AcademicBlue℠
A Division of Health Care Service Corporation, A Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
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Schedule of Benefits

Covered Persons' Benefits are highlighted below. However, to fully understand their Benefits, it is very important that Covered Persons read this entire Policy. Although Covered Persons can go to the Hospital or Provider of their choice, Benefits under this Policy will be greater when they use the services of a Network Provider. Your Deductible applies to all Benefits described below, unless otherwise stated.

Deductible:	Network Provider	Out-of-Network Provider
Per Covered Person per Benefit Period:	$500	$1,000

Out-of-Pocket Maximum:	Network Provider	Out-of-Network Provider
Per Covered Person per Benefit Period:	$8,150	$16,300
Per Family per Benefit Period:	$16,300	$32,600

Covered Expenses	Network Provider Covered Person Pays	Out-of-Network Provider* Covered Person Pays
Inpatient Expenses		
Hospital Expenses	20% of Allowable Amount	50% of Allowable Amount
Surgical Expenses for a Primary Procedure	20% of Allowable Amount	50% of Allowable Amount
- Remaining Eligible Procedures	20% of Allowable Amount	50% of Allowable Amount
- Assistant Surgeon Services	20% of Allowable Amount	50% of Allowable Amount
- Anesthetist Services	20% of Allowable Amount	50% of Allowable Amount
Doctor's Visits	20% of Allowable Amount	50% of Allowable Amount
Mental Health Care/Chemical Dependency	20% of Allowable Amount	50% of Allowable Amount
Substance Use Disorder	20% of Allowable Amount	50% of Allowable Amount
Outpatient Expenses		
Surgical Expenses for a Primary Procedure	20% of Allowable Amount	50% of Allowable Amount

- Remaining Eligible Procedures	20% of Allowable Amount	50% of Allowable Amount
- Assistant Surgeon Services	20% of Allowable Amount	50% of Allowable Amount
- Anesthetist Services	20% of Allowable Amount	50% of Allowable Amount
Day Surgery/Outpatient Surgical Expenses	20% of Allowable Amount	50% of Allowable Amount
Day Surgery Miscellaneous Expenses	20% of Allowable Amount	50% of Allowable Amount
Mental Health Care/Chemical Dependency	20% of Allowable Amount	50% of Allowable Amount
Substance Use Disorder	20% of Allowable Amount	50% of Allowable Amount
Emergency Room Accidents and Emergency Care (including Accidents, and Emergency Care and Non-Emergency Care for Behavioral Health Services)		
Facility Charges (excluding certain diagnostic procedures)	20% of Allowable Amount $300 Copayment per visit (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)	
Physician Charges	20% of Allowable Amount	
Diagnostic X-Ray and Laboratory Services	20% of Allowable Amount	
Emergency Room Non-Emergency Care		
Facility Charges (excluding certain diagnostic procedures)	20% of Allowable Amount After a $300 Copayment per visit	50% of Allowable Amount After a $300 Copayment per visit
Physician Charges	20% of Allowable Amount	
Diagnostic X-ray and Laboratory Services	20% of Allowable Amount	
Other Expenses		
Ground and Air Ambulance Transportation**	20% of Allowable Amount	
Urgent Care	$50 Copayment Deductible Waived	50% of Allowable Amount After a $30 Copayment Deductible Waived

Preventive Care Services	No Charge	50% of Allowable Amount
Routine Well-Baby Care	No Charge	50% of Allowable Amount
Routine Pediatric Hearing Examinations	No Charge	50% of Allowable Amount
Office Visits	$30 Copayment Deductible Waived	50% of Allowable Amount After a $30 Copayment Deductible Waived
Office Visit for Behavioral Health Services	$30 Copayment Deductible Waived	20% of Allowable Amount After a $30 Copayment Deductible Waived
Specialist Office Visit	$30 Copayment Deductible Waived	50% of Allowable Amount After a $30 Copayment Deductible Waived
Telehealth Visits	$30 Copayment Deductible Waived	50% of Allowable Amount After a $30 Copayment Deductible Waived
Telehealth Visits For Behavioral Health Services	$30 Copayment Deductible Waived	20% of Allowable Amount After a $30 Copayment Deductible Waived
Radiation and Chemotherapy Services	20% of Allowable Amount	50% of Allowable Amount
Allergy Testing and Allergy Injections (Copayment and/or Coinsurance may apply if billed in the office)	20% of Allowable Amount	50% of Allowable Amount
Chiropractic and Osteopathic Manipulation Benefits will be limited to 25 visits per Benefit Period	20% of Allowable Amount	50% of Allowable Amount
Additional Surgical Opinion	20% of Allowable Amount	50% of Allowable Amount
Autism Spectrum Disorder Visit limitations are not Applicable to treatment of Autism and Autism Spectrum Disorders	20% of Allowable Amount	50% of Allowable Amount
Durable Medical Equipment	20% of Allowable Amount	50% of Allowable Amount
Orthotic Devices	20% of Allowable Amount	50% of Allowable Amount
Habilitative Services and Devices	20% of Allowable Amount After a $30 Copayment	50% of Allowable Amount After a $30 Copayment

Dental Treatment (Injury only to sound, natural teeth)	20% of Allowable Amount	
Tests and Procedures	20% of Allowable Amount	50% of Allowable Amount
Blood and Blood Components	20% of Allowable Amount	50% of Allowable Amount
Naprapathic Services Benefits will be limited to 15 visits per Benefit Period	20% of Allowable Amount	50% of Allowable Amount
Bariatric Surgery	20% of Allowable Amount	50% of Allowable Amount
Organ and Tissue Transplants	20% of Allowable Amount	50% of Allowable Amount
Injections – when administered in the Doctor's Office and charged on the Doctor's statement Deductible Waived	20% of Allowable Amount	50% of Allowable Amount
Abortion Services	20% of Allowable Amount	50% of Allowable Amount
Extended Care Expenses		
Skilled Nursing Facility No Benefit Period Visit Maximum	20% of Allowable Amount	50% of Allowable Amount
Coordinated Home Health Care No Benefit Period Visit Maximum	20% of Allowable Amount	50% of Allowable Amount
Hospice Services No Benefit Period Visit Maximum	20% of Allowable Amount	50% of Allowable Amount
Private Duty Nursing Services No Benefit Period Visit Maximum	20% of Allowable Amount	50% of Allowable Amount
Cardiac Rehabilitation Services	20% of Allowable Amount	50% of Allowable Amount
Pulmonary Rehabilitation Therapy	20% of Allowable Amount	50% of Allowable Amount

The Copayment and Coinsurance amounts mentioned above are subject to change or increase as permittable by Applicable Law.

* Covered Persons will be responsible for the difference between the Allowable Amount and the billed charges, when receiving Covered Services from an Out-of-Network Provider. For questions concerning Out-of-Network Providers, please call Blue Cross and Blue Shield of Illinois Customer Service at the toll-free telephone number on the back of your Identification Card.

** Notwithstanding anything else described herein, Providers of Ambulance Transportation will be paid based on the amount that represents the billed charges from the majority of the ambulance providers in the Chicago metro area, as submitted to Blue Cross and Blue Shield of Illinois.

Schedule of Benefits for Outpatient Prescription Drugs

Certain covered drugs may be available at no cost through a Participating Pharmacy for the following categories of medication:

- Severe allergic reactions
- Hypoglycemia
- Opioid overdoses
- Nitrates

For further information, call the toll-free telephone number on the back of your Identification Card.

Retail Pharmacy Benefit

Retail Pharmacy:	Participating Pharmacies Covered Person Pays	Non-Participating Pharmacies Covered Person Pays**
Preferred Generic Drugs and Preferred Generic diabetic supplies, insulin, and insulin syringes	$15 Copayment	50% of Allowable Amount after a $15 Copayment
Non-Preferred Generic Drugs and Non-Preferred Generic diabetic supplies, insulin, and insulin syringes	$15 Copayment	50% of Allowable Amount after a $15 Copayment
Preferred Brand Name Drugs and Preferred Brand Name diabetic supplies, insulin, and insulin syringes	$35 Copayment	50% of Allowable Amount after a $35 Copayment
Non-Preferred Brand Name Drugs and Non-Preferred Brand Name diabetic supplies, insulin, and insulin syringes for which there is a Generic Drug or supply available	$50 Copayment	50% of Allowable Amount after a $50 Copayment
Preferred Specialty Drugs	N/A	N/A
Non-Preferred Specialty Drugs	N/A	N/A

* One prescription means up to a 30 day supply of a drug (except for certain drugs).

Students can purchase a 90-day supply for 3 times the schedule amount listed above.

** Non-Participating Pharmacies: When a Covered Person obtains Prescription Drugs, including diabetic supplies from a Non-Participating Pharmacy, Benefits will be provided at 50% of the amount a Covered Person would have received had he/she obtained drugs from a Network Pharmacy minus the Copayment amount or Coinsurance amount.

Mail Order Prescription Drug Program

Mail Order Pharmacy Benefit*:	Mail Order Pharmacy Covered Person Pays
Preferred Generic Drugs; and Preferred Generic diabetic supplies, insulin, and insulin syringes	$45 per prescription
Non-Preferred Generic Drugs; and Non-Preferred Generic diabetic supplies, insulin, and insulin syringes	$45 per prescription
Preferred Brand Name Drugs; and Preferred Brand Name diabetic supplies, insulin, and insulin syringes	$105 per prescription
Non-Preferred Brand Name Drugs; and Non-Preferred Brand Name diabetic supplies, insulin, and insulin syringes for which there is a Generic Drug or supply available	$150 per prescription
Preferred Specialty Drugs	N/A
Non-Preferred Specialty Drugs	N/A

*One prescription means up to a 90 consecutive day supply for a drug (except for certain drugs).

Specialty Pharmacy Benefit

Coverage for Specialty Drugs are limited to a 30-day supply. However, some Specialty Drugs have FDA approved dosing regimens exceeding the 30-day supply limited and may be allowed greater than a 30 day-supply, if allowed by your plan benefits. Cost-share will be based on the day supply dispensed, (1-30 day supply; 31-60 day supply; 61-90 day supply).

Specialty Pharmacy Benefit:	Specialty Pharmacy Covered Person Pays
Preferred Generic Drugs; and Preferred Generic diabetic supplies, insulin, and insulin syringes	N/A
Non-Preferred Generic Drugs; and Non-Preferred Generic diabetic supplies, insulin, and insulin syringes	N/A
Preferred Brand Name Drugs; and Preferred Brand Name diabetic supplies, insulin, and insulin syringes	N/A
Non-Preferred Brand Name Drugs; and Non-Preferred Brand Name diabetic supplies, insulin, and insulin syringes for which there is a Generic Drug or supply available	N/A
Preferred Specialty Drugs	Same as Retail
Non-Preferred Specialty Drugs	Same as Retail

Schedule of Benefits for Pediatric Vision Care Services

Only for Covered Persons under the age of 19

Vision Care Services	EyeMed Provider Benefit	Non-Contracting Provider Reimbursement Amount
Exam (with dilation as necessary):	No Copayment	Up to $30
Frames:		
Any available frame at provider location	No Copayment on provider designated frame $150 allowance on non-provider designated frame 20% off balance over $150	Up to $75
Standard Plastic Lenses:		
Single Vision	No Copayment	Up to $25
Bifocal	No Copayment	Up to $40
Trifocal	No Copayment	Up to $55
Lenticular	No Copayment	Up to $55
Lens Options:		
UV Treatment	No Copayment	Up to $12
Tint (Fashion & Gradient & Glass-Grey)	No Copayment	Up to $12
Standard Plastic Scratch Coating	No Copayment	Up to $12
Standard Polycarbonate	No Copayment	Up to $32
Glass	No Copayment	Up to $12
Oversized	No Copayment	N/A
Photochromic / Transitions Plastic	No Copayment	Up to $57
Contact Lenses: *(Contact Lens allowance includes materials only)*		
Conventional	1 pair from selection of provider designated contact lenses	Up to $150
Disposable	Up to 3 months supply of daily disposable, single vision spherical contact lenses	Up to $150
Medically Necessary Note: In some instances, Participating Providers may charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the contact lenses received is less than the allowance, a Covered Person may submit a Claim for the remaining balance (the combined reimbursement will not exceed the total allowance).	No Copayment Paid-in-Full	Up to $210

Frequency:	
Examinations, Lenses, or Contact Lenses	Once every Benefit Period
Frame	Once every Benefit Period
Routine eye exams do not include professional services for contact lens evaluations. Any Applicable fees are the responsibility of the patient.	
Value-added features: **Laser vision correction:** 15% off Retail Price or 5% off promotional price.	
Additional Pairs Benefit: Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded Benefit has been used.	
Additional Benefits	
Medically Necessary contact lenses: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions: • Keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism. • Medically necessary contact lenses are dispensed in lieu of other eyewear. Participating Providers will obtain the necessary Prior Authorization for these services.	
Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision for Our Covered Persons with low vision. Covered low vision services (both Contracting and Non-Contracting) will include one comprehensive low vision evaluation every 5 years; items such as high-power spectacles, magnifiers, and telescopes; and follow-up care - four visits in any five-year period. Participating Providers will obtain the necessary Prior Authorization for these services.	
Warranty: Warranty limitations may apply to Provider or retailer supplied frames and/or eyeglass lenses. Covered Persons should ask their Provider for details of the warranty that is available to them.	
Note: Additional discounts on materials may be available.	

*The covered charge is the rate negotiated with Network Providers for a particular covered service.

**The Plan pays the lesser of the maximum allowance noted or the retail cost. Retail prices vary by location.