BlueCross BlueShield of Illinois

Lake Forest College

BENEFIT HIGHLIGHTS**

Participating Provider Organization
[PPO] NETWORK

Only highlights of the benefit plan are provided. After enrollment, members will receive a Benefit Booklet that more fully describes the terms of coverage.

PLAN DESIGN	In Network	Out of Network
Calendar Year Deductible		
Embedded/Aggregate	Embedded	
Individual	$750	$1,500
Family	$1,500	$3,000
Deductible Includes Rx	N	N
Out-of-Pocket Maximum		
Embedded/Aggregate	Embedded	
Individual	$2,000	$6,500
Family	$4,000	$13,000
Out of Pocket Includes Rx	Y	Y
Hospital Services		
Inpatient	$250 copay per admission	40% after deductible
Outpatient	20% after deductible	40% after deductible
Emergency Room	$150 copay	$150 copay
Urgent Care	$50 copay	40% after deductible
Outpatient		
Surgery	20% after deductible	40% after deductible
Diagnostic & Imaging	20% after deductible	40% after deductible
PT/ST/OT limits (60 visits each per calendar year)	$20 copay	40% after deductible
Chiropractic (60 visits per calendar year)	$20 copay	40% after deductible
Physician Office Visits		
Primary Care	$20 copay	40% after deductible
Specialist	$40 copay	40% after deductible
Wellness/Preventive	100% no deductible	Not covered
Prescription Drugs		
Rx Network	Traditional Select	
Rx Formulary	Performance Select Drug List	
Retail & Specialty Rx– 30 day supply		
Generic	$10 copay	50% of allowed cost then copay
Preferred Brand	$45 copay	50% of allowed cost then copay
Non-preferred Brand	$75 copay	50% of allowed cost then copay
Mail Order – 90 day supply		
Generic	$25 copay	Not covered
Preferred Brand	$112.50 copay	Not covered
Non-preferred Brand	$187.50 copay	Not covered
Additional Provisions:	Accredo Specialty dispenses a max 30 day supply	

Embedded Deductible and Out-of-Pocket - Once a person meets their Individual deductible, no more deductible is required for that Individual. When the Family deductible is reached, no further deductible will have to be satisfied for the remainder of that calendar/contract year. No participant will contribute more than the Individual deductible amount to the Family deductible amount.

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.

Other Covered Services – General In network payment level - Private duty nursing, Naprapathic services, Blood and blood components, Ambulance Services Medical Supplies.

Inpatient Hospital Services - Coverage includes 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, 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. Routine mammograms performed in an in-network outpatient hospital setting are payable at 100%, no deductible will apply.

Outpatient Emergency Care (Accident or Illness) - The copayment applies to both in- and out-of-network emergency room visits. The copayment is waived if the member is admitted to the hospital.

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 Members℠ (BAM) at bcbsil.com/member 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 **https://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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