East Peoria Community High School/TMCSEA Health and Dental Plan
Summary of Benefits Effective July 1, 2019

MEDICAL SUMMARY OF BENEFITS – Grandfathered Plan	In-Network	Out-of-Network
INDIVIDUAL DEDUCTIBLE: Per Individual, per calendar year. Deductible amounts combine for In and Out-of-Network.	$300	$300
FAMILY DEDUCTIBLE: All individual deductible amounts will satisfy the Family deductible, but no one participant will be required to pay more than the Individual deductible amount.	$900	$900
OUT-OF-POCKET MAXIMUM INCLUDES: Annual medical deductible and coinsurance. It does not include copays or prescription drug benefits or organ transplants performed at a Non-Center of Excellence Facility. Out-of-Pocket amounts combine for In and Out-of-Network. All Individual out-of-pocket amounts will satisfy the Family out-of-pocket, but no one participant will be required to pay more than the Individual out-of-pocket amount.	$1,000 (Individual) $3,000 (Family)	$10,000 (Individual) $10,000 (Family)
CHOICE OF PRIMARY PROVIDER NETWORK: OSF Health Care–Direct Access Network (OSF-DAN) ***or*** UnityPoint Health Plus+ **WRAP & TRAVEL NETWORK:** PHCS		
THIRD PARTY ADMINISTRATOR: Consociate Health 2828 North Monroe Avenue, Decatur IL 62526 Phone: 800-798-2422 | Fax: 217-423-4575 | Website: www.consociatehealth.com		
PRECERTIFICATION NOTIFICATION REQUIREMENTS: 72 hours advanced precertification for all scheduled inpatient admissions, overnight hospital stays, and dialysis required. Within 2 Business days following the admission for Urgent/ Emergency Inpatient admissions.		
COVERED MEDICAL EXPENSES	**PLAN PAYS**	
*** Deductible must be met before benefits are paid where noted.**	**In-Network**	**Out-of-Network**
PREVENTATIVE CARE:		
Routine/Preventive Adult and Child Care - office visits, labs, x-rays, vision/hearing screening, immunizations, child flu/pneumonia immunizations	100% Coinsurance	Not Covered
Routine/Preventative Pap smear, Mammogram, PSA Testing, breast feeding support and supplies, adult care flu/pneumonia immunizations	100% Coinsurance	60% Coinsurance, after deductible*
Routine/Preventative Adult Care Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings (including related services)	80% Coinsurance, after deductible*	60% Coinsurance, after deductible*
Contraceptive Methods - devices (e.g. IUD or diaphragms), injections, implant insertion/removal, emergency contraceptives and condoms; sterilization - tubal ligation and vasectomy (excludes birth control pills/patches, spermicides -see Prescription Drug Benefits)	100% Coinsurance	60% Coinsurance, after deductible*
PHYSICIAN SERVICES:		
Professional office visits include primary care, specialist care, inpatient hospital visits, inpatient surgery and anesthesia, outpatient hospital and ambulatory surgical center visits, mental health and chemical dependency therapy visits and behavioral health residential services, chiropractic exams, manipulations, chiropractic labs and x-rays	80% Coinsurance, after deductible*	60% Coinsurance, after deductible*
High Tech diagnostic services, labs and x-rays at a physician's office, qualified practitioner pathology and radiology, skilled nursing facility (81-day calendar year limit), home health care (80 visit per year limit), outpatient private duty nursing ($12,000 per year limit), outpatient surgery and anesthesia	80% Coinsurance	60% Coinsurance
INPATIENT FACILITY SERVICES: Hospital Room and Board, ancillary facility services, partial hospitalization. Precertification Required on inpatient stays.	80% Coinsurance	60% Coinsurance, after deductible*
OUTPATIENT HOSPITAL and AMBULATORY SURGICAL CENTER FACILITY SERVICES:		
Outpatient Hospital and Ambulatory Surgical Center facility services, surgical and non-surgical services and ancillary services	80% Coinsurance	60% Coinsurance
Outpatient Hospital and Ambulatory Surgical Center High Tech diagnostic services, labs and x-rays, outpatient occupational, speech, physical, cognitive therapy, hospice care, cardiac rehab phase I and II	80% Coinsurance	60% Coinsurance, after deductible*
EMERGENCY ROOM FACILITY, Ancillary Services – Emergent & Non-Emergent, Urgent Care Facility – Facility, ancillary services and qualified practitioner services.	80% Coinsurance	
EMERGENCY MEDICAL TRANSPORTATION	80% Coinsurance, after deductible*	
OTHER COVERED SERVICES: includes respiratory and pulmonary therapy, chemotherapy, radiation, durable medical equipment, prosthetics	80% Coinsurance, after deductible*	60% Coinsurance, after deductible*
PRESCRIPTION DRUG BENEFITS: Retail and Mail order up to a 90-day supply 2 times copay for 31-90 day supply. Specialty drugs are limited to a 30-day supply per fill - $10 Copay Over-the-counter Program - $0 copay	**30 Day Supply** Generic $5 Preferred Brand $10 Non-Preferred Brand $40	**30 Day Supply:** Generic $5 Preferred Brand $10 Non-Preferred Brand $40

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DENTAL SUMMARY OF BENEFITS		
CALENDAR YEAR DEDUCTIBLE All Individual deductible amounts will satisfy the Family deductible, but no one participant will be required to pay more than the Individual deductible amount	**Individual** **$50**	**Family** **$150**
INDIVIDUAL MAXIMUM BENEFIT Preventative, Basic Major, Restorative and Prosthodontic Services	**$1,500 per Calendar Year**	
COVERED DENTAL EXPENSES	**PLAN PAYS**	
PREVENTATIVE SERVICES • **Routine Exams and Cleanings** • **X-rays** • **Fluoride Treatments (to age 16)** • **Space Maintainers (to age 14)** • **Sealants** • **Emergency Evaluation and Palliative (Emergency) Treatment**	**Covered Expense is payable at 100%, not subject to Deductible**	
BASIC SERVICES • **Fillings** • **Extractions** • **Stainless Steel Crowns** • **Oral Surgery** • **Drug Injections/General Anesthesia/IV sedation** • **Periodontal Evaluations/Maintenance** • **Periodontal Scaling/Root Planing/ Site Therapy** • **Endodontics/Root Canals** • **Harmful Habit Appliance** • **Occlusal Guards** • **Maintenance/Repairs of Bridges and Partial and Complete Dentures** • **Tissue Conditioning** • **Pulpotomies on Primary Teeth** • **Full Mouth Debridement**	**Covered Expense is payable at 80%, not subject to Deductible**	
MAJOR RESTORITIVE AND PROSTHODONTIC SERVICES • **Crowns and their maintenance/repairs** • **Inlays or Onlays and their maintenance/repairs** • **Post/Core Build-ups for Crowns** • **Gold Foil Fillings and their maintenance/repairs** • **Occlusal Adjustments when done in conjunction with periodontal surgery** • **Denture/Bridgework**	**After Deductible, Covered Expense is payable at 50%**	
ORTHODONTIA SERVICES **Individual Lifetime Maximum Benefit for Orthodontic Services is $1,500 per covered person. Child orthodontia – Covers children to age 19**	**Covered Expenses is payable at 50%, not subject to Deductible**	

FILING CLAIMS
Generally, your health care provider will submit your claim to us for processing. You will not have to initially complete any claim forms from us. After we receive a claim, we may need additional information from you. We will let you know by letter if we need additional information such as accident details, signed authorization to obtain medical information, Subrogation forms. If your provider will not file your claim, please contact us at 800-798-2422, and we will assist you in getting your claim filed.

On Line Tools: View your claim information securely on line, anywhere, anytime with Consociate Health at www.consociatehealth.com

Still need assistance?
Call Consociate Health:
800-798-2422

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