Insurance Review Committee

Tammy Rich-Stimson, Chairman
McKenzie Building - Jury Room
11 S. 4th Street
Pekin, IL 61554
Tuesday, November 17, 2026 – 3:00 p.m.

I. Roll Call

II. Approve the minutes of the July 17, 2025 meeting

III. New Business

Discussion:

A. Health Insurance Changes

IV. Unfinished Business

V. Recess

Members: Chairman Tammy Rich-Stimson, Nick Graff, Jon Hopkins, Dave Mingus, Janet Johnson, Scott Moon, Jacob Edwards, Trent Strunk, Jake Tucker, Mark Chism, Justin Bauer

Minutes pending Committee approval

Insurance Review Committee Meeting

McKenzie Building – Jury Room
Thursday, July 17, 2025 – 4:01 p.m.

Committee Members Present:	Chairman Tammy Rich-Stimson, Nick Graff, Mark Chism, Janet Johnson, Trent Strunk, Jake Edwards
Committee Members Absent:	Dave Mingus, Ryan Tarby, Jake Tucker, Scott Moon, Jon Hopkins
Others Attending:	Mike Deluhery, County Administrator Jolie Burris, The Wyman Group

MOTION **MOTION BY MEMBER GRAFF, SECOND BY MEMBER JOHNSON** to approve the minutes of the February 27, 2025 meeting.

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

DISCUSSION **HEALTH INSURANCE CHANGES**

Assistant Administrator/Finance Director Mindy Darcy stated that the County was aware that several employees were desiring better benefits with more options for their healthcare. She stated that The Wyman Group has recommended switching to Aetna. She stated that our Agreement with Carle Health expires at the end of November of 2026. Director Darcy stated that she was notified by Carle Health that they would be closing down our plan at the end of calendar year 2025. She stated that Carle Health will allow us to terminate their contract early, therefore, we are looking are September 1, 2025.

Assistant Administrator/Finance Director Mindy Darcy stated that this change will not change the employee benefits, it is just a change of the carrier. She stated that employees would now be able to go to OSF and Springfield Clinic, in addition to Carle Health. She stated that Hopedale will no longer be a part of the plan since they are not part of the Aetna network. She stated that there are a couple of chiropractors in the area that are also not part of the Aetna network. She stated that currently if you live here and want to go to an out-of-network doctor, you would have no coverage. She stated that with the new Aetna plan, if you want to go to someone who is out-of-network, you would pay 40% and the

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the plan would pay 60%. She stated that they believe this will be a cost saving for the employee and for the County.

Assistant Administrator/Finance Director Mindy Darcy stated that we will be taking this to the board in July. She stated that they will recommend no insurance premium increases for FY26.

Member Strunk questioned if a procedure is done at OSF by a Carle Health doctor, will the claim be paid. Jolie Burris from The Wyman Group confirmed that it will now be covered under the Aetna plan since OSF is in-network.

Ms. Burris stated that in the case of an emergency, emergency room services are paid at the in-network rate.

Member Graff questioned if an employee has paid co-pays or deductibles to date, will those carry on or be reset. Ms. Burris confirmed that they will carry on.

Ms. Burris stated that the only change is that all employees will get new ID cards, which will have the Aetna information on them.

Chairman Rich-Stimson recessed the meeting at 4:29 p.m.

(transcribed by S. Gullette)

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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:**

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	

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	

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 1 day of OCTOBER, 2026

Michael L Harris VICE

Authorized Representative Tazewell County Health Benefit Plan and Title

SUMMARY OF BENEFITS

General Limits
Payment for any of the expenses listed below is subject to all Plan Exclusions, limitations and provisions. All coverage figures, if applicable, are after the Out-of-pocket Deductible has been satisfied.

See the Utilization Management section for more information regarding Pre-Certification and/or Notification requirements.

Network and Out-of-Network Provider Arrangement
The Plan contracts with medical Provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical Provider Networks are called "Network Providers". Those who have not contracted with the Networks are referred to in this Plan as "Out-of-Network Providers". This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Participants use a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Out-of-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:
    a. In the event a Network Provider refers a Participant to an Out-of-Network Provider for services, then charges of the Out-of-Network Provider will be paid as though the services were provided by a Network Provider.
    b. The Network Provider level of benefits is payable for any Participant who cannot access Network Providers because they reside outside the Network service area.
    c. The services are not available at a Network Provider. The Network Provider level of benefits will be payable.
    d. The Network Provider level of benefits is payable when a Participant receives Emergency care either Out-of-Area or at an Out-of-Network Hospital for an Accidental Bodily Injury or Emergency.

2. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-Network Provider for any covered service is higher than the Maximum Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously-given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.

3. To receive benefit consideration, Participants may need to submit claims for services provided by out of-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.

Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

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

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

Balance Billing
In the event that a claim submitted by a Network or Out-of-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator, although the Plan has no control over any Provider's actions, including balance billing.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Participant is responsible for any applicable payment of Coinsurances, Deductibles, and Out-of-pocket maximums and may be billed for any or all of these.

Choice of Providers
The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other health care Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Third Party Administrator. The delivery of medical and other health care services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

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

A current list of Network Providers is available, without charge, through the Third Party Administrator's website (located at www.consociatehealth.com). If the Participant does not have access to a computer at his or her home, he or she may access this website at his or her place of employment. If he or she has any questions about how to do this, he or she should contact the Human Relations Department. The Network Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a Network Provider before receiving services. Please refer to the Participant identification card for the Network website address.

Claims Audit
In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges exceed the Maximum Allowable Charge or services that are not Medically Necessary, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.
Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

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

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

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

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

All other sections of the Plan remain unchanged.

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

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

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

1. is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2. is undergoing a course of institutional or Inpatient care from a specific Provider,
3. is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
4. is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5. is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

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

Transition of Care
If a Participant is under the care of an Out-of-Network Provider at the time of joining the Plan, there are a limited number of medical conditions that may qualify for transition of care. If transitional care is appropriate, specific treatment by an Out-of-Network Provider may be covered at the Network level of benefits for a limited period of time. The Third Party Administrator will review and approve or deny such requests.

Summary of Benefits - Medical

The following benefits are per Participant per Calendar Year and are subject to the Maximum Allowable Charge.

Calendar Year Maximum Benefits for Tazewell County Traditional 500 PPO Plan	
All Essential Health Benefits	**Unlimited**

	In Network	Out of Network	Limits
Deductible			
Individual	In and Out of Network combined: $500		
Family	In and Out of Network combined: $1,000		
Embedded deductible: *If you have other family members on the plan, each family member must meet their own individual deductible before the plan starts to pay unless the overall family deductible is satisfied first. In no event will more than the individual deductible apply to one person.*			
Maximum Out-of-Pocket (includes Deductibles, Coinsurance, Copayments, and Prescription Drug Copayments)			
Individual	In and Out of Network combined: $1,300		All copays stop at medical OOP
Family	In and Out of Network combined: $2,600		
Embedded Out-of-Pocket: If you have other family members on this plan, they have to meet their own Out-of-Pocket limits until the overall family Out-of-Pocket limit has been met.			

The following table identifies what does and does not apply toward the Out-of-Pocket Maximums:

Plan Features	Applies to the Out-of-Pocket Maximum?
Payments toward the annual Deductible	Yes
Coinsurance payments, even those for covered services available in the Prescription Drug Benefits section, except for those covered health services identified in the Summary of Benefits that do not apply to the Out-of-Pocket Maximum.	Yes
Copayments	Yes
Charges for non-covered services	No
The amounts of any Pre-Certification penalties	No
Charges that exceed Allowable Expenses	No

The plan includes services at BJC HealthCare Center of Excellence Network (BJC COE). For services at BJC COE, the deductible and out of pocket expenses will be waived.

Coinsurance shown below is what Participant pays and applies after deductible has been met			
Traditional 500 PPO Plan	**In Network**	**Out of Network**	**Limits**
Advanced Radiology			
Includes MRI, MRA, CT scan, coronary CT angiography, PET Scan, and nuclear cardiology, nuclear medicine.	Facility: 10% coinsurance Physician: 20% coinsurance	40% coinsurance	Precertification is required CT & MRI for non-orthopedic and for PET scans
Allergy Services			
Office Visit	$25 copay	40% coinsurance	
Injections	20% coinsurance	40% coinsurance	
Serum	20% coinsurance	40% coinsurance	
Acupuncture	Not Covered		
Ambulance	20% coinsurance	40% coinsurance	
Ambulatory Surgical Center	10% coinsurance	40% coinsurance	Precertification is required for certain outpatient surgeries.
Anesthesia	20% coinsurance	40% coinsurance	
Bariatric Surgery	20% coinsurance	40% coinsurance	The following weight loss surgeries are covered: gastric bypass, duodenal switch, SADI-S, gastric banding and sleeve gastrectomy. Precertification is required and certain criteria must be met.
Birthing Center	20% coinsurance	40% coinsurance	Precertification is required for some maternity stays.
Blood & Plasma	20% coinsurance	40% coinsurance	
Cardiac Rehabilitation	Facility: 10% coinsurance Physician: 20% coinsurance	40% coinsurance	Precertification is required for Nuclear Cardiology.
Chiropractic Care			
Office Visits, Spinal Manipulations, and Adjustments	20% coinsurance	40% coinsurance	
X-Rays	20% coinsurance	40% coinsurance	
Clinical Trials (Routine Patient Costs)	20% coinsurance	40% coinsurance	
Dialysis	20% coinsurance	40% coinsurance	Prenotification is requested
Durable Medical Equipment	20% coinsurance	40% coinsurance	Precertification is required for electric /motorized scooters or wheelchairs and pneumatic compression devices
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			
Traditional 500 PPO Plan	**In Network**	**Out of Network**	**Limits**
Glaucoma, Cataract Surgery and Lenses (one set)	20% coinsurance	40% coinsurance	
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.
Hearing Exam	20% coinsurance	40% coinsurance	
Home Health Care	20% coinsurance	40% coinsurance	Precertification is required.
Hospice			
Inpatient - Facility	10% coinsurance	40% coinsurance	Precertification is required.
Inpatient - Physician	20% coinsurance	40% coinsurance	
Outpatient	20% coinsurance	40% coinsurance	
Family Bereavement Counseling	20% coinsurance	40% coinsurance	
Hospital			
Inpatient Treatment- Facility	10% coinsurance	40% coinsurance	Precertification is required for all inpatient stays and for some outpatient surgeries, 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: Services, Physician Charges, Surgery Services, Hospital Care	20% coinsurance	40% coinsurance	
Outpatient Treatment- Facility	10% coinsurance	40% coinsurance	
Outpatient: Physician Surgery Services	20% coinsurance	40% coinsurance	
Implants	20% coinsurance	40% coinsurance	Cochlear Implants are not covered.
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.
Injections/Infusions	20% coinsurance	40% coinsurance	Certain outpatient medications are a non-covered expense under the Plan if subject to the criteria of the SmithRx Drug Sourcing Program.
Mastectomy Bras	20% coinsurance	40% coinsurance	

Coinsurance shown below is what Participant pays and applies after deductible has been met			
Traditional 500 PPO Plan	**In Network**	**Out of Network**	**Limits**
Mental Health and 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	
Newborn Care	20% coinsurance	40% coinsurance	
Outpatient Diagnostic X-Ray and Lab	10% coinsurance	40% coinsurance	
Outpatient Emergency Services – Life Threatening /Accidental Injury - Facility	$300 copay		Precertification is required if admitted. Copay waived if admitted.
Outpatient Emergency Services – Life Threatening /Accidental Injury – Other Providers	*After $300 copay for Outpatient Emergency Services-Facility (see above):* 10% coinsurance. In Network Deductible applies.		Precertification is required if admitted.
Outpatient Emergency Services – Non-Emergency	$300 copayment, then 10% coinsurance. In Network Deductible applies.		Precertification is required if admitted. Copay is waived if admitted.
Physician Services: In-Office Setting			
Primary Care Office Visits	$25 copay	40% coinsurance	Virtual Visits are covered as any other office visit. Telemedicine with Walmart Health Virtual Care. Call 1-855-636-3669.
Specialist Office Visits	$25 copay	40% coinsurance	
Labs, X-Rays, and Surgery	20% coinsurance	40% coinsurance	
Pregnancy Services			
Office Visit	$25 copay for initial visit	40% coinsurance	Precertification is required for some maternity stays. Cost sharing does not apply to certain preventive services. Dependent daughter pregnancy is covered.
Routine Prenatal and Postnatal Services	No Charge, deductible does not apply		
Non-Routine Prenatal Services	20% coinsurance	40% coinsurance	
Delivery - Inpatient - Facility	10% coinsurance	40% coinsurance	
Delivery - Inpatient - Physician	20% coinsurance	40% coinsurance	
Breast Pump	Covered at 100% ACA requirement, no deductible applies	40% coinsurance	Over the counter purchases covered 100% (no deductible) up to $400 per pregnancy.

Coinsurance shown below is what Participant pays and applies after deductible has been met			
Traditional 500 PPO Plan	**In Network**	**Out of Network**	**Limits**
Pre-natal screening as defined under Women's Preventive Services of the Patient Protection and Affordable Care Act of 2010	No charge	No charge	
Preventive Care – Adult and Child as defined under the Affordable Care Act			
Routine Physical Exam	No charge	No charge	School/sports physical for kids are covered.
Colonoscopies, Cologuard – must be age 45	No charge	No charge	Annual colonoscopy, regardless of diagnosis, is covered at no charge, Deductible waived.
Mammograms, including 3D	No charge	No charge	Annual mammogram, regardless of diagnosis, is covered at no charge, Deductible waived. Comprehensive breast ultrasounds are covered at no charge, and deductible does not apply if mammogram is medically necessary by referring physician.
Mental Health Counseling – First Responder	No charge	No charge	
Pap Smears	No charge	No charge	
Prostate Exam – *must be over age 50, unless Medically Necessary*	No charge	No charge	
Routine Immunizations	No charge	No charge	
Private Duty Nursing	20% coinsurance	40% coinsurance	None
Prosthetics, Orthotics, Supplies, and Surgical Dressings	20% coinsurance	40% coinsurance	Includes replacements which are medically necessary or required by pathological change or normal growth. Covered at 100% for children. Custom molded orthotics/shoe inserts are covered when medically necessary. Orthopedic shoes are covered only when part of a brace.
Second Surgical Opinions	20% coinsurance	40% coinsurance	
Skilled Nursing Facility	20% coinsurance	40% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
Sleep Disorders/Apnea	20% coinsurance	40% coinsurance	Precertification is required for Sleep Studies

Coinsurance shown below is what Participant pays and applies after deductible has been met			
Traditional 500 PPO Plan	**In Network**	**Out of Network**	**Limits**
Surgery			
Inpatient Treatment- Facility	10% coinsurance	40% coinsurance	Precertification is required for all inpatient stays and for some outpatient surgeries, 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: Services, Physician Charges, Surgery Services, Hospital Care	20% coinsurance	40% coinsurance	
Outpatient Treatment- Facility	10% coinsurance	40% coinsurance	
Outpatient: Physician Surgery Services	20% coinsurance	40% coinsurance	
Temporomandibular Treatment (TMJ)	Not Covered		
Therapy			
Chemotherapy/Radiation Treatment	20% coinsurance	40% coinsurance	Precertification is required. Enhanced benefits available through CancerCare program.
Occupational Therapy	20% coinsurance	40% coinsurance	
Physical Therapy	20% coinsurance	40% coinsurance	
Speech Therapy	20% coinsurance	40% coinsurance	
Respiratory Therapy	20% coinsurance	40% coinsurance	
ABA Therapy	20% coinsurance	40% coinsurance	
Vision Therapy	20% coinsurance	40% coinsurance	
Transplants			
Recipient Expenses	Facility: 10% coinsurance Physician: 20% coinsurance	40% coinsurance	Precertification is required. When both the person donating the organ and the person receiving the organ are Participants, each will receive benefits under the Plan. If the recipient is covered by the Plan and the donor has no other source of benefits, benefits for both the donor and the recipient shall be computed in accordance with the provisions governing the recipient's eligibility for benefits under the Plan. If the donor is covered by the Plan and no benefits are available to the donor from any other source, benefits shall be provided to the donor under the provisions of the Plan but no benefits shall be provided to the recipient.
Donor Expenses	Facility: 10% coinsurance Physician: 20% coinsurance	40% coinsurance	
Urgent Care	$75 copay	$75 copay	

Coinsurance shown below is what Participant pays and applies after deductible has been met			
Traditional 500 PPO Plan	**In Network**	**Out of Network**	**Limits**
Weight Loss Medications	Not Covered		The following weight loss surgeries are covered: gastric bypass, duodenal switch, SADI-S, gastric banding and sleeve gastrectomy. Precertification is required and certain criteria must be met.
Wigs	20% coinsurance	40% coinsurance	Initial purchase of a wig following Alopecia, burns, chemotherapy or radiation therapy.
All Other Covered Services	20% coinsurance	40% coinsurance	

Prescription Drug Benefits – Traditional PPO Plan

The Out-of-pocket maximum is the maximum dollar amount Participants are responsible for paying for covered services during a Plan Year, including the Copayments.

A Copayment is the flat dollar amount specified in the Summary of Benefits that a Participant is required to pay for certain covered services. Copayments will not apply after the Out-of-pocket maximum has been reached.

NOTE: Under the Affordable Care Act (ACA) some medications may have limited or $0 cost-sharing; examples of categories of medications that may be subject to limited or $0 cost share include aspirin, breast cancer preventive, fluoride supplements, folic acid supplements, iron supplements, tobacco cessation, bowel preparation for colonoscopy, and some contraceptive medications and devices. ***Check with your Pharmacy Benefits Manager (shown on your ID Card) for details.***

Covered Prescription Drug Expenses:	You Pay at Participating Pharmacy[1]	Non-Participating Pharmacy	Limits[2]
Pharmacy Option: Limit of 30 or 90-day supply			
Copayment per prescription or refill, for generic	30-day: $12 copayment 90-day: $24 copayment	Not Covered	See Prescription Drug Benefits section
Copayment per prescription or refill, for formulary name brands[3]	30-day: $30 copayment 90-day: $60 copayment		See Prescription Drug Benefits section
Copayment per prescription or refill, for non-formulary name brands	30-day: $50 copayment 90-day: $100 copayment		See Prescription Drug Benefits section
Mail Order Option[4]: Limit of 90-day supply			
Copayment per prescription or refill, for generic	$24 copay	Not Covered	See Prescription Drug Benefits section
Copayment per prescription or refill, for formulary name brands[5]	$60 copay		See Prescription Drug Benefits section
Copayment per prescription or refill, for non-formulary name brands	$100 copay		See Prescription Drug Benefits section
Specialty Drug Option: Limit of 30-day supply			
Copayment per prescription or refill	$50 copay		See Prescription Drug Benefits section

You are required to participate in SmithRx's Access program in order to receive coverage under the Plan for certain medications ("Access Medications"). Under the Access program, SmithRx will assist you in locating, and applying for, copayment coupons and financial assistance for Access Medications, which may allow you to receive such medications at little to no cost. However, as part of this program, certain specialty prescription drugs are considered non-essential health benefits under the Plan, and any assistance received through the Access program will not count toward your Deductible or out-of-pocket maximum. For a list of Access Medications included in the Access program, please contact SmithRx member services. Copayments for certain Access Medications may be set to the maximum of the current Plan design or to the amount of copayment assistance available through the Access program. The Plan may cover a 60-day grace period for urgent, Medically Necessary Access Medications to allow time to complete the Access Program application/enrollment process.

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1 100% payment by Plan after Copayment.

2 These limits are in addition to all other Plan exclusions, limitations and provisions set forth in this Plan. Please review the Plan carefully to determine benefits available.

3 Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated "dispense as written" or similar indication.

4 Prescription orders in excess of one refill must be obtained through the Mail Order Option in order to be eligible for benefits under the Plan.

5 Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated "dispense as written" or similar indication.

Calendar Year Maximum Benefits for Tazewell County Mid-Level PPO Plan	
All Essential Health Benefits	Unlimited

	In Network	Out of Network	Limits
Deductible			
Individual	In and Out of Network Combined: $1,000		
Family	In and Out of Network Combined: $2,000		
Embedded deductible: *If you have other family members on the plan, each family member must meet their own individual deductible before the plan starts to pay unless the overall family deductible is satisfied first. In no event will more than the individual deductible apply to one person.*			
Maximum Out-of-Pocket (includes Deductibles, Coinsurance, Copayments, and Prescription Drug Copayments)			
Individual	In and Out of Network combined: $2,000		All copays stop at medical OOP
Family	In and Out of Network combined: $4,000		
Embedded Out-of-Pocket: *If you have other family members on this plan, they have to meet their own Out-of-Pocket limits until the overall family Out-of-Pocket limit has been met.*			

The following table identifies what does and does not apply toward the In Network and Out of Network Out-of-Pocket Maximums:

Plan Features	Applies to the Out-of-Pocket Maximum?
Payments toward the annual Deductible	Yes
Coinsurance payments, even those for covered services available in the Prescription Drug Benefits section, except for those covered health services identified in the Summary of Benefits that do not apply to the Out-of-Pocket Maximum.	Yes
Copayments	Yes
Charges for non-covered services	No
The amounts of any Pre-Certification penalties	No
Charges that exceed Allowable Expenses	No

The plan includes services at BJC HealthCare Center of Excellence Network (BJC COE). For services at BJC COE, the deductible and out of pocket expenses will be waived.

Coinsurance shown below is what Participant pays and applies after deductible has been met			
Mid-Level PPO Plan	**In Network**	**Out of Network**	**Limits**
Advanced Radiology			
Includes MRI, MRA, CT scan, coronary CT angiography, PET Scan, and nuclear cardiology, nuclear medicine.	Facility: 10% coinsurance Physician: 20% coinsurance	40% coinsurance	Precertification is required CT & MRI for non-orthopedic and for PET scans
Allergy Services			
Office Visit	$25 copay	40% coinsurance	
Injections	20% coinsurance	40% coinsurance	
Serum	20% coinsurance	40% coinsurance	
Acupuncture	Not Covered		
Ambulance	20% coinsurance		
Ambulatory Surgical Center	10% coinsurance	40% coinsurance	Precertification required for certain outpatient surgeries.
Anesthesia	20% coinsurance	40% coinsurance	
Bariatric Surgery	20% coinsurance	40% coinsurance	The following weight loss surgeries are covered: gastric bypass, duodenal switch, SADI-S, gastric banding and sleeve gastrectomy. Precertification is required and certain criteria must be met.
Birthing Center	20% coinsurance	40% coinsurance	Precertification is required for some maternity stays.
Blood & Plasma	20% coinsurance	40% coinsurance	
Cardiac Rehabilitation	Facility: 10% coinsurance Physician: 20% coinsurance	40% coinsurance	Precertification is required for Nuclear Cardiology.
Chiropractic Care			
Office Visits, Spinal Manipulations, and Adjustments	20% coinsurance	40% coinsurance	
X-Rays	20% coinsurance	40% coinsurance	
Clinical Trials (Routine Patient Costs)	20% coinsurance	40% coinsurance	
Dialysis	20% coinsurance	40% coinsurance	Prenotification is requested
Durable Medical Equipment	20% coinsurance	40% coinsurance	Precertification is required for electric /motorized scooters or wheelchairs and pneumaticcompression devices
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			
Mid-Level PPO Plan	**In Network**	**Out of Network**	**Limits**
Glaucoma, Cataract Surgery and Lenses (one set)	20% coinsurance	40% coinsurance	
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.
Hearing Exam	20% coinsurance	40% coinsurance	
Home Health Care	20% coinsurance	40% coinsurance	Precertification is required.
Hospice			
Inpatient Treatment- Facility	10% coinsurance	40% coinsurance	Precertification is required.
Inpatient: Physician Charges,	20% coinsurance	40% coinsurance	
Outpatient	20% coinsurance	40% coinsurance	
Family Bereavement Counseling	20% coinsurance	40% coinsurance	
Hospital			
Inpatient Treatment- Facility	10% coinsurance	40% coinsurance	Precertification is required for all inpatient stays and for some outpatient surgeries, 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: Services, Physician Charges, Surgery Services, Hospital Care	20% coinsurance	40% coinsurance	
Outpatient Treatment-Facility	10% coinsurance	40% coinsurance	
Outpatient: Physician Surgery Services	20% coinsurance	40% coinsurance	
Implants	20% coinsurance	40% coinsurance	Cochlear Implants are not covered.
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.
Injections/Infusions	20% coinsurance	40% coinsurance	Certain outpatient medications are a non-covered expense under the Plan if subject to the criteria of the SmithRx Drug Sourcing Program.
Mastectomy Bras	20% coinsurance	40% coinsurance	

Coinsurance shown below is what Participant pays and applies after deductible has been met			
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	
Newborn Care	20% coinsurance	40% coinsurance	
Outpatient Diagnostic X-Ray and Lab	10% coinsurance	40% coinsurance	
Outpatient Emergency Services – Life Threatening /Accidental Injury Facility	$300 copay		Precertification is required if admitted. Copay is waived if admitted.
Outpatient Emergency Services – Life Threatening /Accidental Injury Other Providers	*After $300 copay for Outpatient Emergency Services-Facility (see above):* 10% coinsurance. In Network Deductible applies.		Precertification is required if admitted.
Outpatient Emergency Services – Non-Emergency	$300 copay, then 10% coinsurance, In Network Deductible applies.		Precertification is required if admitted. Copay is waived if admitted
Physician Services: In-Office Setting			
Primary Care Office Visits	$25 copay	40% coinsurance	Virtual Visits are covered as any other office visit. Telemedicine with Walmart Health Virtual Care. Call 1-855-636-3669.
Specialist Office Visits	$25 copay	40% coinsurance	
Labs, X-Rays, and Surgery	20% coinsurance	40% coinsurance	
Pregnancy Services			
Office Visit	$25 copay for initial visit	40% coinsurance	Precertification is required for some maternity stays. Cost sharing does not apply to certain preventive services. Dependent daughter pregnancy is covered.
Routine Prenatal and Postnatal Services	No charge, Deductible does not apply		
Non-Routine Prenatal Services	20% coinsurance	40% coinsurance	
Delivery - Inpatient - Facility	10% coinsurance	40% coinsurance	
Delivery - Inpatient Physician	20% coinsurance	40% coinsurance	
Breast Pump	Covered at 100% ACA requirement, no deductible applies	40% coinsurance	Over the counter purchases covered 100% (no deductible) up to $400 per pregnancy.

Coinsurance shown below is what Participant pays and applies after deductible has been met			
Mid-Level PPO Plan	**In Network**	**Out of Network**	**Limits**
Pre-natal screening as defined under Women's Preventive Services of the Patient Protection and Affordable Care Act of 2010	No charge	No charge	
Preventive Care – Adult and Child as defined under the Affordable Care Act			
Routine Physical Exam	No charge	No charge	School/sports physical for kids are covered.
Colonoscopies, Cologuard – must be age 45	No charge	No charge	Annual colonoscopy, regardless of diagnosis, is covered at no charge, Deductible waived.
Mammograms, including 3D	No charge	No charge	Annual mammogram, regardless of diagnosis, is covered at no charge, Deductible waived. Comprehensive breast ultrasounds are covered at no charge, and deductible does not apply if mammogram is medically necessary by referring physician.
Mental Health Counseling – First Responder	No charge	No charge	
Pap Smears	No charge	No charge	
Prostate Exam – *must be over age 50, unless Medically Necessary*	No charge	No charge	
Routine Immunizations	No charge	No charge	
Private Duty Nursing	20% coinsurance	40% coinsurance	None
Prosthetics, Orthotics, Supplies, and Surgical Dressings	20% coinsurance	40% coinsurance	Includes replacements which are medically necessary or required by pathological change or normal growth. Covered at 100% for children. Custom molded orthotics/shoe inserts are covered when medically necessary. Orthopedic shoes are covered only when part of a brace.
Second Surgical Opinions	20% coinsurance	40% coinsurance	
Skilled Nursing Facility	20% coinsurance	40% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
Sleep Disorders/Apnea	20% coinsurance	40% coinsurance	Precertification is required for Sleep Studies

Coinsurance shown below is what Participant pays and applies after deductible has been met			
Mid-Level PPO Plan	**In Network**	**Out of Network**	**Limits**
Surgery			
Inpatient Treatment- Facility	10% coinsurance	40% coinsurance	Precertification is required for all inpatient stays and for some outpatient surgeries, 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: Services, Physician Charges, Surgery Services, Hospital Care	20% coinsurance	40% coinsurance	
Outpatient Treatment-Facility	10% coinsurance	40% coinsurance	
Outpatient: Physician Surgery Services	20% coinsurance	40% coinsurance	
Temporomandibular Treatment (TMJ)	Not Covered		
Therapy			
Chemotherapy/Radiation Treatment	20% coinsurance	40% coinsurance	Precertification is required. Enhanced benefits available through CancerCare Program.
Occupational Therapy	20% coinsurance	40% coinsurance	
Physical Therapy	20% coinsurance	40% coinsurance	
Speech Therapy	20% coinsurance	40% coinsurance	
Respiratory Therapy	20% coinsurance	40% coinsurance	
ABA Therapy	20% coinsurance	40% coinsurance	
Vision Therapy	20% coinsurance	40% coinsurance	
Transplants			
Recipient Expenses	Facility: 10% coinsurance Physician: 20% coinsurance	40% coinsurance	Precertification is required. When both the person donating the organ and the person receiving the organ are Participants, each will receive benefits under the Plan. If the recipient is covered by the Plan and the donor has no other source of benefits, benefits for both the donor and the recipient shall be computed in accordance with the provisions governing the recipient's eligibility for benefits under the Plan. If the donor is covered by the Plan and no benefits are available to the donor from any other source, benefits shall be provided to the donor under the provisions of the Plan but no benefits shall be provided to the recipient.
Donor Expenses	Facility: 10% coinsurance Physician: 20% coinsurance	40% coinsurance	

Coinsurance shown below is what Participant pays and applies after deductible has been met			
Mid-Level PPO Plan	**In Network**	**Out of Network**	**Limits**
Urgent Care	$75 copay	$75 copay	
Weight Loss Medications	Not Covered		The following weight loss surgeries are covered: gastric bypass, duodenal switch, SADI-S, gastric banding and sleeve gastrectomy. Precertification is required and certain criteria must be met.
Wigs	20% coinsurance	40% coinsurance	Initial purchase of a wig following Alopecia, burns, chemotherapy or radiation therapy.
All Other Covered Services	20% coinsurance	40% coinsurance	

Prescription Drug Benefits – Mid-Level PPO Plan

The Out-of-pocket maximum is the maximum dollar amount Participants are responsible for paying for covered services during a Plan Year, including the Copayments.

A Copayment is the flat dollar amount specified in the Summary of Benefits that a Participant is required to pay for certain covered services. Copayments will not apply after the Out-of-pocket maximum has been reached.

NOTE: Under the Affordable Care Act (ACA) some medications may have limited or $0 cost-sharing; examples of categories of medications that may be subject to limited or $0 cost share include aspirin, breast cancer preventive, fluoride supplements, folic acid supplements, iron supplements, tobacco cessation, bowel preparation for colonoscopy, and some contraceptive medications and devices. ***Check with your Pharmacy Benefits Manager (shown on your ID Card) for details.***

Covered Prescription Drug Expenses:	You Pay at Participating Pharmacy[1]	Non-Participating Pharmacy	Limits[2]
Retail Pharmacy Option: Limit of 30 or 90-day supply			
Copayment per prescription or refill, for generic	30-day: $12 copayment 90-day: $24 copayment	Not Covered	See Prescription Drug Benefits section
Copayment per prescription or refill, for formulary name brands[3]	30-day: $30 copayment 90-day: $60 copayment		See Prescription Drug Benefits section
Copayment per prescription or refill, for non-formulary name brands	30-day: $50 copayment 90-day: $100 copayment		See Prescription Drug Benefits section
Mail Order Option[4]: Limit of 90-day supply			
Copayment per prescription or refill, for generic	$24 copay	Not Covered	See Prescription Drug Benefits section
Copayment per prescription or refill, for formulary name brands[5]	$60 copay		See Prescription Drug Benefits section
Copayment per prescription or refill, for non-formulary name brands	$100 copay		See Prescription Drug Benefits section
Specialty Drug Option: Limit of 30-day supply			
Copayment per prescription or refill	$50 copay		See Prescription Drug Benefits section

You are required to participate in SmithRx's Access program in order to receive coverage under the Plan for certain medications ("Access Medications"). Under the Access program, SmithRx will assist you in locating, and applying for, copayment coupons and financial assistance for Access Medications, which may allow you to receive such medications at little to no cost. However, as part of this program, certain specialty prescription drugs are considered non-essential health benefits under the Plan, and any assistance received through the Access program will not count toward your Deductible or out-of-pocket maximum. For a list of Access Medications included in the Access program, please contact SmithRx member services. Copayments for certain Access Medications may be set to the maximum of the current Plan design or to the amount of copayment assistance available through the Access program. The Plan may cover a 60-day grace period for urgent, Medically Necessary Access Medications to allow time to complete the Access Program application/enrollment process.

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1 100% payment by Plan after Copayment.

2 These limits are in addition to all other Plan exclusions, limitations and provisions set forth in this Plan. Please review the Plan carefully to determine benefits available.

3 Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated "dispense as written" or similar indication.

4 Prescription orders in excess of one refill must be obtained through the Mail Order Option in order to be eligible for benefits under the Plan.

5 Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated "dispense as written" or similar indication.

Calendar Year Maximum Benefits for Tazewell County Qualified PPO HDHP Plan	
All Essential Health Benefits	Unlimited

	In Network	Out of Network	Limits
Deductible			
Individual	In and Out of Network combined: $3,500		
Family	In and Out of Network combined: $7,000		
Embedded deductible: *If you have other family members on the plan, each family member must meet their own individual deductible before the plan starts to pay unless the overall family deductible is satisfied first. In no event will more than the individual deductible apply to one person.*			
Maximum Out-of-Pocket (includes Deductibles, Coinsurance, Copayments, and Prescription Drug Copayments)			
Individual	In and Out of Network combined: $6,200		
Family	In and Out of Network combined: $8,400		
Embedded Out-of-Pocket: *If you have other family members on this plan, they have to meet their own Out-of-Pocket limits until the overall family Out-of-Pocket limit has been met.*			

The following table identifies what does and does not apply toward the Out-of-Pocket Maximums:

Plan Features	Applies to Out-of-Pocket Maximum?
Payments toward the annual Deductible	Yes
Coinsurance payments, even those for covered services available in the Prescription Drug Benefits section, except for those covered health services identified in the Summary of Benefits that do not apply to the Out-of-Pocket Maximum.	Yes
Copayments	Yes
Charges for non-covered services	No
The amounts of any Pre-Certification penalties	No
Charges that exceed Allowable Expenses	No

The Plan includes services at BJC HealthCare Center of Excellence Network (BJC COE). Services at BJC COE will be covered 100%, after deductible.

Coinsurance shown below is what Participant pays and applies after deductible has been met			
Qualified PPO HDHP Plan	**In Network**	**Out of Network**	**Limits**
Advanced Radiology			
Includes MRI, MRA, CT scan, coronary CT angiography, PET Scan, and nuclear cardiology, nuclear medicine.	20% coinsurance	40% coinsurance	Precertification is required CT & MRI for non-orthopedic and for PET scans
Allergy Services			
Office Visit	20% coinsurance	40% coinsurance	
Injections	20% coinsurance	40% coinsurance	
Serum	20% coinsurance	40% coinsurance	
Acupuncture	Not Covered		
Ambulance	20% coinsurance		
Ambulatory Surgical Center	20% coinsurance	40% coinsurance	Precertification is required for certain outpatient surgeries.
Anesthesia	20% coinsurance	40% coinsurance	
Bariatric Surgery	20% coinsurance	40% coinsurance	The following weight loss surgeries are covered: gastric bypass, duodenal switch, SADI-S, gastric banding and sleeve gastrectomy. Precertification is required and certain criteria must be met.
Birthing Center	20% coinsurance	40% coinsurance	Precertification required for some maternity stays.
Blood & Plasma	20% coinsurance	40% coinsurance	
Cardiac Rehabilitation	20% coinsurance	40% coinsurance	Precertification is required for Nuclear Cardiology.
Chiropractic Care			
Office Visits, Spinal Manipulations, and Adjustments	20% coinsurance	40% coinsurance	
X-Rays	20% coinsurance	40% coinsurance	
Clinical Trials (Routine Patient Costs)	20% coinsurance	40% coinsurance	
Dialysis	20% coinsurance	40% coinsurance	Prenotification is requested
Durable Medical Equipment	20% coinsurance	40% coinsurance	Precertification is required for electric /motorized scooters or wheelchairs and pneumaticcompression devices
Genetic Counseling	20% coinsurance	40% coinsurance	
Genetic Testing	Deductible then $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 Plan	**In Network**	**Out of Network**	**Limits**
Glaucoma, Cataract Surgery and Lenses (one set)	20% coinsurance	40% coinsurance	
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.
Hearing Exam	20% coinsurance	40% coinsurance	
Home Health Care	20% coinsurance	40% coinsurance	Precertification is required.
Hospice			
Inpatient	20% coinsurance	40% coinsurance	Precertification is required.
Outpatient	20% coinsurance	40% coinsurance	
Family Bereavement Counseling	20% coinsurance	40% coinsurance	
Hospital			
Inpatient: Facility, Services, Physician Charges, Surgery Services, Hospital Care	20% coinsurance	40% coinsurance	Precertification is required for all inpatient stays and for some outpatient surgeries, 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.
Outpatient: Physician Surgery Services	20% coinsurance	40% coinsurance	
Implants	20% coinsurance	40% coinsurance	Cochlear Implants are excluded
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.
Injections	20% coinsurance	40% coinsurance	
Mastectomy Bras	20% coinsurance	40% coinsurance	
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 shown below is what Participant pays and applies after deductible has been met			
Qualified PPO HDHP Plan	**In Network**	**Out of Network**	**Limits**
Newborn Care	20% coinsurance	40% coinsurance	
Outpatient Diagnostic X-Ray and Lab	20% coinsurance	40% coinsurance	
Outpatient Emergency Services – Life Threatening /Accidental Injury – Facility and Other Providers	20% coinsurance		Precertification is required if admitted.
Outpatient Emergency Services – Non-Emergency	20% coinsurance		Precertification is required if admitted.
Physician Services: In-Office Setting			
Primary Care Office Visits	20% coinsurance	40% coinsurance	Virtual visits are covered as any other Office Visit. Telemedicine with Walmart Health Virtual Care. Call 1-855-636-3669.
Specialist Office Visits	20% coinsurance	40% coinsurance	
Labs, X-Rays, and Surgery	20% coinsurance	40% coinsurance	
Pregnancy Services			
Office Visit	20% coinsurance	40% coinsurance	Precertification is required for some maternity stays. Cost sharing does not apply to certain preventive services. Dependent daughter pregnancy is covered
Routine Prenatal and Postnatal Services	20% coinsurance	40% coinsurance	
Non-Routine Prenatal Services, Delivery and all Inpatient Care	20% coinsurance	40% coinsurance	
Breast Pump	Covered at 100% ACA requirement, no deductible applies	40% coinsurance	Over the counter purchases covered 100% (no deductible) up to $400 per pregnancy.
Pre-natal screening as defined under Women's Preventive Services of the Patient Protection and Affordable Care Act of 2010	No charge	No charge	
Preventive Care – Adult and Child as defined under the Affordable Care Act			
Routine Physical Exam	No charge	No charge	School/sports physical for kids are covered.
Colonoscopies, Cologuard – must be age 45	No charge	No charge	Annual colonoscopy, regardless of diagnosis, is covered at no charge, Deductible waived.
Mammograms, including 3D	No charge	No charge	Annual mammogram, regardless of diagnosis, is covered at no charge, Deductible waived. Comprehensive breast ultrasounds are covered at no charge, and deductible does not apply if mammogram is medically necessary by referring physician.

Coinsurance shown below is what Participant pays and applies after deductible has been met			
Qualified PPO HDHP Plan	**In Network**	**Out of Network**	**Limits**
Preventive Care – Adult and Child as defined under the Affordable Care Act (continued)			
Mental Health Counseling – First Responder	No charge	No charge	
Pap Smears	No charge	No charge	
Prostate Exam – *must be over age 50, unless Medically Necessary*	No charge	No charge	
Routine Immunizations	No charge	No charge	
Private Duty Nursing	20% coinsurance	40% coinsurance	None
Prosthetics, Orthotics, Supplies, and Surgical Dressings	20% coinsurance	40% coinsurance	Includes replacements which are medically necessary or required by pathological change or normal growth. Covered at 100% for children. Custom molded orthotics/shoe inserts are covered when medically necessary. Orthopedic shoes are covered only when part of a brace.
Second Surgical Opinions	20% coinsurance	40% coinsurance	
Skilled Nursing Facility	20% coinsurance	40% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
Sleep Disorders/Apnea	20% coinsurance	40% coinsurance	Precertification is required for Sleep Studies
Surgery	20% coinsurance	40% coinsurance	Precertification is required for all inpatient stays and for some outpatient surgeries, 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.
Temporomandibular Treatment (TMJ)	Not Covered		
Therapy			
Chemotherapy/Radiation Treatment	20% coinsurance	40% coinsurance	Precertification is required. Enhanced benefits available through CancerCare program.
Occupational Therapy	20% coinsurance	40% coinsurance	
Physical Therapy	20% coinsurance	40% coinsurance	
Speech Therapy	20% coinsurance	40% coinsurance	
Respiratory Therapy	20% coinsurance	40% coinsurance	
ABA Therapy	20% coinsurance	40% coinsurance	
Vision Therapy	20% coinsurance	40% coinsurance	

Coinsurance shown below is what Participant pays and applies after deductible has been met			
Qualified PPO HDHP Plan	**In Network**	**Out of Network**	**Limits**
Transplants			
Recipient Expenses	20% coinsurance	40% coinsurance	Precertification is required. When both the person donating the organ and the person receiving the organ are Participants, each will receive benefits under the Plan. If the recipient is covered by the Plan and the donor has no other source of benefits, benefits for both the donor and the recipient shall be computed in accordance with the provisions governing the recipient's eligibility for benefits under the Plan. If the donor is covered by the Plan and no benefits are available to the donor from any other source, benefits shall be provided to the donor under the provisions of the Plan but no benefits shall be provided to the recipient.
Donor Expenses	20% coinsurance	40% coinsurance	
Urgent Care	20% coinsurance	40% coinsurance	
Weight Loss Medications	Not Covered		The following weight loss surgeries are covered: gastric bypass, duodenal switch, SADI-S, gastric banding and sleeve gastrectomy. Precertification is required and certain criteria must be met.
Wigs	20% coinsurance	40% coinsurance	Initial purchase of a wig following Alopecia, burns, chemotherapy or radiation therapy.
All Other Covered Services	20% coinsurance	40% coinsurance	

Prescription Drug Benefits – Qualified HDHP Plan

The Out-of-pocket maximum is the maximum dollar amount Participants are responsible for paying for covered services during a Plan Year, including the Copayments.

Coinsurance is the applicable percentage amount specified in the Summary of Benefits that a Participant is required to pay for certain covered services and applies after the deductible has been me. Coinsurance will not apply after the Out-of-pocket maximum has been reached.

NOTE: Under the Affordable Care Act (ACA) some medications may have limited or $0 cost-sharing; examples of categories of medications that may be subject to limited or $0 cost share include aspirin, breast cancer preventive, fluoride supplements, folic acid supplements, iron supplements, tobacco cessation, bowel preparation for colonoscopy, and some contraceptive medications and devices. ***Check with your Pharmacy Benefits Manager (shown on your ID Card) for details.***

Covered Prescription Drug Expenses:	You Pay at Participating Pharmacy[1]	Non-Participating Pharmacy	Limits[2]
Pharmacy Option: Limit of 30 or 90-day supply			
Coinsurance per prescription or refill, for generic	20% coinsurance	Not Covered	See Prescription Drug Benefits section
Coinsurance per prescription or refill, for formulary name brands[3]	20% coinsurance		See Prescription Drug Benefits section
Coinsurance per prescription or refill, for non-formulary name brands	20% coinsurance		See Prescription Drug Benefits section
Mail Order Option[4]: Limit of 90-day supply			
Coinsurance per prescription or refill, for generic	20% coinsurance	Not Covered	See Prescription Drug Benefits section
Coinsurance per prescription or refill, for formulary name brands[5]	20% coinsurance		See Prescription Drug Benefits section
Coinsurance per prescription or refill, for non-formulary name brands	20% coinsurance		See Prescription Drug Benefits section
Specialty Drug Option: Limit of 30-day supply			
Coinsurance per prescription or refill	20% coinsurance		See Prescription Drug Benefits section

You are required to participate in SmithRx's Access program in order to receive coverage under the Plan for certain medications ("Access Medications"). Under the Access program, SmithRx will assist you in locating, and applying for, copayment coupons and financial assistance for Access Medications, which may allow you to receive such medications at little to no cost. However, as part of this program, certain specialty prescription drugs are considered non-essential health benefits under the Plan, and any assistance received through the Access program will not count toward your Deductible or out-of-pocket maximum. For a list of Access Medications included in the Access program, please contact SmithRx member services. Copayments for certain Access Medications may be set to the maximum of the current Plan design or to the amount of copayment assistance available through the Access program. The Plan may cover a 60-day grace period for urgent, Medically Necessary Access Medications to allow time to complete the Access Program application/enrollment process.

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1 100% payment by Plan after Copayment.

2 These limits are in addition to all other Plan exclusions, limitations and provisions set forth in this Plan. Please review the Plan carefully to determine benefits available.

3 Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated "dispense as written" or similar indication.

4 Prescription orders in excess of one refill must be obtained through the Mail Order Option in order to be eligible for benefits under the Plan.

5 Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated "dispense as written" or similar indication.

HR-26-15

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:

RESOLUTION

WHEREAS, the Human Resources Committee recommends to the County Board to approve premium costs for Tazewell County medical, dental, and vision insurance coverage for calendar year 2027 for all full-time, non-union employees, and all full-time employees covered by the terms of the F.O.P. Deputies' Bargaining Unit, P.B.L.C. Control Room Operators, F.O.P. Correction Officer's Unit, F.O.P. Court Services Probation Officers and Teamsters ASSEU collective bargaining agreements, in accordance with the below schedules and effective January 1, 2027; and

WHEREAS, a six percent (6%) increase to total premiums for all medical and dental insurance plans is scheduled for 2027. There is no planned increase in premiums for vision insurance for 2027; and

WHEREAS, insurance premium increases are shared between the County and employee according to the applicable policy or collective bargaining agreement per group.

THEREFORE BE IT RESOLVED by the County Board that the Tazewell County employee Medical, Dental, and Vision insurance premiums for 2027 be approved.

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

PASSED THIS 28th DAY OF OCTOBER, 2026.

ATTEST:

Tazewell County Clerk

Tazewell County Board Chairman Vice

2027 HEALTH CARE PREMIUMS FOR NON-UNION EMPLOYEES

PLAN	TYPE	2027 TOTAL PREMIUM	2027 COUNTY PER MONTH	2027 EMPLOYEE PER MONTH	2027 PER PAY PERIOD (24)
PPO 500 - Traditional Plan	Employee Only Medical	1,279.32	1,055.90	223.42	$111.71
	Employee + Child(ren) Medical	2,280.09	1,686.39	593.70	$296.85
	Employee + Spouse Medical	2,371.29	1,751.00	620.29	$310.15
	Employee + Family Medical	2,532.13	1,826.61	705.52	$352.76
PPO 1000 - Mid-Level Plan	Employee Only Medical	1,151.39	950.30	201.09	$100.55
	Employee + Child(ren) Medical	2,052.06	1,517.76	534.30	$267.15
	Employee + Spouse Medical	2,134.14	1,575.89	558.25	$279.13
	Employee + Family Medical	2,278.90	1,643.94	634.96	$317.48
HDHP 3200 Qualified Plan	Employee Only Medical	895.52	739.12	156.40	$78.20
	Employee + Child(ren) Medical	1,596.05	1,180.46	415.59	$207.80
	Employee + Spouse Medical	1,659.88	1,225.68	434.20	$217.10
	Employee + Family Medical	1,772.49	1,278.62	493.87	$246.94
Medical Reimbursement	Employee Only	567.82	514.97	52.85	$26.43
	Dependent Only	663.88	562.44	101.44	$50.72
	Employee + Family	1,231.70	1,077.41	154.29	77.15
Retiree (65 and older)	Employee Only	456.91	$0.00	456.91	$228.46
	Spouse Only	456.91	$0.00	456.91	$228.46
	Employee + Spouse	913.82	$0.00	913.82	$456.91
Dental	Employee Only	38.87	38.87	$0.00	$0.00
	Employee + Family	136.34	67.45	68.89	$34.45
Vision	Employee Only	$10.76	$10.76	$0.00	
	Employee + Plus One (Spouse or Child) Or	$21.52	$10.76	$10.76	
	Employee + Children	$23.02	$10.76	$12.26	
	Employee + Family	$36.79	$10.76	$26.03	
Symetra Life Insurace $25k	Employee Only	$6.63	$6.63	$0.00	

2027 HEALTH CARE PREMIUMS FOR F.O.P. DEPUTIES

PLAN	TYPE	2027 TOTAL PREMIUM	2027 COUNTY PER MONTH	2027 EMPLOYEE PER MONTH	2027 PER PAY PERIOD (24)
PPO 500 - Traditional Plan	Employee Only Medical	1,279.32	1,010.72	268.60	$134.30
	Employee + Child(ren) Medical	2,280.09	1,610.02	670.07	$335.04
	Employee + Spouse Medical	2,371.29	1,679.40	691.89	$345.95
	Employee + Family Medical	2,532.13	1,742.59	789.54	$394.77
PPO 1000 - Mid-Level Plan	Employee Only Medical	1,151.39	909.65	241.74	$120.87
	Employee + Child(ren) Medical	2,052.06	1,449.03	603.03	$301.52
	Employee + Spouse Medical	2,134.14	1,511.44	622.70	$311.35
	Employee + Family Medical	2,278.90	1,568.33	710.57	$355.29
HDHP 3200 Qualified Plan	Employee Only Medical	895.52	707.50	188.02	$94.01
	Employee + Child(ren) Medical	1,596.05	1,127.01	469.04	$234.52
	Employee + Spouse Medical	1,659.88	1,175.55	484.33	$242.17
	Employee + Family Medical	1,772.49	1,219.81	552.68	$276.34
Medical Reimbursement	Employee Only	567.82	508.54	59.28	$29.64
	Dependent Only	663.88	546.71	117.17	$58.59
	Employee + Family	1,231.70	1,055.25	176.45	88.23
Retiree (65 and older)	Employee Only	456.91	$0.00	456.91	$228.46
	Spouse Only	456.91	$0.00	456.91	$228.46
	Employee + Spouse	913.82	$0.00	913.82	$456.91
Dental	Employee Only	38.87	38.87	-	$0.00
	Employee + Family	136.34	65.14	71.20	$35.60
Vision	Employee Only	$10.76	$10.76	$0.00	
	Employee + Plus One (Spouse or Child) Or	$21.52	$10.76	$10.76	
	Employee + Children	$23.02	$10.76	$12.26	
	Employee + Family	$36.79	$10.76	$26.03	
Symetra Life Insurace $25k	Employee Only	$6.63	$6.63	$0.00	

2027 HEALTH CARE PREMIUMS FOR F.O.P. PROBATION OFFICERS, F.O.P. CORRECTIONS OFFICERS, P.B.L.C. CONTROL ROOM OPERATORS, & TEAMSTERS ASSEU

PLAN	TYPE	2027 TOTAL PREMIUM	2027 COUNTY PER MONTH	2027 EMPLOYEE PER MONTH	2027 PER PAY PERIOD (24)
PPO 500 - Traditional Plan	Employee Only Medical	1,279.32	989.82	289.50	$144.75
	Employee + Child(ren) Medical	2,280.09	1,573.55	706.54	$353.27
	Employee + Spouse Medical	2,371.29	1,645.55	725.74	$362.87
	Employee + Family Medical	2,532.13	1,702.28	829.85	$414.93
PPO 1000 - Mid-Level Plan	Employee Only Medical	1,151.39	890.84	260.55	$130.28
	Employee + Child(ren) Medical	2,052.06	1,416.18	635.88	$317.94
	Employee + Spouse Medical	2,134.14	1,480.98	653.16	$326.58
	Employee + Family Medical	2,278.90	1,532.05	746.85	$373.43
HDHP 3200 Qualified Plan	Employee Only Medical	895.52	692.88	202.64	$101.32
	Employee + Child(ren) Medical	1,596.05	1,101.49	494.56	$247.28
	Employee + Spouse Medical	1,659.88	1,151.87	508.01	$254.01
	Employee + Family Medical	1,772.49	1,191.61	580.88	$290.44
Medical Reimbursement	Employee Only	567.82	505.33	62.49	$31.25
	Dependent Only	663.88	538.85	125.03	$62.52
	Employee + Family	1,231.70	1,044.18	187.52	93.76
Retiree (65 and older)	Employee Only	456.91	$0.00	456.91	$228.46
	Spouse Only	456.91	$0.00	456.91	$228.46
	Employee + Spouse	913.82	$0.00	913.82	$456.91
Dental	Employee Only	38.87	38.87	-	$0.00
	Employee + Family	136.34	63.98	72.36	$36.18
Vision	Employee Only	$10.76	$10.76	$0.00	
	Employee + Plus One (Spouse or Child) Or	$21.52	$10.76	$10.76	
	Employee + Children	$23.02	$10.76	$12.26	
	Employee + Family	$36.79	$10.76	$26.03	
Symetra Life Insurace $25k	Employee Only	$6.63	$6.63	$0.00	

What to expect with the move in Third Party Administrators (TPA) effective 1/1/2027

The administration of Tazewell County's Medical and Dental plans is moving from Consociate as their TPA to Allied.

Some facts about Allied:

- Allied is the largest Independent TPA in the U.S. supporting over 14,500 employers.
- Allied's claims team is world class. This results in faster turnaround times, fewer mistakes and greater confidence for every stakeholder in the claims process.
- You can connect with an Allied representative in seconds. Member calls are answered within 48 seconds, and the average call wait time is less than 27 seconds. Note, these times may be greater at the beginning of a calendar year.
- Allied has an annual Quality Assurance Performance score of 97% or higher. 100% of all calls are recorded for continued education and training.
- Each Member Services Associate is an actual employee and benefit member of Allied – No third-party concierge. This means they can spend time resolving any issues and they are fluent in Allied's system and processes.
- Their Member Services Team is available Monday through Friday 8:00 a.m. to 8:00 p.m. CST and Saturdays from 9:00 a.m. to 12:00 p.m. CST.
- 97% of the time, issues are resolved on the first call to their Member Services Team.
- Allied has a robust member portal and mobile app. Their digital tools keep you connected and your health plan will always be with you when you need it.

What to expect because of this change:

- You will be getting new ID cards in the mail prior to 1/1/27. BE SURE TO SHOW YOUR NEW ID CARD TO HEALTHCARE PROVIDERS, DENTISTS, AND PHARMACY PROVIDERS ON AND AFTER 1/1/27.
- As of 1/1/27, you can access the Allied member portal or mobile app to upload your ID card. On and after 1/1/27, you can use your new User ID from your ID card or your SSN to log into the Allied member portal or mobile app.
- Aetna will remain the PPO Network. This means you don't have to change healthcare providers.
- SmithRx will remain the Pharmacy Benefit Manager (PBM). This means you don't have to change pharmacies.
- The Wyman Group will remain your Benefits Consultant. Please contact Jolie Burris with any issues you may experience or any questions you may have. 217-474-6311 or jburris@wyman-group.com.
- As in years past, IF YOU'RE MAKING ANY CHANGES DURING OPEN ENROLLMENT, you will sign on to the EASE platform and make any changes. Further details will follow. If you do not make changes during open enrollment, you will not be able to make changes until the 2027/2028 open enrollment window or unless you experience a special enrollment qualifying event. If the latter, you must notify HR within 30 days of the qualifying event (ie., marriage, birth of a child, divorce, etc.).
- Tazewell County HR will have SBCs (Summary of Benefits and Coverage) available closer to open enrollment. Open Enrollment is expected to occur 11/2/26 – 11/10/26.
- Consociate will process "run-out" claims. These are claims incurred prior to 1/1/27. Questions on any claims incurred prior to 1/1/27 should be directed to Consociate.

TAZEWELL COUNTY 1827 ILLINOIS

the WYMAN group

ALLIED

Only employees that need to make changes are required to work through the following steps.

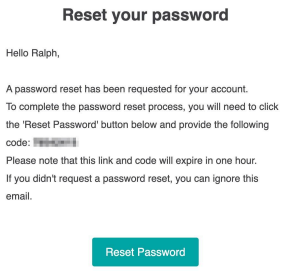
1. Go to tazcounty.ease.com

2. Select the “Forgot?” option in the password box.

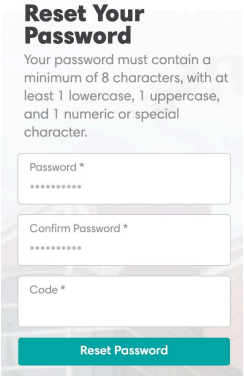


3. Enter your Tazewell County email address and click “Submit”.

4. After a couple of minutes, you’ll receive an email with a reset link and reset code. Click the “Reset Password” button.



5. After answering a security question, you’ll be prompted to enter your new password and the reset code from the email.



6. After resetting the password, you’ll be given the option to login using your email address and new password.

7. Click the “Open Enrollment” button in the upper right. You can then follow the directions on the screen to complete your desired changes.

   Please email info@wyman-group.com or call 309-685-8222 if you run into any issues.

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.

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VSP, VSP (Heart) Logo, Eyeconic, and WellVision Exam are registered trademarks, and VSP LightCare™ and VSP Premier Edge are trademarks of Vision Service Plan. All other brands or marks are the property of their respective owners. 142819 VCCM

Classification: Restricted

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.		
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