



ILLINOIS EASTERN COMMUNITY COLLEGES

Premiums & Coverage effective 1/1/2019	Option 1 - (HSA Eligible)		Option 2 - (HSA Eligible)		Option 3 - (HSA Eligible)		Option 4	
Premiums comparison	2019 Premium per Month***		2019 Premium per Month***		2019 Premium per Month***		2019 Premium per Month***	
Employee Only	<b>(\$61.81)</b>		\$0.00		\$85.77		\$185.95	
Employee & Spouse	\$808.92		\$942.11		\$1,126.90		\$1,342.78	
Employee & Child(ren)	\$386.53		\$485.09		\$621.85		\$781.60	
Employee & Family	\$1,378.46		\$1,558.34		\$1,807.90		\$2,099.44	
Benefits of Plan	Option 1		Option 2		Option 3		Option 4	
Deductible	PPO (In-Network)	Non-PPO (Out-of-Network)	PPO (In-Network)	Non-PPO (Out-of-Network)	PPO (In-Network)	Non-PPO (Out-of-Network)	PPO (In-Network)	Non-PPO (Out-of-Network)
- Per Person	\$6,000*	\$12,000*	\$2,650*/**	\$5,300*	\$1,500		\$250	
- Per Family	\$12,000*	\$24,000*	\$5,300*	\$10,600*	\$3,000		\$750	
	<b>*Embedded deductible</b>		<b>*Embedded deductible</b>		<b>Aggregate deductible</b>		<b>Aggregate deductible</b>	
Coinsurance	80% after deductible	60% after deductible	80% after deductible	60% after deductible	100% after deductible, with exceptions		90%	80%
Medical Out-Of-Pocket								
- Per Person	\$6,550	\$13,100	\$5,300	\$10,600	\$3,000		\$1,500	\$3,500
- Per Family	\$13,100	\$26,200	\$10,600	\$21,200	\$6,000		\$2,500	\$6,500
(What is not included in the Out-of-Pocket Maximums?)	Premiums, balance-billed charges, and health care this plan doesn't cover.		Premiums, balance-billed charges, and health care this plan doesn't cover.		Premiums, balance-billed charges, and health care this plan doesn't cover.		Prescription copay, premiums, balanced-billed charges, and health care this plan doesn't cover.	
Copay: Office Visit	Deductible & Coinsurance		Deductible & Coinsurance		Deductible & Coinsurance		\$20	80% after deductible

Percentages listed above are what the INSURANCE COMPANY will cover

\*\*When Dependent or Family coverage is elected for Option 2 coverage, the individual embedded deductible will be \$2,700 due to changes in IRS regulations.

\*\*\*Premium rates listed are per month. These premium rates will be divided equally between 2 payrolls per month. IECC deducts insurance and voluntary benefit premiums from 24 payrolls per year. In months with 3 pays, insurance and voluntary benefit premiums will NOT be deducted.

IECC District will contribute \$1,000/year toward HSA eligible plans (Options 1, 2 & 3), prorated based on hire date. If you choose Option 4, which is not HSA eligible, or choose to waive medical coverage, you would not receive the HSA contribution.



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Benefits of Plan (continued)	Option 1		Option 2		Option 3		Option 4	
	PPO (In-Network)	Non-PPO (Out-of-Network)	PPO (In-Network)	Non-PPO (Out-of-Network)	PPO (In-Network)	Non-PPO (Out-of-Network)	PPO (In-Network)	Non-PPO (Out-of-Network)
Physician Services								
Well Care (Adult & Child)	100% (no deductible applies)	80% after deductible	100% (no deductible applies)	80% after deductible	100% (no deductible applies)	80% after deductible	100% (no deductible applies)	80% after deductible
Maternity Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible	100% after deductible	80% after deductible		
Medical/Surgical Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible	100% after deductible	80% after deductible	90% of Max Allowance	80% of Max Allowance
Hospital Services								
Hospital Admission Deductible	NA	NA	NA	NA	NA	NA	\$0	\$250
Inpatient Hospital Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible	100% after deductible	80% after deductible	90% after deductible	80% after deductible
Outpatient Hospital Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible	100% after deductible	80% after deductible	90% after deductible	80% after deductible
Outpatient Emergency Care	80% after deductible		80% after deductible		90% after deductible		\$50 copy, waived if admitted to hospital	\$50 copy, waived if admitted to hospital
Muscle Manipulation Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible	100% after deductible	80% after deductible	90% after deductible	80% after deductible
Therapy Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible	100% after deductible	80% after deductible	90% after deductible	80% after deductible

Percentages listed above are what the INSURANCE COMPANY will cover

Prescription Drug-	PPO (In-Network)	Non-PPO (Out-of-Network)	PPO (In-Network)	Non-PPO (Out-of-Network)	PPO (In-Network)	Non-PPO (Out-of-Network)	PPO (In-Network)	Non-PPO (Out-of-Network)
		75% after coinsurance		75% after coinsurance		75% after coinsurance		75% after copay
Retail 30 day/ Mail Order 90 Day	20% Generic		20% Generic		20% Generic		\$10/\$20 Generic	
	20% Pref Brand		20% Pref Brand		20% Pref Brand		\$20/\$40 Pref Brand	
	20% Non-Pref		20% Non-Pref		20% Non-Pref		\$35/\$70 Non-Pref	

Percentages listed under Prescription drugs are what the EMPLOYEE will cover after deductible is met