



AcademicBlue<sup>SM</sup>



# University of Illinois - Springfield Student Health Insurance Plan 2017-2018

Underwritten by:  
Blue Cross and Blue Shield of Illinois  
(BCBSIL)

*Please read the brochure to understand your coverage.  
Please see "Important Notice" on the final page of this document.*

Account Number:  
Medical: 97337



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## Introduction

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**University Of Illinois Springfield** is pleased to offer the AcademicBlue Student Health Insurance Plan, underwritten by Blue Cross and Blue Shield of Illinois and administered by Academic HealthPlans (AHP). This brochure explains your health care benefits, including what health care services are covered and how to use the benefits. This Insurance Plan protects Insured students and their covered Dependents on or off campus for weekends, holidays, summer vacations, at home or while traveling 24 hours per day for the Policy year. This Plan meets the requirements of the Affordable Care Act. The actuarial value meets or exceeds a "Gold" metal level of coverage. This policy will always pay benefits in accordance with any applicable federal and Illinois state insurance law(s).

Please keep these three fundamental Plan features in mind as you learn about this Policy:

- **This Student Health Insurance Plan is a Participating Provider Option (PPO) Plan.** You should seek treatment from the BCBSIL Participating Provider Option (PPO) Network, which consists of hospitals, doctors, ancillary, and other health care providers who have contracted with BCBSIL for the purpose of delivering covered health care services at negotiated prices, so you can maximize your benefits under this Plan. A list of Network Providers can be found online at [uis.myahpcare.com](http://uis.myahpcare.com) or by calling **(855) 267-0214**. Using BCBSIL providers may save you money.
- **Participating in an insurance Plan does not mean all of your health care costs are paid in full by the insurance company.** There are several areas for which you could be responsible for payment, including, but not limited to, a Deductible, a Copayment or Coinsurance (patient percentage of Covered Expenses), and medical costs for services excluded by the Plan.
- **It is your responsibility to familiarize yourself with this Plan.** Exclusions and limitations are applied to the coverage as a means of cost containment (please see page 17 for more details). To make this coverage work for you, it is helpful to be informed and proactive. Check the covered benefits in this brochure before your procedure whenever possible. Know the specifics and communicate them to your health care provider. Review the User Guide for a step-by-step overview of how to use your benefits.

### **We are here to help.**

Representatives from Academic HealthPlans and BCBSIL are available to answer your questions. You may contact AHP at **(855) 856-3549** for enrollment and eligibility questions and BCBSIL at **(855) 267-0214** for benefit and claim questions.

AcademicBlue<sup>SM</sup> is offered by 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.

Academic HealthPlans, Inc. (AHP) is a separate company that provides program management and administrative services for the student health plans of Blue Cross and Blue Shield of Illinois.

**Please Note:** We have capitalized certain terms that have specific, detailed meanings, which are important to help you understand your Policy. Please review the meaning of the capitalized terms in the “Definitions” section on page 13.

## Privacy Notice

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We know that your privacy is important to you and we strive to protect the confidentiality of your personal health information. Under the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA), we are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You will receive a copy of the HIPAA Notice of Privacy Practices upon request. Please write to Academic HealthPlans, Inc., P.O. Box 1605, Colleyville, TX 76034-1605 or call **(855) 856-3549**, or you may view and download a copy from the website at [uis.myahpcare.com](http://uis.myahpcare.com).

## Eligibility/How to Enroll

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The Policy issued to the University is a non-renewable, one-year-term Policy. However, if you still maintain the required eligibility, you may purchase the Plan the next year. It is the Covered Person’s responsibility to enroll for coverage each year in order to maintain continuity of coverage, unless you are automatically enrolled. If you no longer meet the eligibility requirements, contact Academic HealthPlans at **(855) 856-3549** prior to your termination date.

### *Eligibility Requirements*

All students physically participating in classes on campus are required to maintain health insurance as a condition of enrollment unless proof of comparable coverage is provided. A student may waive out of the Policy by completing the online waiver by the absolute deadlines of September 25, 2017, for the fall semester, February 28, 2018, for spring semester and June 15, 2018, for the summer semester.

A student must actively attend classes for at least the first 31 days after the date for which coverage is purchased unless he or she withdraws from classes due to an Injury or Sickness and the absence is an approved medical leave. Home study, correspondence, Internet classes and television (TV) courses do not fulfill the eligibility requirements that the student must actively attend classes. The Company maintains its right to investigate student status and attendance records to verify that the eligibility requirements have been met. If the Company discovers the eligibility requirements have not been met, its only obligation is refund of premium.

Eligible students who enroll may also insure their Dependents. Dependent enrollment must take place within 30 days of student’s first day of academic enrollment, if the premium is billed with the student’s tuition; exceptions to this rule are made for newborn or adopted children, or for Dependents who become eligible for coverage as the result of a qualifying event. (Please see “Qualifying Events,” on page 3 for more details.) “Dependent” means an Insured’s lawful spouse including Domestic Partner; or an Insured’s child, stepchild, child of a Covered Person’s Domestic Partner, foster child, dependent grandchild or spouse’s dependent grandchild; or a child who is adopted by the Insured or placed for adoption with the Insured, or for whom the Insured is a party in a suit for the adoption of the child; or a child whom the Insured is required to insure under a medical support order issued or enforceable by the courts. Any such child must be under age 26.

Coverage will continue for a child who is 26 or more years old, chiefly supported by the Insured and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to the Company within 31 days after the date the child ceases to qualify as a dependent for the reasons listed above. During the next two years, the Company may, from time to time, require proof of the continuation of such condition and dependence. After that, the Company may require proof no more than once a year. Dependent coverage is available only if the student is also insured. Dependent coverage must take place within the exact same coverage period as the Insured's; therefore, it will expire concurrently with that of the Insured's Policy.

A newborn child will automatically be covered for the first 31 days following the child's birth. To extend coverage for a newborn child past the 31-day period, the covered student must:

- 1) Enroll the child within 31 days of birth, and
- 2) Pay any required additional premium

If you're not eligible for the Student Health Insurance Plan and would like coverage, please visit **ahpcare.com**.

If you're enrolled in Medicare due to age or disability, you are not eligible for the Student Health Insurance Plan.

## Qualifying Events

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Eligible students who have a change in status and lose coverage under another health care plan are eligible to enroll for coverage under the Policy provided that, within 31 days of the qualifying event, such students send to Academic HealthPlans:

- A copy of the Certificate of Creditable Coverage, or a letter of ineligibility (lost coverage), from their previous health insurer
- A Qualifying Events form, which they can download from **uis.myahpcare.com**

A change in status due to a qualifying event includes but is not limited to:

- Birth or adoption of a child
- Loss of a spouse, whether by death, divorce, annulment or legal separation
- If you are no longer covered on a family member's policy because you turned 26

The premium will be prorated based on what it would have been at the beginning of the semester or quarter, whichever applies. However, the effective date will be the later of the following: the date the student enrolls for coverage under the Policy and pays the required premium, or the day after the prior coverage ends. To apply for coverage that is needed because of a qualifying event, you may download the "Qualifying Events Form" from **uis.myahpcare.com**.

## Effective Dates and Termination

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The Policy on file at the school becomes effective at 12:00 a.m. Central time at the University's address on the later of the following dates:

- 1) The effective date of the Policy, **August 16, 2017**; or
- 2) The date premium is received by the Company or its authorized representative.

### *Effective & Termination Dates*

	From	Through
<b>Fall</b>	08/16/2017	01/09/2018
<b>Spring</b>	01/10/2018	05/31/2018
<b>Summer</b>	06/01/2018	08/15/2018

### *OPEN ENROLLMENT PERIODS*

The open enrollment periods during which those voluntary students may apply for or change coverage for their eligible spouses and/or Dependents, is as follows:

**Fall** - 07/14/2017 – 09/25/2017

**Spring** - 12/01/2017 – 02/28/2018

**Summer** - 05/01/2018 – 06/15/2018

The coverage provided with respect to the Covered Person shall terminate at 11:59 p.m. Central time on the earliest of the following dates:

- 1) The last day of the period through which the premium is paid;
- 2) **August 15, 2018**; or
- 3) The date the eligibility requirements are not met.

### *Renewal Notice*

It is the student's responsibility to make a timely renewal payment to avoid a lapse in coverage. Please refer to your enrollment form to review the payment options you selected as a reminder of the enrollment periods and effective dates for your campus. Mark your calendar now to avoid any lapse in coverage. All Insureds who enroll for periods of less than one year will be mailed a renewal notice, to the Insured's last known address, to submit their next premium payment; however, it is the Insured's responsibility to make a timely renewal payment.

**PLEASE NOTE:** Renewal notices will not be mailed from one policy year to the next. If you maintain your student status, you will be eligible to enroll in the following year's policy. If you do not maintain your student status, you may be eligible for continuation of coverage (please see page 5 for more information). Contact your campus office that is responsible for student insurance before the policy termination date for information on continuation of coverage.

**Coverage period notice:** Coverage Periods are established by the University and subject to change from one Policy year to the next. In the event that a coverage period overlaps another coverage period, the prior coverage period will terminate as of the effective date of the new coverage period. In no case will an eligible member be covered under two coverage periods within the same group.

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## Extension of Benefits After Termination

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The coverage provided under the Plan ceases on the termination date. However, if a Covered Person is hospital-confined on the termination date for a covered Injury or Sickness for which benefits were paid before the termination date, the Covered Expenses for such covered Injury or Sickness will continue to be paid provided the condition continues. However, payments will not continue after the earlier of the following dates: 90 days after the termination date of coverage, or the date of the Insured's discharge date from the hospital. The total payments made for the Covered Person for such condition, both before and after the termination date, will never exceed the stated benefit. After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

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## Coordination of Benefits

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Under a Coordination of Benefits (COB) provision, the Plan that pays first is called the Primary Plan. The Secondary Plan typically makes up the difference between the Primary Plan's benefit and the Covered Expenses. When one Plan does not have a COB provision, that Plan is always considered the Primary Plan, and always pays first. You may still be responsible for applicable Deductible amounts, Copayments and Coinsurance.

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## Continuation of Coverage

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Insureds who have graduated or are otherwise ineligible for coverage under this Policy, and have been continuously insured under the Policy offered by the Policyholder for six (6) months, are eligible to continue their existing coverage for a period of not more than three (3) months under the school's Policy in effect at the time of such continuation.

Premium rates for continuation of coverage are higher than rates for students at University Of Illinois - Springfield. Enrollment must be made and applicable premium must be paid directly to Academic HealthPlans and must be received prior to the expiration date of your student coverage. For more information on Continuation of Coverage, please contact Academic HealthPlans at **(855) 856-3549**.

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## Additional Covered Expenses

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The Policy will always pay benefits in accordance with any applicable federal and state insurance law(s).

## Schedule of Benefits

**The provider network for this Plan is Blue Cross and Blue Shield of Illinois (BCBSIL) Participating Provider Option PPO Network.** After the Deductible is satisfied, benefits will be paid based on the selected provider. Benefits will be paid at **80%** of the Allowable Amount for services rendered by Network Providers in BCBSIL Participating Provider Option PPO Network, unless otherwise specified in the Policy. Services obtained from Out-of-Network Providers (any provider outside the BCBSIL Participating Provider Option PPO Network) will be paid at **50%** of the Allowable Amount, unless otherwise specified in the Policy. Benefits will be paid up to the maximum for each service as specified below, regardless of the provider selected.

**AT PHARMACIES CONTRACTING WITH THE PRIME THERAPEUTICS NETWORK:** You must go to a pharmacy contracting with the Prime Therapeutics Network in order to access this program. Present your insurance ID card to the pharmacy to identify yourself as a participant in this Plan. Eligibility status will be online at the pharmacy. You can locate a participating pharmacy by calling **(800) 423-1973**; you also can locate one online at **uis.myahpcare.com**.

Maximum Benefit		Unlimited
Deductible (Per Covered Person, Per Policy Year)	Network Provider	Out-of-Network Provider
	\$400 Student \$1,200 Family	\$800 Student \$2,400 Family
Out-Of-Pocket Maximum (Per Covered Person, Per Policy Year)	\$6,850 Student \$13,700 Family	\$13,700 Student \$27,400 Family

**OUT-OF-POCKET MAXIMUM** means the maximum liability that may be incurred by a Covered Person in a benefit period for covered services, under the terms of a Coverage Plan. Once the Out-of-Pocket Maximum has been satisfied, Covered Expenses will be payable at **100%** for the remainder of the Policy year, up to any maximum that may apply. Coinsurance applies to the Out-of-Pocket Maximum.

The relationship between Blue Cross and Blue Shield of Illinois (BCBSIL) and Contracting Pharmacies is that of Independent Contractors, contracted through a related company, Prime Therapeutics, LLC. Prime Therapeutics also administers the pharmacy benefit program. BCBSIL, as well as several other independent Blue Cross Plans, has an ownership interest in Prime Therapeutics.

The Network Out-of-Pocket Maximum may be reached by:

- The network Deductible
- Charges for outpatient prescription drugs
- The hospital emergency room Copayment
- The payments for which a Covered Person is responsible after benefits have been provided (except for the cost difference between the hospital's rate for a private room and a semi-private room, or any expenses incurred for Covered Services rendered by an Out-of-Network Provider other than Emergency Care and Inpatient treatment during the period of time when a Covered Person's condition is serious)

The Out-of-Network Out-of-Pocket Maximum may be reached by:

- The Out-of-Network Deductible
- The hospital emergency room Copayment
- The payments for Covered Services rendered by an Out-of-Network Provider for which a Covered Person is responsible after benefits have been provided (except for the cost difference between the hospital's rate for a private room and a semi-private room)

***Deductible applies unless otherwise noted***

Inpatient	Network Provider	Out-of-Network Provider
<b>Hospital Expenses:</b> Includes 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.	<b>80%</b> after <b>\$100</b> Copayment of Allowable Amount (Deductible waived)	<b>50%</b> after <b>\$100</b> Copayment of Allowable Amount
<b>Surgical Expense:</b> When multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for 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	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Assistant Surgeon</b>	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Anesthetist</b>	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Doctor's Visits</b>	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Routine Well-Baby Care</b>	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Mental Illness/Substance Use Disorder</b>	Paid as any other covered Sickness	Paid as any other covered Sickness

Outpatient	Network Provider	Out-of-Network Provider
<b>Surgical Expenses:</b> When multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full allowance 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.	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Day Surgery Miscellaneous:</b> Related to scheduled surgery performed in a hospital, including the cost of the operating room, laboratory tests, X-ray examinations, professional fees, anesthesia, drugs or medicines and supplies.	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Assistant Surgeon</b>	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Anesthetist</b>	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Doctor Office visit/consultation</b>	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Physical Medicine Services:</b> Physical therapy or chiropractic care – office services. Physical medicine services include, but are not limited to, physical, occupational, and manipulative therapy.	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Benefit Period Visit Maximum</b>	Chiropractic and osteopathic manipulations will be limited to a combined maximum of 25-visits per Benefit Period. Naprapathic will be limited to a 15-visit maximum per Benefit Period.	
<b>Radiation Therapy and Chemotherapy:</b> Includes dialysis and respiratory therapy.	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Emergency Care and Accidental Injury</b>		
<b>Facility Services:</b> Copayment is waived if the Insured is admitted; Inpatient hospital expenses will apply.	<b>80%</b> of Allowable amount after <b>\$50</b> Copayment	
<b>Physician Services</b>	<b>80%</b> of Allowable amount	
<b>Non-Emergency Care</b>		
<b>Facility Services:</b> Copayment is waived if the Insured is admitted; Inpatient hospital expenses will apply.	<b>80%</b> of Allowable amount after <b>\$50</b> Copayment	<b>50%</b> of Allowable Amount after <b>\$50</b> Copayment
<b>Physician Services</b>	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount

<b>Urgent Care Services</b>	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Diagnostic X-rays and Laboratory Procedures</b>	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Tests and Procedures:</b> Diagnostic services and medical procedures performed by a Doctor, other than Doctor's visits.	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Allergy Injection and Testing</b>	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Mental Illness/Substance Use Disorder</b>	Paid as any covered sickness	Paid as any covered sickness
<b>Other</b>	<b>Network Provider</b>	<b>Out-of-Network Provider</b>
<b>Extended Care Expenses:</b> All services must be pre-authorized	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
Home Health Care	No Benefit Period Visit Maximum	
Skilled Nursing		
Hospice Care		
Private Duty Nursing		
<b>Ground and Air Ambulance Services</b>	<b>80%</b> of Allowable Amount	<b>80%</b> of Allowable Amount
<b>Virtual Visits (through MD Live)</b>	<b>\$20</b> Copayment	<b>NA</b>
<b>Durable Medical Equipment:</b> When prescribed by a Doctor and a written prescription accompanies the claim when submitted.	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Maternity/Complications of Pregnancy</b>	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Speech and Hearing Services:</b> Services to restore loss of hearing/speech, or correct an impaired speech or hearing function. Hearing exams and hearing aids are covered for members under age 19 only.  Hearing Aids Hearing Aid Maximum	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
	Hearing aids are limited to one hearing aid per ear, per 36-month period. Limited to members under age 19; no age limit on bone-anchored hearing aids.	
<b>Organ and Tissue Transplant Services:</b> The transplant must meet the criteria established by BCBSIL for assessing and performing organ or tissue transplants as set forth in BCBSIL's written medical policies.	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Temporomandibular and Craniomandibular Disorders</b>	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Elective Abortion</b>	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount

Other	Network Provider	Out-of-Network Provider
<b>Dental:</b> Made necessary by Injury to sound, natural teeth only.	<b>80%</b> of Allowable Amount	<b>80%</b> of Allowable Amount
<b>Dental:</b> Benefits for the removal of full bony fully impacted wisdom teeth only. <i>(Benefits include dental care services for anesthetics and associated hospital or ambulatory facility charges provided in conjunction with dental care for children age 6 and under. Benefits also apply to individuals with medical conditions, or disabled individuals, who require hospitalization or general anesthesia for dental care. This benefit does not cover dental care charges, only the charges for anesthesia.)</i>	<b>80%</b> of Allowable Amount	<b>80%</b> of Allowable Amount
<b>Pediatric Vision, up to age 19:</b> See benefit flyer for details.	<b>100%</b> of Allowable Amount	Refer to set Fee Schedule
<b>Pediatric Routine Dental Care, up to age 19:</b> See benefit flyer for details.	<b>80%</b> of Allowable Amount	<b>60%</b> of Allowable Amount
<b>Pediatric Basic and Major Dental, up to age 19:</b> See benefit flyer for details.	<b>50%</b> of Allowable Amount	<b>30%</b> of Allowable Amount
<b>Pediatric Medically Necessary Orthodontia, up to age 19:</b> See benefit flyer for details.	<b>50%</b> of Allowable Amount	<b>30%</b> of Allowable Amount
<b>Gender Reassignment Surgery:</b> Cosmetic Surgery, procedures and drugs not covered even if related to sexual reassignment.	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Intercollegiate Sports:</b> Benefits paid up to \$90,000.	<b>80%</b> of Allowable Amount	<b>50%</b> of Allowable Amount

<p><b>Preventive Care Services</b> benefits include but not limited to:</p> <ul style="list-style-type: none"> <li>a. An annual routine physical exam, annual pap smear, annual mammogram screening, prostate screening, colorectal screening and immunizations.</li> <li>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”);</li> <li>c. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”);</li> <li>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</li> <li>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.</li> </ul> <p>Preventive care services as mandated by state and federal law. Please refer to the Policy or call Blue Cross and Blue Shield of Illinois for more information at <b>(855) 267-0214</b>.</p>	<p><b>100%</b> of Allowable Amount (Deductible waived)</p>	<p><b>50%</b> of Allowable Amount</p>
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Pharmacy Benefits	Network Provider	Out-of-Network Provider
<b>Retail Pharmacy</b> (Deductible waived)  Benefits include diabetic supplies. Copayment amounts are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available at three (3) times the copayment at retail or mail order. Copayment amounts will apply to Out-of-Pocket Maximum.	At pharmacies contracting with Prime Therapeutics Network: <b>100%</b> of Allowable Amount after a	When a Covered Person obtains prescription drugs from an Out-of-Network pharmacy (other than a Network pharmacy): Benefits will be provided at <b>50%</b> of the allowable amount a Covered Person would have received had he/she obtained drugs from a Network pharmacy minus the copayment amount or Coinsurance amount.
<b>Generic Drug</b>	<b>\$10</b> Copayment	<b>\$10</b> Copayment
<b>Brand-name Drug*</b>	<b>\$30</b> Copayment	<b>\$30</b> Copayment
<b>Non-Preferred Brand-name Drug*</b>	<b>\$60</b> Copayment	<b>\$60</b> Copayment

\*Copayment plus the cost difference between the brand-name drug or supplies per prescription for which there is a generic drug or supply available.

## Pre-Authorization Notification

BCBSIL should be notified of all hospital confinements prior to admission.

- 1) **Pre-authorization Notification of Medical Non-emergency Hospitalizations:** The patient, Doctor or hospital should telephone **(800) 635-1928** at least one (1) working day prior to the planned admission.
- 2) **Pre-authorization Notification of Medical Emergency Hospitalizations:** The patient, patient's representative, Doctor or hospital should telephone **(800) 635-1928** within two (2) working days of the admission or as soon as reasonably possible to provide the notification of any admission due to medical emergency.

BCBSIL is open for pre-authorization notification calls from 8 a.m. to 6 p.m. Central time, Monday through Friday.

**IMPORTANT:** Failure to follow the notification procedures will not affect benefits otherwise payable under the Policy; in addition, pre-authorization notification is not a guarantee that benefits will be paid.

The relationship between Blue cross and Blue Shield of Illinois (BCBSIL) and Contracting Pharmacies is that of Independent Contractors, contracted through a related company, Prime Therapeutics, LLC. Prime Therapeutics also administers the pharmacy benefit program. BCBSIL, as well as several other independent Blue Cross Plans, has an ownership interest in Prime Therapeutics.

## Definitions

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**Allowable Amount** means the maximum amount determined by Us to be eligible for consideration of payment for a particular service, supply or procedure.

**For Professional Providers** - The Allowable Amount is the amount determined by Us which Network Providers have agreed to accept as payment in full for a particular Covered Expense. All benefit payments for Covered Expenses rendered by Network Providers, whether In-Network or Out-of-Network, will be based on a schedule of Allowable Amounts.

**For a Provider other than a Professional Provider** which has a written agreement with Us or another Blue Cross and/or Blue Shield Plan to provide care to the Covered Person at the time Covered Expenses are incurred, the Allowable Amount is such provider's claim charge for Covered Expenses.

**For a Provider other than a Professional Provider** which does not have a written agreement with Us or another Blue Cross and/or Blue Shield Plan to provide care to the Covered Person at the time Covered Expenses are incurred, the Allowable Amount will be the lesser of:

- (i) The Provider's billed charges, or;
- (ii) Our non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare reimbursements and represents approximately 105% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Allowable Amount for Coordinated Home Health Care Program Covered Expenses will be 50% of the Out-of-Network Provider's standard billed charge for such Covered Expense.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Expense or is unable to be determined on the information submitted on the Claim, the Allowable Amount for Out-of-Network providers will be 50% of the Out-of-Network provider's standard billed charge for such Covered Expense.

We will utilize the same claim processing rules and/or edits that We utilize in processing Network Provider Claims for processing claims submitted by Out-of-Network providers, which may also alter the Allowable Amount for a particular service. In the event We do not have any claim edits or rules, We may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Allowable Amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by Us within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

**For multiple surgeries** - The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed.

**For Prescription Drugs as applied to Network Provider and Out-of-Network Provider Pharmacies** - The Allowable Amount for pharmacies that are Network Providers will be based on the provisions of the contract between BCBSIL and the pharmacy in effect on the date of service. The Allowable Amount for pharmacies that are not Network Providers will be based on the Average Wholesale Price.

**Benefit Period** means the period of time starting with the effective date of this Policy through the termination date as shown on the face page of the Policy. The Benefit Period is as agreed to by the policyholder and the Insurer.

**Coinsurance** means a percentage of an eligible expense that the Covered Person is required to pay toward a Covered Expense.

**Company** means Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (also referred to herein as "BCBSIL").

**Copayment** means a fixed dollar amount that the Covered Person must pay before benefits are payable under the Policy.

**Covered Expenses** means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies not excluded or limited by the Policy. Coverage under the Policy must remain continuously in force from the date of the accident or Sickness until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply that gave rise to the expense or the charge was rendered or obtained.

**Covered Person** means any eligible student or an eligible dependent who applies for coverage, and for whom the required premium is paid to the Company.

**Deductible** means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Covered Person on a Policy Term basis before benefits are payable under the Policy.

**Dependent** means an Insured's lawful spouse including Domestic Partner; or an Insured's child, stepchild, child of a Covered Person's Domestic Partner, foster child, dependent grandchild or spouse's dependent grandchild; or a child who is adopted by the Insured or placed for adoption with the Insured, or for whom the Insured is a party in a suit for the adoption of the child; or a child whom the Insured is required to insure under a medical support order issued or enforceable by the courts. Any such child must be under age 26.

**Doctor** means a Doctor licensed to practice medicine. It also means any other practitioner of the healing arts who is licensed or certified by the state in which his or her services are rendered and acting within the scope of that license or certificate. It will not include a Covered Person or a member of the Covered Person's immediate family or household.

**Domestic Partner** means a person with whom a student has entered into a Domestic Partnership.

**Domestic Partnership** means a long-term committed relationship of indefinite duration with a person that meets the following criteria: (i) a student and his/her Domestic Partner have lived together for at least six (6) months; (ii) neither a student nor his/her Domestic Partner is married to anyone else or has another domestic partner; (iii) a student's Domestic Partner is at least 18 years of age and mentally competent to consent to a contract; (iv) a student's Domestic Partner resides with him/her and intends to do so indefinitely; (v) a student and his/her Domestic Partner have an exclusive mutual commitment similar to marriage; and (vi) a student and his/her Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

**Emergency Care** means health care services provided in a hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, Sickness or Injury is of such a nature that failure to get immediate care could result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment of bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

**Emergency Services** means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate such emergency medical condition and, within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient.

**Injury** means accidental bodily harm sustained by a Covered Person that results directly and independently from all other causes from a covered accident. The Injury must be caused solely through external, violent and accidental means. All injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

**Inpatient** means that a Covered Person is a registered bed patient and is treated as such in a health care facility.

**Insured** means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person. An Insured is not a dependent covered under the Policy.

**Interscholastic Activities** means playing, participating and/or traveling to or from an interscholastic, club sports, professional, or semi-professional sport, contest or competition, including practice or conditioning for such activity.

**Medically Necessary** means those services or supplies covered under the Plan that are:

- Essential to, consistent with, and provided for in the diagnosis or in the direct care and treatment of the condition, Sickness, disease, Injury, or bodily malfunction; and
- Provided in accordance with, and are consistent with, generally accepted standards of medical practice in the United States; and
- Not primarily for the convenience of the Insured, his physician, behavioral health practitioner, the hospital, or the other provider; and
- The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Insured. When applied to hospitalization, this further means that the Insured requires acute care as a bed patient due to the nature of the services provided or the Insured's condition, and the Insured cannot receive safe or adequate care as an outpatient.

The medical staff of BCBSIL shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities; the guidelines and practices of Medicare, Medicaid, or other government-financed programs; and peer-reviewed literature. Although a physician, behavioral health practitioner or professional other provider may have prescribed treatment; such treatment may not be Medically Necessary within this definition.

**Network Provider** means a hospital, Doctor or other provider who has entered into an agreement with BCBSIL (and, in some instances, with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care provider.

**Out-of-Network Provider** means a hospital, Doctor or other provider who has not entered into an agreement with BCBSIL (or other participating Blue Cross and/or Blue Shield Plan) as a managed care provider.

**Outpatient** means that a Covered Person is receiving treatment while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an emergency room regardless of whether a Covered Person is subsequently registered as an Inpatient in a health care facility.

**Out-of-Pocket Maximum** means the maximum liability that may be incurred by a Covered Person in a Benefit Period before benefits are payable at 100% of the Allowable Amount.

**Pre-authorization** means the process that determines in advance the Medical Necessity or experimental, Investigational and/or unproven nature of certain care and services under this Policy.

**Qualifying Intercollegiate Sport** means a sport: a.) which has been accorded varsity status by the Institution as an NCAA sport; and (b.) which is administered by such Institution's department of intercollegiate athletics; and (c.) for which the eligibility of the participating student athlete is reviewed and certified in accordance with NCAA legislation, rules, or regulations; and (d.) which entitles qualified participants to receive the Institution's official awards.

**Sickness** means an illness, disease or condition causing the Covered Person to incur medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

**Virtual visits** means services provided for the treatment of non-emergency medical and behavioral health conditions as described under the Policy.

**We, Our, Us** means Blue Cross and Blue Shield of Illinois or its authorized agent.

## Exclusions and Limitations

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Except as specified in this Policy, coverage is not provided for loss or charges incurred by or resulting from:

1. Charges that are not Medically Necessary or in excess of the Allowable Amount;
2. Services that are provided, normally without charge, by the Student Health Center, infirmary or hospital, or by any person employed by the University;
3. Acupuncture procedures;
4. Biofeedback procedures;
5. Breast augmentation or reduction;
6. Routine circumcision, unless the procedure is Medically Necessary for treatment of a sickness, disease or functional congenital disorder not excluded hereunder or as may be necessitated due to an accident or except for covered infants within 28 days of birth;
7. Non-malignant warts;
8. Moles;
9. Lesions;
10. Testing or treatment for sleep disorders;
11. Any charges for surgery, procedures, treatment, facilities, supplies, devices, or drugs that We determine are experimental or investigational;
12. Expenses incurred for Injury or Sickness arising out of, or in the course of, a Covered Person's employment, regardless if benefits are, or could be, paid or payable under any worker's compensation or occupational disease law or act, or similar legislation;
13. Treatment, services or supplies in a Veteran's Administration facility or hospital owned or operated by a national government or its agencies, unless there is a legal obligation for the Covered Person to pay for the treatment;
14. Blood derivatives that are not classified as drugs in the official formularies;
15. Expenses in connection with services and prescriptions for routine eye examinations, eye refractions, eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses; radial keratotomy or laser surgery for vision correction or the treatment of visual defects or problems, except for pediatric vision;

16. Expenses in connection with cosmetic treatment or cosmetic surgery, except as a result of:
  - a. A covered Injury that occurred while the Covered Person was insured;
  - b. An infection or other diseases of the involved part; or
  - c. A covered child's congenital defect or anomaly;
17. Injury resulting from racing or speed contests, skin diving, sky diving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, mountaineering (where ropes or guides are customarily used), or any other hazardous sport or hobby;
18. Injuries arising from Interscholastic Activities;
19. War, or any act of war, whether declared or undeclared or while in service in the active or reserve Armed Forces of any country or international authority;
20. Any expenses incurred in connection with sterilization reversal and vasectomy reversal;
21. Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Policy;
22. Expenses incurred for dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth. This exclusion does not apply to the repair of Injuries to sound natural teeth caused by a covered Injury or full bony impacted teeth;
23. Foot care, including: flat-foot conditions, subluxations, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, foot strain, and symptomatic complaints of the feet, except those related to diabetic care;
24. Hirsutism;
25. Alopecia;
26. Gynecomastia;
27. Weight management, weight reduction, or treatment for obesity including any condition resulting therefrom, including hernia of any kind;
28. Surgery for the removal of excess skin or fat;
29. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intra-articular (in the joint) injection in the home setting, except as specifically mentioned in this Policy. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases;
30. Custodial Care;
31. Long-term care service;

32. Inpatient private duty nursing service;
33. Weight loss programs;
34. Habilitative services that are solely educational in nature or otherwise paid under state or federal law for purely educational services;
35. Any loss to which a contributing cause was the Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the Covered Person's being engaged in an illegal occupation;
36. Hearing examinations; hearing aids; or other treatment for hearing defects or problems, except as provided for children and for bone anchored hearing aids (osseointegrated auditory implants) as described in the Benefit Description section of this Policy. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
37. Prescription drug coverage is not provided for:
  - a. Refills in excess of the number specified or dispensed after one (1) year from the date of the prescription;
  - b. Drugs labeled "Caution - limited by federal law to investigational use" or experimental drugs;
  - c. Immunizing agents, biological sera, blood or blood products administered on an outpatient basis;
  - d. Any devices, appliances, support garments, or hypodermic needles, except as used in the administration of insulin, or non-medical substances regardless of their intended use;
  - e. Drugs used for cosmetic purposes, including, but not limited to, Retin-A for wrinkles, Rogaine for hair growth, anabolic steroids for body building, anorectics for weight control, etc.;
  - f. Fertility Agents or sexual enhancement drugs, medications or supplies for the treatment of impotence and/or sexual dysfunction, including, but not limited to: Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, Viagra, Cialis, or Levitra, except when used to treat Medically Necessary Covered Services resulting from an organic disease or illness, injury or congenital defect;
  - g. Lost or stolen prescriptions;
  - h. Non-sedating antihistamines;
  - i. Compound medications;
  - j. Weight loss medications;
  - k. Proton pump inhibitors;
  - l. Drugs determined by the Plan to have inferior efficacy or significant safety issues;

## Academic Emergency Services\*

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To ensure immediate access to assistance if you experience a crisis while traveling over 100 miles from home, or outside your home country, Academic HealthPlans has included Academic Emergency Services (AES) benefits in your student health plan coverage. AES offers a wide range of services and benefits to provide everything you need to prepare for your international experience, as well as get the help or information you need in a crisis, no matter how large or small.

The following services and benefits are available to you 24 hours a day, 7 days a week:

**Medical Assistance:** Pre-travel information; physician referrals; medical monitoring to ensure adequate care; 24/7 Nurse Help Line; prescription assistance or medicine dispatch.

**Emergency Medical Evacuation and Repatriation:** Unlimited benefit for evacuation from inadequate facility to a higher level of care facility, repatriation home for continued care if medically necessary, or recovery and repatriation of deceased remains.

**Accidental Death and Dismemberment:** \$25,000 benefit

**Emergency Family Assistance:** Benefits for visit of a family member or friend if hospitalized for 3 or more days, return of children if left unattended, bereavement reunion, emergency return home in the event a participant's family member suffers life threatening illness or death and return of participant's personal belongings in the event of evacuation or death.

**Travel, Legal and Security Assistance:** Pre-travel destination information or security advice; assistance locating lost luggage; passport replacement assistance; emergency travel arrangements; translation assistance; interpreter referral; legal consultation and referral; emergency message forwarding.

**Preparing for your time away from home is easy; simply visit  
the Academic Emergency Services portal:**

[aes.myahpcare.com](https://aes.myahpcare.com)

**To obtain additional pre-travel information or advice, or in the event of a medical, travel or security crisis,  
call Academic Emergency Services immediately.**

**(855) 873-3555** call toll free from the US  
**+ 1 (410) 453-6354** call collect from anywhere  
**Email:** [assistance@ahpcare.com](mailto:assistance@ahpcare.com)

This provides you with a brief outline of the services available to you. Terms, conditions, limitations and exclusions apply. All services must be arranged and paid for through the AES service provider. There is no claim process for reimbursement of self-paid expenses unless specifically described in the service plan.

\*Academic Emergency Services (AES) is a global emergency services product. These services are provided by a separate and independent company from AES or Academic HealthPlans. AES provides medical, security and natural disaster evacuation services, repatriation of remains, emergency medical and travel assistance, travel information and other services for Academic HealthPlans.

Like all Blue Cross and Blue Shield Licensees, We participate in a program called “BlueCard.” Whenever the Covered Person accesses health care services outside Our service area, the Claims for those services may be processed through BlueCard and presented to Us for payment in conformity with network access rules of the BlueCard Policies then in effect (“Policies”). Under BlueCard, when Covered Persons incur Covered Expenses within the geographic area served by an onsite Blue Cross and/or Blue Shield Licensee (“Host Blue”), We will remain responsible to the Covered Person for fulfilling the Policy’s contract obligations. The Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating providers and handling all interaction with its participating providers.

## Summary of Benefits and Coverage

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The Affordable Care Act requires all health insurers to provide consumers with a Summary of Benefits and Coverage (SBC). The SBC is a description of the benefits and health coverage offered by a particular health plan. The SBC is intended to provide clear, consistent descriptions that may make it easier for people to understand their health insurance coverage.

The items in the SBC just represent an overview of coverage; they are not an exhaustive list of what is covered or excluded. The full terms of coverage are located in your insurance Policy. To obtain an SBC for your Policy, please go to **uis.myahpcare.com**.

## BCBSIL Online Resources

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BCBSIL members have online access to claims status, Explanations of Benefits, ID cards, Network Providers, correspondence and coverage information by logging in to **Blue Access for Members<sup>SM</sup> (BAM)**. Visit **BCBSIL.com** and click on the “Log in” tab. Follow the simple, onscreen directions to establish an online account in minutes.

**BAM** has been enhanced to include BAM Mobile, a self-service tool that provides a quick and easy way to view any email notifications we may have sent. In Message Center, notifications are securely sent directly to the Insured student’s email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into My Email Preferences and making the change there.

Please go to **uis.myahpcare.com** for additional premium and benefit information.

## Claims Procedure

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In the event of Injury or Sickness, the student should:

1. Report to the Student Health Center for treatment, or, when not in school, to his/her doctor or hospital. Insureds should go to a participating doctor or hospital for treatment if possible.

**IN AN EMERGENCY, REPORT DIRECTLY TO THE NEAREST EMERGENCY ROOM FOR TREATMENT.**

2. Mail to the address below all prescription drug receipts (for providers outside of those contracting with Prime Therapeutics), medical and hospital bills, along with patient's name and Insured student's name, address, Social Security Number, BCBSIL member ID Number and name of the University under which the student is Insured.
3. File claims within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

**The Plan is underwritten by:**

BCBSIL

**Submit all claims or inquiries to:**

Blue Cross and Blue Shield of Illinois

P.O. Box 805107

Chicago, IL 60680-4112

BCBSIL Customer Service **(855) 267-0214**

Medical Providers Call **(800) 972-8088**

All Others: Call AHP **(855) 856-3549**

**Plan is administered by:**

Academic HealthPlans, Inc.

P. O. Box 1605

Colleyville, TX 76034-1605

Fax **(855) 858-1964**

For more information

**[uis.myahpcare.com](http://uis.myahpcare.com)**

## Important Notice

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The information in this brochure provided a brief description of the important features of the insurance plan. It is not a contract of insurance. The Master Policy on file at the University contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this brochure. The Master Policy is the contract and will govern and control the payment of benefits. The terms and conditions of coverage are set forth in the Policy issued in the state in which the Policy was delivered. Complete details may be found in the Policy on file at your school's office. The Policy is subject to the laws of the state in which it was issued. Please keep this information as a reference.

**See the Policy on file with your school for more information.**

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعدك أسئلة، ف لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 855-710-6984.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય અથવા કોઈ બાજુ વ્યક્તને એસ.બી.એમ. કાયદેમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में नि:शल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídiłkidgo, ts'ídá bee ná ahóótí'i' t'áá níík'e níká a'doolwoł dóó bina'ídiłkidígíí bee níł h odoonih. Ata'dahalne'ígíí bich'í' hodíílnih kwe'é 855-710-6984.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

**Health care coverage is important for everyone.**

We provide free communication aids and services for anyone with a disability or who needs language assistance.  
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator  
300 E. Randolph St.  
35th Floor  
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960  
Email: [CivilRightsCoordinator@hcsc.net](mailto:CivilRightsCoordinator@hcsc.net)

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>