

[Effective March 1, 2019]



WILL COUNTY ILLINOIS

FOP 738-1

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			Not available		Not available
Individual	\$1,350				
Family	\$2,700				
Annual Deductible			Salary < \$50,000	Salary > \$50,000	
Individual	\$1,350		\$350	\$500	None
Family	\$2,700		\$700	\$1,000	None
Out-of-Pocket - Includes Deductibles, Copays, and Coinsurance					
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%
Physician Care Office Visits					
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
Hospital Services					
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%
Emergency Services					
Hospital Emergency Room	\$150 copay, then 85%	60%	\$150 copay, then 85%	60%	\$150 copay, then 100%
Urgent Care	85%	60%	85%	60%	100%
Prescription Drugs					
	Subject to deductible, then:		In-Network	Out-of-Network	In-Network Only
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 Per-Paycheck Pre-Tax Deductions		
Employee Only	3% of base pay				
Family	4% of base pay				
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.

** Subject to deductible.

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

† 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.

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

BlueCare[®] DENTAL

PREFERRED CHOICE (PPO) DENTAL PLAN

COUNTY OF WILL



BlueCross BlueShield
of Illinois

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 per benefit period \$150 maximum per family (Deductible does not apply to preventive and orthodontic 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) Dental X-rays Scalants (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 – apicectomy – direct pulp caps – hemisection Periodontics – scaling and root planing – gingivectomy – periodontal maintenance – osseous surgery Oral Surgery – extractions, except as excluded under "Special Limitations" – alveoplasty 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
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 Licensee of the Blue Cross and Blue Shield Association

AFSCME 1028 Deputy Correctional Officers

[Effective July 1, 2019]

Medical Benefits: At-a-Glance Summary



**WILL COUNTY
ILLINOIS**

	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			Not available		Not available
Individual	\$1,350				
Family	\$2,700				
Annual Deductible			Salary < \$50,000	Salary > \$50,000	
Individual	\$1,350##		\$350	\$500	None
Family	\$2,700##		\$700	\$1,000	None
Out-of-Pocket - Includes Deductibles, Copays, and Coinsurance					
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%
Physician Care Office Visits					
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
Hospital Services					
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%
Emergency Services					
Hospital Emergency Room	\$150 copay, then 85%		\$150 copay, then 85%		\$150 copay, then 100%
Urgent Care	85%	60%	85%	60%	100%
Prescription Drugs					
	Subject to deductible, then:		In-Network	Out-of-Network	In-Network Only
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 Per-Paycheck Pre-Tax Deductions				
Employee Only	See your rate sheet for details				
Employee +Spouse					
Employee +Child(ren)					
Family	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.

** Subject to deductible.

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

† 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.

Subject to annual IRS indexing

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

BlueCare[®] DENTAL

PREFERRED CHOICE (PPO) DENTAL PLAN

COUNTY OF WILL



BlueCross BlueShield
of Illinois

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

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 per benefit period \$150 maximum per family (Deductible does not apply to preventive and orthodontic 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) 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, Rebasement and Relining	50% of Maximum Allowance	50% of Usual & Customary
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 Licensee of the Blue Cross and Blue Shield Association