COUNTY BOARD ADDENDUM

County of Champaign, Urbana, Illinois
Thursday, September 24, 2009 – 7:00 p.m.

Lyle Shields Meeting Room, Brookens Administrative Center
1776 East Washington Street, Urbana, Illinois

Page Number

XI. Committee Reports:

C. Policy, Personnel, & Appointments Committee:

*Roll Call
**Roll call and 18 votes
***Roll call and 21 votes
****Roll call and 14 votes
Except as otherwise stated, approval requires the vote of a majority of those County Board members present.

County Board members and guests are encouraged to park in the north parking lot, off Lierman Avenue, and enter the Brookens facility through the north door. The Brookens Administrative Center is an accessible facility. For additional information, contact Kay Rhodes in the County Administrator's Office at (217) 384-3776

RESOLUTION NO. 7136

RESOLUTION APPROVING EMPLOYEE INSURANCE BENEFITS FOR FY2010

WHEREAS, The Champaign County Board annually determines the employee insurance benefits to be provided in the ensuing fiscal year; and

WHEREAS, The County Administrator and Insurance Specialist have recommended to the County Board approval of the recommendations for employee insurance benefits for FY2010 as documented in Attachment A to this Resolution;

NOW, THEREFORE, BE IT AND IT IS HEREBY RESOLVED by the County Board of Champaign County, Illinois that the FY2010 employee insurance benefits as recommended in Attachment A to this Resolution shall be and hereby are approved for FY2010.

PRESENTED, ADOPTED, APPROVED, AND RECORDED this 24th day of September, 2009.

_____
C. Pius Weibel, Chair
Champaign County Board

ATTEST:

_____
Mark Shelden, County Clerk and
Ex-Officio Clerk of the County Board

ATTACHMENT A

FY2010 HEALTH INSURANCE PLANS

RECOMMENDATION FOR FY2010 HEALTH INSURANCE PLANS

The following health insurance plans shall be made available to county employees, for FY2010:

Health Alliance Plans –

Health Alliance Custom HMO 80/20 Plan with Prescription drug benefit $10/$20/$40
Health Alliance Custom HRA PPO Plan with Prescription drug benefit $10/$20/$40

The County's contribution for health insurance for FY2010 shall be $521/month, which is equal to the cost single premium for the 80/20 Plan, for all non-bargaining employees with the exception of the non-bargaining employees of the Champaign County Nursing Home and Regional Planning Commission.

The County's contribution for health insurance for FY2010 shall be $478.40/month for non-bargaining employees of the Champaign County Nursing Home.

The County's contribution for health insurance for FY2010 for non-bargaining employees of the Regional Planning Commission will be set by the Regional Planning Commission.

For employees selecting the HRA Plans, the County will establish an HRA and after the first $100.00 of deductible has been paid by the employee, the County will pay the next $800.00 in deductible expense for employees on the HRA Plan.

Premium contributions for the County's bargaining employees will be consistent with current contract language.

RECOMMENDATION for FLEXIBLE SPENDING ACCOUNT LIMITS

The annual amount an employee may set aside in a flexible spending account for medical expenses is increased from $2,500/year to $3,600/year for FY2010.

RECOMMENDATION FOR FLEXIBLE SPENDING ACCOUNT/HEALTH REIMBURSEMENT ACCOUNT ADMINISTRATION

Champaign County Employee Flexible Spending Accounts will be administered by Benefit Planning Consultants, as the county's third party administrator for flexible spending and health reimbursement accounts for the plan year December 1, 2009 to November 30, 2010 at a rate of $4.80/flexible spending account participant/month; and a rate of $5.50/health reimbursement account participant/month. The total anticipated annual cost to the County is $14,400.

RECOMMENDATION FOR FY2010 LIFE INSURANCE

The life insurance benefit program for County Employees shall be through Lincoln Financial Group for the period December 1, 2009 to November 30, 2010 at a rate of $.13 per $1,000 of coverage per employee per month. The premium is paid by the County.

RECOMMENDATION FOR DENTAL INSURANCE

The dental insurance benefit program offered to County Employees shall be through Trustmark Insurance Company for the policy period January 1, 2010 to December 31, 2010. The entire premium is paid by the employee.

Trustmark PPO MONTHLY Premium		Trustmark Premier MONTHLY Premium	
Single	$15.76	Single	$27.48
Employee + child(ren)	$44.90	Employee + child(ren)	$55.36
Employee + spouse	$32.00	Employee + spouse	$54.94
Family	$72.26	Family	$102.34

RECOMMENDATION FOR OPTIONAL LIFE INSURANCE

The following optional life insurance program will be offered to county employees for FY2010, with the entire premium paid by the employee:

1. **Optional Term Life insurance through Lincoln Financial Group – premiums to be paid by the employee.**
2. **Optional Universal Life insurance through AllState Insurance Company – premiums to be paid by the employee.**

RECOMMENDATION FOR OPTIONAL VOLUNTARY INSURANCE

The following optional voluntary insurance programs will be offered to county employees for FY2010, with the entire premium paid by the employee:

1. **Voluntary Group Accident insurance through AllState Insurance Company – premiums to be paid by the employee.**
2. **Voluntary Group Cancer insurance through AllState Insurance Company – premiums to be paid by the employee.**
3. **Voluntary Critical Illness insurance through AllState Insurance Company – premiums to be paid by the employee.**

CHAMPAIGN COUNTY ADMINISTRATIVE SERVICES

1776 EAST WASHINGTON
URBANA, IL 61802
(217) 384-3776
(217) 384-3765 – PHYSICAL PLANT
(217) 384-3896 – FAX
(217) 384-3864 – TDD
Website: www.co.champaign.il.us

ADMINISTRATIVE SUPPORT
DATA PROCESSING
MICROGRAPHICS
PURCHASING
PHYSICAL PLANT
SALARY ADMINISTRATION

MEMORANDUM

TO: **C. Pius Weibel, Chair, and MEMBERS of the CHAMPAIGN COUNTY BOARD**

FROM: **Deb Busey, County Administrator** DB
Debbie Chow, Insurance Specialist DChow

DATE: **September 24, 2009**

RE: **RECOMMENDATIONS FOR EMPLOYEE INSURANCE BENEFITS FOR FY2010 - Health, Flexible Spending Accounts, Life, Dental & Optional Life**

The following recommendations are for employee insurance benefits for the December 1, 2009 to November 30, 2010 benefit plan year.

RECOMMENDATION FOR FY2010 HEALTH INSURANCE PLANS

We recommend the following health insurance plans be made available to county employees, for FY2010:

Health Alliance Plans –

Health Alliance Custom HMO 80/20 Plan with Prescription drug benefit $10/$20/$40
Health Alliance Custom HRA PPO Plan with Prescription drug benefit $10/$20/$40

We recommend the County's contribution for health insurance for FY2010 be $521/month, which is equal to the cost single premium for the 80/20 Plan, for all non-bargaining employees with the exception of the non-bargaining employees of the Champaign County Nursing Home and Regional Planning Commission.

We recommend the County's contribution for health insurance for FY2010 be $478.40/month for non-bargaining employees of the Champaign County Nursing Home.

We recommend that for employees selecting the HRA Plans, the County establish an HRA and after the first $100.00 of deductible has been paid by the employee, the County will pay the next $800.00 in deductible expense for employees on the HRA Plan.

The Regional Planning Commission will set the employer contribution rate for non-bargaining employees.

Premium contributions for the County's bargaining employees will be consistent with current contract language.

Summary sheets regarding the benefits provided with each of these plans are attached to this Memorandum for your information.

RECOMMENDATION for FLEXIBLE SPENDING ACCOUNT LIMITS

Currently, the maximum annual amount an employee may set aside in a medical expense Flexible Spending Account is $2,500. Several employees have requested the maximum amount be increased. In response to those requests, we recommend the County Board approve an increase to the maximum amount an employee may set aside in a medical expense Flexible Spending Account to $3,600 annually.

We recommend approval that annual amount that employee may set aside for medical expenses be increased from $2,500/year to $3,600/year.

RECOMMENDATION FOR FLEXIBLE SPENDING ACCOUNT/HEALTH REIMBURSEMENT ACCOUNT ADMINISTRATION

The following recommendation is for third party administration of the county's flexible spending and health reimbursement accounts. Benefit Planning Consultants (BPC) is a local company, which has been in business in Champaign County for 25 years. BPC has an excellent reputation with numerous local clients. BPC is the current third party administrator of the county's flexible spending accounts and health reimbursement accounts.

We recommend approval of a contract with Benefit Planning Consultants, Inc. as the county's third party administrator for flexible spending and health reimbursement accounts for the plan year December 1, 2009 to November 30, 2010 at a rate of $4.80/flexible spending account participant/month and a rate of $5.50/health reimbursement account participant/month, anticipated annual cost of $14,400.

RECOMMENDATION FOR FY2010 LIFE INSURANCE

Lincoln Financial Group provided the county with a three year rate guarantee at last year's renewal. This recommendation is for the second year of the three year rate guarantee.

We recommend renewal of the life insurance benefit program through Lincoln Financial Group for the period December 1, 2009 to November 30, 2010 at a rate of $.13 per $1,000 of coverage per employee per month.

RECOMMENDATION FOR DENTAL INSURANCE

Trustmark Insurance Company provided the county with a two year rate guarantee at last year's renewal. This recommendation is for the second year of the two year rate guarantee.

We recommend approval of the dental insurance benefit program through Trustmark Insurance Company for the policy period January 1, 2010 to December 31, 2010. The entire premium is paid by the employee.

Trustmark PPO MONTHLY Premium		Trustmark Premier MONTHLY Premium	
Single	**$15.76**	**Single**	**$27.48**
Employee + child(ren)	**$44.90**	**Employee + child(ren)**	**$55.36**
Employee + spouse	**$32.00**	**Employee + spouse**	**$54.94**
Family	**$72.26**	**Family**	**$102.34**

RECOMMENDATION FOR OPTIONAL LIFE INSURANCE

We recommend the following be offered to county employees for FY2010:

1. **Optional Term Life insurance through Lincoln Financial Group – premiums to be paid by the employee.**
2. **Optional Universal Life insurance through AllState Insurance Company – premiums to be paid by the employee.**

RECOMMENDATION FOR OPTIONAL VOLUNTARY INSURANCE

We recommend the following be offered to county employees for FY2010:

1. **Voluntary Group Accident insurance through AllState Insurance Company – premiums to be paid by the employee.**
2. **Voluntary Group Cancer insurance through AllState Insurance Company – premiums to be paid by the employee.**
3. **Voluntary Critical Illness insurance through AllState Insurance Company – premiums to be paid by the employee.**

Thank you for your consideration of the Employee Benefits Package for FY2010. We will be present at your meeting to further address questions or concerns you may have.

attachments

Proposal Rates for:
Champaign County Employees
Group #: H0023A
Current Plan Sole Source: 11676

LGHMO410 $10/20/40 - 1109
Effective Period: 12/01/2009 through 11/30/2010

Co-payments apply to office visits with Physicians, Physician Assistants, Nurses and other mid-level providers.

Prescription Drug Benefit Co-payments
$10 generic drugs, $20 brand name, preferred drugs or $40 brand name, non-preferred drugs

Premium Rates:	
EMPLOYEE:	$521.00
FAMILY:	$958.00

"Primary Medicare Eligible" Rates:	
SINGLE (with "Primary Medicare Eligibility"):	$460.00
TWO-PERSON (both with "Primary Medicare Eligibility"):	$920.00
TWO-PERSON (one with "Primary Medicare Eligibility"):	$981.00
FAMILY 3+ (one with "Primary Medicare Eligibility"):	$897.00

Total Increase: 5%

Approved by: _____
(Benefits Administrator)

Date Approved: _____

Please Note:
These rates assume that Health Alliance Medical Plans, Inc. is offered alongside other health insurance options. A minimum of 25% of all eligible employees at Champaign County Employees must enroll in the Health Alliance plan to meet our minimum participation requirements, and the employer contribution methodology must be non-discriminatory. In the event that membership changes by 20% or more during the contract year OR the conditions listed above are not met, Health Alliance reserves the right to review, revise and/or rescind this offer.

Health Alliance

Proposal Rates for:
Champaign County Employees
Group #: H0023A
Current Plan Sole Source: 11677

H0023A NSPPO500 $10/20/40 - 1209
Effective Period: 12/01/2009 through 11/30/2010

Co-payments apply to office visits with Physicians, Physician Assistants, Nurses and other mid-level providers.

Prescription Drug Benefit Co-payments
$10 generic drugs, $20 brand name, preferred drugs or $40 brand name, non-preferred drugs

Premium Rates:	
EMPLOYEE:	$392.00
EMPLOYEE + 1	$763.00
FAMILY:	$1174.00

"Primary Medicare Eligible" Rates:	
SINGLE (with "Primary Medicare Eligibility"):	$355.00
TWO-PERSON (both with "Primary Medicare Eligibility"):	$689.00
TWO-PERSON (one with "Primary Medicare Eligibility"):	$726.00
FAMILY 3+ (one with "Primary Medicare Eligibility"):	$1137.00

Total Increase: 5%

Approved by: _____
(Benefits Administrator)

Date Approved: _____

Please Note:
These rates assume that Health Alliance Medical Plans, Inc. is offered alongside other health insurance options. A minimum of 25% of all eligible employees at Champaign County Employees must enroll in the Health Alliance plan to meet our minimum participation requirements, and the employer contribution methodology must be non-discriminatory. In the event that membership changes by 20% or more during the contract year OR the conditions listed above are not met, Health Alliance reserves the right to review, revise and/or rescind this offer.

Health Alliance

301 S. Vine St.
Urbana, IL 61801-3347
1-800-851-3379
www.healthalliance.org

Health Alliance HMO Group Plan Description of Coverage Worksheet

Maximums/Deductibles/Limitations	Description of Coverage
Your Doctor	Choose a Primary Care Physician from the Provider Directory in your Service Area. Female Members may also select a Woman's Principal Health Care Provider from the Provider Directory in your Service Area.
Plan Year Deductibles	
Medical	Not applicable
Plan Year Out-of-Pocket Maximums	
Medical	Single: $1,500 Family: $3,000
Specialty (including Infertility) Prescription Drugs	Single: $1,500 Family: $4,500
Lifetime Maximum Benefits	
Overall	Not applicable
Pre-Existing Condition Limitation	50% (if applicable)*
Plan Year Maximum Benefits	
Outpatient (including Infertility) Prescription Drugs	Unlimited per Member
Specialty (including Infertility Specialty) Prescription Drugs	$300,000 per Member
See Service/Benefit section for visit, day and unit limits	

	Service/Benefit	Description of Coverage	Health Alliance Pays	You Pay
In the Hospital	**Hospital Care**			
	Inpatient Care Days	Unlimited number of days	80% Coinsurance	20% Coinsurance
	Room and Board	Semi-private room		
	Surgeon's Fees	Included		
	Doctor's Visits	Included		
	Medications	Included		
	Other Miscellaneous	Except personal comfort items		
Emergency Services	**Emergency Services**	ER Copay is waived if admitted to the Hospital when Plan requires an inpatient Hospital Copay or Coinsurance. Includes services received in or outside of the Service Area for an Emergency Medical Condition.	100 % after Copay	$125 Copay per visit
	Emergency Post-Stabilization Services	Same as Hospital Care	100% after Copay/ Coinsurance	Hospital Care Copay/ Coinsurance applies

	Service/Benefit	Description of Coverage	Health Alliance Pays	You Pay
Emergency Services	**Emergency Ambulance Transportation**	Ground ambulance for Emergency Medical Condition; air ambulance when cannot be safely transported by ground. Includes services received in or outside of the Service Area for an Emergency Medical Condition.	100 % after Copay	$100 Copay
In the Doctor's Office *(Each Office Visit or Routine Physical Exam requires the Copayment or Coinsurance listed. In addition, other services obtained while in the office may require an additional Copayment or Coinsurance amount.)*	**Office Visit – Primary Care**	Office visit charge. In addition, other services obtained while in the office may require an additional Copayment or Coinsurance	100 % after Copay	$20 Copay per visit
	Office Visit – Specialty Care	Office visit charge. In addition, other services obtained while in the office may require an additional Copayment or Coinsurance	100 % after Copay	$20 Copay per visit
	Routine Physical Exams	Well child care and annual and school physicals	100 % after Copay	$20 Copay per visit
	Immunizations	Preventive immunizations and inoculations for Wellness Care	100 % after Copay	$0 Copay per service
	Allergy Treatment and Testing	Treatment and testing	80% Coinsurance	20% Coinsurance
	Wellness Care	Includes mammograms, PAP smears, prostate screening, colorectal screening, cholesterol screening, glaucoma screening, ovarian cancer testing and osteoporosis screening *(If service is not provided in the Physician's office, it may be subject to the Outpatient Surgery Copayment or Coinsurance.)*	100 % after Copay	$0 Copay per service
Medical Services	**Diagnostic Tests and X-Rays**	X-Rays, laboratory tests and pathology services	80% Coinsurance	20% Coinsurance
	Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scanning	Outpatient MRIs and CTs. Does not include MRIs and CTs performed during a Hospital stay.	80% Coinsurance	20% Coinsurance
	Outpatient Surgery/Procedures	Services performed in the Outpatient department of a Hospital, free-standing surgical center or free-standing medical clinic. The Copayment and/or Coinsurance applies to any associated facility fee that is charged for the surgery or procedure.	80% Coinsurance	20% Coinsurance

	Service/Benefit	Description of Coverage	Health Alliance Pays	You Pay
Medical Services	**Maternity Care**			
	Hospital Care	Minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a delivery by cesarean section	100% after Copay/ Coinsurance	Hospital Care Copay/ Coinsurance applies
	Routine Prenatal Care	Routine prenatal visits and postpartum checkup	80% Coinsurance	20% Coinsurance
	Newborn Care	Minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a delivery by cesarean section	80% Coinsurance	20% Coinsurance
	Infertility Services	Diagnostic and treatment services	100% after Copay or Coinsurance	Office Visit Copay or Coinsurance and Hospital Care Copay/Coinsurance apply
	Serious Mental Health Care			
	Outpatient	60 visits per Plan Year for each service	80% Coinsurance	20% Coinsurance
	Inpatient	45 days per Plan Year for each service	80% Coinsurance	20% Coinsurance
	Non-Serious Mental Health Care			
	Outpatient Services received from a Participating Provider	20 visits per Plan Year combined Participating Provider and Non-Participating Provider for each service	80% Coinsurance	20% Coinsurance
	Inpatient Services received from a Participating Provider	10 days per Plan Year combined Participating Provider and Non-Participating Provider for each service	80% Coinsurance	20% Coinsurance
	Inpatient and Outpatient Services received from a Non- Participating Provider*		50% Coinsurance	50% Coinsurance
	Substance Abuse Treatment			
	Outpatient	20 visits per Plan Year for each service	80% Coinsurance	20% Coinsurance
	Inpatient	10 days per Plan Year for each service	80% Coinsurance	20% Coinsurance

	Service/Benefit	Description of Coverage	Health Alliance Pays	You Pay
Medical Services	**Rehabilitation Services** (speech, physical and occupational)			
	Outpatient (includes home setting)	Combined total of 60 visits per condition per Plan Year	80% Coinsurance	20% Coinsurance
	Outpatient Speech Therapy for Pervasive Developmental Disorder (includes home setting)	Total of 20 additional visits per Plan Year	80% Coinsurance	20% Coinsurance
	Inpatient (includes Skilled Nursing)	Up to a combined total of 120 days per Plan Year for rehabilitation and Skilled Nursing Care in an approved nursing facility	80% Coinsurance	20% Coinsurance
Other Services	**Durable Medical Equipment, Orthopedic Appliances and Orthotics***	Corrective and orthopedic appliances, durable medical equipment for home use and custom-made orthotics. *(A maximum benefit limit may apply.)*	80% Coinsurance	20% Coinsurance
	Prostheses*	Prosthetic devices up to the maximum allowable.	80% Coinsurance	20% Coinsurance
	Hospice Care	Palliative and supportive medical, nursing and other services through at-home or inpatient care	80% Coinsurance	20% Coinsurance
	Home Health Services	Intermittent Skilled Nursing and skilled therapeutic home services for homebound Members	80% Coinsurance	20% Coinsurance
	Vision Care*	Vision screenings and examinations		
		for Age 18 and over	100 % after Copay	$20 Copay per visit
		Age 17 and under	100 % after Copay	$20 Copay per visit
	Dental Services	Not covered	$0	100%
	Spinal Manipulation	Spinal manipulations and mobilizations	100 % after Copay	$20 Copay per visit
	Human Organ Transplant	Non-experimental organ or tissue transplants and procedures at a Health Alliance approved facility	100% after Copay or Coinsurance	Office Visit Copay or Coinsurance and Hospital Care Copay/ Coinsurance apply
	Temporomandibular Joint (TMJ) Treatment	Treatment of temporomandibular joint-pain dysfunction syndrome is not covered	$0	100%
Other Services	**Prescription Contraceptive Devices/Injectables***	Covered when provided on an Outpatient basis in a Physician's office when services are received by or under the supervision of a Participating Physician	80% Coinsurance	20% Coinsurance

	Service/Benefit	Description of Coverage	Health Alliance Pays	You Pay
Outpatient Prescription Drugs	**Outpatient Prescription Drugs*** For a 30 day supply, you pay:	Value-based Drugs	90% Coinsurance	10% Coinsurance
		Tier 1 Drugs	100 % after Copay	$10 Copay
		Tier 2 Drugs	100 % after Copay	$20 Copay
		Tier 3 Drugs	100 % after Copay	$40 Copay
	Specialty Prescription Drugs*	Covered	80% Coinsurance	20% Coinsurance
	Infertility Outpatient Prescription Drugs* Limited to manufacturer's standard packaging			
		Tier 1 Drugs	100 % after Copay	$10 Copay
		Tier 2 Drugs	100 % after Copay	$20 Copay
		Tier 3 Drugs	100 % after Copay	$40 Copay
	Infertility Specialty Prescription Drugs*	Covered	80% Coinsurance	20% Coinsurance

* Copays and Coinsurance for these services do not apply to your Medical Plan Year Out-of-Pocket Maximum.

In no event will the Member's responsibility exceed 50 percent of the Usual, Customary and Reasonable charge determined by Health Alliance for specific Basic Health Care Services which include emergency care, inpatient Hospital and Physician care, Outpatient medical services and Substance Abuse treatment.

Members with Medicare Parts A and B as their primary coverage will not be subject to Health Alliance Copayments, Coinsurance or any applicable Medicare deductibles or coinsurance, except for prescription drugs (if applicable) for services received from Participating Providers under the HMO Policy.

This is a brief summary of Health Alliance HMO benefits and exclusions which are subject to change. Please refer to the Health Alliance HMC Policy for detailed information regarding your Plan.

Health Alliance

301 S. Vine St.
Urbana, IL 61801-3347
1-800-851-3379
www.healthalliance.org

Health Alliance PPO Group Plan Description of Coverage Worksheet

Maximums/Deductibles/Limitations	Description of Coverage	
Preauthorization Deductible ** (applies if you fail to Preauthorize required services)	**Preferred Provider**	**Non-Preferred Provider**
Medical	Not Applicable	50% up to $500
Plan Year Deductibles (Deductible applies unless otherwise specified. If Deductible applies, the Deductible must be met before benefits are paid by the Plan.)	**Preferred Provider**	**Non-Preferred Provider**
Medical Deductible	Single: $1,000 Family: $2,000	Single: $2,000 Family: $4,000
Plan Year Out-of-Pocket Maximums (The maximum annual out-of-pocket expense includes Deductible expenses)	**Preferred Provider**	**Non-Preferred Provider**
Medical	Single: $3,500 Family: $7,000	Single: $5,500 Family: $11,000
Specialty (including Infertility Specialty) Prescription Drugs	Single: $1,500 Family: $4,500	Single: Unlimited Family: Unlimited
Plan Year Maximum Benefits		
Spinal Manipulation	$500 Combined Preferred and Non-Preferred Provider	
Outpatient (including Infertility) Prescription Drugs	Unlimited Preferred Provider	
Specialty (including Infertility Specialty) Prescription Drugs	$300,000 Preferred Provider	
Pre-Existing Condition Limitation**	50% (if applicable)	
Lifetime Maximum Benefits		
Overall	$5,000,000 Combined Preferred and Non-Preferred Provider	
Inpatient Substance Abuse Treatment	$10,000 Combined Preferred and Non-Preferred Provider	
Temporomandibular Joint (TMJ) Disorder	$2,500 Combined Preferred and Non-Preferred Provider	

See Service/Benefit section for visit, day and unit limits

	Service/Benefit	You Pay Preferred Provider	You Pay Non-Preferred Provider*
In the Hospital	**Hospital Care** (includes semi-private room and other Medically Necessary services)	20% Coinsurance	40% Coinsurance
Emergency Services	**Emergency Services (Outpatient)**	$150 Copayment per visit (Deductible does not apply)	Preferred Provider benefit applies

	Service/Benefit	You Pay Preferred Provider	You Pay Non-Preferred Provider*
Emergency Services	**Emergency Ambulance Transportation.** Ground ambulance for Emergency Medical Condition; air ambulance when cannot be safely transported by ground. Includes services received in or outside of the Service Area for an Emergency Medical Condition.	$100 Copayment (Deductible does not apply)	Preferred Provider benefit applies
In the Doctor's Office *(Each Office Visit or Routine Physical Exam requires the Copayment or Coinsurance listed. In addition, other services obtained while in the office may require an additional Copayment or Coinsurance amount.)*	**Office Visit – Primary Care**	$20 Copayment per visit for office visit charge only (other services obtained while in the office may require an additional Copayment or Coinsurance amount). (Deductible does not apply)	40% Coinsurance
	Office Visit – Specialty Care	$20 Copayment per visit for office visit charge only (other services obtained while in the office may require an additional Copayment or Coinsurance amount). (Deductible does not apply)	40% Coinsurance
	Routine Physical Exams (Well child care, annual and school physicals)	$20 Copayment per visit (Deductible does not apply)	40% Coinsurance
	Immunizations (Preventive immunizations and inoculations for Wellness Care)	$0 Copayment per service (Deductible does not apply)	40% Coinsurance
	Allergy Treatment and Testing	20% Coinsurance	40% Coinsurance
	Wellness Care (Includes mammograms, PAP smears, ovarian screening, prostate screening, colorectal screening, cholesterol screening, glaucoma and osteoporosis screening) *(If service is not provided in the Physician's office, it may be subject to the Outpatient Surgery Copayment, Coinsurance and/or Deductible. Refer to your Policy.)*	$0 Copayment per service (Deductible does not apply)	40% Coinsurance
Medical Services	**Diagnostic Tests and X-Rays**	20% Coinsurance	40% Coinsurance
	Outpatient Surgery/Procedures (includes services performed in an Outpatient setting for which there is an associated facility fee)	20% Coinsurance	40% Coinsurance

	Service/Benefit	You Pay Preferred Provider	You Pay Non-Preferred Provider*
Medical Services	**Maternity Care** **Hospital Care**	20% Coinsurance	40% Coinsurance
	Routine Prenatal Care	20% Coinsurance	40% Coinsurance
	Newborn Care	20% Coinsurance (Newborn is subject to a separate Deductible and Coinsurance)	40% Coinsurance (Newborn is subject to a separate Deductible and Coinsurance)
	Infertility Services Diagnostic and treatment services	Office Visit and Hospital Copayments or Coinsurance apply	Office Visit and Hospital Copayments or Coinsurance apply
	Serious Mental Health Care **Outpatient** 60 visits per Plan Year combined Preferred and Non-Preferred Provider	20% Coinsurance	40% Coinsurance
	Inpatient 45 days per Plan Year combined Preferred and Non-Preferred Provider	20% Coinsurance	40% Coinsurance
	Non-Serious Mental Health Care **Outpatient** 20 visits per Plan Year combined Preferred and Non-Preferred Provider	20% Coinsurance	40% Coinsurance
	Inpatient 10 days per Plan Year combined Preferred and Non-Preferred Provider	20% Coinsurance	40% Coinsurance
	Substance Abuse Treatment **Outpatient** 20 visits per Plan Year combined Preferred and Non-Preferred Provider	20% Coinsurance	40% Coinsurance
	Inpatient 10 days per Plan Year combined Preferred and Non-Preferred Provider	20% Coinsurance	40% Coinsurance

	Service/Benefit	You Pay Preferred Provider	You Pay Non-Preferred Provider*
Medical Services	**Rehabilitation Services (speech, physical and occupational)**		
	Outpatient (includes home setting) Combined total of 60 visits per condition per Plan Year combined Preferred and Non-Preferred Provider	20% Coinsurance	40% Coinsurance
	Outpatient Speech Therapy for Pervasive Developmental Disorder (includes home setting) Total of 20 additional visits per Plan Year	20% Coinsurance	40% Coinsurance
	Inpatient (including Skilled Nursing) Combined total of 120 days per Plan Year combined Preferred and Non-Preferred Provider	20% Coinsurance	40% Coinsurance
Other Services	**Durable Medical Equipment, Orthopedic Appliances and Orthotics**** *(a maximum benefit limit may apply)*	20% Coinsurance	50% Coinsurance
	Prosthetic Devices**	20% Coinsurance	50% Coinsurance
	Hospice Care	Office Visit and Hospital Care Copayments or Coinsurance apply	Office Visit and Hospital Care Copayments or Coinsurance apply
	Home Health Services Unlimited visits per Plan Year	20% Coinsurance	40% Coinsurance
	Vision Care**	$20 Copayment per visit (Deductible does not apply)	40% Coinsurance
	Spinal Manipulation**	50% Coinsurance (Deductible does not apply)	50% Coinsurance (Deductible does not apply)
	Human Organ Transplant	Office Visit and Hospital Care Copayments or Coinsurance apply. Transplants are covered when performed at a Health Alliance approved facility.	
	Temporomandibular Joint (TMJ) Disorder	Office Visit and Hospital Care Copayments or Coinsurance apply	Office Visit and Hospital Care Copayments or Coinsurance apply
Outpatient Prescription Drugs	**Prescription Contraceptive Devices/Injectables****	20% Coinsurance	50% Coinsurance

	Service/Benefit	You Pay Preferred Provider	You Pay Non-Preferred Provider*
Outpatient Prescription Drugs	**Outpatient Prescription Drugs**** For a 30 day supply, you pay:		
	Value Based	10% Coinsurance	50% Coinsurance
	Tier 1 Drugs	$10 Copayment	50% Coinsurance
	Tier 2 Drugs	$20 Copayment	50% Coinsurance
	Tier 3 Drugs	$40 Copayment	50% Coinsurance
	Specialty Prescription Drugs**	20% Coinsurance	50% Coinsurance
	Infertility Outpatient Prescription Drugs** Limited to manufacturer's standard packaging		
	Tier 1 Drugs	$10 Copayment	50% Coinsurance
	Tier 2 Drugs	$20 Copayment	50% Coinsurance
	Tier 3 Drugs	$40 Copayment	50% Coinsurance
	Infertility Specialty Prescription Drugs	20% Coinsurance	50% Coinsurance

* You also pay any charges in excess of the Usual, Customary and Reasonable (UCR) amount. Amounts over the UCR do not apply to the Out-of-Pocket Maximum.

** Copayments and Coinsurance payments for these services do not apply to the Medical Plan Year Out-of-Pocket Maximum.

Charges applied toward satisfying your Medical Deductible and Out-of-Pocket Maximum for Non-Preferred Providers are also applied to your Deductible and Out-of-Pocket Maximum for Preferred Providers. However, Preferred Provider charges do not apply toward your Non-Preferred Medical Deductible and Out-of-Pocket Maximum.

Members with Medicare Parts A and B as their primary coverage will not be subject to Health Alliance Copayments, Coinsurance or any applicable Medicare deductibles or coinsurance, except for prescription drugs (if applicable) for services received from Preferred Providers. For services received from Non-Preferred Providers, Members with Medicare Parts A and B as their primary coverage are responsible for Plan Copayments, Coinsurance and Out-of-Pocket Maximums prior to the Plan covering any applicable Medicare deductibles or coinsurance.

Service Area

To be eligible for enrollment in the Plan, you must live or work within the Service Area. Listed below are the counties within which Health Alliance Medical Plans, Inc., is authorized to offer the Health Alliance PPO Plan.

Adams, Alexander, Boone, Brown, Bureau, Carroll, Cass, Champaign, Christian, Clark, Clay, Coles, Crawford, Cumberland, DeWitt, Douglas, Edgar, Edwards, Effingham, Fayette, Ford, Franklin, Fulton, Greene, Grundy, Gallatin, Hamilton, Hancock, Hardin, Henderson, Henry, Iroquois, Jackson, Jasper, Jefferson, Jersey, Johnson, Knox, LaSalle, Lawrence, Lee, Livingston, Logan, Macon, Macoupin, Marion, Madison, Marshall, Mason, Massac, McDonough, McLean, Menard, Mercer, Montgomery, Morgan, Moultrie, Ogle, Peoria, Perry, Piatt, Pike, Pope, Pulaski, Putnam, Randolph, Richland, Rock Island, Saline, Sangamon, Schuyler, Scott, Shelby, St. Clair, Stark, Stephenson, Tazewell, Union, Vermilion, Wabash, Washington, Warren, Wayne, White, Whiteside, Williamson, Winnebago, Woodford, Benton (Iowa), Boone (Iowa), Calhoun (Iowa), Carroll (Iowa), Clinton (Iowa), Dallas (Iowa), Delaware (Iowa), Greene (Iowa), Hamilton (Iowa), Hardin (Iowa), Jasper (Iowa), Johnson (Iowa), Lee (Iowa), Linn (Iowa), Marshall (Iowa), Polk (Iowa), Sac (Iowa), Scott (Iowa), Story (Iowa), Tama (Iowa), Warren (Iowa), Washington (Iowa), Webster (Iowa), Wright (Iowa)

This is a brief summary of Health Alliance group PPO benefits and exclusions, which are subject to change. Please refer to your Health Alliance Policy for detailed information regarding your Plan.

COUNTY BOARD ADDENDUM II

County of Champaign, Urbana, Illinois
Thursday, September 24, 2009 – 7:00 p.m.

Lyle Shields Meeting Room, Brookens Administrative Center
1776 East Washington Street, Urbana, Illinois

XII. Other Business

1. Adoption of Resolution No. 7137 Approving the Head Start Collective Bargaining Agreement

*Roll Call
**Roll call and 18 votes
***Roll call and 21 votes
****Roll call and 14 votes
Except as otherwise stated, approval requires the vote of a majority of those County Board members present.

County Board members and guests are encouraged to park in the north parking lot, off Lierman Avenue, and enter the Brookens facility through the north door. The Brookens Administrative Center is an accessible facility. For additional information, contact Kay Rhodes in the County Administrator's Office at (217) 384-3776