Northwestern

2023 Benefits Guide

Visiting Faculty, Scholars, and Researchers Plan Benefit Program

BENEFITS

Gallagher Benefit Services (GBS) is pleased to administer the Northwestern University Visiting Benefit Program. The Program is a comprehensive package of benefits that closely matches the benefits offered to faculty and staff.

Medical Insurance:

Blue Cross and Blue Shield of Illinois

HMO, PPO and Buy-up PPO

Vision Insurance:

EyeMed PPO

Dental Insurance:

Guardian HMO and PPO

ENROLLMENT

Period of Initial Eligibility

Your period of initial eligibility is your window of time to enroll in benefits when you begin. This window of

time is 31 days from the date you being your appointment.

If you do not submit your enrollment during this time, you will not be eligible to enroll in benefits until the next annual Open Enrollment period.

Qualifying Life Events

Qualifying life events allow you to make changes to your insurance outside of your period of initial eligibility and the annual open enrollment period.

Qualifying events include, but are not limited to:

•Marriage
•Divorce
•Birth of Child
•Adoption of a Child
•Entrance into the United States or relocation
•Loss of prior coverage

Please note: Documented proof of the qualifying event will be required.

Completing Your Initial Enrollment

- To complete your enrollment, visit the Gallagher Benefit Services (GBS) web site at **nupd.gpa.services** and click **Begin Enrollment.**
- Fill out required information to register as a NEW USER
- Once you have registered as a NEW USER and are viewing the enrollment wizard, interact with the required fields and progress through he wizard in order to:

1. Indicate which plans you wish to enroll in for the 2023 plan year
2. Enroll any eligible dependents, or
3. Waive coverage for you and/or your dependents

- Once the enrollment wizard is complete, please confirm that you have read and understand the applicable notices, then click **Finish Enrollment**.
- An electronic version of the enrollment form will be submitted to the GBS' secure website for enrollment & billing purposes. Feel free to print a copy for your records.
- Processing time is typically 3-5 business days. Feel free to contact us if the change you requested is not reflected within 5 business days.
- Your new ID cards (if applicable) will be mailed to your home directly from the Insurance Carrier(s).

Please Note: If you are adding a dependent to your health insurance , you will need to provide documentation to prove dependency. All documents can be uploaded via the link provided in the dependent section of the enrollment wizard. A list of documents approved to verify dependent status can be found on the website under **Dependent Verification**.

WEBSITE RESOURCES

Provider Directories

You can find a list of providers on the GBS website via the **Find a Provider** tool. If you enroll in the HMO plan, you are required to select a Primary Care Physician (PCP) or else one will be assigned to you. You do not need to choose a PCP if you are enrolled in the PPO plan. To find an HMO PCP, or a PPO provider when you wish to access service, follow the instructions under **Find a Provider**.

Benefit Summaries

This booklet contains benefit "snapshots" of the plans offered with information about core benefits. More detailed plan documents, including full benefit summaries and summaries of benefits and coverage (SBCs), are available on the GBS website.

SBCs summarize important information about medical insurance to help you learn about your benefits and compare options. On the website, click on **Plan Documents Library** to access detailed plan documents for all plans offered.

2023 Monthly Rates & Contributions

This information is available online under **Insurance Benefits and Rates**.

MEDICAL PLAN INFORMATION

HMO vs. PPO Medical Plan

HMO (Health Maintenance Organization)

- This plan offers a broad spectrum of benefit coverage with a higher degree of managed care. Managed care is a method of healthcare delivery designed to lower costs by limiting your ability to choose providers outside of your primary care physician's medical group (a group of physicians who have contractually agreed to share and coordinate patient care).
- Under the Health Maintenance Organization (HMO) model, you must choose a Primary Care Physician (PCP) within the network. You can change your PCP up to once a month. **Note:** If you do not choose a PCP, one will be assigned to you.
- Your Primary Care Physician (PCP) will be your first point of contact when accessing care, acting as your "healthcare gatekeeper."
- If you need to see a specialist, you will need a referral from your PCP first.
- The network is smaller than that of the PPO plan and limited to Illinois. The HMO does not offer an out-of-network benefit.
- In the event of a life/limb-threatening emergency, the member should dial 911 and all medical care will be covered as per the plan contract. Once the patient is stabilized, the HMO may require that the patient be transferred to an in-network facility.
- HMO out-of-pocket costs (i.e. deductible, co-payments, etc.) tend to be lower than the PPO plan option.

PPO (Preferred Provider Organization)

- The PPO plan offers more flexibility and choice than the HMO plan because it offers both "in-network" and "out-of-network" options.
- The in-network benefits (coinsurance, out-of-pocket maximum, etc.) will result in lower out-of-pocket costs than the out-of-network benefits.
- The PPO Plan and the Provider agree to a "discounted fee for service" model. This means that the participating provider has agreed to provide their services at a discounted rate. Providers outside the network have not agreed to that discounted rate and typically charge a "Reasonable and Customary" fee, resulting in higher out-of-pocket costs.

Due to HIPAA (Health Insurance Portability and Accountability Act) protection laws, Northwestern and Gallagher **do not** have access to your medical claims information.

GLOSSARY OF TERMS

Deductible

A specific dollar amount that your health insurance company requires you to pay out-of-pocket each year before your health insurance plan begins to make payments for claims. Not all health insurance plans require a deductible.

Out-of-Pocket Maximum

Out-of-pocket maximums apply to all medical plans. This is the maximum amount you will pay for health care costs in a calendar year. Once you have reached the out-of-pocket maximum, the plan will fully cover eligible medical expenses for the rest of the plan year. If you see an out-of-network provider, you will still be responsible for out-of-pocket costs that are above the “reasonable and customary” fees.

Copayment

A specific charge that you pay for a specific medical service or supply, also referred to as a "copay." For example, your health insurance plan may require a $20 copayment for an office visit or brand-name prescription drug, after which the insurance company pays the rest.

Coinsurance

The amount that you are required to pay for covered medical services after you've satisfied any co-payment or deductible required by your health insurance plan. Coinsurance is typically a percentage of the charge for a service. For example, if your insurance company covers 80% of the allowable charge for a specific service, you are responsible for the remaining 20% as coinsurance.

In-Network Provider

A healthcare professional, hospital, or pharmacy that has a contractual relationship with your health insurance company. This contract establishes allowable charges for specific services. In return, healthcare providers gain patients; primary care physicians may receive a fee for each patient assigned to their care. An ***out-of-network*** provider is a healthcare professional, hospital, or pharmacy that ***is not*** part of your health plan's network of preferred (in-network) providers. You will pay more for services received from out-of-network providers because you will be responsible for costs considered above the “reasonable and customary” fees.

Out-of-Pocket Maximum

Out-of-pocket maximums apply to all medical plans. This is the maximum amount you will pay for health care costs in a calendar year. Once you have reached the out-of-pocket maximum, the plan will cover most eligible medical expenses for the rest of the year.

Claim

A request by a plan member, or a plan member's health care provider, for the insurance company to pay for medical services.

Qualifying Life Event

A life event that allows you to make changes to your insurance coverage that otherwise are only allowed during the annual Open Enrollment period.

Examples of a qualifying life event include, but are not limited to, marriage, divorce, birth or adoption of a child, loss of prior coverage, relocation, and the arrival of a dependent from another country.

MEDICAL PLAN OPTIONS | HMO

BlueCross BlueShield of Illinois

	HMO
	In-Network
Core Benefits	**Visitor Pays**
Deductible **Single/Family**	None
Out of Pocket Maximums **Single/Family**	Medical: $1,500 / $3,000 Prescriptions: $1,500 / $10,200
Office Visit	$25 / $35 Copay
Annual Wellness Visit	No Charge
Inpatient Hospital	$500 per admission
Outpatient Surgery	$250 per visit
Emergency Room	$150 Copay*
Rx	$10 Tier 1 $30 Tier 2 $60 Tier 3 $90 Tier 4

**Copay waived if admitted*

Blue Access—Member Portal

Blue Access allows members to access a plethora of health insurance resources including digital ID cards, claims review, provider directory access and more. Please see page 11 for more information.

To register for Blue Access, simply:

- Visit bcbsil.com/member
- Click Register Now
- Use the information on your BCBSIL ID card to complete the registration process

Please note: HMO Plans require that you be assigned to a Primary Care Provider (PCP). If you do not designate a PCP when enrolling, one will be assigned to you based on the home address given .

MEDICAL PLAN OPTIONS | PPO

BlueCross BlueShield of Illinois

	PPO	
	In-Network / NMG	Out- of-Network
Core Benefits	**Visitor Pays**	**Visitor Pays**
Deductible Single/Family	$750 / $2,250	$1,500 / $4,500
Out of Pocket Maximums Single/Family	Medical: $3,000 / $8,000 Prescriptions: $1,500 / $5,450	Medical: $6,000 / $16,000 Prescriptions: $1,500 / $5,450
Office Visit	$25 / $35 Copay	40%*
Annual Wellness Visit	No Charge	20%*
Inpatient Hospital	20%*	20%*
Outpatient Surgery	20%*	20%*
Emergency Room	$150 Copay + 20%**	
Rx	$10 Tier 1 $30 Tier 2 $60 Tier 3 $90 Tier 4	$10 + 25% Tier 1 $30 + 25% Tier 2 $60 + 25% Tier 3 Tier 4 Not Covered

**After deductible has been met*

***Copay waived if admitted*

Blue Access—Member Portal

Blue Access allows members to access a plethora of health insurance resources including digital ID cards, claims review, provider directory access and more. Please see page 11 for more information.

To register for Blue Access, simply:

- Visit bcbsil.com/member
- Click Register Now
- Use the information on your BCBSIL ID card to complete the registration process

MEDICAL PLAN OPTIONS | BUY-UP PPO

BlueCross BlueShield of Illinois

	Buy-up PPO	
	In-Network / NMG	Out- of-Network
Core Benefits	**Visitor Pays**	**Visitor Pays**
Deductible **Single/Family**	$500 / $1,500	$1,500 / $4,500
Out of Pocket Maximums **Single/Family**	Medical: $1,800 / $4,800 Prescriptions: $1,500 / $5,450	Medical: $6,000 / $16,000 Prescriptions: $1,500 / $5,450
Office Visit	$10 / $20 Copay	40%*
Annual Wellness Visit	No Charge	40%*
Inpatient Hospital	10%*	40%*
Outpatient Surgery	10%*	40%*
Emergency Room	$150 Copay + 10%**	
Rx	$10 Tier 1 $30 Tier 2 $60 Tier 3 $90 Tier 4	$10 + 25% Tier 1 $30 + 25% Tier 2 $60 + 25% Tier 3 Tier 4 Not Covered

**After deductible has been met*

***Copay waived if admitted*

Blue Access—Member Portal

Blue Access allows members to access a plethora of health insurance resources including digital ID cards, claims review, provider directory access and more. Please see page 11 for more information.

To register for Blue Access, simply:

- Visit bcbsil.com/member
- Click Register Now
- Use the information on your BCBSIL ID card to complete the registration process

BlueCross BlueShield of Illinois

Find what you need

at Blue Access for Members℠

Blue Access for Members (BAM℠) is your online tool for health and insurance information. You can also use BAM from your mobile device, web browser, or download the app at **bcbsil.com**. BAM can give you access to your plan details anytime, anywhere.

My Coverage

Check your health care benefits and those for covered members of your family.

My Health

Make informed choices by reading about health topics and researching specific conditions.

Claims Center

View and arrange details such as payments, dates of service, claims status and more.

Providers & Hospitals

Find health care providers, hospitals and urgent care clinics near you.

Forms & Documents

Use the form finder to get medical, dental, pharmacy and other forms quickly.

Member ID Card

Print, download (through our app) or re-order your member ID Card.

MEDICAL PLAN WELLNESS PROGRAMS

24/7 Nurseline

Nurses available anytime you need them. Health happens – good or bad, 24 hours a day, seven days a week. That is why BCBSIL has registered nurses waiting to talk to you whenever you call the 24/7 Nurseline.

Behavioral Health Support

If you struggle with thoughts or feelings that make it harder to get through your day, you're not alone. About half of people in the U.S. will suffer from a mental health issue at some point in their lives. Care from a mental health expert can help you manage your emotions and deal with challenges.

Blue Access for Members (BAM) - Wellness Features

Online…on the phone…on the go. However you choose to fit good health into your daily life, you've got tools to help you. Sign up for Blue Access for Members (BAM) — where you can access all the health and wellness programs included with your plan.

Flu Prevention

Everyone six months of age and older should get a flu shot every season (beginning in October through February). Call the Customer Service number on the back of your member ID card to check your benefits.

Oncology Support

A cancer diagnosis can change your life forever. BCBSIL is here to help. Their oncology team will work with you to get the treatment, care and support that you and your family need.

Pharmaceutical Care Management

Your medical insurance plan has a program called Pharmaceutical Care Management (PCM). PCM can help answer questions you may have about your prescription drugs. It may also help you find ways to save on your out-of-pocket costs.

Preauthorization

Preauthorization (also known as 'prior authorization') means that approval is needed from your health plan before you have certain health tests or services. To help make sure your care is appropriate and avoid unexpected costs, it's important that approval is received before you get these services. Usually, your network provider will take care of preauthorization before the service is performed. But it is always a good idea to check if your doctor has gotten the needed approval.

Well OnTarget Fitness & Blue365 Member Discount Program

Well onTarget features a health assessment that helps tailor the program to help you reach your goals, the Blue Points program that allows members to earn points by participating in wellness activities and achieving goals online, and the Fitness Program that offers members unlimited access to a nationwide network of independently contracted fitness centers for a small monthly fee.

Please Note: PDFs with additional information on these programs can be found under **Wellness Programs** on the benefit program homepage.

DENTAL PLAN OPTIONS

Guardian

	HMO	PPO	
	In-Network	In-Network	Out-of-Network
Core Benefits	**Visitor Pays**	**Visitor Pays**	
Annual Deductible	None	$50 / $150	
Annual Benefit Maximums	Unlimited	$3,000	
PREVENTIVE/DIAGNOSTIC			
Routine Exam	$0	0%	0% of UCR
Teeth Cleanings (Prophylaxis)	$0	0%	0% of UCR
X-rays	$0	0%	0% of UCR
BASIC PROCEDURES			
Fillings	Varies up to $63 Copay	20%*	20% of UCR*
Endodontics	Varies up to $400 Copay	20%*	20% of UCR*
Periodontics	Varies up to $231 Copay	20%*	20% of UCR*
Oral Surgery	Varies up to $259 Copay	20%*	20% of UCR*
MAJOR PROCEDURES			
Crowns	Varies up to $511 Copay	50%*	50% of UCR*
Dentures	Varies up to $709 Copay	50%*	50% of UCR*
ORTHODONTIA			
Child	$3,070 Copay*	Child Only—50%* ($3,000 lifetime max)	Child Only—50% of UCR* ($3,000 lifetime max)
Adult	$3,430 Copay*		

*Does not include start-up and retention fees

*After deductible has been met

Accessing Out-of-Network Care Under a PPO Plan

When you seek services in-network, meaning, from providers listed in the PPO network, you pay less for care. When you pay 50% for major services from an in-network PPO dentist, you are paying 50% of a contracted, discounted rate. This is not the case with out-of-network providers.

Out-of-Network Example: The out-of-network dentist charges $1,000 for a porcelain crown on a molar. This dentist can charge whatever they want for this service. Your percentage of the cost for out-of-network care is 50% after the $50 deductible. For this service (a crown), the Usual, Customary and Reasonable (UCR) cost is $800, so you pay $425.

IN ADDITION, you owe the difference between the UCR amount and the dentist's charge ($1,000 -

$800), which is an additional $200.

Total estimated cost out-of-network for the porcelain crown on a molar: $625

What is a Usual, Customary and Reasonable (UCR) Charge?

Usual, customary and reasonable charges are set by the insurance company, based on the prevailing cost of a service in your geographic area. The insurance company then determines how much it will pay for a given service in your area.

VISION PLAN

	In-Network	Out-of-Network
Core Benefits	**Visitor Pays**	
Vision Examinations	$10 Copay	$40 Allowance
	Every 12 Months	
Corrective Lenses	$10 Copay	$30 - $70 Allowance
Conventional Contact Lenses*	$200 Allowance (15% off remaining balance)	$140 Allowance
Medically Necessary Contact Lenses*	$0 Copay	$210 Allowance
	Every 12 Months	
Frames	$200 Allowance (20% off remaining balance)	$140 Allowance
	Every 12 Months	

*Materials only; In lieu of corrective glasses

Additional Features

Eye Care Supplies: Receive 20% off retail price for eye care supplies like cleaning cloths and solutions purchased at in-network providers (not valid on doctor's services or contact lenses).

Laser Vision Correction: Save 15% off retail price or 5% off the promotional price for LASIK or PRK procedures.

Replacement Contact Lens Purchases: Visit www.eyemedcontacts.com to order replacement contact lenses at less than retail price.

VISITING RATES AND CONTRIBUTIONS

Medical HMO	
Postdoctoral Trainee	$521.46
Postdoc + Spouse/Partner	$1,007.97
Postdoc + Child(ren)	$967.30
Family	$1,496.58
Medical PPO	
Postdoctoral Trainee	$488.96
Postdoc + Spouse/Partner	$945.17
Postdoc + Child(ren)	$907.03
Family	$1,403.32
Medical Buy-up PPO	
Postdoctoral Trainee	$516.46
Postdoc + Spouse/Partner	$998.31
Postdoc + Child(ren)	$958.03
Family	$1,482.23
Dental HMO	
Postdoctoral Trainee	$18.52
Postdoc + Spouse/Partner	$33.57
Postdoc + Child(ren)	$34.73
Family	$50.94
Dental PPO	
Postdoctoral Trainee	$49.75
Postdoc + Spouse/Partner	$108.21
Postdoc + Child(ren)	$121.89
Family	$172.89
Vision	
Postdoctoral Trainee	$8.53
Postdoc + Spouse/Partner	$16.21
Postdoc + Child(ren)	$17.06
Family	$25.08

**Amounts listed are per month

INFORMATION SOURCES

Insurance Carrier Member Services

Blue Cross Blue Shield of Illinois Medical.....	HMO— (800) 892-2803 PPO and Buy-up PPO — (800) 541-2767
Guardian Dental.....	HMO—(866) 494-4542 PPO—(800) 541-7846
EyeMed Vision.....	(866) 723-0514

Gallagher Benefit Services (GBS)

Phone.....	(844) 315-4550
Email.....	UniversityServices.GBS.nupfbp@ajg.com
Benefit Program Website.....	http://clients.garnett-powers.com/pd/northwesternu/

Gallagher

Insurance | Risk Management | Consulting