by Covered Persons to VSP in writing, by telephone, online or through Covered Persons' VSP Network Providers, as explained in the Evidence of Coverage for this Policy. VSP will resolve all complaints and grievances within thirty (30) calendar days following receipt unless special circumstances require an extension of time. Where such extension is required, VSP will resolve all complaints and grievances as soon as possible, but not later than one hundred twenty (120) calendar days after receipt. If VSP determines that a complaint or grievance cannot be resolved within thirty (30) calendar days, it will notify Covered Person of the expected resolution date. VSP will notify Covered Person in writing of the final resolution of all complaints and grievances.

4.06. **Claim Denial Appeals:** If a claim is denied in whole or in part, under the terms of this Policy, a request may be submitted to VSP by Covered Person or Covered Person's authorized representative for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

a) **Initial Appeal**: All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. The Covered Person may review, during normal business hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal .

b) **Second Level Appeal**: If Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to VSP within sixty (60) calendar days after receipt of VSP's response to the initial appeal. VSP shall communicate its final determination to Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. VSP's communication to the Covered Person shall include the specific reasons for the determination.

c) **Other Remedies**: When Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U. S. Department of Labor or the insurance regulatory agency for Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a) (1) (B) [29 U.S.C. 1132(a) (1) (B)], Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and Covered Person disagrees with the outcome of such appeals.

4.08. **Time of Action:** No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with VSP. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy.

4.08. **Insurance Fraud:** Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or

federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

V.
CONTINUATION OF COVERAGE

5.01. **COBRA**: If, and only to the extent, COBRA applies to the parties to this Policy, VSP shall make the required COBRA continuation coverage available to Covered Persons in accordance with the provisions of COBRA.

5.02. **Replacement Coverage**: VSP reserves the right to offer replacement VSP coverage to individuals whose previous VSP coverage has terminated or is subject to termination. Any such offer of replacement coverage shall be separate and distinct from, and not in lieu of, any COBRA-required offer of continuation coverage.

VI.

DISPUTE RESOLUTION

6.01. Dispute Resolution: VSP and Client agree that all disputes arising out of or relating to this Policy shall be resolved, wherever possible, through mediation. When such negotiation is not successful, both parties agree to try in good faith to settle disputes by mediation administered by the American Arbitration Association under its Commercial Mediation Procedures. All efforts shall be made by both parties to avoid arbitration, litigation, or other dispute resolution procedures.

6.02. Choice of Law: If any matter arises in connection with this Policy which becomes the subject of arbitration or legal process, the law of the State of Delivery of this Policy shall be the applicable law.

VII.

NOTICES

7.01. **Notices**: Any notices required under this Policy to either Client or VSP shall be in written format. Notices sent to the Client will be sent to the address or email address shown on the Client's Application unless otherwise directed by Client. Notices to VSP shall be sent to the address shown on the front page of this Policy. Notwithstanding the above, any notices may be hand-delivered by either party to an appropriate representative of the other party. The party effecting hand-delivery bears the burden to prove delivery was made, if questioned.

VIII.
STANDARD PROVISIONS

8.01. **Entire Agreement**: This Policy, the Client Application, the Evidence of Coverage, and all Exhibits and attachments hereto, constitute the entire agreement of the parties and supersede any prior understandings and agreements between them, either written or oral. Any change or amendment to this Policy must be mutually agreed upon by both VSP and Client. No agent has the authority to change this Policy or waive any of its provisions. Communication materials prepared by Client for distribution to Enrollees do not constitute a part of this Policy.

8.02. **Indemnity**: VSP agrees to indemnify, defend and hold harmless Client, its shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising from the failure of VSP, its officers, agents or employees, to perform any of the activities, duties or responsibilities specified herein. Client agrees to indemnify, defend and hold harmless VSP, its members, shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising or resulting from the failure of Client, its officers, agents or employees to perform any of the duties or responsibilities specified herein.

8.03. **Liability**: VSP arranges for the provision of vision care services and materials through agreements with VSP Preferred Providers. VSP Preferred Providers are independent contractors and are responsible for exercising independent judgment. VSP does not itself directly furnish vision care services or supply materials. Under no circumstances shall VSP or Client be liable to each other for the negligence, wrongful acts or omissions of any doctor, non-VSP owned laboratory, or any other person or organization performing services or supplying materials in connection with this Policy.

8.04. **Assignment**: Neither this Policy nor any of the rights or obligations of either of the parties hereto may be assigned or transferred without the prior written consent of both parties hereto, except as expressly authorized herein.

8.05. **Severability**: Should any provision of this Policy be declared invalid, the remaining provisions shall remain in full force and effect.

8.06. **Governing Law:** This Policy shall be governed by and construed in accordance with applicable federal and state law. Any provision that is in conflict with, or not in conformance with, applicable federal or state statutes or regulations is hereby amended to conform with the requirements of such statutes or regulation, now or hereafter existing.

8.07. **Gender**: All pronouns used herein are deemed to refer to the masculine, feminine, neuter, singular, or

plural, as the identity(ies) of the person(s) may require.

8.08. **Equal Opportunity:** VSP is an Equal Opportunity and Affirmative Action employer.

IX.

DEFINITIONS

The key terms in this Policy are defined:

9.01. ADDITIONAL BENEFIT RIDER: The document, attached as Exhibit C to this Policy (when purchased by Client), which lists selected vision care services and vision care materials which a Covered Person is entitled to receive under this Policy. Additional Benefits are only available when purchased by Client in conjunction with a Plan Benefit offered under Exhibit A.

9.02. ADMINISTRATIVE SERVICES PROGRAM: A self-insured vision care plan whereby Client pays VSP for the Plan Benefits in addition to a monthly administrative fee.

9.03 ASSIGNMENT OF BENEFITS: A written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing VSP to pay available Plan Benefits to a named Open Access Provider.

9.04. BENEFIT AUTHORIZATION: A process used to confirm eligibility of an individual named as a Covered Person of VSP, and identifying those Plan Benefits to which Covered Person is entitled.

9.05. CLIENT: An employer or other entity which contracts with VSP to provide coverage under this Policy for its Enrollees and their Eligible Dependents.

9.06. CLIENT APPLICATION: The form signed by an authorized representative of the Client to apply for Enrollee coverage under this Policy.

9.07. COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985.

9.08. COMPLAINTS AND GRIEVANCES: Disagreements regarding access to care, quality of care, treatment or service.

9.09. CONFIDENTIAL MATTER: All confidential information concerning the medical, personal, financial or business affairs of Covered Persons acquired by VSP in the course of providing Plan Benefits hereunder.

9.10. COORDINATION OF BENEFITS: A procedure which allows more than one insurance plan to consider a Covered Person's vision care claims for payment or reimbursement.

9.11. COPAYMENTS: Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.

9.12. COVERED PERSON: An Enrollee or Eligible Dependent who meets Client's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under this Policy.

9.13. **ELIGIBLE DEPENDENT**: Any dependent of an Enrollee who meets the criteria for eligibility established by Client.

9.14. **ENROLLEE**: An employee or member of Client who meets the criteria for eligibility established by Client.

9.15. **EVIDENCE OF COVERAGE ("EOC"):** A summary of the provisions of this Policy, prepared by VSP and provided to Client for distribution to Enrollees by Client.

9.16. **OPEN ACCESS PROVIDER**: Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.

9.17. **PLAN or PLAN BENEFITS**: The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this Policy.

9.18. **POLICY PERIOD**: The length of time this Policy is in effect, as shown on the front page of this Policy.

9.19. **RENEWAL DATE**: The date when this Policy shall renew or terminate if proper notice is given.

9.20. **RETENTION**: VSP's administrative fee deducted from net premiums paid by Client.

9.21. **RISK PROGRAM**: A fully insured vision care plan whereby VSP will calculate a rate per Enrollee to cover the cost of claims incurred and administrative costs. Under the arrangement, VSP assumes the risk of utilization exceeding the rate per Enrollee over the full Policy Term.

9.22. **SCHEDULE OF BENEFITS:** The document, attached as Exhibit A to this Policy, which lists the vision care services and vision care materials which a Covered Person is entitled to receive under this Policy.

9.23. **SCHEDULE OF PREMIUMS:** The document, attached as Exhibit B to this Policy, which defines the payments a Client is obligated to pay to VSP on behalf of a Covered Person to entitle him/her to Plan Benefits.

9.24. **STATE OF DELIVERY:** The State in which this Policy is being issued, delivered or renewed.

9.25. **TERMINATION:** Cancellation of the Policy as stated in Article I.

9.26. **URGENT CONDITION**: A condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate care; or an unforeseen occurrence calling for immediate action.

9.27. **VISION CARE POLICY or POLICY**: The Policy issued by VSP to a Client, under which the Client's Enrollees or members, and their Eligible Dependents, are entitled to become Covered Persons of VSP and receive Plan Benefits in accordance with the terms of such Policy. The Policy includes any and all Exhibits and/or attachments thereto.

9.28. **VSP PREFERRED PROVIDER**: An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide Plan Benefits to Covered Persons of VSP.

EXHIBIT A

SCHEDULE OF BENEFITS
VSP Choice Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VISION SERVICE PLAN OF ILLINOIS, NFP ("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Any child of Enrollee, including a natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they turn age 26.

Unmarried dependent children are covered up to age 26 or to age 26 if full time students.

A dependent unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

PLAN BENEFITS
VSP PREFERRED PROVIDERS

COPAYMENT

There shall be no Copayment payable by the Covered Person at the time services are rendered.

Lens Enhancements, if covered under this Plan, may have a separate Copayment. Please refer to COVERED SERVICES AND MATERIALS, below.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**
Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Polycarbonate lenses are covered in full for dependent children up to age 26.

Standard Progressive Lenses covered in full.

FRAMES - Covered up to the Plan allowance* once every 24 months**
The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

CONTACT LENSES

ELECTIVE
Elective Contact Lenses (materials only) are covered up to $220.00 once every 12 months**

Elective Contact Lens fitting and evaluation services are covered in full once every 12 months.

NECESSARY
Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

NOT COVERED

1. Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
2. Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed in the Frames benefit section, above.
3. Two pair of glasses instead of bifocals.
4. Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
5. Orthoptics or vision training and any associated supplemental testing.
6. Medical or surgical treatment of the eyes.
7. Refitting of contact lenses after the initial (90-day) fitting period.
8. Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.
9. Contact lens modification, polishing or cleaning.
10. Local, state and/or federal taxes, except where VSP is required by law to pay.
11. Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

PLAN BENEFITS
OPEN ACCESS PROVIDERS

COPAYMENT

There shall be no Copayment payable by the Covered Person at the time services are rendered.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Up to $ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES: Up to $ 30.00-100.00* once every 12 months**
Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular) including Lens Enhancements (if purchased by Client).

FRAMES: Covered up to $ 70.00* once every 24 months**

CONTACT LENSES

Elective
Elective Contact Lenses are covered up to $105.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

Necessary
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Up to $125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of Open Access Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

EXCLUSIONS AND LIMITATIONS OF BENEFITS
OPEN ACCESS PROVIDERS

1. Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
2. Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider or an Affiliate Provider.
3. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
4. VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

EXHIBIT B

VISION SERVICE PLAN OF ILLINOIS, NFP (VSP)
SCHEDULE OF PREMIUMS
VSP Choice Plan

VISION SERVICE PLAN OF ILLINOIS, NFP ("VSP") shall be entitled to receive premiums for each month on behalf of each Enrollee and his/her Eligible Dependents, if any, in the amounts specified below.

$ 10.35 per month for each eligible Enrollee without dependents.
$ 20.70 per month for each eligible Enrollee with an eligible spouse.
$ 22.14 per month for each eligible Enrollee with eligible child(ren).
$ 35.38 per month for each eligible Enrollee with eligible spouse and child(ren).

NOTICE: The premium under this Policy is subject to change upon renewal (after the end of the initial Policy Term or any subsequent Policy Term), or upon change of the Schedule of Benefits or a material change in any other terms or conditions of the Policy.

EXHIBIT C

ADDITIONAL BENEFIT RIDER
SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE

GENERAL

The Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN OF ILLINOIS, NFP ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. The Supplemental Essential Medical Eye Care benefit is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the benefit, eye care professionals provide treatment and services for urgent ocular emergencies as well as the management of chronic systemic diseases that manifest in the eyes. This Rider forms a part of the Policy and Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner
- Legal Spouse or civil union partner of Enrollee
- Any child of Enrollee, including a natural child from the date of birth, child of a civil union, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they turn age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

Essential Medical Eye Care benefits are available to Covered Persons only after covered benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered benefits include specific medical eye care procedure codes when appropriate for the optometric scope of licensure as well as the current laws, rules and regulations as determined by the State and Federal Government.

OBTAINING SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine available benefits and how to obtain medical plan benefits.

The eye care provider should first submit a claim to Covered Person's group medical plan when participating in the medical plan's network. Any amounts not paid by the primary medical plan may then be considered for payment by VSP. This process is referred to as Coordination of Benefits ("COB"). Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, or when a VSP Preferred Provider does not participate with Covered Person's group medical plan, the Supplemental Essential Medical Eye Care provides plan benefits as follows:

1. Covered Person contacts VSP Preferred Provider and makes an appointment.

2. Covered Person pays any applicable Copayment at the time Supplemental Essential Medical Eye Care services are rendered and amounts for any additional services not covered by the Plan.

PLAN BENEFITS - VSP PREFERRED PROVIDERS
COVERED SERVICES

Medical Eye Examinations: Covered in Full after a Copayment of $20.00.

Urgent/Emergency Care* and Special Ophthalmological Services:** Covered in Full

*Urgent/Emergency Care refers to VSP covered services for an emergency medical eye condition including, but not limited to eye infections, foreign body and abrasions, ocular injuries, and chemical exposure to the eye or eyelid.

**Special Ophthalmological Services refer to eye care services that are problem-focused and involve medical decision-making. Special ophthalmological services go beyond general services and relate to the diagnosis, evaluation, treatment, and management of ocular conditions.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be made available to the Client upon request.

NOT COVERED

1. Eyeglasses or contact lenses.
2. General anesthesia surgical procedures.
3. Preoperative or postoperative surgical procedures.
4. Inpatient hospital services.
5. Services provided for refractive diagnoses that are part of the Covered Person's routine vision care coverage.
6. Prescription medication or supplies of any type.
7. Local, state and/or federal taxes, except where VSP is required by law to pay.
8. Services and/or materials not specifically included in this Rider as covered Plan Benefits.

PLAN BENEFITS - OPEN ACCESS PROVIDERS

An eye care professional that is an Open Access Provider may require Covered Person to pay for all services in full at the time of the visit. Covered Person may then submit a claim to VSP for reimbursement.

COVERED SERVICES

Eye Examinations, Urgent/Emergency Care, and Special Ophthalmological Services: Covered up to $300.00 less any applicable Copayment amount; based on coverage limits for the specific medical eye care service and state service was received.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
2. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services in full.
3. VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

VISION SERVICE PLAN OF ILLINOIS, NFP
ADDENDUM TO
CLIENT VISION CARE POLICY
FOR THE STATE OF ILLINOIS

1. The following is added as Section 1.04 **Termination for Fraud**:

This Policy may be terminated by VSP immediately upon written notice if Client commits fraud or misrepresentation in respect to this Policy as stated in Section 4.08.

2. The following is added after the last sentence of Section 2.02, Administration of Plan Benefits:

"Should claim payment exceed 30 days, VSP will pay interest to the VSP Preferred Provider at the rate of 9% per year from the 30th day after receipt of a complete claim to the date of late payment. Reimbursement to Enrollees for services received from an Open Access Provider will be pursuant to the Reimbursement Schedule, if any, attached to the Schedule of Benefits or Additional Benefit Rider.

A Look at Your VSP Vision Coverage

With VSP and TAZEWELL COUNTY, your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.

vsp vision care

Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

Maximize your benefits at a Premier Program location, including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

vsp PREMIER PROGRAM

Preferred private practice and retail in-network choices

private practice doctors

Visionworks

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

More Ways to Save

Extra

$20

to spend on Featured Brands†

bebe · CALVIN KLEIN · COLE HAAN · DRAGON · FLEXON · LACOSTE · and more

See all brands and offers at **vsp.com/offers**.

+

Up to

40%

Savings on lens enhancements‡

Create an account today.

Contact us: **800.877.7195** or **vsp.com**

Your VSP Vision Benefits Summary

TAZEWELL COUNTY and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Choice
EFFECTIVE DATE:
12/01/2022

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$0	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$0**	
FRAME†	• $220 featured frame brands allowance • $200 frame allowance • 20% savings on the amount over your allowance • $200 Walmart®/Sam's Club® frame allowance • $110 Costco® frame allowance	Included in Prescription Glasses	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $200 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington.

Classification: Restricted

vsp vision care

Make Eye Health a Priority with VSP!

With VSP® Vision Care and Tazewell County, your eye health matters. Take a look at your vision care coverage.

VSP members save an annual average of

$501*

Get an Extra $20 to spend on Featured Frame Brands.

Just look for the **VSP heart logo** on the lens to maximize your benefits.†

bebe Calvin Klein COLE HAAN

DRAGON FLEXON LONGCHAMP PARIS

and more at **vsp.com/framebrands**

Up to 40% savings on lens enhancements‡

Learn more at **vsp.com/offers**.

Enroll through your employer today.
Questions?
vsp.com
800.877.7195 (TTY: 711)

Scan QR code or visit **vsp.com** to learn more.

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your eye doctor can detect signs of more than 270 health conditions during your annual eye exam—including diabetes and high blood pressure, as well as eye conditions such as glaucoma and diabetic eye disease.**

Savings you'll love.

See and look your best without breaking the bank. VSP members can get special savings on popular frame brands and contact lenses, and additional discounts on things like LASIK, and more.

The choice is yours!

vsp PREMIER edge

With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.

eyeconic a vsp vision company

Simply connect your benefits when you log in to **eyeconic.com** and have a valid prescription ready when you check out.

Getting started is easy!

Make the most of your plan by creating an account on **vsp.com**. Log in to view your in-network coverage, find a VSP network doctor, download your Member ID card (and save it to your digital wallet), and discover extra savings.

*Based on state and national averages for eye exams and most commonly purchased brands. This represents the average savings for a VSP member with a full-service plan at an in-network provider. Your actual savings will depend on the eyewear you choose, the plan available to you, the eye doctor you visit, your copays, your premium, and whether it is deducted from your paycheck pre-tax. Source: VSP book-of-business paid claims data for Aug-Jan of each prior year. **Full Picture of Eye Health, American Optometric Association. †Frame brands and promotion subject to change. Only available to VSP members with applicable plan benefits. Only available at in-network locations. Members who participate in a Medicaid/state-funded plan are not eligible. ‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details. +Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Availability of VSP Premier Edge™ may vary.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**. Visionworks, Eyeconic, and Eyemart Express family of stores are VSP-affiliated companies.

Your VSP Benefits Summary

With a VSP plan through Tazewell County, you get affordable vision coverage for glasses, contacts, and more.

Provider Network:
VSP Choice
Effective Date:
12/01/2026

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP DOCTOR			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$0 Up to $39	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES			
FRAME[+]	• $240 Featured Frame Brands allowance • $220 frame allowance • 20% savings on the amount over your allowance • $220 Walmart/Sam's Club frame allowance • $120 Costco frame allowance	$0	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	$0	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $220 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	$0	Every 12 months
VSP LIGHTCARE™[+]	• $220 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts.	$0	Every 24 months
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers/special-offers/hearing-aids** for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

GET MORE AT PREFERRED IN-NETWORK LOCATIONS

With so many in-network choices, including private practice and retail locations, VSP makes it easy to maximize your benefits. Log in to **vsp.com** to find an in-network doctor near you!

HR-26-07

COMMITTEE REPORT

Mr. Chairman and Members of the Tazewell County Board:

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

RESOLUTION

WHEREAS, the Human Resource Committee recommends to the County Board to update the County's Health Insurance Plan document for changes as required by State law; and

WHEREAS, the changes to the current Plan are outlined below with more detailed information provided in Amendment #2 to the Tazewell County Health Benefit Plan attached. Updates to the Summary of Benefits are as follows:

1. Effective January 1, 2025, coverage of hearing aids, which includes examinations for the prescription, fitting, and/or repair will be added to the plan. Coinsurance applies after deductibles have been met for all plans;

2. Effective January 1, 2025, mental health counseling – first responder coverage under preventative care – adult and child as defined under the Affordable Care Act. There will be no charge for first responders. First responders under the Sheriff's Departments consist of deputies and corrections officers;

3. Effective January 1, 2025, joint therapy for first responder and spouse/partner is added under the Mental Health & Substance Use Disorder Services. Coinsurance applies after deductibles have been met for all plans;

4. Effective January 1, 2026, in addition to coverage specified under Genetic Counseling or Testing, Preventative Care, benefits are available for genetic testing for inherited susceptibility to a medical condition and counseling related to family history, when medically necessary. Coinsurance applies after deductibles have been met for all plans;

5. Effective January 1, 2026, infertility treatment is limited to coverage which includes diagnosis and treatment of infertility, including IVF and pre-implantation genetic screening, up to 4 oocyte retrievals are covered, maximum of 6 if following a live birth. Coinsurance applies after deductibles have been met for all plans.

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 SEPTEMBER, 2026.

ATTEST:

_____	_____
Tazewell County Clerk	Tazewell County Board Chairman

Amendment #2
To the Plan Document and Summary Plan Description for Tazewell County

This Amendment to the Tazewell County Health Benefit Plan ("Plan") is made effective as of the date indicated herein.

Whereas, applicable provision of the Plan grants the Employer the right to amend the Plan, and;

Whereas, the Employer desires to make such amendment.

Now, therefore, the Plan is hereby amended as follows, with such amendment to be effective on and after the date listed herein:

1. Effective January 1, 2025, the addition of coverage for Hearing Aids:

A. **The following is added to MEDICAL BENEFITS:**

Hearing Aids. Charges for hearing aids, which includes examinations for the prescription, fitting, and/or repair of hearing aids.

B. **Hearing Aids coverage is added to the Summary of Benefits as shown below:**

Coinsurance shown below is what Participant pays and applies after deductible has been met.			
Traditional 500 PPO Plan Mid-Level PPO Plan	**In Network**	**Out of Network**	**Limits**
Hearing Aids	20% coinsurance	40% coinsurance	One hearing aid per ear is covered every 24 months. Related services (exams fittings and adjustments) and repairs covered when medically necessary.

Coinsurance shown below is what Participant pays and applies after deductible has been met.			
Qualified PPO HDHP	**In Network**	**Out of Network**	**Limits**
Hearing Aids	Deductible then 20% coinsurance	40% coinsurance	One hearing aid per ear is covered every 24 months. Related services (exams fittings and adjustments) and repairs covered when medically necessary.

Coinsurance applies after the deductible has been met and is listed as the amount the plan pays.			
Retiree Plan	**In Network**	**Out of Network**	**Limits**
Hearing Aids	100%	100%	One hearing aid per ear is covered every 24 months. Related services (exams fittings and adjustments) and repairs covered when medically necessary.

C. **The Joint Therapy for First Responder & Spouse/Partner is added to the Summary of Benefits under the Mental Health & Substance Use Disorder Services (fka: Behavioral Health Services & Substance Use) section as shown below:**

Coinsurance shown below is what Participant pays and applies after deductible has been met.			
Traditional 500 PPO Plan Mid-Level PPO Plan	**In Network**	**Out of Network**	**Limits**
Mental Health & Substance Use Disorder Services			
Residential, Inpatient, and Partial Day Treatment - Facility	10% coinsurance	40% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
Residential, Inpatient, and Partial Day Treatment - Providers	20% coinsurance	40% coinsurance	
Office Visits/Therapy	$25 copay	40% coinsurance	Virtual visits covered as any other Office Visit.
Joint Therapy for First Responder & Spouse/Partner	$25 copayment	40% coinsurance	Limited to the First Responder and their Spouse/Partner.
Outpatient Physician	20% coinsurance	40% coinsurance	

Coinsurance shown below is what Participant pays and applies after deductible has been met.			
Qualified PPO HDHP	**In Network**	**Out of Network**	**Limits**
Mental Health & Substance Use Disorder Services			
Residential Treatment	20% coinsurance	40% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
Inpatient Treatment	20% coinsurance	40% coinsurance	
Partial Day Program	20% coinsurance	40% coinsurance	
Office Visits/Therapy	20% coinsurance	40% coinsurance	Virtual visits are covered as any other Office Visit.
Joint Therapy for First Responder & Spouse/Partner	20% coinsurance	40% coinsurance	Limited to the First Responder and their Spouse/Partner.
Outpatient Physician	20% coinsurance	40% coinsurance	

Coinsurance applies after the deductible has been met and is listed as the amount the plan pays.			
Retiree Plan	**In Network**	**Out of Network**	**Limits**
Mental Health & Substance Use Disorder Services			
Residential Treatment	100%	100%	Precertification is required. If you don't get precertification, benefits could be reduced. For inpatient hospital services, the maximum the plan will pay is $1,500 per admission.
Inpatient Treatment	100%	100%	
Partial Day Program	100%	100%	
Office Visits/Therapy	100%	100%	Virtual Visits are covered as any other office visit.
Joint Therapy for First Responder & Spouse/Partner	100%	100%	Limited to the First Responder and their Spouse/Partner.
Outpatient Physician	100%	100%	

D. **The MEDICAL BENEFITS Section is updated to include Joint Mental Health Therapy and will read as follows:**

Mental Health and Substance Use Disorder Benefits. Benefits are available for Inpatient or Outpatient care for mental health and Substance Abuse conditions, including individual and group psychotherapy, psychiatric tests, and expenses related to the Diagnosis when rendered by a covered Provider.

Joint mental health therapy is covered for any Participant and their spouse/partner who is a member of a County Sheriff's office, a member of a Police Department, or a member of a Fire Department.

Benefits are available, but not limited to Residential Treatment Facility, Partial Hospitalization, and Intensive Outpatient Services.

2. Effective January 1, 2026, the following changes are made to the Plan for compliance with State of Illinois statues.

A. **In MEDICAL BENEFITS, Genetic Counseling or Testing is revised to read:**

Genetic Counseling or Testing. In addition to coverage specified under Preventive Care, benefits are available for genetic testing for inherited susceptibility to a medical condition and counseling related to family history, when Medically Necessary. Refer to the Genetic Information Nondiscrimination Act of 2008 (GINA) subsection for information regarding the prohibition of discriminating on the basis of genetic information.

B. **Genetic Counseling and Genetic Testing coverage are added to the Summary of Benefits as shown below:**

Coinsurance shown below is what Participant pays and applies after deductible has been met.			
Traditional 500 PPO Plan Mid-Level PPO Plan	**In Network**	**Out of Network**	**Limits**
Genetic Counseling	20% coinsurance	40% coinsurance	
Genetic Testing	$50 copayment	40% coinsurance	Genetic Counseling or Testing when Medically Necessary.

Coinsurance shown below is what Participant pays and applies after deductible has been met.			
Qualified PPO HDHP	**In Network**	**Out of Network**	**Limits**
Genetic Counseling	20% coinsurance	40% coinsurance	
Genetic Testing	Deductible then $50 copayment	40% coinsurance	Genetic Counseling or Testing when Medically Necessary.

Coinsurance applies after the deductible has been met and is listed as the amount the plan pays.			
Retiree Plan	**In Network**	**Out of Network**	**Limits**
Genetic Counseling	100%	100%	
Genetic Testing	100%	100%	Genetic Counseling or Testing when Medically Necessary.

C. **Infertility Treatment is changed in the Summary of Benefits as shown below:**

Coinsurance shown below is what Participant pays and applies after deductible has been met.			
Traditional 500 PPO Plan Mid-Level PPO Plan	**In Network**	**Out of Network**	**Limits**
Infertility	20% coinsurance	40% coinsurance	Coverage includes diagnosis and treatment of infertility, including IVF and pre-implantation genetic screening. Up to 4 oocyte retrievals are covered, maximum of 6 if following a live birth.

Coinsurance shown below is what Participant pays and applies after deductible has been met.			
Qualified PPO HDHP	**In Network**	**Out of Network**	**Limits**
Infertility	Deductible then 20% coinsurance	40% coinsurance	Coverage includes diagnosis and treatment of infertility, including IVF and pre-implantation genetic screening. Up to 4 oocyte retrievals are covered, maximum of 6 if following a live birth.

Coinsurance applies after the deductible has been met and is listed as the amount the plan pays.			
Retiree Plan	**In Network**	**Out of Network**	**Limits**
Infertility	100%	100%	Coverage includes diagnosis and treatment of infertility, including IVF and pre-implantation genetic screening. Up to 4 oocyte retrievals are covered, maximum of 6 if following a live birth.

D. **Mental Health Counseling – First Responder coverage is added to the Summary of Benefits under the Preventive Care – Adult and Child as defined under the Affordable Care Act section as shown below:**

Coinsurance shown below is what Participant pays and applies after deductible has been met.			
Traditional 500 PPO Plan and Mid-Level PPO Plan	**In Network**	**Out of Network**	**Limits**
Preventive Care – Adult and Child as defined under the Affordable Care Act			
Mental Health Counseling – First Responder	No charge	No charge	

Coinsurance shown below is what Participant pays and applies after deductible has been met.			
Qualified PPO HDHP	**In Network**	**Out of Network**	**Limits**
Preventive Care – Adult and Child as defined under the Affordable Care Act			
Mental Health Counseling – First Responder	No charge	No charge	

Coinsurance applies after the deductible has been met and is listed as the amount the plan pays.			
Retiree Plan	**In Network**	**Out of Network**	**Limits**
Preventive Care – Adult and Child as defined under the Affordable Care Act			
Mental Health Counseling – First Responder	No charge	No charge	

3. **Effective 1/1/2025, the following is added to CONTINUATION OF COVERAGE:**

Employer Continuation Coverage

Employer-approved Extended Leave (not meeting the definition of a FMLA Leave); will only continue until the Employee exhausts all accrued benefit time.

At the end of the period listed above, if the Employee fails to return to work and another leave of absence is not applicable, the Employee's coverage will be deemed to have terminated for purposes of Continuation of Coverage under COBRA.

Note: While the Employer offers extended Leave of Absence up to 18 months including Health Leave, Educational Leave and Personal Leave, an Employee will be offered Continuation of Coverage through COBRA when they exhaust all accrued benefit time and/or FMLA entitlement. Eligibility for Health Leave, Educational Leave and Personal Leave are at the discretion of the Employer and are dependent on an Employee's time of service with the Employer.

4. **Effective 12/1/2023, ELIGIBILITY FOR COVERAGE, Eligibility for Retiree Coverage is removed entirely and replaced with the following:**

Eligibility for Retiree Coverage

A person is eligible for retiree coverage from the first day that he or she meets one of the following requirements:

1. Is a retired Employee of the Employer.
2. Is an Active Employee who is eligible for retirement under the Plan having a minimum of two consecutive years of employment and is between the ages of 62 and 65. Spouses and Dependents of a retiree are also eligible provided they meet the requirements stated in the provision entitled "Eligibility for Dependent Coverage".

Retiree will be covered under the Tazewell County RETIREE Health Care Plan (please refer to corresponding Schedule of Benefits).

Retiree's eligible dependents, if enrolled, will be covered under the Tazewell County Health Care Plan (please refer to corresponding Schedule of Benefits). If a Retiree age 65+ is covered under the **Tazewell County Retiree Plan (Age 65+),** then eligible dependents under age 65 can be covered under Tazewell County's Traditional Plan, Mid-Level Plan, HDHP, MRP, Dental, or Vision Plans.

PLEASE NOTE: As Retirees and/or Retiree's Spouses under the age of 65 who qualify for Social Security Disability Benefits and Retirees and/or Retiree's Spouses over the age of 65, **both** qualify for Medicare, **you are not eligible, nor will be covered by the County's prescription benefits; you will only be covered for medical benefits.**

If you are 65 and older with **both** Medicare and County medical benefits, medical services will be charged first to Medicare and second to the County Plan.

PLEASE NOTE: As Retirees and/or Retiree's Spouses under the age of 65 who qualify for Social Security Disability Benefits including prescription benefits and Retirees and/or Retiree's Spouses over the age of 65 covered by Medicare **– you are not eligible for, nor will be covered by, the County's prescription benefits. You will only be covered for medical benefits.**

PLEASE NOTE: If a retiree terminates medical coverage under the plan, they can re-enroll for medical coverage in the future as long as such retiree maintained Dental or Vision coverage immediately following termination of medical coverage.

Attached to this amendment is a Summary of Benefits for each Plan reflecting all of the changes described above.

All other provisions of this document remain as stated. The above is effective on and after the dates stated herein.

Signed this_____day of_____, 2026

_____
Authorized Representative Tazewell County Health Benefit Plan and Title

COMMITTEE REPORT

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 changes to the calendar year minimum deductibles and out-of-pocket maximums for the High-Deductible Health Plans (HDHP) to meet IRS requirements; and

WHEREAS, the deductible will be increased for individuals from $3,400.00 in 2026 to $3,500.00 in 2027 and for families from $6,800.00 in 2026 to $7,000.00 in 2027; and

WHEREAS, the out-of-pocket limit will be increased for individuals from $6,100.00 in 2026 to $6,200.00 in 2027 and for families from $8,200.00 in 2026 to $8,400.00 in 2027.

THEREFORE BE IT RESOLVED that the County Board approve this recommendation.

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

PASSED THIS 30th DAY OF SEPTEMBER, 2026.

ATTEST:

_____ _____

Tazewell County Clerk Tazewell 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: ~~$3,400~~ $3,500 Individual ~~$6,800~~ $7,000 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 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: ~~$6,100~~ $6,200 Individual ~~$8,200~~ $8,400 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, 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 1-877-752-3937 for a list of network providers. You can also see aetna.com/asa.	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.
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.

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% coinsurance	Telemedicine with MeMD: Call 1-855-636-3669. All other virtual visits covered as any other office visit. Chiropractic Care covered at 20% coinsurance for Network Providers.
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	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% coinsurance	Imaging: Imaging: Preauthorization is required for CT and MRI for non-orthopedic and for PET scans.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% 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, Participants must contact SmithRx for assistance.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required for some outpatient procedures or benefits could be reduced.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance		Preauthorization is required if admitted.
	Emergency medical transportation	20% coinsurance		None
	Urgent care	20% coinsurance	40% coinsurance	None

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

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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced.
	Physician Charges, Surgery Services, Hospital care	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health services, or substance use services	Office Visit	20% coinsurance	40% coinsurance	Virtual visit covered as any other office visit.
	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services, Residential, and Partial Day Services	20% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced.
If you are pregnant	Office visits	20% coinsurance	40% 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.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization is required for electric /motorized wheelchairs and for pneumatic compression devices, or benefits could be reduced.
	Hospice services	20% coinsurance	40% 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
	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
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-network prescription drugs
- 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.)

- Bariatric Surgery
- Chiropractic care
- Hearing Aids: Limited to one hearing aid per ear is covered every 24 months.
- Infertility Treatment

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.

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

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	$3,400
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	$3,400
Copayments	$0
Coinsurance	$1,860
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$5,260

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

The plan's overall deductible	$3,400
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	$3,400
Copayments	$0
Coinsurance	$440
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$3,840

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

The plan's overall deductible	$3,400
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)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
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.

COMMITTEE REPORT HR-26-09

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 renew the agreement for the County's group stop loss coverage with Pareto/HCC; and

WHEREAS, Illinois State Statutes at 55 ILCS 5/5-1022 provides that the general requirement to competitively bid purchases in excess of $30,000 does not apply to contracts which by their nature are not suitable to competitive bids pursuant to an ordinance adopted by the County Board; and

WHEREAS, attempts to obtain pricing through the statutory competitive bidding process is not possible due to the disclosure of protected health information of members; and

WHEREAS, the Wyman Group serves as the County's consultant for the County's health, dental and vision benefit plans and coverages; and

WHEREAS, the Wyman Group has evaluated provider options for stop-loss coverage on behalf of Tazewell County and has recommended Pareto/HCC remain the stop-loss carrier for the County through September 30, 2027. Pareto/HCC was initially selected as the County's stop-loss coverage provider in 2024 based on rates offered as well as the policy of not raising deductibles on individuals (aka lasers). It is recommended by our health plan consultant, Tim Wyman, to renew the agreement for the County's group stop-loss coverage with Pareto/HCC - Option 1 (see attached quote) covering 10/01/2026 through 9/30/2027; and

WHEREAS, Pareto/HCC has a partnership with Cancer Care and offers free or discount services through this partnership.

THEREFORE BE IT RESOLVED, the County Board approves these recommendations and authorizes the County Board Chairman to execute the agreement with Pareto/HCC.

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 SEPTEMBER 2026

ATTEST:

_____	_____
County Clerk	County Board Chairman

TOKIO MARINE HCC

Stop Loss Proposal for: Tazewell County

Effective Dates: 10/01/2026 - 09/30/2027
Quoted for: Pareto Captive Services, LLC

Proposal Number: 2-1399803

Proposal Valid Through: 10/01/2026

One Commerce Square, 2005 Market Street, Suite 3900
Philadelphia, PA
19104
Telephone:
Facsimile:

Underwriter:
Pareto Health
proposals@paretohealth.com

Marketing Representative:
Pareto Health
renewals@paretohealth.com

INDIVIDUAL STOP LOSS COVERAGE

Plan Description		Option 1	Option 2	Option 3
Coverages		Medical, Rx Card	Medical, Rx Card	Medical, Rx Card
Annual Specific Deductible per Individual		$ 125,000	$ 130,000	$ 135,000
Contract Basis		Paid	Paid	Paid
Maximum Contract Period Reimbursement		Unlimited	Unlimited	Unlimited
Rate(s) Per Month	Enrollment			
Employee	182	$ 260.26	$ 254.40	$ 248.56
Employee plus Spouse	19	$ 518.44	$ 506.77	$ 495.13
Employee plus Child(ren)	28	$ 458.84	$ 448.51	$ 438.19
Family	39	$ 778.70	$ 761.17	$ 743.68
Composite	268	$ 374.76	$ 366.32	$ 357.90
Estimated Contract Period Premium		$ 1,205,214	$ 1,178,080	$ 1,151,019
Rate(s) include Commission of		0.00 %	0.00 %	0.00 %

TOKIO MARINE HCC

Stop Loss Proposal for: Tazewell County

Effective Dates: 10/01/2026 - 09/30/2027
Quoted for: Pareto Captive Services, LLC

Proposal Number: 2-1399803

Proposal Valid Through: 10/01/2026

One Commerce Square, 2005 Market Street, Suite 3900
Philadelphia, PA
19104
Telephone:
Facsimile:

Underwriter:
Pareto Health
proposals@paretohealth.com

Marketing Representative:
Pareto Health
renewals@paretohealth.com

AGGREGATE STOP LOSS COVERAGE

Plan Description		Option 1	Option 2	Option 3
Coverages		Medical, Rx Card	Medical, Rx Card	Medical, Rx Card
Contract Basis		Paid	Paid	Paid
Loss Limit per Individual		$ 125,000	$ 130,000	$ 135,000
Maximum Contract Period Reimbursement		$ 1,000,000	$ 1,000,000	$ 1,000,000
Rate Per Month	Enrollment			
Composite	268	$ 13.94	$ 14.03	$ 14.09
Estimated Contract Period Premium		$ 44,831	$ 45,120	$ 45,313
Rate(s) include Commission of		0.00 %	0.00 %	0.00 %
Annual Aggregate Deductible		$ 6,305,072	$ 6,367,348	$ 6,426,430
Minimum Aggregate Deductible		$ 6,305,072	$ 6,367,348	$ 6,426,430
Monthly Aggregate Claim Factors Medical, Rx Card	Enrollment			
Employee	182	$ 1361.55	$ 1375.00	$ 1387.76
Employee plus Spouse	19	$ 2712.22	$ 2739.00	$ 2764.41
Employee plus Child(ren)	28	$ 2400.42	$ 2424.12	$ 2446.61
Family	39	$ 4073.76	$ 4114.00	$ 4152.17
Composite	268	$ 1960.54	$ 1979.90	$ 1998.26
Run-In Limited To		$ 0	$ 0	$ 0

OVERALL COST SUMMARY

Plan Description	Option 1	Option 2	Option 3
Total Annual Fixed Cost	$ 1,250,045	$ 1,223,200	$ 1,196,332
Specific Variable	$ 0	$ 0	$ 0
Aggregate Variable	$ 6,305,072	$ 6,367,348	$ 6,426,430
Maximum Annual Liability	$ 7,555,117	$ 7,590,548	$ 7,622,762

Stop Loss Proposal for: Tazewell County

Effective Dates: 10/01/2026 - 09/30/2027
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PROPOSAL QUALIFICATIONS AND CONTINGENCIES

Quoted terms and conditions are subject to possible revision based upon the receipt and review of the following Items:

• Paid claims experience to the effective date including monthly enrollment figures.

• Updated shock loss information to the date Lasso Healthcare Insurance Company has been notified that the proposal has been accepted by the group. Shock loss information should include injuries, illnesses, diseases, diagnoses, or other losses of the type, which are reasonably likely to result in a significant medical expense claim or disability, regardless of current claim dollar amount. In addition, shock loss information should include any claimant that has incurred claim dollars in excess of $ 62,500, regardless of diagnosis. Information is also needed on any claims processed and unpaid, pended or denied for any reason. Please refer to our Trigger Diagnosis Disclosure List, which provides examples of some, but not all, types of shock losses.

• We will accept final shock loss disclosure no earlier than 15 days prior to the effective date.

• Please see the attached exhibit for plan document assumptions and requirements.

• Should a large claim(s) (non-reoccurring and/or ongoing) become known and the initial date of service is prior to the date of written acceptance by HCC Life Insurance Company, we reserve the right to re-underwrite the case.

• In the event there is a greater than 10% change in enrollment between the submitted initial enrollment data and the final enrollment data, rates and factors may be recalculated.

• Minimum participation level of 75% of all eligible employees is required.

• Our proposal includes Simultaneous Funding on Specific reimbursements.

• Rates and Factors are calculated with the plan anniversary date and the Policy effective date as the same date. Should the plan anniversary date and the stop loss policy effective date be different we reserve the right to modify our rates, factors and terms of coverage to accommodate for additional liabilities incurred by the plan due to state and/or federal mandates during the stop loss contract period.

• Quote rated with retirees covered. Quote rated with no COBRAs being covered based on the census information provided.

• Quote Rated with the following UR Vendors: American Health Holding, Inc. - UR.

• Quote Rated with the following Cost Containment Program(s): Aetna Signature Adminstrators.

Initial the selected proposal option (please initial both the selected Specific and Aggregate option):

Option	Specific	Aggregate
1 TJW	$ 125,000 / Paid	$ 125,000 / Paid
2	$ 130,000 / Paid	$ 130,000 / Paid

TOKIO MARINE HCC

Stop Loss Proposal for: Tazewell County

Effective Dates: 10/01/2026 - 09/30/2027
Quoted for: Pareto Captive Services, LLC

Proposal Number: 2-1399803

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3	$ 135,000 / Paid	$ 135,000 / Paid

The Premium and Aggregate Deductibles are based on the data submitted. Any inaccurate or incomplete data submitted may require changes at final underwriting. We will not be bound by any typographical errors or omissions contained herein.

Date: 8/19/2026

By: _____
Agent of Record or Administrator

This proposal expires if applications are not requested before the valid through date.

COMMITTEE REPORT

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 that the County Board elect not to renew the TPA Administrative Services Agreement ("Agreement") with Consociate, Inc., d/b/a Consociate Health, with the Agreement terminating effective December 31, 2026; and

WHEREAS, Consociate Health provides Administrative Services for the County's health and dental plans; and

WHEREAS, the Agreement specified a one-year term with the option to renew for additional one-year terms; and

WHEREAS, the County's health insurance consultant, The Wyman Group, has recommended a change in TPA to Allied Benefit Systems, LLC beginning January 1, 2027 which is expected to significantly improve customer service, reduce the turnaround time for processing claims, and result in cost savings for claims; and

WHEREAS, the County will continue to rely on Consociate Health to process 2026 claims into 2027 due to the timing of claims being processed for payment known as claims run out.

THEREFORE, BE IT RESOLVED that the County Board approves the non-renewal of the TPA Administrative Services Agreement with Consociate Health effective December 31, 2026, and authorizes the County Administrator or The Wyman Group to provide written notification of the non-renewal to Consociate Health.

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 SEPTEMBER, 2026.

ATTEST:

_____	_____
Tazewell County Clerk	Tazewell County Board Chairman

COMMITTEE REPORT

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 that the County Board considers the recommendation from the County's health insurance consultant, The Wyman Group, to retain the services of Allied Benefit Systems, LLC as the County's new Third Party Administrator (TPA) for the County's medical and dental benefits plans; and

WHEREAS, Allied Benefit Systems, LLC will provide Administrative Services for the County's medical and dental benefits plans; and

WHEREAS, the Agreement specifies a two-year term with the option to renew for additional terms; and

WHEREAS, Allied Benefit Systems, LLC will provide significant benefits to both the County and its employees by improving customer service, reducing claim processing turnaround times, and resulting in cost savings on claims; and

WHEREAS, Allied Benefit Systems, LLC has an established working relationship with the County's current prescription carrier, SmithRx, stop loss carrier, ParetoHealth, and our new payroll service provider, ADP.

THEREFORE BE IT RESOLVED that the County Board approve the recommendation and authorize the County Board Chairman to enter into an agreement with Allied Benefit Systems, LLC.

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

PASSED THIS 30th DAY OF SEPTEMBER, 2026.

ATTEST:

_____ _____

Tazewell County Clerk Tazewell County Board Chairman

Proposal

Tazewell County

Effective Date: January 1, 2027
Presented By: The Wyman Group
Prepared By: Allied Benefit Systems, LLC

ALLIED

ADMINISTRATIVE SERVICES

Tazewell County

Effective Date: January 01, 2027

ADMINISTRATIVE SERVICE FEES	ENROLLMENT	ALLIED - Approved PBM Trading Partner
Network		Aetna 2.0
Medical Administration	271	$29.74
Pharmacy Benefit Manager		SmithRx
PBM Coordination	271	Waived
PPO Access	271	$16.25
Utilization Review[1]	271	$2.25
Stop Loss Coordination Fee[2]	271	Waived
Allied Digital (My Allied Portal, Compliance, Care Navigation)[3]	271	$4.00
Allied Annual Administration Fee		$3,250.00
Monthly Administrative Service Fee		**$14,157.04**
Annual Administrative Service Fee		**$173,134.48**
Optional Services		
Allied Care Solutions Behavioral Health	271	$1.50
COBRA Administration	271	$1.75
Dental Administration	271	$2.00
Teladoc	271	$3.50
Monthly Optional Service Fee		**$2,371.25**
Annual Optional Service Fee		**$28,455.00**

TOTAL MONTHLY FEES	**$16,528.29**
TOTAL ANNUAL FEES	**$201,589.48**

To approve selected administrative rates, simply initial and date the line beneath the option you want and return to your Allied Representative. Allied must be notified at time of acceptance of any additional fees to be collected and remitted by Allied.

Please Initial Accepted Administrative Option: _____

Allied Administrative fees are guaranteed for a two year period.

This single page is a part of a larger proposal and must be reviewed in the context of the entire proposal, of which Allied's Terms and Conditions apply.

1) Inpatient precert only; other benefits may be covered dependent on network requested. Additional pricing may apply depending on precert requirements requested.

2) A stop loss coordination fee will apply if the stop loss contracts are placed by an independent party other than Allied.

3) Allied Digital seamlessly integrates Allied's advanced medical and cost management solutions with innovative digital tools, including the new My Allied Portal mobile app. By empowering our members to make informed healthcare decisions, and being fully compliant with numerous new government mandates such as 'No Surprise Billing' and 'Transparency in Coverage,' Allied Digital enhances the member experience, making the navigation of complex healthcare landscapes more efficient, intuitive and compliant.

ALLIED

Tazewell County - ASO Comparison

	Employee Enrollment	Consociate Health 2027	Consociate Annual Total	Allied 2027	Allied Annual Total
Aetna Network Fee	271	$16.25	$52,845.00	$16.25	$52,845.00
Medical Administration	271	$25.00	$81,300.00	$29.74	$96,714.48
Dental Administration	271	$2.25	$7,317.00	$2.00	$6,504.00
HRA Administration	1	$3.00	$36.00	NA	NA
Medical Administration Banking (annual fee)			$3,000.00	NA	NA
Utilization Review (American Health Holdings AHH)[1]	271	$2.99	$9,723.48	$2.25	$7,317.00
Stop Loss Coordination Fee	271	$5.00	$16,260.00	Waived	Waived
TPA Portal Access[3]	271	NA	$0.00	$4.00	$13,008.00
PBM Coordination Fee	271	NA	$0.00	Waived	Waived
Annual Administration Fee		NA	$0.00	$3,250.00	$3,250.00
COBRA Administration[4]	271	$1.00	$3,252.00	$1.75	$5,691.00
Teladoc[4] (OPYN is current virtual urgent care with Consociate)	271	$3.50	$11,382.00	$3.50	$11,382.00
Allied Behavioral Health[4] (Telus Health is current EAP)	271	$1.37	$4,455.24	$1.50	$4,878.00
BJC COE	271	$3.00	$9,756.00	NA	NA
Healthcare Bluebook	271	$1.25	$4,065.00	NA	NA
NQTL[4]			$4,999.00		$5,000.00
CAA[4]			$1,750.00		$0.00
Annual Notice Mailings[4]*	271	$8.00	See below	$6.50	See below
ID Cards[5]	271	$2.00	$6,504.00	$2.50	$8,130.00
Broker Fee	271	Paid Direct	Paid Direct	Paid Direct	Paid Direct
PPO Access Multi-Plan Wrap Network	271	30% of savings	$0.00	25% of savings	$0.00
Total			$216,644.72		$214,719.48
Difference[6]					**-$1,925.24**

[1]AHH Inpatient Pre-cert list applies.

[3]Allied Digital seamlessly integrates Allied's advanced medical and cost management solutions with innovative digital tools, including the new My Allied mobile app. By empowering Allied's members to make informed healthcare decisions and being fully compliant with numerous new government mandates such as "No Surprise Billing" and "Transparency in Coverage", Allied Digital enhances the member experience making the navigation of complex healthcare landscapes more efficient, intuitive and compliant.

[4]Optional Services. For NQTL and CAA, additional fees may apply. With Allied, most employers do not use/need Allied's assistance, so this fee likely won't come into play.

[4*]Allied's fee is $6.50 per packet of ALL notices combined. Allied recommends sending the notices electronically subject to electronic guidelines. Consociate charges $2.00 PER annual notice which equates to $8.00 total.

[5]Effective 1/1/2026, Allied can print dependent's names on the ID cards for an additional $0.50 per ID card printed.

[6]Allied Advocate Program should help reduce total claim costs by ~10%.

the WYMAN group

Put *Care* at the Heart of Your Benefits Strategy

You don't have to choose between compassion and cost-control. Create personalized self-funded health plans that deliver best-in-class care and bottom line results.

Presented by:

ALLIED

For:

Meet Allied: The Largest Independent TPA in the U.S.

Size, Scale, Stability

Supporting over 14,500 clients across the US

Founded in 1980, licensed nationwide. Headquartered in Chicago with virtual offices extending to 44 states.

Tailored Solutions for Every Industry Vertical

Healthcare Systems · Manufacturing & Industrial · Consumer Industries · Education & Public Sector · SaaS & High-Growth Companies · Sovereign Nations

URAC ACCREDITED

Expertise for Mid-Market & Enterprise Employers

Forest River · Atrium Hospitality · Blue Bell Ice Cream · James Avery Jewelry · Utz · Landry's

AICPA SOC

BPO Partnerships for Insurance Companies & Large Health Plans

Nationwide · Christian Brothers Services · Optimyl · GBA Georgia Bankers Association

ALLIED

Administrative Services

Claims Processing

Allied's claims team is world class. This group of seasoned professionals is highly experienced, and ongoing training keeps their professional skills sharp. Coupled with state-of-the-art technology, the team ensures that claims are processed efficiently and accurately.

The result?

Faster turnaround times, fewer mistakes, and greater confidence for every stakeholder in the claims process.

10 days
Average TaT Claims Processing

100%
Financial Accuracy
Industry standard is 99%

99.9%
Payment Accuracy
Industry standard is 97%

100%
Procedural Accuracy
Industry standard is 97%

0%
Facility Claims Auto-Adjudicated
Every facility claim reviewed

Source: 1. Wolcott & Associates, Inc., based on independent internal audit of 31,167 randomly selected claims processed by Allied Benefit Systems, LLC for the year, 2025.

Member Services

Member Advocacy & Concierge Support:

Personalized Guidance for Quality Care

Language Support Available

Certified interpreter services are available to assist non-English speaking members, helping ensure clear communication and equitable access to support.

Connect With an Allied Representative in Seconds

- Member calls are answered within 45 seconds
- Average call wait time is <27 seconds

Fully-Integrated Service Team

- Each Member Services Associate is an actual employee – and benefit member – of Allied (no third-party concierge)
- That means they can spend time resolving issues, and are fluent in Allied's system and processes

Quality Training & Expertise

- Annual Quality Assurance Performance score of 97% or higher
- 100% of calls are recorded for continued education and training

Available When You Are

- Extended weekday and weekend operating hours, so members can call us at a time that works best

Mon – Fri:	8:00am - 8:00pm CST
Sat:	9:00am - 12:00pm CST

Member Services

Delivering Excellence

Member-Centric Service Meets Performance Metrics

96.49%

Call Quality Assurance Audit Score[3]

Allied 2025 corporate KPI was 95%.

1.68%

Average call center abandonment rate[1]

Allied 2025 corporate KPI was 5% or less.

27 secs

Average call speed to answer[1]

Allied 2025 corporate KPI was 45 seconds.

97.44%

First Call Resolution (FCR)[2]

Allied's 2025 corporate KPI was 95%.

Source: 1. Contact CX One Voice System Reports 2025.; 2. Internal QA Audit 2025.; 3. 2025 BoB Results. Call Quality Score is based on monthly quality assessment of 5 calls per month per Contact Center Specialist..

Comprehensive Medical and Cost Management Suite:

Allied Care Solutions

1. Allied Care
Integrated Utilization Management, Case Management & Medical Review

2. Allied Advocate
Integrated Medical Claim & Cost Management

3. Enhanced Case Management
Integrated Member-Centric Care Management

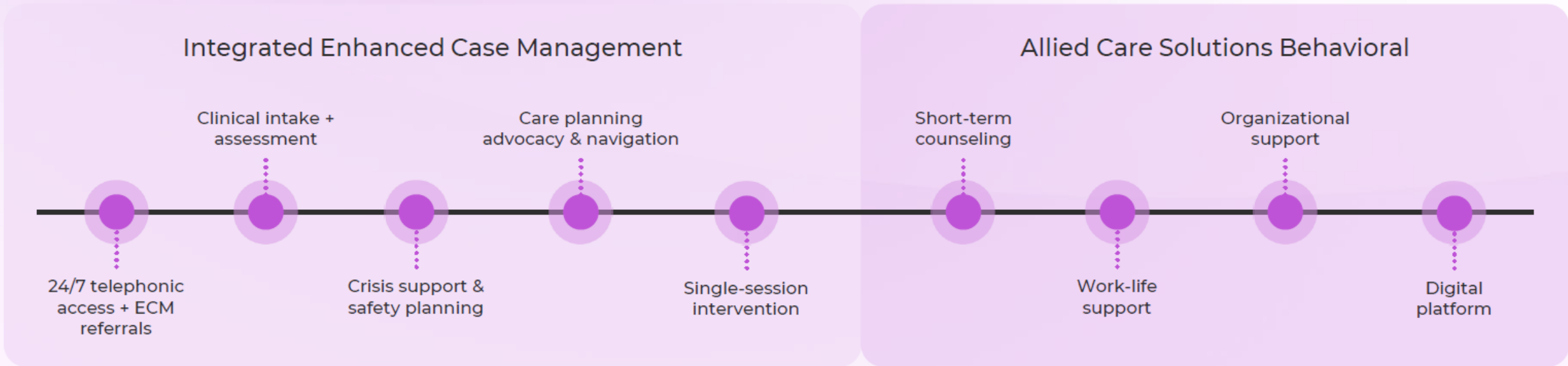
4. Behavioral Health
Integrated Mental Health Management

5. Wellness
Integrated Wellness & Lifestyle Management

Care Solutions

Integrated Behavioral Health

Embedded support and structure expansion deliver one connected experience



All services are integrated within the Allied Care model, creating seamless access, reducing fragmentation, and delivering consistent, high-quality care without the disruption of carve-out programs.

Allied Digital

What is VPC

Virtual Primary Care

is the delivery of primary healthcare services through digital platforms.

It enables patients to connect with healthcare remotely via video calls, phone consultations, and secure messaging for routine check-ups, chronic disease management prescriptions, and preventive services.

Benefits

- Convenience and accessibility
- Time savings
- Cost-effective
- Expanded access to quality providers

	Virtual Primary Care	vs.	Urgent Care
Availability	Scheduled appointment with selected physician, often during regular business hours.		Available 24/7, with appointments often available within minutes, first available physician on-call.
Purpose	Ongoing management of overall health, preventive care, chronic conditions		Immediate care for minor illnesses or injuries that need prompt attention
Services Provided	Preventive care, chronic disease management, routine check-ups, mental health support.		Treatment for acute conditions like flu, infections, minor injuries, and more.
Provider Relationship	Long-term relationship with a primary care provider.		Typically, a one-time visit with a healthcare provider.
Follow-up	Regular follow-ups and continuous care		Usually, no follow-up unless further care is needed.
Examples of Use	Managing diabetes, hypertension, mental health, routine screenings.		Treating a sore throat, ear infection, minor cuts or sprains.

Allied Digital

OUR SOLUTION

Virtual Primary Care

POWERED BY

RECURO HEALTH

Goal:

Make primary care accessible, affordable without sacrificing quality.

Enable proactive use of primary care to prevent reactive emergency care down the road.

1 Virtual-First Access to Care

- Convenient visits via phone or video with dedicated board-certified physicians (MD/DO)
- 24/7 on-call physician access, ensures members can connect when they need support while maintaining care continuity.
- Reduces downstream high-severity claims through earlier intervention.

2 Cost-Effective Alternative to In-Person Visits

- Zero out-of-pocket to members, and flat, predictable rate for plan to control and predict spend.
- Specialist referrals via Allied Navigation.

3 Proactive, Holistic Care Engagement

- Everyday health needs and chronic condition management
- Wellness visits and at-home screening lab kits to close care gaps
- Genomics testing to improve medication management
- Integrated virtual behavioral health therapy/counseling

4 Builds a Personal, Longitudinal Care Relationship

- Members stay connected to a dedicated virtual PCP.
- Long-term monitoring improves chronic care management and outcomes.
- Commitment to ensuring ample provider availability for optimal service.

Complete Care Management

2025 Allied Book of Business

Medical & Administrative Aetna Performance

-10.67%

Average Total Program Impact on Cost of Care

Administrative Excellence/Claims Editing/Clinical Review	Impact
Financial Accuracy	-0.67%
Procedural Accuracy	-1.01%
Audit Protocols/Non-Auto-Adjudicated of Facility Charges Performance	-2.83%
Medical Payment Integrity	-3.30%
CERiS (Forensic Claim Review)	-0.02%
Medical Management Performance	
Allied Care Utilization Review	-0.91%
Allied Care Case Management	-0.78%
Allied Advocate Strategies	
Infusion Claims Management*	-1.14%

*Inclusive of estimated savings from the Infusion Site of Administration claim management strategy