WILL COUNTY ILLINOIS

Medical Benefits: At-a-Glance Summary

	Blue Cross Blue Shield of Illinois				Blue Advantage	
	HDHP-HSA Medical Plan		PPO Plan		HMO Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	
HSA Employer Contribution						
Individual		\$1,350		Not available		
Family	\$2,	700				
Annual Deductible			Salary <	Salary >		
			\$50,000	\$50,000		
v 1 1	6 4	250	\$350	\$500	N	
Individual Family	\$1,350 \$2,700		\$700	\$1,000	None None	
	ocket - Includes Deducti					
	ocket - Incli	udes Deducti	bles, Copays,	and Coinsuran	ce	
Maximum*	#2.000	## (2F	¢2.000	\$5,625	\$2,000	
Individual	\$3,000 \$6,000	\$5,625 \$11,250	\$2,000 \$4,000	\$11,250	\$4,000	
Family	\$0,000	\$11,230		\$11,250	Ψ1,000	
Lifetime Maximum		1001	Unlimited	1	1000/	
Co-Insurance**	85%	60%	85%	60%	100%	
		Physician Care				
PCP Copay / Coinsurance	85%	60%	85%	60%	\$20 copay	
Specialist Copay / Coinsurance	85%	60%	85%	60%	\$30 copay	
Preventive Care***	100% covered	Not covered	100% covered	Not covered	100% covered	
	Alexand November	Hospital Se	rvices			
THE RESERVE THE PROPERTY AND ADDRESS OF THE PARTY OF THE				\$400 per	\$125 copay per day fo	
	0504	6004	OFN	admission (limit 2	the first 2 days per	
In-patient Hospital#	85%	60%	85%	per year) then,	Plan Year, then	
				60%	100%	
Out-Patient Hospital	85%	60%	85%	60%	\$50 copay, then 100%	
		Emergency :	Services			
Hospital Emergency Room	\$150 cc	pay, then	\$150 co	pay, then	\$150 copay, then	
	85%	60%	85%	60%	100%	
Urgent Care	85%	60%	85%	60%	100%	
entila (Casala) sassitati sant		Prescriptio	n Drugs			
	Subject to de	ductible, then:	In-Network	Out-of-Network	In-Network Only	
Datail	Subject to de		III HOUNGIN	- Cut Of Hotherin		
Retail (30-day supply)						
Generic	85%	25%	\$10 copay	25%	\$10 copay [†]	
Brand Formulary	85%	coinsurance	\$25 copay	coinsurance	\$25 copay [†]	
Brand Non-Formulary	85%	plus copay	\$45 copay	plus copay	\$45 copay [†]	
Mail Order						
(90-day supply)						
Generic	85%		\$20 copay		\$20 copay	
Brand Formulary	85%	Not available	\$50 copay	Not available	\$50 copay	
Brand Non-Formulary	85%		\$90 copay		\$90 copay	
Coverage Tiers		Bi-Weekly Po	er-Paycheck Pr	e-Tax Deducti	ons	
Employee Only	3% of base pay					
Family	4% of base pay					
	Rates do not includ	Rates do not include the additional \$125 monthly premium surcharge levied as a result of non-participation in the County's Employee Health & Wellness Program ~ Will Be Well. The wellness premium surcharges run from July 1st - June				
V	County's Employee	Health & Wellness Prog	ram ~ will be Well. The	wenness premium surcha	nges run irom July 180- Jul	
	1 2001					

^{*} Includes annual deductible, coinsurance, and copays.

When both spouses work for the County, the one with the longest continuous service covers the family.

^{**} Subject to deductible.

^{***} In-network routine preventive care (e.g., annual physical, immunizations, well women exam, mammograms) not subject to deductible.

 $[\]dagger$ A 90-day retail supply can also be obtained with the same mail order copays under the HMO Plan.

[#] \$700 MSA penalty for failure to pre-authorize hospital admission—HDHP-HSA and PPO Medical Plans.

BlueCare® DENTAL PREFERRED CHOICE (PPO) DENTAL PLAN COUNTY OF WILL





The following is a listing of common services available through your BlueCare® Mutually Preferred Dental Network. The member's share of the costs is determined whether care is received from a contracting or non-contracting provider.

HIGHLIGHT SHEET

Effective 01/01/2018

Benefits	Contracting Network Provider PPO*	Non-contracting Provider Non-PPO*		
Benefit Period Maximum	\$1,675 for contracting providers and	\$1275 for non-contracting providers.		
	Dollars feed both buckets.			
Deductible	\$50 per person i	per benefit period		
	\$150 maximum per family			
	(Deductible does not apply to preventive and orthodontic services.)			
	(Boddetible does not apply to pre	vonave and orthodonae services.		
Dependent Coverage	Spouse and dependents up to age 26			
Preventive Services				
Dental Exams (2 exams per benefit period)				
Prophylaxis (2 cleanings per benefit period)				
Fluoride Treatment (to age 19)	100% of Maximum Allowance	100% of Usual & Customary		
Dental X-rays		,		
Sealants (to age 19)				
Space Maintainers (to age 19)				
Emergency Services				
Emergency Exams	100% of Maximum Allowance	100% of Usual & Customary		
Treatment for the relief of pain				
Primary Services				
Routine Fillings (amalgams and resins)				
Endodontics				
- root canals				
- apicoectomy				
 direct pulp caps 				
- hemisection				
Periodontics	900/ of Maximum Allowanes	909/ of House & Customer		
 scaling and root planing 	80% of Maximum Allowance	80% of Usual & Customary		
- gingivectomy				
- periodontal maintenance				
 osseous surgery 				
Oral Surgery				
 extractions, except as excluded under "Special Limitations" 				
- alveoloplasty				
Recementing of Crowns and Bridges				
Major Services				
Inlays, Onlays and Crowns (other than temporary crowns)				
Full and Partial Dentures				
Bridges	50% of Maximum Allowance	50% of Usual & Customary		
Implants				
Crown, Bridge and Denture Repairs				
Denture Adjustments, Rebasing and Relining				
Orthodontics Coverage for children under age 19	50% of Maximum Allowance to the Orthodontia Lifetime Maximum Benefit of \$1,200; \$50 Lifetime Deductible also applies.	50% of Usual & Customary to the Orthodontia Lifetime Maximum Benefit of \$1,200; \$50 Lifetime Deductible also applies		

Please note: This information only provides highlights of this program. After enrollment please refer to your dental benefit Certificate for additional benefit information.

*Schedule of Maximum Allowances

Contracting PPO providers have agreed to accept the Schedule of Maximum Allowances as payment in full for covered services. Non-contracting providers are reimbursed based on the Usual & Customary fee. You will be liable for any difference between the dentist's charge and your covered benefits.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent License of the Blue Cross and Blue Shield Association

AFSCME 1028 Deputy Correctional Officers

[Effective July 1, 2019]

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	Blue Cross Blue Shield of Illinois				Blue Advantage
	HDHP-HSA Medical Plan		PPO Plan		HMO Plan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
HSA Employer Contribution					
Individual	\$1,350 \$2,700		Not available		Not available
Family					
Annual Deductible			Salary < \$50,000	Salary > \$50,000	
Individual	\$1	.350##	\$350	\$500	None
Family	\$2.700##		\$700	\$1,000	None
Out-of-P	ocket - Incl	udes Deductil	oles, Copays,	and Coinsuran	ce
Maximum*					
Individual	\$3,000	\$5,625	\$2,000	\$5,625	\$2,000
Family	\$6,000	\$11,250	\$4,000	\$11,250	\$4,000
Lifetime Maximum			Unlimited	-	•
Co-Insurance**	85%	60%	85%	60%	100%
and the second second		Physician Care (Office Visits		THE STATE OF THE S
PCP Copay / Colnsurance	85%	60%	85%	60%	\$20 copay
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Preventive Care***	100% covered	Not covered	100% covered	Not covered	100% covered
THE PROPERTY OF THE PARTY OF TH	and Maria Con	Hospital Se	rvices	Sales Sane"	Transition was life
In-patient Hospital#	85%	60%	85%	\$400 per admission (limit 2 per year) then, 60%	\$125 copay per day for the first 2 days per Plan Year, then 100%
Out-Patient Hospital	85%	60%	85%	60%	\$50 copay, then 100%
المناورة المحروفين كالربيج المناورة	Inches Inches	Emergency S	ervices		THE STATE OF
	\$150 copay, then		\$150 copay, then		\$150 copay, then
Hospital Emergency Room	85%	60%	85%	60%	100%
Urgent Care	85%	60%	85%	60%	100%
on III. A. attl. Klass if vital its		Prescriptio	n Drugs	. I - Ur. 18. 18. 18. 18	
Subject to		ductible, then:	In-Network	Out-of-Network	In-Network Only
Retail (30-day supply) Generic Brand Formulary Brand Non-Formulary	85% 85% 85%	25% coinsurance plus copay	\$10 copay \$25 copay \$45 copay	25% coinsurance plus copay	\$10 copay† \$25 copay† \$45 copay†
Mail Order (90-day supply) Generic Brand Formulary Brand Non-Formulary	85% 85% 85%	Not available	\$20 copay \$50 copay \$90 copay	Not available	\$20 copay \$50 copay \$90 copay
Coverage Tiers	Bi-Weekly Per-Paycheck Pre-Tax Deductions				
Employee Only Employee +Spouse Employee +Child(ren) Family	See your rate sheet for details Rates do not include the additional \$125 monthly premium surcharge levied as a result of non-participation in the County's Employee Health & Wellness Program ~ Will Be Well. The wellness premium surcharges run from July 1st- June 30th				

^{*} Includes annual deductible, coinsurance, and copays.

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[†] A 90-day retail supply can also be obtained with the same mail order copays under the HMO Plan.

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^{##} Subject to annual IRS indexing

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Dependent Coverage	Spouse and dependents up to age 26			
Preventive Services Dental Exams (2 exams per benefit period) Prophylaxis (2 cleanings per benefit period) Fluoride Treatment (to age 19) Dental X-rays Sealants (to age 19) Space Maintainers (to age 19)	100% of Maximum Allowance	100% of Usual & Customary		
Emergency Services Emergency Exams Treatment for the relief of pain	100% of Maximum Allowance	100% of Usual & Customary		
Primary Services Routine Fillings (amalgams and resins) Endodontics - root canals - apicoectomy - direct pulp caps - hemisection Periodontics - scaling and root planing - gingivectomy - periodontal maintenance - osseous surgery Oral Surgery - extractions, except as excluded under "Special Limitations" - alveoloplasty Recementing of Crowns and Bridges	80% of Maximum Allowance	80% of Usual & Customary		
Major Services Inlays, Onlays and Crowns (other than temporary crowns) Full and Partial Dentures Bridges Implants Crown, Bridge and Denture Repairs Denture Adjustments, Rebasing and Relining	50% of Maximum Allowance	50% of Usual & Customary		
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