BRADLEY University

EFFECTIVE: October 1, 2018

	PPO Plan In-Network	PPO Plan *Out-of-Network*	QHDHP In-Network	QHDHP Out-*of*-Network
Overall Lifetime Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Overall Plan Year Benefit Maximum Per Person (Oct. 2018 through Sept. 2019)	Unlimited	Unlimited	Unlimited	Unlimited
Morbid Obesity Surgery, including complications	Not covered	Not covered	Not covered	Not covered
TMJ Treatment	Unlimited	Unlimited	Unlimited	Unlimited
Wigs (for hair loss due to medical procedures/treatments)	Unlimited	Unlimited	Unlimited	Unlimited
Per Person Calendar Year Deductible	$0	$1,000	$1,500 Individual	$3,000 Individual
Per Person Plus One Calendar Year Deductible	$0	$2,000	$3,000 Family	$6,000 Family
Per Family Unit Calendar Year Deductible	$0	$3,000		
Per Person Medical Out-of-Pocket Maximum*	$2,000	$4,000	$3,000 Individual	$6,000 Individual
Per Person Plus One Medical Out-of-Pocket Maximum*	$4,000	$8,000	$6,000 Family	$12,000 Family
Per Family Unit Medical Out-of-Pocket Maximum*	$5,000	$10,000		
Per Person Prescription Out-of-Pocket Maximum**	$1,500	Does not apply	Does not apply	Does not apply
Per Person Plus One Prescription Out-of-Pocket Maximum**	$3,000	Does not apply	Does not apply	Does not apply
Per Family Unit Prescription Out-of-Pocket Maximum**	$4,500	Does not apply		
*The amount of money an individual will have to pay toward covered health care expenses during any one calendar year.				
The following items do not apply to the **PPO medical out-of-pocket (OOP) maximums:** Premiums, prescription copayments (subject to a separate OOP maximum), vision & dental benefits, services excluded from coverage, and balance-billed charges.				
** The amount of money an individual will have to pay toward covered prescription drug expenses during any one calendar year.				
Deductible and coinsurance apply to the QHDHP OOP maximums. The following items do not apply to the **QHDHP OOP maximums:** dental benefits, services excluded from coverage, and balance-billed charges. **The family QHDHP OOP maximum is satisfied when one or all family members combine to meet the family OOP amount.**				
Prescription Drug Card (Retail and Mail Order)	Retail 30-day Copay: $10 / 30 / 50 BCBS Retail 90-day Copay: $30 / 90 / 150 Mail Copay: $20 / 60 / 100	Not covered	20% coinsurance after deductible is met	Not covered

Updated 8-9-18

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Physician Services					
Physician Office Visits Includes surgeries, therapies and certain diagnostic procedures performed in a physician's office.	$30 copay, then 100%	40% coinsurance after deductible is met		20% coinsurance after deductible is met	40% coinsurance after deductible is met
Virtual Physician & Behavioral Health Office Visits Includes online doctor visits and behavioral health consultations through MD Live.	$20 copay, then 100%	N/A		20% coinsurance after deductible is met	N/A
Preventive mammograms.	100%	40% coinsurance after deductible is met		plan covers 100% (no ded.)	40% coinsurance after deductible is met
Well Child Care (to age 16) Coverage for routine physical exams, immunizations and routine diagnostic tests.	$0 copay, then 100%	40% coinsurance after deductible is met		plan covers 100% (no ded.)	40% coinsurance after deductible is met
Maternity Physician Services Maternity physician covered services are paid the same as Medical/Surgical Services.	$30 copay, then 100%	40% coinsurance after deductible is met		20% coinsurance after deductible is met	40% coinsurance after deductible is met
Medical/Surgical Physician Services Includes surgical procedures, inpatient visits, allergy injections or treatments, certain diagnostic procedures as well as other physician services.	100%	40% coinsurance after deductible is met		20% coinsurance after deductible is met	40% coinsurance after deductible is met
Mental Health/Substance Abuse Physician Services Mental health and substance abuse physician services are paid the same as Medical/Surgical Services.	$30 copay, then 100%	40% coinsurance after deductible is met		20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital Services					
Inpatient Hospital Services Includes room and board, general nursing care, ICU, operating and recovery rooms, anesthesia, inpatient rehabilitation, mental health/substance abuse, and hospice, and other services and supplies. Inpatient hospital services require prior authorization.	$400 copay per admit, then 100%	40% coinsurance after deductible is met		20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Facility Services Includes short-term, non-custodial care in a skilled nursing facility up to a maximum of 120 days per calendar year. Requires prior authorization.	100%	40% coinsurance after deductible is met		20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital Services Includes, but is not limited to, outpatient or ambulatory surgical procedures performed in a hospital or ambulatory surgical center.	$100 copay per procedure, then 100%	40% coinsurance after deductible is met		20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Emergency Care (Injury or Illness)	$125 copay, then 100%	$125 copay, then 100%		20% coinsurance after deductible is met	20% coinsurance after deductible is met

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Additional Medical Services					
Outpatient Rehabilitation Therapy Services Includes physical, occupational and/or speech therapy services provided in an outpatient or home setting.	$30 copay, then 100%	40% coinsurance after deductible is met		20% coinsurance after deductible is met	40% coinsurance after deductible is met
Home Health Services Includes home health and home infusion services up to a maximum of 100 visits per benefit year.	$30 copay, then 100%	40% coinsurance after deductible is met		20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Covered Services Includes durable medical equipment, prosthetics, private duty nursing (outpatient or home only), autism spectrum disorder services for children birth to 21.	100%	40% coinsurance after deductible is met		20% coinsurance after deductible is met	40% coinsurance after deductible is met
Vision Benefit**					
Routine Eye Exam (once per 24 months)	100%	PPO Plan covers regardless of network		plan covers 100%	QHDHP Plan covers regardless of network
Lenses, frames and contacts (once per 24 months)	$100 for any combination of eyewear	PPO Plan covers regardless of network		not covered	not covered

****To maximize your vision benefit, you may choose to visit a vision provider in the BCBSIL network although it is not required. A network provider will submit your claim for processing. Check the website, call BCBSIL, or ask the doctor if s/he is in the vision network.**

	PPO Plan In-Network	PPO Plan *Out-of-Network*		QHDHP In-Network	QHDHP Out*-of-Network*
Dental Benefit * - included with medical insurance or can be purchased as a stand-alone benefit.					
(Based on the calendar year - not the plan year)					
Members may use dentist of their choice (dental provider network not required although available with BCBSIL)					
Deductible Per Calendar Year	$50 Employee only $100 Employee + 1 $150 Employee + 2 or more				
Calendar Year Maximum Active Employee or Retiree	$1,000 per covered individual				
	Services				
Type A Preventative Care Oral Exams, X-rays, Etc	Deductible waived You pay 0%				
Type B Basic Care Restorative Type Fillings, Extractions, Etc	Deductible Applies You pay 20%				
Type C Major Restorative Inlays, Onlays, Gold Fillings, Crowns, Partials, Dentures, Etc.	Deductible Applies You pay 20%				
Orthodontic Services or supplies are not covered					
*** The Bradley University dental plan is administered by BCBSIL and is available with PPO/HDHP medical coverage or on a stand-alone basis.**					
****To maximize your dental benefit, you may choose to visit a dental provider in the BCBSIL network, although it is not required. Network providers have agreed to accept negotiated rates as payment in full, which may lower your out of pocket costs. Check the website, call BCBSIL, or ask your doctor if s/he is in the dental network.**					

NOTE: The information contained in these pages is only intended to provide a general summary - please read your benefit booklet for detailed coverage. You may also call BCBSIL customer service to verify benefits.