

## Benefits Summary Report

**Account Name:** Prairie Central CUSD #8  
**Account Number:** 106093  
**Benefit Agreement:** 0001  
**Product:** BlueEdge HSA (PPO 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.:** 0001  
**Group Name:** Option 1  
**Group & Section Numbers:** PE2426/ 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

### HSA Composition

#### BlueEdge (PPO Hospital & Physician)

**HSA Administered by:** Other Vendor\*  
**Vendor information** Morton Community Bank  
804 W. Oak Street  
Fairbury  
IL 61739

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### HSA Composition

Phone Number 815-692-4000

Pharmacy Benefit Manager Prime Therapeutics

**NOTE: For HSA, Rx MUST share accums with Medical Accums. 4th quarter carryover does not apply**

For Custom Insured & ASO groups, the fully integrated drug card is drug coverage administered as part of a Drug Card benefit under Outpatient Prescription Drugs and can be a copay or coinsurance benefits. The Drug Card benefits for HSA plans only apply AFTER the deductible has been met per IRS guidance.

The ID Number is needed for all PBMs except for Prime Therapeutics.

**Additional Spending Accounts paired with HSA:** NO

### HSA - 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

**Program Deductible** Separate Aggregate

Benefits begin after the program deductible has been met. Refer to US Treasury website for the minimum HSA deductible required.

#### PPO

Individual \$1,750.00

Family \$3,500.00

#### Non-PPO

Individual \$3,500.00

Family \$7,000.00

Benefits begin after the family program deductible has been met

**Prior carrier Deductible Credit Applies (new plans only)** No

Note: 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 Provisions 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 Aggregate

Benefits will be paid at 100% after the entire family out-of-pocket expense limit has been met. OPXs may be common or separate and MUST mirror logic selected for deductible.

**Separate Aggregate PPO/Non PPO OPX**

#### PPO

Individual \$1,750.00

Family \$3,500.00

#### Non-PPO

Individual \$9,500.00

Family \$19,000.00

All charges applied to the Individual OPX amount will be applied towards the Family OPX amount. Once the Family OPX is met, no more OPX is required for any Individual. When the Family OPX is reached, no further OPX will have to be satisfied for the remainder of that calendar/contract year.

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### HSA - Overall Program Payment Provisions

**Prior carrier OPX Credit Applies (new plans only)**

No

Note: 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 Provisions section to also share Out of Network accums.

**OPX Excludes**

Grandfather Plan

No

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.

Additional OPX Exclusions:

No

### HSA - Inpatient Hospital Benefits

Benefits begin after the program deductible has been met.

**Inpatient Hospital/Facility Services**

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

**PPO**

General Payment Level

100%

**Non-PPO**

General Payment Level

50%

**Skilled Nursing Facility (extended care facility)**

Plan skilled nursing facility services are paid at the inpatient hospital payment level stated above. (standard)

Days

No limit on number of days (standard)

**Coordinated Home Care (home health care)**

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

Visits

No limit on number of visits (standard)

**Hospice Care**

Plan hospice program services are paid at the PPO/NON PPO general payment level stated above. No annual or lifetime dollar maximums applies.

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

### HSA - Outpatient Hospital Benefits

Benefits begin after the program deductible has been met.

**Outpatient Hospital/Facility Services**

Includes benefits for surgery, radiation therapy, chemotherapy, electroconvulsive therapy, renal dialysis treatments, diagnostic services and cardiac rehabilitation services, mammograms, pap smear tests, prostate tests, and digital rectal examinations.

**PPO**

Payment Level

100%

**Non-PPO**

Payment Level

50%

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### HSA - Outpatient Hospital Benefits

#### Outpatient Surgical Services

##### PPO

Payment Level 100%

##### Non-PPO

Payment Level 50%

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#### Outpatient Diagnostic Services

##### PPO

Payment Level 100%

##### Non-PPO

Payment Level 50%

---

#### Ambulatory Surgical Facility

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

### HSA - Professional Service Benefits

#### Coverage Level

Benefits begin after the program deductible has been met.

#### Covered Services Included

Allergy injections and allergy testing, anesthesia, assist at surgery, bone mass measurement and osteoporosis, cardiac rehab services, certain oral surgery procedures, chemotherapy, chiropractic and osteopathic manipulations, colorectal cancer screening, diagnostic services (x-ray/lab), diabetes management training, digital rectal examinations, durable medical equipment, electroconvulsive therapy, home infusion therapy, inpatient consultations, mammograms, medical care visits (inpatient & outpatient), occupational therapy, outpatient contraceptive services, ovarian cancer screening, pap smear tests, physical therapy, prostate tests, radiation therapy, renal dialysis treatments, speech therapy, leg, back, arm, and neck braces, oxygen and its administration, prosthetic appliances and surgery.

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

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#### General payment level

##### PPO

Payment Level 100%

##### Non-PPO

Payment Level 50%

---

#### Office Visit Copayment

##### PPO

Copay No

##### Non PPO

Copay No

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#### Outpatient Surgical Services

##### PPO

Payment Level 100%

##### Non-PPO

Payment Level 50%

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### HSA - Professional Service Benefits

#### Outpatient Diagnostics

##### PPO

Payment Level 100%

##### Non-PPO

Payment Level 50%

#### 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

### HSA - Outpatient Emergency Benefits

#### Emergency Medical and Emergency Accident Care (EMC/EAC)

Includes benefits for the initial treatment of medical emergency. Benefits are paid after the program deductible has been met.

Hospital Payment Level 100%

Physician Payment Level 100%

Office Visit Copayment No

**Do Emergency medical and Emergency Accident pay the same?** Yes

### HSA - 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)**

**Benefits begin after the program deductible has been met.**

**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.

**Employee Assistance Program:** No

**Is this an Exempt Group?** No

### Preventive Health Benefits

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### 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

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

### HSA - 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, medical and surgical dressings, private duty nursing, supplies, cast and splints.

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### HSA - Other Covered Services

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

### Miscellaneous Benefits Provisions

**Infertility Coverage**

**Coverage Type**

**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 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



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### Eligibility Provisions

|   |  |
|---|--|
| <b>Eligible Employees</b>                   | Definition of eligible person stated in Group Policy   |
| <b>Dependents Covered</b>                   | Yes  |
| <b>Eligible Dependents</b>                  | 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   |
| <b>Dependent Child Limiting Age</b>         | Eligible military personnel are covered up to age 30.  |
| Dependent Age                               | 26   |
| Coverage Ends                               | End of the month following the limiting age birthday   |
| <b>Student Age</b>                          | No   |
| <b>Student Certification</b>                | No   |
| <b>Medicare Secondary Payer applies</b>     | Yes  |
| <b>Special Enrollment:</b>                  | 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. |
| <b>Late Enrollment Accepted</b>             | Yes  |
| When accepted                               | At open enrollment only  |
| <b>Preexisting Condition Waiting Period</b> | No   |
| <b>Cobra Administrator</b>                  | Group Administrator  |

### HSA - Outpatient Prescription Drug Benefits

|  |   |
|--|---|
| <b>Outpatient Prescription Drug Benefits</b> | Prime   |
| <b>Prime Definitions:</b>                    | <p>HCSC "Aggregate" is called "Contract/Family" on Prime's Benefit Edit Tool (BET)</p> <p>HCSC "Embedded" is called "Aggregate/Individual" on Prime's Benefit Edit Tool (BET)</p>   |
| <b>Covered Services Include</b>              | 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. Prescription and OTC Smoking Cessation drugs are covered at drug status. |
| <b>Funding Type</b>                          | Fully Insured   |
| <b>Contraceptives</b>                        | ACA and 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.   |

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### HSA - Outpatient Prescription Drug Benefits

#### Drug Card Program - Integrated

Integrated Drug Card is where the benefit which allows integration with medical and pharmacy accrums (Deductibles and Out of Pocket amounts.)

#### HSA Must Share Deductible and OPX

#### Pricing Program Bundle - Cost Plus Insured Plans Only

D

Select the group's program bundle as of the plan effective date.

Bundle P requires prior Underwriting approval for new or renewal accounts.

#### Prescription Drug List

Enhanced (old Generics Plus; standard)

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

#### Pharmacy Network

Advantage

If Preferred is selected, it must be paired with a differential amount.

#### Prescription Drug Program Type

Other\*

Please indicate member's copayment, coinsurance or copayment/coinsurance as applicable.

#### Other

All tiers:  
 PPO- 100% after deductible  
 NON-PPO- 50% after deductible

#### 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 &#8804;150 groups.

#### Diabetic Supplies

For Performance Drug List, coverage is based on the Drug List. Customization is not allowed.

#### Diabetic Supplies, Insulin and Insulin Syringes Covered at

Drug status

Diabetic supplies include test strips, glucagon emergency kits and urine testing reagents.

Lancets will pay \$0 for any BCBSIL member with a drug card.

For HSA - Coverage for Lancets applies after the deductible has been met.

#### ACA Vaccinations covered

Yes

#### ACA aspirin, vitamin D, folic acid, iron and fluoride Covered

Yes

#### 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

Implement prescription Drug List exclusions?

No

(Note: Categories will not be updated as of 1/1/2018.)

#### Rx Exclusions

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### HSA - Outpatient Prescription Drug Benefits

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

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

#### 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.

### Exclusions

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

(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

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### Exclusions

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

### 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 covered at 100% after deductible per calendar year.

### HSA Virtual Visits

Benefits begin after the program deductible has been met.

Virtual Visit-Effective 1/1/17 for Non-Grandfathered and 2/1/17 for Grandfathered Status

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### HSA Virtual Visits

**MDLIVE (Standard Offering)**

**PPO**

|  |      |
|--|------|
| <b>Medical</b>                                 | Yes  |
| <b>Medical Copay</b>                           | No   |
| <b>Program Deductible Applies Then Paid at</b> | 100% |
| <b>Behavioral Health</b>                       | Yes  |
| <b>Behavioral Health Copay</b>                 | No   |
| <b>Program Deductible Applies Then Paid at</b> | 100% |

\*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:** 0001  
**Product:** BlueEdge HSA (PPO Network)

**Division:** IL  
**Status:** EWFReady  
**Effective Date:** 01-01-2018 to 12-31-2018  
**Funding Type:** Insured

### Additional Provisions Summary

#### Miscellaneous Benefits Provisions

|   |       |
|---|-------|
| Transportation, Lodging and Meals (for recipient and companion) | Yes   |
| Transportation, Lodging and Meals Maximum                       | Other |
| Other   |       |
| \$10,000/transplant   |       |

#### HSA - Outpatient Prescription Drug Benefits

|                                       |        |
|---------------------------------------|--------|
| Outpatient Prescription Drug Benefits | Prime  |
| Drug Card Program - Integrated        |        |
| Prescription Drug Program Type        | Other* |
| Other                                 |        |
| All tiers:                            |        |
| PPO- 100% after deductible            |        |
| NON-PPO- 50% after deductible         |        |

#### Vision Benefits

|   |                   |
|---|-------------------|
| Coverage Level  | HCSC Administered |
| Payment Level   | Other             |
| Other   |                   |
| 1 vision exam covered at 100% after deductible per calendar year. |                   |

## **Benefits Summary Report**

**Account Name:** Prairie Central CUSD #8

**Division:** IL

**Account Number:** 106093

**Status:** EWFReady

**Benefit Agreement:** 0001

**Effective Date:** 01-01-2018 to 12-31-2018

**Product:** BlueEdge HSA (PPO Network)

**Funding Type:** Insured

## **Benefits Changes Summary**

No benefit changes for this benefit period.