| Lake Forest College |
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| BENEFIT HIGHLIGHTS\*\* | Blue Edge HSASM [PPO] Network  |
| Only highlights of this benefit plan are provided. After enrollment,members will receive a Benefit Booklet that more fully describes the terms of coverage.

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| **PROPOSED PLAN DESIGN** | **In Network** | **Out of Network** |
| **Calendar Year Deductible** |   |
| Embedded/Aggregate | Aggregate |
| Individual | $1,650 | $3,200 |
| Family | $3,300 | $6,400 |
| Deductible Includes Rx | Y | Y |
| **Out-of-Pocket Maximum** |   |
| Embedded/Aggregate | Aggregate |
| Individual | $2,750 | $6,500 |
| Family | $5,500 | $13,000 |
| Out of Pocket Includes Rx  | Y | Y |
| **Hospital Services** |   |   |
| Inpatient | 20% after deductible | 40% after deductible |
| Outpatient | 20% after deductible | 40% after deductible |
| Emergency Room | 20% after deductible | 40% after deductible |
| **Outpatient** |   |   |
|  Surgery | 20% after deductible | 40% after deductible |
| Diagnostic | 20% after deductible | 40% after deductible |
| PT/ST/OT limits (60 visits each per calendar year)Chiropractic (60 visits per calendar year) | 20% after deductible20% after deductible | 40% after deductible40% after deductible |
| **Physician Office Visits** |   |   |
|  Primary Care | 20% after deductible | 40% after deductible |
| SpecialistVirtual | 20% after deductible20% after deductible | 40% after deductible40% after deductible |
| **Wellness/Preventive** | 100% no deductible | Not covered |
| **Prescription Drugs** |   |   |
|  Rx Network  | Traditional Select |
| Rx Formulary | Performance Select Drug List |
|   |   |   |
| **Retail & Specialty Rx (home delivery)** | **AFTER MEDICAL DEDUCTIBLE** |
|  Generic | 20% with a $300 max | 50% allowed cost, then deductible coinsurance |
| Preferred Brand | 20% with a $300 max | 50% allowed cost, then deductible coinsurance |
| Non-preferred Brand | 20% with a $300 max | 50% allowed cost, then deductible coinsurance |
|  |  |  |
| **Mail Order** |  |  |
|  Generic | 20% with a $300 max | Not covered |
| Preferred Brand | 20% with a $300 max | Not covered |
| Non-preferred Brand | 20% with a $300 max | Not covered |
| Additional Provisions: | Mail Order is through ESI Home Delivery and Specialty is dispensed on a 30-day fill via Accredo. |

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**Aggregate Deductible and Out-of-Pocket –** If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay. No participant will contribute more than the Family deductible amount. The family out of pocket limits is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.

Individual Coverage Out-of-Pocket Expense (OPX) Limit

The OPX limit is the amount of money that any individual will have to pay toward covered health care expenses during any one calendar year. The following items will **not** be applied to the out-of-pocket expense limit:

Reductions in benefits due to non-compliance with utilization management program requirements

Charges that exceed the eligible charge or the Schedule of Maximum Allowances (SMA)

Preventive Care

Services that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”). Includes benefits for routine physical examinations, well child care and routine diagnostic tests including, but not limited to: PSA, Pap Smear, Bone Density, and Colonoscopy. Health Education and Counseling services including, but not limited to: Smoking Cessation and Obesity.

Inpatient Hospital Services

Coverage includes pre-admission testing and services received in a hospital, skilled nursing facility, coordinated home care and hospice, including mental health and substance abuse services. Room allowances based on the hospital’s most common semi-private room rates.

Outpatient Hospital Services

Coverage for services includes, but is not limited to, outpatient or ambulatory surgical procedures, diagnostic X-rays, lab tests, chemotherapy, radiation therapy, renal dialysis, and mammograms performed in a hospital or ambulatory surgical center, including mental health and substance abuse services. For routine services such as mammograms, lab tests and X-rays performed in an outpatient hospital setting, see Well Care benefits.

Outpatient Emergency Care (Accident or Illness)

The coinsurance applies to both in- and out-of-network emergency room visits.

**Durable Medical Equipment (DME)** is a covered benefit. Please refer to Certificate for details.

Optometrists, Orthotics, Prosthetic, Pedorthists, Registered Surgical Assistants, Registered Nurse First Assistants and Registered Surgical Technologists are covered providers. Please refer to Certificate for details on these and other provider types.

**Discounts on Eye Exams, Prescription Lenses, Eyewear and Other Devices**

Members can present their ID cards to receive discounts on eye exams, prescription lenses and eyewear. To locate participating vision providers, log into Blue Access for MembersSM (BAM) at [bcbsil.com/member](file:///C%3A%5CUsers%5CAmanda%20Cohen%5CDesktop%5CFine%20Point%5CAquent%5CHSC-BSBS%5Ctemplates%20to%20update%5Cbcbsil.com%5Cmember) and click on the Blue365® Member Discount Program link.

WellBeing Management

When members receive covered inpatient hospital services, (outpatient mental health and substance abuse services [MHSA]), coordinated home care, skilled nursing facility or private duty nursing from a participating provider, the member will be responsible for precertifying these services, if applicable.

You must call one day prior to any hospital admission (and/or certain outpatient MH/SA services) or within 2 business days after an emergency medical or maternity admission. Please refer to your benefit booklet for information regarding benefit reductions based on failure to contact the applicable preauthorization line.

**To Locate a Participating Provider:** Visit our Web site at [www.bcbsil.com](http://www.bcbsil.com) find care and use our Provider Finder® tool.

\*\* This is a general summary of your benefits. Please refer to your Summary of Benefits and Coverage (SBC), or you may request a copy of the Benefit booklet/Plan document by contacting your Employer. You may also log onto BAM and/or contact Customer Service at the number on the back of your ID card for additional information. This plan does not cover all health care expenses. Please carefully review the plan’s limitations and exclusions.

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