



**BlueCross BlueShield
of Illinois**

University of Illinois-Springfield
Student Health Insurance Plan

Dear Student:

Under the Affordable Care Act, all health insurers and group health plans are required to provide consumers with a Summary of Benefits and Coverage (SBC). The SBC is a summary of the benefits and health coverage offered by a particular plan.

Attached is the SBC for the University of Illinois-Springfield Student Health Plan covering plans purchased between 08/01/16 - 08/15/17. In accordance with your College/University, coverage may be purchased for varying periods of time. The coverage periods University of Illinois-Springfield are listed below:

Coverage Period	Date
Fall	08/16/16 - 01/09/17
Spring	01/10/17 - 05/31/17
Summer	06/01/17 - 08/15/17
Early Athletes	08/01/16 - 08/15/17

If you have any questions regarding your coverage or the length of time you purchased, please contact customer service at 855-267-0214.



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsil.com/member/policy-forms or by calling 1-855-267-0214.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	For In-Network \$400 Individual/ \$1,200 Family For Out-of-Network \$800 Individual/ \$2,400 Family Doesn't apply to certain preventative care.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes. \$100 deductible for In-Network hospital admission. \$100 deductible for Out-of-Network hospital admission.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For In-Network \$6,850 Individual/ \$13,700 Family For Out-of-Network \$13,700 Individual/ \$27,400 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums, balanced-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Does this plan use a network of providers ?	Yes. For a list of In-Network Providers see www.bcbsil.com or call 1-855-267-0214.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-855-267-0214 or visit us at www.bcbsil.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-855-756-4448 to request a copy.

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



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	No benefits will be provided for services which are not, in the reasonable judgment of Blue Cross and Blue Shield, medically necessary.
	Specialist visit	20% coinsurance	50% coinsurance	---none---
	Other practitioner office visit	20% coinsurance	50% coinsurance	Chiropractic and Osteopathic manipulation services are limited to a combined maximum of 25 visits per benefit period.
	Preventive care/screening/immunization	No Charge	50% coinsurance	---none---
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	---none---

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsil.com .	Generic drugs	\$10 copay/prescription for up to 30 day supply.	\$10 copay/prescription for up to 30 day supply.	For Out-of-Network drug provider you are responsible for 50% of the eligible amount after the copay.
	Formulary brand drugs	\$30 copay/prescription for up to 30 day supply.	\$30 copay/prescription for up to 30 day supply.	Certain women's preventative services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service. Retail covers a 30 day supply/Mail Order is available up to 90 days with 1 copay per 30 days.
	Non-Formulary brand drugs	\$60 copay/prescription for up to 30 day supply.	\$60 copay/prescription for up to 30 day supply.	For Out-of-Network drug provider you are responsible for 50% of the eligible amount after the copay.
	Specialty drugs	Covered	Covered	---none---
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	50% coinsurance	---none---
If you need immediate medical attention	Emergency room services	Emergency room \$50 copay plus Emergency room services 20% coinsurance.	Emergency room \$50 copay plus Emergency room services 20% coinsurance.	Copay waived if admitted. Non-emergency use of the emergency room is 50% coinsurance after deductible and copay Out-of-Network.
	Emergency medical transportation	20% coinsurance	20% coinsurance	---none---
	Urgent care	20% coinsurance	50% coinsurance	---none---

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	\$100 deductible per admission for In-Network providers. \$100 deductible per admission for Out-of-Network providers.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	50% coinsurance	---none---
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	\$100 deductible per admission for In-Network providers. \$100 deductible per admission for Out-of-Network providers.
	Substance use disorder outpatient services	20% coinsurance	50% coinsurance	---none---
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	\$100 deductible per admission for In-Network providers. \$100 deductible per admission for Out-of-Network providers.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	---none---
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	\$100 deductible per admission for In-Network providers. \$100 deductible per admission for Out-of-Network providers.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	---none---
	Rehabilitation services	20% coinsurance	50% coinsurance	---none---
	Habilitation services	20% coinsurance	50% coinsurance	---none---
	Skilled nursing care	20% coinsurance	50% coinsurance	---none---
	Durable medical equipment	20% coinsurance	50% coinsurance	Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice service	20% coinsurance	50% coinsurance	---none---
If your child needs dental or eye care	Eye exam	Covered	Covered	---none---
	Glasses	Covered	Covered	---none---
	Dental check-up	Covered	Covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Routine Eye Care (Adult)
- Routine Foot Care (with the exception of person with diagnosis of diabetes)
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids (Limited coverage for children)
- Infertility Treatment
- Most coverage provided outside the United States. See www.bcbsil.com.
- Non-Emergency Care When Traveling Outside the U.S.
- Private Duty Nursing (with the exception of inpatient private duty nursing)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-538-8833. You may also contact your state insurance department at 1-877-527-9431.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Illinois Department of Insurance at (877) 527-9431 or visit <http://insurance.illinois.gov>.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-267-0214.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-267-0214.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-267-0214.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-267-0214.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,520
- Patient pays \$2,020

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$500
Copays	\$20
Coinsurance	\$1,350
Limits or exclusions	\$150
Total	\$2,020

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,120
- Patient pays \$1,280

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$400
Copays	\$400
Coinsurance	\$400
Limits or exclusions	\$80
Total	\$1,280

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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