EFFECTIVE: January 1, 2024

BRADLEY University

	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 Calendar Year Benefit Maximum Per Person (Jan 2024 through Dec 2024)	Unlimited	Unlimited	Unlimited	Unlimited
Individual Calendar Year Deductible	$1,000	$2,000	$2,000	$4,000
Family Calendar Year Deductible	$2,000	$4,000	$4,000	$8,000
Individual Medical Out-of-Pocket Maximum*	$4,500	$9,000	$4,000	$8,000
Family Medical Out-of-Pocket Maximum*	$9,000	$18,000	$8,000	$16,000
Individual Prescription Out-of-Pocket Maximum**	Does not apply	Does not apply	Does not apply	Does not apply
Family Prescription Out-of-Pocket Maximum**	Does not apply	Does not apply	Does not apply	Does not apply
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
*The amount of money an individual will have to pay toward covered health care expenses during any one calendar year (also called "co-insurance")				
The following items do not apply to the **PPO medical out-of-pocket (OOP) maximums:** Premiums, dental benefits, services excluded from coverage, and balance-billed charges. Pharmacy benefits no longer have an out of pocket maximum separate from the medical OPX.				
** 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) **Specialty Drugs**	**Retail 30-day Copay**: $10 / $20 / $70 / $150 **BCBS Retail 90-day Copay**: $30 / $60 / $210 / $450 **Mail Copay**: $20 / $40 / $140 / $300 **Specialty 30-day Copay:** $150	Not covered	20% coinsurance after deductible is met	Not covered

	PPO Plan In-Network	PPO Plan *Out-of-Network*	QHDHP In-Network	QHDHP *Out-of-Network*
Physician Services				
Physician Office Visits Includes surgeries, therapies and certain diagnostic procedures performed in a physician's office.	$30 copay	40% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Office Visits Includes surgeries, therapies and certain diagnostic procedures performed in a physician's office. Specialists (not primary care physicians) include, for example, Orthopedist, ENT, Neurologist, Urologist, Gastroenterologist, OB-GYN and others.	$60 copay	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 / BlueAccess for Members	$0 copay	N/A	20% coinsurance after deductible is met	N/A
Preventive mammograms	plan covers 100% (no ded.)	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.	plan covers 100% (no ded.)	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.	20% coinsurance after deductible is met	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.	20% coinsurance after deductible is met	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.	20% coinsurance after deductible is met	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.	20% coinsurance after deductible is met	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.	20% coinsurance after deductible is met	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.	20% coinsurance after deductible is met	40% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Emergency Care (Injury or Illness)	$175 copay, then 20%	$175 copay, then 20%	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.	20% coinsurance after deductible is met	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.	20% coinsurance after deductible is met	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.	20% coinsurance after deductible is met	40% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Vision Benefit				
Bradley University vision benefits are covered through BCBS EyeMed vision insurance plan, which utilizes the national EyeMed vision network.				

Service	Frequency	In-Network Member Cost	Out of Network Reimbursement
Eye exam with dilation as necessary	Once every 12 months	$10 copay	Up to $40
Lenses (eyeglass ***or*** contacts)		see below	see below
Eyeglass lenses - single vision, bifocal, trifocal, lenticular	Once every 12 months	$25 copay	Up to $40 - $90
Contacts - conventional		$150 allowance; 15% off balance over $150	Up to $105
Contacts - disposable		$150 allowance + balance over $150	Up to $105
Frames	Once every 24 months	$150 allowance; 20% off balance over $150	Up to $70
Eyeglass lens options -			
Tinting (solid & gradient) and UV coating		$15	n/a
Scratch resistant coating		$0	Up to $5
High index & polarized lenses		20% off retail	n/a
Polycarbonate lenses		$0 kids; $40 adults	Up to $5 kids
Photochromatic / transitions plastic		$75	n/a
Standard anti-reflective coating		$45	n/a
Other discounted services -			
Laser vision correction		15% off retail price or 5% off promotional price	n/a
Additional pairs benefit		40% off purchase of complete pair of eyeglasses and a 15% off conventional contact lenses once the funded benefit has been used	n/a
Additional discounts		20% off non-covered items (with limtations)	n/a

Dental Benefit *

Dental benefits & deductibles are based on a calendar year

Deductible Per Calendar Year

$50 Employee only
$150 Family

Calendar Year Maximum **(Active EE or Retiree)**

$1,000 per covered individual

Services	In-Network	Out-of-Network
Type A - Preventive Care	***Deductible waived***	***Deductible waived***
Oral Exams, Routine Cleanings, X-rays, Etc	You pay 0%	You pay 0%
Type B - Basic Care	**Deductible Applies**	**Deductible Applies**
Restorative Type Fillings, Extractions, Etc	Plan pays 80% of Maximum Allowance; member pays 20%	
Type C - Major/Restorative Care	**Deductible Applies**	**Deductible Applies**
Inlays, Onlays, Gold Fillings, Crowns, Partials, Dentures, Etc.	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 dentist 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 at the number listed on the back of your ID card to verify benefits.