Schedule of Medical Expense Benefits
Injury and Sickness Benefits

Plan Maximum Benefit (per Covered Person, per Policy Year)	**$500,000**
Deductible (per Covered Person, per Policy Year)	**$200**

After the Deductible is satisfied, benefits will be paid based on the selected Provider up to the Plan Maximum. Benefits will be paid at 80% of the Allowable Amount for services rendered by Network Providers in the Blue Cross and Blue Shield of Illinois (BCBSIL) PPO Network, unless otherwise specified in the Policy. Services obtained from Out-of-Network Providers (any provider not participating in the BCBSIL PPO Network) will be paid at 60% of the Allowable Amount, unless otherwise specified in the Policy. Students are responsible to pay amounts over the Allowable Amount, if any. Benefits will be paid up to the maximum benefit for each service as specified below regardless of the provider selected.

BEU Health Center (BHC): The Deductible will be waived and benefits provided at the BHC are paid at 100% of Covered Expenses.

Covered Expenses are:

Inpatient	Network Provider	Out-of-Network Provider
Hospital Expense, daily semi-private room rate; intensive care; general nursing care provided by the Hospital; Hospital Miscellaneous Expenses such as the cost of the operating room, Laboratory tests, X-ray examinations, pre-admission testing, anesthesia, drugs (excluding take home drugs) or medicines, Physical Therapy, therapeutic services and supplies.	80% of Allowable Amount	60% of Allowable Amount
Surgical Expense, when multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for the full Allowable Amount for that procedure. The surgical procedure with the highest Allowable Amount should be priced at 100% of the Allowable Amount and the remaining eligible procedures should be priced at 50% of the Allowable Amount.	80% of Allowable Amount	60% of Allowable Amount
Assistant Surgeon	80% of Allowable Amount	60% of Allowable Amount
Anesthetist	80% of Allowable Amount	60% of Allowable Amount
Doctor's Visits	80% of Allowable Amount	60% of Allowable Amount
Routine Well-Baby Care	80% of Allowable Amount	60% of Allowable Amount
Mental & Nervous Disorder / Alcoholism & Drug Abuse	Paid as any other covered Sickness	Paid as any other covered Sickness

OUTPATIENT	NETWORK Provider	OUT-OF-NETWORK PROVIDER
Surgical Expense, when multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for the full Allowable Amount for that procedure. The surgical procedure with the highest Allowable Amount should be priced at 100% of the Allowable Amount and the remaining eligible procedures should be priced at 50% of the Allowable Amount.	80% of Allowable Amount	60% of Allowable Amount
Day Surgery Miscellaneous, related to scheduled surgery performed in a Hospital, including the cost of the operating room, Laboratory tests, X-ray examinations, including professional fees, anesthesia, drugs or medicines and supplies.	80% of Allowable Amount	60% of Allowable Amount
Assistant Surgeon	80% of Allowable Amount	60% of Allowable Amount
Anesthetist	80% of Allowable Amount	60% of Allowable Amount
Doctor's Visits	80% of Allowable Amount	60% of Allowable Amount
Physical Therapy, includes but not limited to chiropractic care, occupational therapy, cardiac rehabilitation therapy, manipulative treatment and speech therapy.	80% of Allowable Amount	60% of Allowable Amount
Emergency Room Expenses, benefits are payable for the use of the Emergency Room & Supplies.	80% of Allowable Amount	60% of Allowable Amount for Non-Emergency 80% of Allowable Amount for Emergency
Radiation Therapy and Chemotherapy	80% of Allowable Amount	60% of Allowable Amount
Diagnostic X-rays & Laboratory Procedures	80% of Allowable Amount	60% of Allowable Amount
Injections, when administered in the Doctor's office and charged on the Doctor's statement.	80% of Allowable Amount	60% of Allowable Amount
Tests & Procedures, diagnostic services and medical procedures performed by a Doctor, other than Doctor's Visits, Physical Therapy and X-rays and Lab procedures. The following therapies will be paid under this benefit: inhalation therapy, infusion therapy, pulmonary therapy and respiratory therapy.	80% of Allowable Amount	60% of Allowable Amount
Prescription Drugs, all prescriptions are limited to 30 day retail supply. Includes benefits for diabetic supplies.	***At pharmacies contracting with the Prime Therapeutics Network*** 100% of Allowable Amount after a $20 Copayment for each Generic Drug $40 Copayment for each Preferred Brand Name Drug $60 Copayment for each Non-Preferred Brand Name Drug	60% of Allowable Amount after a $20 Copayment for each Generic Drug $40 Copayment for each Preferred Brand Name Drug $60 Copayment for each Non-Preferred Brand Name Drug
Mental & Nervous Disorder / Alcoholism & Drug Abuse, includes all related or ancillary charges incurred as a result of a Mental & Nervous Disorder.	Paid as any other covered Sickness	Paid as any other covered Sickness

OTHER	NETWORK Provider	OUT-OF-NETWORK PROVIDER
Ambulance Service	80% of Allowable Amount	80% of Allowable Amount
Durable Medical Equipment, when prescribed by a Doctor and a written prescription accompanies the claim when submitted.	80% of Allowable Amount	60% of Allowable Amount
Dental, $1,000 maximum, made necessary by Injury to sound, natural teeth only.	80% of Allowable Amount	80% of Allowable Amount
Maternity/Complications of Pregnancy	80% of Allowable Amount	60% of Allowable Amount
Preventive Care Services, benefits include but not limited to: a. An annual routine physical exam, annual Pap smear, annual mammogram screening, prostate screening, colorectal screening and immunizations. b. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF"); c. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC"); d. Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, child(ren), and adolescents; and e. With respect to women, such additional preventive care and screenings, not described in item "a" above, as provided for in comprehensive guidelines supported by the HRSA. Preventive Care services as mandated by state and federal law. Please refer to the Policy or call Blue Cross and BCBSIL for more information at (855) 267-0214.	100% of Allowable Amount	60% of Allowable Amount