AcademicBlue℠

SAIC School of the Art Institute of Chicago

School of the Art Institute of Chicago Student Health Insurance Plan 2020-2021

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 Medical Number: 254596

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Introduction

School of the Art Institute of Chicago 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 of this plan meets or exceeds a "Platinum, Gold, Silver or Bronze" 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 **saic.myahpcare.com**. Using BCBSIL providers may save you money.
  If your plan includes benefits covered at your Student Health Center, many of them may be provided at low or no cost to you. Review this brochure for details.
- **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 the “Exclusions and Limitations” section 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. For enrollment and eligibility questions go to **saic.myahpcare.com**. For benefit and claims questions call BCBSTX at (855) 267-0214.

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"

Privacy Notice

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 you may view and download a copy from the website at **saic.myahpcare.com.**

Eligibility/How to Enroll

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, visit Academic HealthPlans at **saic.myahpcare.com** prior to your termination date.

Eligibility Requirements

SAIC requires health insurance coverage for all domestic undergraduate, graduate, exchange and certificate students enrolled full-time, and all international students.

Unless full-time undergraduate, domestic, graduate, exchange and certificate students, and international students submit a waiver online through saic.myahpcare.com, they will automatically be enrolled in SAIC's Student Health Insurance Plan.

To waive the student health insurance plan, you must complete the online waiver by the deadline. If you do not waive coverage by the deadline, the premium will be charged per semester to your student account.

Students must maintain their Institution's eligibility in order to maintain or continue coverage under this policy. Covered Students who lose eligibility status prior to the end of their enrolled coverage period will no longer be covered as of the first of the month following the loss of eligibility. Students enrolled for the Summer semester will not experience a loss in coverage as long as they were covered immediately preceding the Summer semester. We maintain the right to investigate student status and attendance records to verify that eligibility requirements have been met. If We discover the eligibility requirements have not been met, Our only obligation is to refund any unearned premium paid for that person.

Eligible students who enroll may also insure their Dependents. Dependent enrollment must take place at the initial time of student enrollment (or within 30 days if tuition billed); 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," 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

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 **saic.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 as it would have been at the beginning of the semester. 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 **saic.myahpcare.com**.

Effective Dates and Termination

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

1) The effective date of the Policy**, August 18, 2020**; or

2) The date **after the** premium is received by the Company or its authorized representative.

Effective and Termination Dates

Domestic and International Students	From	Through
Fall	8/18/2020	1/27/2021
Spring – New Students	1/20/2021	8/17/2021
Spring – Returning Students	1/28/2021	8/17/2021
Summer – New Students	6/12/2021	8/17/2021

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 17, 2021**; or
3) The date the eligibility requirements are not met.

Renewal Notice

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.

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.

Extension of Benefits After Termination

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 maximum benefit. After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

Coordination of Benefits

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. Your own Plan will be primary and any other plan will be secondary. 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.

Additional Covered Expenses

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**; or visit **saic.myahpcare.com.**

Maximum Benefit	Unlimited	
Deductible (Per Covered Person, Per Benefit Period)	Network Provider	Out-of-Network Provider
	$500 Student	**$1,000 Student**
Out-Of-Pocket Maximum (Per Covered Person, Per Benefit Period)	**$8,150 Student** **$16,300 Family**	**$16,300 Student** **$32,600 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 Network Out-of-Pocket Maximum may be reached by:

- The network Deductible
- Charges for outpatient prescription drugs
- The hospital emergency room Copayment
- The Copayment for Doctor office visits
- The Copayment for Specialist's office visits
- 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 relationship between Blue Cross and Blue Shield of Illinois (BCBSIL) and Contracting Pharmacies is that of Independent Contractors, contracted through a relate 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 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
Hospital Expenses: 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.	**80%** of Allowable Amount	**50%** of Allowable Amount
Surgical Expense: 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.	**80%** of Allowable Amount	**50%** of Allowable Amount
Assistant Surgeon	**80%** of Allowable Amount	**50%** of Allowable Amount
Anesthetist	**80%** of Allowable Amount	**50%** of Allowable Amount
Doctor's Visits	**80%** after a **$30** Copayment	**50%** after a **$30** Copayment
Routine Well-Baby Care	**80%** of Allowable Amount	**50%** of Allowable Amount
Mental Illness/Substance Use Disorder	Paid as any other covered sickness	Paid as any other covered sickness

Outpatient	Network Provider	Out-of-Network Provider
Surgical Expenses: When multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full allowance for that procedure.	**80%** of Allowable Amount	**50%** of Allowable Amount
Day Surgery Miscellaneous: Related to scheduled surgery performed in a hospital, including the cost of the operating room, laboratory tests, X-ray examinations, professional fees, anesthesia, drugs or medicines and supplies.	**80%** of Allowable Amount	**50%** of Allowable Amount
Assistant Surgeon	**80%** of Allowable Amount	**50%** of Allowable Amount
Anesthetist	**80%** of Allowable Amount	**50%** of Allowable Amount
Doctor Office Visit/Consultation:	**100%** of Allowable Amount after a:	**50%** of Allowable Amount after a:
Doctor Copayment Amount: For office visit/consultation when services rendered by a Professional Provider, OB/GYN, Pediatrician, Behavioral Health Practitioner, or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians	**$30** Copayment per visit (Deductible waived)	**$30** Copayment per visit (Deductible waived)
Specialist Copayment Amount: For office visit/consultation when services rendered by a Specialty Care Provider refer to Medical/Surgical Expenses section for more information.	**$30** Copayment per visit (Deductible waived)	**$30** Copayment per visit (Deductible waived)
Physical Medicine Services: Physical therapy or chiropractic care – office services. Physical medicine services include, but are not limited to, physical, occupational, and manipulative therapy.	**80%** after a **$30** Copayment	**50%** after a **$30** Copayment
Benefit Period Visit Maximum	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.	
Radiation Therapy and Chemotherapy: Includes dialysis and respiratory therapy	**80%** of Allowable Amount	**50%** of Allowable Amount

Outpatient	Network Provider	Out-of-Network Provider
Emergency Care and Accidental Injury		
Facility Services: (Copayment is waived if the Insured is admitted; Inpatient hospital expenses will apply)	**80%** of Allowable Amount after a: **$300** Copayment	
Physician Services	**80%** of Allowable Amount	
Non-Emergency Care		
Facility Services: (Copayment is waived if the Insured is admitted; Inpatient hospital expenses will apply)	**80%** of Allowable Amount after a: **$300** Copayment	
Physician Services	**80%** of Allowable Amount	**50%** of Allowable Amount
Outpatient	**Network Provider**	**Out-of-Network Provider**
Urgent Care Services	**100%** after a **$50** Copayment (Deductible waived)	**50%** after a **$30** Copayment (Deductible waived)
Diagnostic X-rays	**80%** of Allowable Amount	**50%** of Allowable Amount
Laboratory Procedures	**80%** of Allowable Amount (Deductible waived)	**50%** of Allowable Amount (Deductible waived)
Tests and Procedures: Diagnostic services and medical procedures performed by a Doctor, other than Doctor's visits.	**80%** of Allowable Amount	**50%** of Allowable Amount
Allergy Injection and Testing: Copay may apply if billed in the office	**80%** of Allowable Amount	**50%** of Allowable Amount
Mental Illness/Substance Use Disorder	**100%** after a **$30** Copayment (deductible waived)	**50%** of Allowable Amount (deductible waived)
Extended Care Expenses	**Network Provider**	**Out-of-Network Provider**
Extended Care Expenses All services must be pre-authorized	**80%** of Allowable Amount	**50%** of Allowable Amount
Home Health Care	No Benefit Period Visit Maximum	
Skilled Nursing		
Hospice Care		
Private Duty Nursing		

Other	Network Provider	Out-of-Network Provider
Ground and Air Ambulance Services	**80%** of Allowable Amount	
Durable Medical Equipment: When prescribed by a Doctor and a written prescription accompanies the claim when submitted.	**80%** of Allowable Amount	**50%** of Allowable Amount
Maternity/Complications of Pregnancy	**80%** of Allowable Amount	**50%** of Allowable Amount
Speech and Hearing Services: Services to restore loss of hearing/speech, or correct an impaired speech or hearing function.	**80%** of Allowable Amount	**50%** of Allowable Amount
Hearing Aids Hearing Aid Maximum	Hearing exams and hearing aids are covered. Hearing aids are limited to one hearing aid per ear, per 24-month period. For specific details, refer to your school policy.	
Habilitative Services and Devices (limited services covered)	**80%** of Allowable Amount	**50%** of Allowable Amount
Dental: Made necessary by Injury to sound, natural teeth only.	**80%** of Allowable Amount	**80%** of Allowable Amount
Routine Eye Exam for Adults (One (1) vision exam per benefit period)	**80%** of Allowable Amount	**50%** of Allowable Amount
Pediatric Vision, **up to age 19:** See benefit flier for details.	**100%** of Allowable Amount	Refer to Set Fee Schedule
Pediatric Routine Dental Care, **up to age 19:** See benefit flier for details.	**80%** of Allowable Amount	**50%** of Allowable Amount
Pediatric Basic and Major Dental, up to age 19: See benefit flier for details.	**50%** of Allowable Amount	**30%** of Allowable Amount
Pediatric Medically Necessary Orthodontia, up to age 19: See benefit flier for details.	**50%** of Allowable Amount	**30%** of Allowable Amount
Organ and Tissue Transplant Services: 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.	**80%** of Allowable Amount	**50%** of Allowable Amount
Gender Reassignment including surgery if meets medical necessity criteria	Paid as any other covered sickness	Paid as any other covered sickness

Other	Network Provider	Out-of-Network Provider
Preventative Care Services: Benefits include but not limited to: a. An annual routine physical exam, annual pap smear, annual mammogram screening, prostate screening, colorectal screening and immunizations. b. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF"); c. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC"); d. Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, child(ren), and adolescents; and e. With respect to women, such additional preventative care and screenings, not described in item "a" above, as provided for in comprehensive guidelines supported by the HRSA. Preventative 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 **(855) 267-0214.**	**100%** of Allowable Amount (Deductible waived)	**50%** of Allowable Amount

Pharmacy Benefits	Network Provider	Out-of-Network Provider
Retail Pharmacy: (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. Copayment amounts will apply to Out-of-Pocket Maximum.	*At pharmacies contracting with Prime Therapeutics Network:* **100%** 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 **50%** of the allowable amount a Covered Person would have received had they obtained drugs from a Network pharmacy minus the Copayment amount or Coinsurance amount.
Generic Drug	**$15** Copayment	**50%** of allowable amount
Preferred Brand-name Drug	**$35** *Copayment**	
Non-Preferred Brand-name Drug	**$50** Copayment*	

*Copayment plus the cost difference between the Brand Name Drug or supplies per prescription for which there is Generic Drug or supply available.

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.

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. Please refer to your policy for additional details.

Definitions

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.

In addition, enrolled unmarried children will be covered up to the age of 30 if they:

- Live within the service area of Blue Cross and Blue Shield's network for this Policy; and
- Have served as an active or reserve member of any branch of the Armed Forces of the United States; and
- Have received a release or discharge other than a dishonorable discharge.

Doctor means a Doctor licensed to practice medicine. It also means any other Professional Provider of the healing arts who is licensed or certified by the state in which their 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 their Domestic Partner have lived together for at least six (6) months; (ii) neither a student nor their 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 them and intends to do so indefinitely; (v) a student and their Domestic Partner have an exclusive mutual commitment similar to marriage; and (vi) a student and their 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.

Habilitative Services and Devices means Occupational Therapy, Physical Therapy, Speech Therapy and other health care services and devices that help a Covered Person keep, learn, or improve skills and functioning for daily living, as prescribed by a Covered Person's Physician pursuant to a treatment plan. Examples include therapy for a child who is not walking or talking at the expected age and includes therapy to enhance the ability of a child to function with a Congenital, Genetic or Early Acquired Disorder. These services may include Physical Therapy and Occupational Therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in the Policy.

Hearing Aid means any wearable non-disposable, non-experimental instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold.

Hearing Care Professional means a person who is a licensed Hearing Aid dispenser, licensed audiologist, or licensed physician operating within the scope of such license.

Hearing Implants – Benefits will be provided for bone anchored hearing aids and cochlear implants.
Note that you may have additional Other Expenses as specified in the Hearing Aid section of the Policy.

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.

Intensive Outpatient Program means this is a Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Use Disorder or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorder. Dual diagnosis programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that you will benefit from programs that focus solely on Mental Illness conditions. Dual diagnosis programs are delivered by Behavioral Health Practitioners who are cross-trained. Requirements: the Claim Administrator requires that any Mental Illness and/or Substance Use Disorder Intensive Outpatient Program must be licensed in the state where it is located, or accredited by a national organization that is recognized by the by your Participating IPA or Participating Medical Group as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

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.

Latrogenic Infertility means an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

May Directly or Indirectly Cause means the likely possibility that treatment will cause a side effect of fertility, based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

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, 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 Pharmacy means an independent retail Pharmacy, chain of retail Pharmacies, mail-order Pharmacy or Specialty Pharmacy that has entered into a written agreement with the Plan, or other entity chosen by the Plan to administer its Prescription Drug program, to provide pharmaceutical services to Covered Persons at the time they receive the services.

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.

Non-Preferred Specialty Drug means a Specialty Drug, which may be a Generic or Brand Name Drug, that is identified on the on the Drug List as a Non-Preferred Specialty Drug. The Drug List is available by accessing the Blue Cross and Blue Shield website at **www.bcbsil.com**.

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.

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.

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**.**

Partial Hospitalization Treatment Program means a Hospital's planned therapeutic treatment program, which has been approved by your Participating IPA or Participating Medical Group or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Treatment, in which patients Treatment in which patients spend days. This behavioral healthcare is typically 5 to 8 hours per day, 5 days per week (not less than 20 hours of treatment services per week) and may typically run from 1 to 8 weeks duration. The program is staffed similarly to the day shift of an inpatient unit, i.e. medically supervised by a Physician and nurse. The program shall ensure a psychiatrist sees the patient face to face at least once a week and is otherwise available, in person or by telephone, to provide assistance and direction to the program as needed. Participants at this level of care do not require 24 hour supervision and are not considered a resident at the program. Requirements: the Claim Administrator requires that any Mental Illness and/or Substance Use Disorder Partial Hospitalization Treatment Program must be licensed in the state where it is located, or accredited by a national organization that is recognized by your Participating IPA or Participating Medical Group as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Pharmacy means a state and federally licensed establishment that is physically separate and apart from any Provider's office, and where legend drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

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.

Preferred Specialty Drug means a Specialty Drug, which may be a Generic or Brand Name Drug, that is identified on the Drug List as a Preferred Specialty Drug. The Drug List is available by accessing the Blue Cross and Blue Shield website at **www.bcbsil.com**.

Prescription Order means a written or verbal order from a Professional Provider to a pharmacist for a drug to be dispensed. Orders written by a Professional Provider located outside the Unites States to be dispensed in the United States are not covered under this Policy.

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.

Standard Fertility Preservation Services means procedure based upon current evidence based standards of care established by the American Society for Reproductive Medicine, the American Society for Clinical Oncology, or other national associations that follow current evidence-based standards of care.

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

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. Acne; including acne prescription drugs covered under outpatient prescription drugs;

4. Acupuncture 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. Moles;

8. Lesions;

9. Testing or treatment for sleep disorders

10. Any charges for surgery, procedures, treatment, facilities, supplies, devices, or drugs that We determine are experimental or investigational;

11. 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;

10. 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;

13. Blood derivatives which are not classified as drugs in the official formularies;

14. Expenses in connection with services and prescriptions for 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;

15. Expenses in connection with cosmetic treatment or cosmetic surgery, except as a result of:

    - A covered Injury that occurred while the Covered Person was insured;
    - An infection or other diseases of the involved part; or
    - A covered child's congenital defect or anomaly;

16. Riding as a passenger or otherwise in any vehicle or device for aerial navigation except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline;

17. Injury resulting from racing or speed contests, skin diving, sky diving, parachuting, hang gliding, glider flying, parasailing, sail planning, bungee jumping, mountaineering (where ropes or guides are customarily used), or any other hazardous sport or hobby;

18. 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;

19. Any expenses incurred in connection with sterilization reversal and vasectomy reversal

20. 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;

21. 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;

22. Alopecia;

23. Surgery for the removal of excess skin or fat;

25. 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;

26. Custodial Care;

27. Long-term care service;

28. Inpatient private duty nursing service;

29. Weight loss programs;

30. Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services;

31. Prescription drug coverage is not provided for:

- Refills in excess of the number specified or dispensed after one (1) year from the date of the prescription;

- Drugs labeled “Caution - limited by federal law to investigational use” or experimental drugs;

- Immunizing agents, biological sera, blood or blood products administered on an outpatient basis;

- 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;

- 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.;

- 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;

- Lost or stolen prescriptions;

- Non-sedating antihistamines;

- Compound medications;

- Weight loss medications;

- Brand Proton Pump inhibitors;

- Drugs determined by the Plan to have inferior or significant safety issues.

- Drugs which are not included on the Drug List; unless specifically covered elsewhere in the Contract and/or such coverage is required in accordance with applicable law or regulatory guidance.

Academic Emergency Services*

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. For more details, visit **saic.myahpcare.com**.

BlueCard®

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.

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard service area, you will typically have to pay the Providers and submit the claims yourself to obtain reimbursement for these services.
If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

For additional information regarding the BlueCard® Program or Blue Cross and Blue Shield Global Core, refer to your policy located at **saic.myahpcare.com.**

**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. Academic EmergencyServices and AD&D coverage are underwritten by 4 Ever Life International Limited and administered by Worldwide Insurance Services, LLC, separate and independent companies from Academic HealthPlans.*

Summary of Benefits and Coverage

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 visit **saic.myahpcare.com.**

BCBSIL Online Resources

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℠ (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, they may opt-out of electronic delivery by going into My Email Preferences and making the change there.

Please visit **saic.myahpcare.com** for additional premium and benefit information.

Claims Procedure

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 their 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**
All Others: Call AHP **(855) 844-3019**

Plan is administered by:
Academic HealthPlans, Inc.
P. O. Box 1605
Colleyville, TX 76034-1605

For more information visit
saic.myahpcare.com

Important Notice

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.

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, sexual orientation, health status 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: TTY/TDD: Fax: Email:	855-664-7270 (voicemail) 855-661-6965 855-661-6960 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: TTY/TDD:	800-368-1019 800-537-7697
	Complaint Portal: Complaint Forms:	https://ocrportal.hhs.gov/ocr/portal/lobby.jsf http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

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.

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.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكاليف. 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.
ગુજરાતી Gujara ti	જો તમને અથવા તમે મદદ કરી ર ા હોય એવી કોઈ બીજી વ્યિક્તને એસ.બી.એમ. કાયર્ક્રમ બાબતે પ્ર ો હોય, તો તમને િવના ખચેર્, તમારી ભાષામાં મદદ અને મા િહતી મેળવવાનો હક્ક છે.દભા ષયા સાથે વાત કરવા માટ આ નબર 855-710-6984 પર કોલ કરો.
िहदी Hindi	यिद आपके , या आप िजसकी सहायता कर रहे ह उसके , प्र न ह , तो आपको अपनी भाषा म िनःशु क सहायता और जानकारी प्रा त करने का अिधकार है। िकसी अनुवादक से बात करने के िलए 855-710-6984 पर कॉल कर ।.
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’11 ni, 47 doodago [a’da b7k1 an1n7lwo’7g77, na’7d7[kidgo, ts’7d1 bee n1 ah00ti’i’ t’11 n77k’e n7k1 a’doolwo[d00 b7na’7d7[kid7g77 bee ni[h odoonih. Ata’dahalne’7g77 bich’8’ hod77lnih kwe’4 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek 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.
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 لئے، 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.