Benefits Summary Report

Account Name: Prairie Central CUSD #8
Account Number: 106093
Benefit Agreement: 0004
Product: PPO Hospital & Physician Network
Division: IL
Status: EWFReady
Effective Date: 01-01-2018 to 12-31-2018
Funding Type: Insured

Account Information

Account Number:	106093
Effective Date:	From: 01-01-2018 Through: 12-31-2018
Account Name:	Prairie Central CUSD #8
Benefit Agreement No.:	0004
Group Name:	Option 4
Group & Section Numbers:	106252/0100(active), 0200(retirees), 8888(cobra)
Business:	New
Account Type:	Local
Performance Guarantees:	No
Alpha Prefix:	XOF

HCSC Benefit Booklet

HCSC Benefit Booklet Requested:	Yes
ERISA Plan Administration Information included in Benefit Booklet?	No

Contact Information

Strategic Account Executive Information:

Account Executive Information:

Name:	Sherri Phillips
Cost Center:	848
Phone:	(217) 778-0444

Underwriter Information:

Name:	Gregory Hatton
Phone:	(630) 824-5056

Other

Full Service Unit:	Quincy
FSU Phone:	(800) 828-3116
eReview Approval Received:	No
NMAS Implementation:	N/A

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Federal Mandates

Federal Mandates

Grandfathered Plan	No
EHB State Benchmark Plan	Illinois

ACA Out-of-Pocket Maximum (OPX)

ACA limits on member cost-sharing cap OPX spending on services considered essential health benefits (EHBs) apply to non-grandfathered health plans.
All member cost-sharing (in-network copayments, deductibles, coinsurance, and out-of-network emergency services) for EHBs must apply to the OPX.
Limits no greater than the IRS-required OPX limits may apply to qualified HDHPs.
The self-only maximum annual limit on cost -sharing applies to each individual, whether the individual is enrolled in self-only or other coverage.
If (EHBs) for pediatric vision and dental are, defined as "non-excepted" benefits, they must comply with the ACA OPX cost -sharing rules.
If an account's interpretation differs from HCSC's, causing the plan to exceed the ACA-required OPX, ACA cost-sharing rules still apply to non-excepted benefits.

If applicable, for all business, the following changes must be made in the sections of the ABS referenced below, as well as noted in the Benefit Changes boxes at the bottom of each impacted section.

Federal Mandates Section:

If Religious Employer Temporary Safe Harbor applied in the previous year, change this field to 'No' for the following year. If the Group now claims the permanent exemption, change the 'Religious Employer Exemption Applies' field to 'Yes'.

Overall Program Payment Provisions Section:

Family Program Deductible and Out of Pocket Expense Limit must use an Aggregate accumulation method. Number of Individual Deductible accumulation is no longer allowed.

In the OPX Excludes section, deselect any previously selected elections. The new definition for OPX Excludes is: Charges over the eligible charge or maximum allowance; charges for non-covered services; and preauthorization penalties only.

ACA Women`s Preventive Services (contraception methods & counseling)

For non-grandfathered plans, ACA HRSA guidelines requires coverage of FDA-approved contraception methods and counseling without cost-sharing. Accounts with religious employer exemption or temporary safe harbor may not have to comply with this 100% coverage mandate.

Religious Employer Exemption Applies	No
Eligible Organization Accommodation Applies?	No
Collective Bargaining Agreement (CBA)	Yes
CBA Term Date	06/30/2018

Overall Program Payment Provisions

Lifetime Maximum

Based on ACA, LTM is unlimited for new or renewal plans effective on or after 09/23/2010.

Benefit Period	Calendar Year
Grandfathered	No
Program Deductible	Separate PPO/Non-PPO deductible

PPO

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Overall Program Payment Provisions

Individual	$2,500.00
Family	
Embedded (Formerly referred to as IL PPO Aggregate)	$7,500.00

All charges applied to the Individual deductible amount will be applied towards the Family deductible amount. Once a person meets their Individual deductible, no more deductible is required for that Individual. When the Family deductible is reached, no further deductibles will have to be satisfied for the remainder of that calendar/contract year. No participant will contribute more than the Individual deductible amount to the Family deductible amount.

Non-PPO

Individual	$5,000.00
Family	
Embedded (Formerly referred to as IL PPO Aggregate)	$15,000.00

All charges applied to the Individual deductible amount will be applied towards the Family deductible amount. Once a person meets their Individual deductible, no more deductible is required for that Individual. When the Family deductible is reached, no further deductibles will have to be satisfied for the remainder of that calendar/contract year. No participant will contribute more than the Individual deductible amount to the Family deductible amount.

Prior Carrier Deductible Credit Applies (new plans only)	No
Carry-Over Deductible Credit Applies	No
Shared Accums	Yes

Only In Network accums will be shared. If the intent is for the Out of Network accums to feed In Network, a special comment must be made in the Additional Provision section to also share Out of Network accums.

Are there any incentives with the reward type of Medical Deductible Adjustment associated with this benefit agreement(s)?	No
Out-of-Pocket Expense Limit (OPX)	Separate PPO/Non-PPO OPX

PPO

Individual	$2,500.00
Family	
Embedded (Formerly referred to as IL PPO Aggregate)	$7,500.00

All charges applied to the Individual OPX amount will be applied towards the Family OPX amount. Once a person meets their Individual OPX, no more OPX is required for that Individual. When the Family OPX is reached, no further OPX will have to be satisfied for the remainder of that calendar/contract year. No participant will contribute more than the Individual OPX amount to the Family OPX amount.

Non-PPO

Individual	$20,000.00
Family	
Embedded (Formerly referred to as IL PPO Aggregate)	$45,000.00

All charges applied to the Individual OPX amount will be applied towards the Family OPX amount. Once a person meets their Individual OPX, no more OPX is required for that Individual. When the Family OPX is reached, no further OPX will have to be satisfied for the remainder of that calendar/contract year. No participant will contribute more than the Individual OPX amount to the Family OPX amount.

Prior Carrier OPX Credit Applies (New Plans only)	No

OPX Excludes

Charges over the eligible charge or maximum allowance, non-covered charges, and BCC non-compliance reductions are excluded from the OPX. Please specify any additional exclusions, below.

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Overall Program Payment Provisions

Additional OPX Exclusions:	No

Inpatient Hospital Benefits

Inpatient Hospital/Facility Services

Includes benefits for room and board and ancillary charges in a Hospital, MH/SUD facility and Skilled Nursing Facility (extended care facility),Preadmission testing, Coordinated Home Care and care in a Hospice program.

PPO

General Payment Level	80%
Program Deductible Applies	No*

Non-PPO

General Payment Level	50%
Program Deductible Applies	Yes

Skilled Nursing Facility (extended care facility)

Plan facility services are paid the at the Inpatient Hospital payment level above. (standard)

Days	Days per benefit period
Days Per Benefit Period	120

Coordinated Home Care (home health care)

Plan program services are paid at the PPO/NON PPO general payment level above. Select one of the following:

Visits	No limit on number of visits (standard)

Hospice Care

Plan program services are paid at the PPO/NON PPO general payment level above with no dollar maximum applied.

All NON-PLAN FACILITY SERVICES/CHARGES ARE PAID AT 50% OF THE ELIGIBLE CHARGE.

Additional Provisions for Inpatient Hospital Benefits

PPO - Inpatient benefit: $500 copay applies, then pay at 80%.

Outpatient Hospital Benefits

Outpatient Hospital/Facility Services

Includes benefits for surgery, radiation therapy, chemotherapy, electroconvulsive therapy, urgent care, renal dialysis treatments, diagnostic services and cardiac rehabilitation services.

PPO

Payment Level	80%
Program Deductible Applies:	No

Non-PPO

Payment Level	50%
Program Deductible Applies:	Yes

Outpatient Surgical Services

PPO

Payment Level	80%
Program Deductible Applies:	No

Non-PPO

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Outpatient Hospital Benefits

Payment Level	50%
Program Deductible Applies	Yes

Outpatient Diagnostic Services

PPO

Payment Level	100%
Program Deductible Applies	Yes

Non-PPO

Payment Level	50%
Program Deductible Applies	Yes

Ambulatory Surgical Facility

Program Deductible Applies	No

Plan facility services are paid at the Outpatient Surgical Services PPO payment level specified above. Non-Plan facility services are paid at 50% of the eligible charge.

Additional Provisions Pertaining to Outpatient Hospital Benefits

PPO Outpatient services and outpatient surgery: $250 copay applies, then pay at 80%.

Professional Service Benefits

Coverage Level

Covered Services Included

Benefits for inpatient and outpatient medical visits, consultations, office visits, allergy surveys and injections, muscle manipulation, diabetes management training, surgery, anesthesia, surgery assistance, diagnostic services, physical therapy, occupational therapy, speech therapy, radiation therapy, chemotherapy, renal dialysis treatments, cardiac rehabilitation services and electroconvulsive therapy. Diagnostic services include the following routine tests: Mammograms, pap smear tests, PSA tests and colorectal screenings.

Payment percentages are based upon the schedule of maximum allowances (SMA).

General payment level

PPO

Payment Level	100%
Program Deductible Applies	No*

Non-PPO

Payment Level	50%
Program Deductible Applies	Yes

Office Visit Copayment

PPO

Copay	Yes
Option	Option 5

Copay applies to the office visit and all other services provided in office on same day, except for surgery, mental health, physical, occupational and speech therapies or chiropractic and osteopathic manipulation.

Split Copay	Yes
PCP Copay-Office Visit	$40.00

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Professional Service Benefits

Then paid at	100%
Specialist Copay-Office Visit	$65.00
Then paid at	100%
Non PPO	
Copay	No
Outpatient Surgical Services	
PPO	
Payment Level	80%
Program Deductible Applies	No
Non-PPO	
Payment Level	50%
Program Deductible Applies	Yes
Outpatient Diagnostics	
PPO	
Payment Level	100%
Program Deductible Applies	Yes
Non-PPO	
Payment Level	50%
Program Deductible applies	Yes
Chiropractic and Osteopathic Manipulations	
Payment Level	Paid at professional general payment level
Benefit Period Maximum	Visit Limit
Visits	12
Outpatient Physical, Occupational and Speech Therapies	
Paid at the general payment level.	
Benefit Period Maximum	Visits/Therapy
Visits	Benefit Period
Benefit Period	60
Elective Abortion Covered	No
Acupuncture Covered	No

Additional Provisions Pertaining to Professional Services Benefits

PPO - Outpatient surgical services: $250 copay applies, then pay at 100%

Chiro and Osteopathic manipulation services: pay at 50% IN and OUT of network, up to 12 visit max per calendar year. No deductible applies.

Allergy testing is covered at 100%, after deductible.

Outpatient Emergency Benefits

Emergency Medical and Emergency Accident Care (EMC/EAC)

Includes benefits for the initial treatment of medical emergency.

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Outpatient Emergency Benefits

Hospital Payment Level	100%
Physician Payment Level	100%
Program Deductible Applies	No
Emergency Room Copayment	$250.00
Emergency Room Copayment waived if patient admitted	Yes
Office Visit Copayment	No
Do Emergency Medical and Emergency Accident pay the same?	Yes (Accident Benefit Type section will not populate)

Mental Health & Substance Use Disorder Benefits

Mental Health/Substance Use Disorder Benefits Covered same as any other illness

Mental Health (MH) includes Serious Mental Illness (SMI)

Covered Services/Covered Providers include:

Inpatient and outpatient treatment rendered by a hospital, Substance Use Disorder treatment facility, partial hospitalization (day/night) treatment program, Residential Treatment Center, intensive outpatient program, physician, psychologist, licensed clinical social worker, licensed clinical professional counselor and licensed marriage and family therapist.

Copay applies for Psychotherapy provided in Office Visit Yes

The Copay amount is at the PCP level. Behavioral Health Practitioners are considered Non Specialists.

Copay applies for Psychotherapy provided in the Outpatient Setting Yes

The Copay amount is at the PCP level. Behavioral Health Practitioners are considered Non Specialists.

Employee Assistance Program: No

Is this an Exempt Group? No

Preventive Health Benefits

Preventive health benefits do not have dollar maximums (PPO and Non PPO Providers) for plan years beginning on or after 9/23/2010. In-network coverage is provided at no member cost share for FDA-approved contraceptives for women, sterilization and related patient education, and counseling on contraception regardless of Grandfather status or religious exception.

Grandfathered Plan No

Preventive Health Services apply to all ages.

Religious Employer Exemption Applies No

PPO

For PPO Providers, Benefits will be provided for the following Preventive Health Services and WILL NOT be subject to a Coinsurance, Deductible, Copayment or Dollar Maximum.

- Health Education/Counseling Services
- Immunizations
- Preventive Care Services
- Routine Bone Density Test
- Routine Breast Exam
- Routine Colonoscopy

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Preventive Health Benefits

Routine Colorectal Cancer Screening-Lab
Routine Digital Rectal Exam
Routine Gynecological Exam
Routine Lab Procedures
Routine Mammogram
Routine Pap Smear
Routine Physical Exam
Routine Prostate Test
Smoking Cessation
Visual Acuity
Well Baby Care
Women's Preventive Care (including, but not limited to: well-woman visits, FDA-approved contraceptives for women, female sterilization, breast feeding support, supplies and counseling.

Non PPO

For Non PPO providers, Preventive Health Services benefits can be subject to the Coinsurance, Deductible and/or Copayment.

Hospital Payment Level	50%
Physician Payment Level	50%
Office Visit Copayment	No
Program Deductible Applies	Yes

Other Covered Services

Coverage Level

Covered Services Include:

Ambulance transportation(local ground or air transportation to the nearest appropriately equipped facility), blood and blood components, dental accident care, leg, back, arm, and neck braces, medical and surgical dressings, oxygen and its administration, private duty nursing, prosthetic appliances, supplies, cast and splints.

Other Covered Services received from a PPO or Non PPO Providers will be provided at the payment levels previously described in the Professional and/or Hospital Benefits Services section of the Benefit Summary.

General Payment Level	100%
Private Duty Nursing	
Maximum per Calendar Year	Unlimited visits
Naprapathic Services	No

Additional Provisions Pertaining to Other Covered Services

$150 copay applies for ambulance transportation, then pay 100%.

Miscellaneous Benefits Provisions

Infertility Coverage

Coverage Type

Grandfathered

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Miscellaneous Benefits Provisions

Standard includes in-vitro fertilization, gamete intrafallopian tube transfer and zygote intrafallopian tube (only if less costly procedures have not been successful and limited to four completed oocyte retrievals and two more oocyte retrievals after a live birth), uterine embryo lavage, embryo transfer, artificial insemination and low tubal ovum transfer.

Non-Grandfathered

Standard includes in-vitro fertilization, gamete intrafallopian tube transfer and zygote intrafallopian tube (only if less costly procedures have not been successful and limited to four completed oocyte retrievals per benefit period), uterine embryo lavage, embryo transfer, artificial insemination and low tubal ovum transfer.

Human Organ Transplants

The following human organ or tissue transplants are covered only when performed in a BCBS-approved program: heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants.

Transportation, Lodging and Meals (for recipient and companion)	Yes
(Recipient must reside more than 50 miles from transplant facility)	

Lodging: Effective 1/1/2011 upon renewal, the amount for lodging cannot be more than $50 per person per night. Members can include a person traveling with the person receiving the medical care. Reimbursement will require submission of a qualifying receipt. Meals are no longer allowed to be included in lodging expenses per IRS Codecare per IRS Code §213(d). Meals: Effective 1/1/2011 upon renewal, meals outside a hospital or similar facility are not considered medical care per IRS Code §213(d) / Publication 502.

Transportation, Lodging and Meals Maximum	Other
Other	$10,000/transplant

Temporomandibular Joint Disease is covered as any other illness with no dollar maximums.

Autism Spectrum Disorders

Include benefit for treatment of Autism Spectrum Disorders for ABA services and providers.

Reimbursement Provisions	Yes
Reimbursement recovery fee is 25% of the net recovery after attorney fees	

Medicare

Coverage for persons who are not subject to the Medicare Secondary Payer laws, e.g. retirees:

Medicare Part B Payment has not been purchased by member	Estimate Part B Coverage

Coordination of Benefits(COB)

Birthday rule applies

Eligibility Provisions

Eligible Employees	Definition of eligible person stated in Group Policy
Dependents Covered	Yes

Eligible Dependents

Eligible dependents may include a spouse, natural children, legally adopted children, stepchildren, children placed in the home for adoption, children in your custody under legal guardianship. A Civil Union Partner and his or her dependents are automatically eligible to enroll for coverage and, once enrolled, eligible for continuation of coverage.

Domestic Partners Eligible	No

Dependent Child Limiting Age

Eligible military personnel are covered up to age 30.

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Eligibility Provisions

Dependent Age	26
Coverage Ends	End of the month following the limiting age birthday
Student Age	No
Student Certification	No
Medicare Secondary Payer applies	Yes

Special Enrollment:
An eligible person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a qualifying event if he/she did not apply prior to his/her eligibility date or when eligible to do so. Such person's coverage date, family coverage date, and/or dependent's coverage date will be the effective date of the qualifying event or, in the event of Special Enrollment due to termination of previous coverage, the date of application for coverage.

Late Enrollment Accepted	Yes
When accepted	At open enrollment only
Preexisting Condition Waiting Period	No
Cobra Administrator	Group Administrator

Outpatient Prescription Drug Benefits

Outpatient Prescription Drug Benefits Prime

Prime Definitions:
HCSC Aggregate is defined on Prime's BET as Contract
HCSC Embedded is defined on Prime's BET as Aggregate

Covered Services Include:
Prescription equivalents for generic lansoprazole and omeprazole. Drugs that require, by federal law, a written prescription and injectable insulin and insulin syringes. Infertility drugs are included in the covered services. Benefits are available for drugs purchased from a participating pharmacy or professional provider (retail) or through the home delivery program. FDA-approved prescription and OTC tobacco cessation medications, when prescribed by a health care provider, are covered with $0 copay for two 90 day treatment regimens per calendar year. No coverage for tobacco cessation medications will be provided after the two 90 day cycles per calendar year.

Funding Type	Fully Insured

Contraceptives
FDA approved female contraceptives and OTC contraceptives are covered. Contraceptives are covered with no member share for one therapeutic equivalent. Up to a 12-month supply maybe dispensed at any time. Male condoms are not covered. Grandfathered plans and religious exempt plans must provide contraceptive coverage.

Drug Card Program	Traditional Drug Card (Non-Integrated)

Traditional (non-integrated) Drug Card is where member pays applicable copay or coinsurance at pharmacy. Not available with HSA

Is there a separate Drug Deductible?	No drug deductible
Is there a separate drug OPX?	No
Prescription Drug List	Enhanced (old Generics Plus; standard)

For Performance, no customization is allowed for individual drug categories.

Pricing Program Bundle - Cost Plus Insured Plans Only	D

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Outpatient Prescription Drug Benefits

Select the group's program bundle as of the plan effective date.
Bundle P requires prior Underwriting approval for new or renewal accounts.

Pharmacy Network	Advantage
If Preferred is selected, it must be paired with a differential amount.	
Prescription Drug Program Type	Four-Tier Program
Please indicate member's copayment, coinsurance or copayment/coinsurance as applicable.	
Four Tier Program	
Four Tier Program Type	Mixed Program
Mixed Program	
Retail Generic	Copay*
Copay	$20.00
Retail Preferred Brand	Copay*
Copay	$40.00
Retail Non Preferred Brand	Copay*
Copay	$50.00
Retail Specialty	CoInsurance %*
CoInsurance %	20%
Retail Minimum and Maximum amount per prescription apply:	No*
Home Delivery	2x Retail
Self-Injectables Covered	Yes (standard)
For Performance Drug List, coverage is based on the Drug List. Customization is not allowed.	
Days Supply -Retail	30 (standard)
Days Supply-Home delivery is 90 consecutive days.	
Member Pays the Difference (MPTD) applies to brand drugs when there is a generic equivalent available.	Yes
Note: MPTD is standard for all 2016 Insured business. It is standard but not mandatory for Insured 151+ groups.	
Dispense as Written (DAW 1) Override applicable (Penalty will not apply if Doctor indicates brand medically necessary.)	Yes
Note: DAW1 Override is not an option for Insured ≤150 groups.	
Diabetic Supplies, Insulin & Insulin Syringes Covered at	Ist Tier
For Performance Drug List, coverage is based on the Drug List. Customization is not allowed.	
Diabetic supplies include test strips, glucagon emergency kits, and urine testing reagents.	
Lancets will pay at $0 for any BCBSIL member with a drug card.	
For HSA - Coverage for Lancets applies after the deductible has been met.	
ACA Mandated Coverage	
Grandfathered Plan	No
ACA vaccinations, aspirin, vitamin D, folic acid, iron, fluoride, and breast cancer risk reducing medications are covered as preventive services with no member cost-sharing.	
Specialty Program	
Grandfathered	No
Available (30-day supply per fill) at in-network benefit level through Prime Specialty Pharmacy only. All other pharmacies payable at the non-participating pharmacy benefit level.	
Prescription Drug List Exclusions	Based on Basic or Enhanced Drug List

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Outpatient Prescription Drug Benefits

Implement prescription Drug List exclusions?	No
(Note: Categories will not be updated as of 1/1/2018.)	

Rx Exclusions

Prescription drug benefits will not be provided for: drugs used for cosmetic purposes; drugs that are not self administered; any devices or appliances, except as specifically mentioned above; any charges that a member may incur for the drugs being administered to the member; non-FDA-approved products.

Note: Weight Loss and Non-sedating Antihistamine drugs are not available coverage options for Insured 150 and under groups.

Additional Rx Exclusions

Are Weight Loss drugs covered?	Yes
Non-sedating Antihistamine Drugs Coverage	Based on Basic or Enhanced Drug List
Are Non-sedating Anithistamine drugs covered?	No
Sexual Dysfunction drugs are covered.	
Are Compound drugs covered?	No
Brand Name Proton Pump Inhibitor (PPI) Coverage	Based on Basic or Enhanced Drug List
Are Brand Name PPI's covered?	No

Payment for drugs obtained from a non-participating prescription drug provider:

(a) 75% of the eligible charge will be paid minus the Copayment amount, under the Copayment programs.

(b) 75% of the amount that would be paid if the drugs were purchased through a Participating Prescription Drug Provider will be paid under the coinsurance program.

Note: To confirm standard benefits, refer to the Pharmacy page on Product Central on FYIBlue.

Prescription Drug Utilization Management Programs

No customization is allowed for Utilization Management (UM). UM package for each drug list will automatically apply. Grandfathered groups will remain on their current UM programs if currently non-standard. Grandfathered business with standard UM programs will receive new programs as they are implemented upon renewal.

Vision Benefits

Coverage Level	HCSC Administered

Covered Services Include

Vision examinations, single vision lenses, bifocal lenses, trifocal lenses, lenticular lenses, contact lenses and frames.

Benefits are limited to one examination and one pair of lenses and a frame per benefit period (unless there has been a prescription change).

For plan years beginning on or after 9/23/2010, Vision test do not have a dollar maximum.

Benefit Period	Calendar Year
Payment Level	Other
Other	1 vision exam per calendar year at $40 copay, then 100%.

Exclusions

The following services and supplies will not be covered under this benefit program:

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Exclusions

(Please note, it is necessary to refer to the certificate booklet for a comprehensive list.)
Services and supplies which are not medically necessary, as determined by Blue Cross Blue Shield.
Services and supplies for which benefits are available under Workers' Compensation Law.
Services and supplies which are provided by or for which benefits are available from the government.
Services and supplies for any illness or injury that occurs after the coverage date and is a result of war.
Services and supplies that do not meet accepted standards of medical/dental practice.
Investigational services and supplies.
Custodial Care Service.
Long Term Care Service.
Respite Care Service, except as specifically mentioned under the Hospice Care Program.
Inpatient Private Duty Nursing Service.
Maintenance care
Services or supplies not specifically mentioned in the benefit booklet.
Services and supplies received on an inpatient basis as the result of antisocial actions which are not the result of mental illness.
Cosmetic surgery except for the correction of congenital deformities or resulting from accidental injuries, scars, tumors or disease.
Services or supplies for which one would not have to pay in the absence of this coverage.
Charges for failure to keep a visit or for completion of a claim form.
Personal hygiene or comfort or convenience items (air conditioner, physical fitness equipment, etc.).
Specialized equipment, special braces, splints, appliances, etc., except as specifically mentioned in the certificate booklet.
Prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient or unrelated to the treatment of an illness or injury.
Blood derivatives that are not officially classified as drugs.
Treatment of flat feet and subluxations of the foot.
Routine foot care (except for persons diagnosed with diabetes).
Services and supplies for Human Organ Transplants other than those specifically mentioned in the certificate booklet.
Maintenance Physical, occupational and speech therapy.
Speech therapy rendered for the treatment of psychological speech delay, behavioral problems, attention disorder, conceptual handicap or mental retardation.
Services and supplies to the extent benefits are duplicated because more than one family member is a member of the group and covered separately.
Diagnostic testing that is part of a survey or research study or that is investigational.
Routine physical examinations, routine diagnostic testing and immunizations (unless wellness benefits have been purchased).
Eye glasses, contact lenses and cataract lenses and the examination for prescribing or fitting them or for determining the refractive state of the eye (unless the vision benefit program has been purchased).
Hearing aids or the examination for prescribing or fitting hearing aids (unless the hearing benefit program has been purchased).
Wigs (also referred to as cranial prostheses).

Exclusion Changes Apply	No

Virtual Visits

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Virtual Visits

Virtual Visit	
MDLIVE (Standard Offering)	
PPO	
Medical	Yes
Medical Copay	Yes
Copay per virtual visit	$40.00
Program Deductible Applies	No
Behavioral Health	Yes
Behavioral Health Copay	Yes
Psychotherapy copay per virtual visit	$40.00
Program Deductible Applies	No

*NOTE: Behavioral Health Virtual Visit Applies to MHP unless group is exempt from MHP

Benefits Summary Report

Account Name: Prairie Central CUSD #8
Account Number: 106093
Benefit Agreement: 0004
Product: PPO Hospital & Physician Network
Division: IL
Status: EWFReady
Effective Date: 01-01-2018 to 12-31-2018
Funding Type: Insured

Additional Provisions Summary

Inpatient Hospital Benefits

Additional Provisions for Inpatient Hospital Benefits
PPO - Inpatient benefit: $500 copay applies, then pay at 80%.

Outpatient Hospital Benefits

Additional Provisions Pertaining to Outpatient Hospital Benefits
PPO Outpatient services and outpatient surgery: $250 copay applies, then pay at 80%.

Professional Service Benefits

Additional Provisions Pertaining to Professional Services Benefits
PPO - Outpatient surgical services: $250 copay applies, then pay at 100%

Chiro and Osteopathic manipulation services: pay at 50% IN and OUT of network, up to 12 visit max per calendar year. No deductible applies.

Allergy testing is covered at 100%, after deductible.

Other Covered Services

Additional Provisions Pertaining to Other Covered Services
$150 copay applies for ambulance transportation, then pay 100%.

Miscellaneous Benefits Provisions

Transportation, Lodging and Meals (for recipient and companion)	Yes
Transportation, Lodging and Meals Maximum	Other

Other
$10,000/transplant

Vision Benefits

Coverage Level	HCSC Administered
Payment Level	Other

Other
1 vision exam per calendar year at $40 copay, then 100%.

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Benefits Changes Summary

No benefit changes for this benefit period.