



# STUDENT HEALTH INSURANCE PLAN

## 2021 - 2022 BENEFITS GUIDE

POLICY NUMBER: 254596

# TABLE OF CONTENTS

03	Health Insurance Contact Information What the SAIC Student Health Plan Offers
04	Top 5 Things You Need to Know
05	Eligibility Enrollment and Waiver Details
06	Online Tools Rates Effective Dates
07	Covered Services
12	Commonly Used Terms
13	Exclusions 24-Hour Nurseline Worldwide Assistance

# HEALTH INSURANCE CONTACTS

## ENROLLMENT & WAIVER QUESTIONS

Academic HealthPlans  
visit [saic.myahpcare.com](http://saic.myahpcare.com)

## CLAIMS QUESTIONS

BlueCross and BlueShield  
of Illinois (BCBSIL)  
  
call 1-855-267-0214

## MEDICAL & PRESCRIPTION CLAIMS FORMS

visit [saic.myahpcare.com](http://saic.myahpcare.com)  
click on "Claims"

**MAIL CLAIMS TO:**  
BCBSIL  
PO Box 805107  
Chicago, IL 60680-4112

## SEARCH FOR A BCBS NETWORK PROVIDER

visit [saic.myahpcare.com](http://saic.myahpcare.com)  
click on "Quick Links"  
click on "Find a Doctor or Hospital"

## WHAT THE SAIC STUDENT HEALTH INSURANCE PLAN OFFERS

The School of the Art Institute of Chicago Health Insurance Plan is a fully insured Student Health Insurance Plan underwritten by BlueCross and BlueShield of Illinois (BCBSIL).

Your Plan is a Preferred Provider Organization or "PPO" Plan. It provides you with a higher level of coverage when you receive Covered Medical Expenses from physicians who are part of the Plan's network referred to as "Network". The Network providers participate in the BCBSIL PPO Network.

The Plan also provides coverage when you obtain Covered Medical Expenses from Physicians who are not part of the Plan's network, referred to as "Out-of-Network".

The Premium Rates and the list of Covered Services are illustrated in this guide. Please contact our Customer Care Representatives with any questions you may have about the Plan.

## DID YOU KNOW?

The cost of the Student Health Insurance Plan may be less expensive than coverage as a dependent on your Parent's Plan.

# TOP 5 THINGS YOU NEED TO KNOW

1.

The Student Health Insurance Plan (SHIP) provides coverage for basic care and prescription drugs which includes, but is not limited to the following:

- Primary Care
- Care from many specialists
- Urgent Care
- Mental and behavioral health care/counseling

2.

The Student Health PPO Plan provides coverage through BCBSIL with access to 1.3 million medical and behavioral health providers and 8,000 hospitals nationwide. Within a five-mile radius of SAIC's campus, there are currently 11,763 providers, 13 hospitals, and 97 urgent care centers included in the network.

3.

Your Student Health PPO Plan also includes Prescription Drug Coverage. To find In-Network pharmacies in or out of the Chicago area go to [saic.myahpcare.com](http://saic.myahpcare.com) and click on the "Find a Pharmacy" link.

4.

Full-time domestic undergraduate, graduate, exchange and certificate students and all international students are automatically enrolled in and billed for the Student Health Insurance Plan. Students who have comparable health insurance can elect to waive the Student Health Insurance Plan.

5.

ID cards will be mailed to students with domestic addresses. An electronic copy will also be available through your BCBSIL Member Account. For questions regarding Benefits, Claims and ID Cards, please contact BCBS Customer Service at 1-855-267-0214.

## ARE YOU ELIGIBLE?

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](http://saic.myahpcare.com), they will automatically be enrolled in SAIC's Student Health Insurance Plan. The premium will be charged, per semester, to each student's account.

If a student has comparable coverage and wishes to waive SAIC's Student Health Insurance Plan for the entire academic year, a waiver must be completed online by visiting [saic.myahpcare.com](http://saic.myahpcare.com) by the first day of fall classes. Spring-only waivers are due by the first day of spring classes. Summer waivers are required only of new students who begin their degree program in the summer.

### DID YOU KNOW?

The Student Health Insurance Plan includes  
worldwide travel assistance

## ENROLLMENT AND WAIVER DETAILS

### DEPENDENT ELIGIBILITY

Eligible students who enroll in the plan may also enroll their eligible dependents. Eligible dependents are the Insured Student's spouse/domestic partner residing with the Insured Student; or the Insured Student's unmarried Children to age 26.

For additional plan information please refer to your Certificate of Coverage at [saic.myahpcare.com](http://saic.myahpcare.com). Eligible students are automatically enrolled in and billed for the Student Health Insurance Plan. Students who have comparable health insurance can elect to waive the Student Health Insurance Plan. To provide proof of comparable coverage, an online waiver form must be completed and submitted by September 1, 2021. To waive the Student Insurance Plan visit [saic.myahpcare.com](http://saic.myahpcare.com).

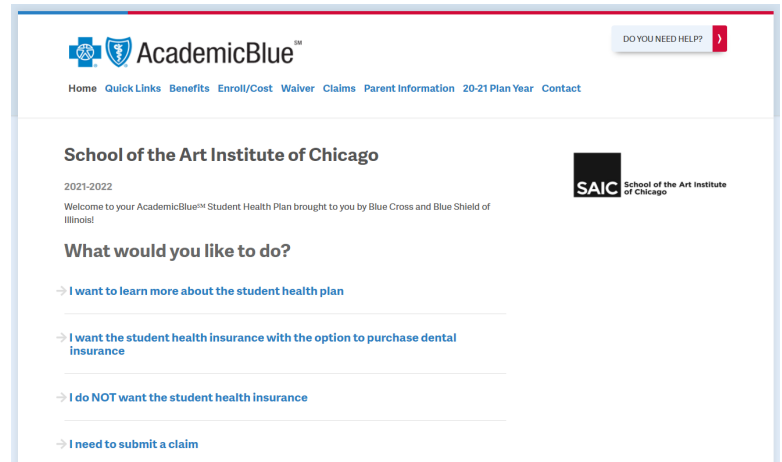
### WAIVER DEADLINE

Students who do not wish to be enrolled in the plan and have comparable coverage can elect to waive their coverage. Students who do not submit an online waiver form by the deadline will be enrolled in and billed for the Student Health Insurance Plan.

SAIC reserves the right to audit and subsequently reject a waiver request. If it is determined that a student waived coverage with a health insurance plan that was not comparable coverage, the student will be automatically enrolled in the Student Health Insurance Plan.

# ONLINE TOOLS

Our Student Portal, [saic.myahpcare.com](http://saic.myahpcare.com), provides students with one central location for all of your student health insurance needs, including how to get a copy of your ID card, searching for a provider or hospital and viewing benefit documents.



## RATES

DOMESTIC & INTERNATIONAL	FALL	SPRING (NEW STUDENTS)	SPRING (RETURNING STUDENTS)	SUMMER (NEW STUDENTS)
STUDENT	\$1,270	\$1,270	\$1,270	\$473
SPOUSE/DOMESTIC PARTNER	\$1,270	\$1,270	\$1,270	\$473
EACH CHILD	\$1,270	\$1,270	\$1,270	\$473

## EFFECTIVE DATES

DOMESTIC & INTERNATIONAL	EFFECTIVE DATE	TERMINATION DATE
		<i>The coverage periods are effective and will terminate at 11:59 PM on the dates advertised.</i>
FALL	08/18/2021	01/26/2022
SPRING (NEW STUDENTS)	01/18/2022	08/17/2022
SPRING (RETURNING STUDENTS)	01/27/2022	08/17/2022
SUMMER (NEW STUDENTS)	06/11/2022	08/17/2022

## COVERED SERVICES

	NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
<b>DEDUCTIBLE</b>	<b>\$500</b>	<b>\$1,000</b>
<b>INDIVIDUAL OUT-OF-POCKET MAXIMUM</b>	<b>\$8,150</b>	<b>\$16,300</b>

INPATIENT BENEFITS	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% of Allowable Amount after a \$30 Copayment

50% of Allowable Amount after a \$30 Copayment

**Routine Well-Baby Care**

80% of Allowable Amount

50% of Allowable Amount

**Mental Illness/Substance Abuse Disorder**

Paid as any other covered sickness

Paid as any other covered sickness

OUTPATIENT BENEFITS	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)

OUTPATIENT BENEFITS	NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
<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.	80% of Allowable Amount after a \$30 Copayment	50% of Allowable Amount after a \$30 Copayment
<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.	80% of Allowable Amount	50% of Allowable Amount

**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

<b>Non-Emergency Care</b>		
<b>Facility Services:</b> (Copayment is waived if the Insured is admitted; Inpatient hospital expenses will apply)	80% of Allowable amount after a \$300 Copayment	50% of Allowable amount
<b>Physician Services</b>	80% of Allowable Amount	85% of Allowable Amount
<b>Urgent Care Services</b>	100% after a \$50 Copayment (Deductible waived)	50% after a \$30 Copayment (Deductible waived)
<b>Diagnostic X-rays</b>	80% of Allowable Amount	50% of Allowable Amount
<b>Laboratory Procedures</b>	80% of Allowable Amount (Deductible waived)	50% of Allowable Amount (Deductible waived)
<b>Tests and Procedures</b> Diagnostic services and medical procedures performed by a Doctor, other than Doctor's visits.	80% of Allowable Amount	50% of Allowable Amount
<b>Allergy Injection and Testing</b> Copay may apply if billed in the office	80% of the Allowable Amount	50% of the Allowable Amount
<b>Mental Illness/Substance Abuse Disorder</b>	100% after a \$30 Copayment (Deductible waived)	50% of Allowable Amount (Deductible waived)

EXTENDED CARE EXPENSES	NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
<b>Extended Care Expenses</b> All services must be pre-authorized	80 of Allowable Amount	50% of Allowable Amount
<b>Home Health Care</b>	No Benefit Period Visit Maximum	
<b>Skilled Nursing</b>		
<b>Hospice Care</b>		
<b>Private Duty Nusing</b>		



OTHER	NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
<b>Ground and Air Ambulance Services</b>	80% of Allowable Amount	
<b>Durable Medical Equipment</b> When prescribed by a Doctor and a written prescription accompanies the claim when submitted.	80% of Allowable Amount	50% of Allowable Amount
<b>Maternity/Complications of Pregnancy</b>	80% of Allowable Amount	50% 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.	80% of Allowable Amount	50% of Allowable Amount
<b>Hearing Aids</b> <b>Hearing Aid Maximum</b>	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 and cochlear implants.	
<b>Habilitative Services and Devices</b> (Limited services covered)	80% of Allowable Amount	50% of Allowable Amount
<b>Dental</b> Made necessary by Injury to sound, natural teeth only.	80% of Allowable Amount	80% of Allowable Amount
<b>Routine Eye Exam for Adults</b> (One (1) vision exam per benefit period)	80% of Allowable Amount	50% of Allowable Amount
<b>Pediatric Vision, up to age 19</b> See benefit flyer for details	100% of Allowable Amount	Refer to set fee schedule
<b>Pediatric Routine Dental Care, up to age 19</b> See benefit flyer for details	80% of Allowable Amount	50% of Allowable Amount
<b>Pediatric Basic and Major Dental, up to age 19</b> See benefit flyer for details	50% of Allowable Amount	30% of Allowable Amount
<b>Pediatric Medically Necessary Orthodontia, up to age 19</b> See benefit flyer for details	50% of Allowable Amount	30% of Allowable Amount
<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.	80% of Allowable Amount	50% of Allowable Amount
<b>Gender Reassignment including surgery if meets medically necessary criteria</b>	Paid as any other covered sickness	Paid as any other covered sickness
<p>Preventative Care Services: Benefits include but not limited to:</p> <ul style="list-style-type: none"> <li>An annual routine physical exam, annual pap smear, annual mammogram screening, prostate screening, colorectal screening and immunizations.</li> <li>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>Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC");</li> <li>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>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.</li> </ul> <p>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.</p>	100% of Allowable Amount (Deductible waived)	50% of Allowable Amount

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. Copayment amounts will apply to Out-of-Pocket Maximum.	<i>At pharmacies contracting with Prime Therapeutics Network: 100% of Allowable Amount after a:</i>	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 they obtained drugs from a Network pharmacy minus the Copayment amount or Coinsurance amount.
<b>Generic Drug</b>	\$15 Copayment	50% of Allowable Amount
<b>Preferred Brand-Name Drug</b>	*\$35 Copayment <i>*Copayment plus the cost difference between the Brand Name Drug or supplies per prescription for which there is Generic Drug or supply available.</i>	
<b>Non-Preferred Brand-Name Drug</b>	*\$50 Copayment <i>*Copayment plus the cost difference between the Brand Name Drug or supplies per prescription for which there is Generic Drug or supply available.</i>	

## OPTIONAL ADULT DENTAL COVERAGE

BLUECARE DENTAL	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
<b>Monthly Premium Rate</b>		\$20.85
<b>Deductible</b>		\$75
<b>Annual Maximum</b>		\$1,000
<b>Diagnostic Evaluations</b> (Deductible waived) Oral examinations (2 every 12 months)	90%	70%
<b>Preventive Services</b> (deductible waived) Prophylaxis (2 cleanings every 12 months)	90%	70%
<b>Diagnostic Radiographs</b> (Deductible waived) Dental X-rays, full mouth (1 every 36 months)	90%	70%
<b>Miscellaneous Preventive Services</b> Sealants/space maintainers	90%	70%
<b>Basic Restorative Services</b> Services for restorations needed to repair damage caused by basic dental decay, including tooth preparation, all adhesives, bases, liners and polishing; routine fillings (amalgam and resin-based composite)	70%	50%
<b>Non-Surgical Extractions</b> Removal of erupted tooth	70%	50%
<b>Non-Surgical Periodontal</b> Periodic scaling and planing	70%	50%
<b>Adjunctive Services</b> Services for palliative treatment (emergency) of dental pain, when not performed in conjunction with planned treatment; general anesthesia	70%	50%

**Endodontic Services**

Services for treatment related to dental disease of the tooth pulp

50%

30%

**Oral Surgery Services**

Surgical tooth extractions

50%

30%

**Surgical Periodontal**

Gingivectomy/gingivoplasty/osseous surgery and grafts

50%

30%

**Major Restorative Services**

Services to restore tooth structures lost as a result of decay or fracture; single-crown restorations; inlay/onlay restorations

50%

30%

**Prosthodontic Services**

Bridges/full and partial dentures

50%

30%

**Misc Restorative & Prosthodontics Services**

Recementation of crowns, inlays, onlays/crown repair

50%

30%

**View Plan Details at:**[saic.myahpcare.com](http://saic.myahpcare.com)

## COMMONLY USED TERMS

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

**Claim:** A request for payment that is submitted to your health insurance company for services received.

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

**Copayment (copay):** A fixed dollar amount that the Covered Person must pay before benefits are payable under the Policy.

**Deductible:** 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.

**Eligibility:** Terms of an insurance policy that define the requirements to become a member on the insurance plan.

**Exclusions:** Expenses for which the plan does not cover nor provide benefits for.

**Inpatient Care:** A Covered Person is a registered bed patient and is treated as such in a health care facility.

**Network Provider:** 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:** 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:** 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.

**Premium:** The amount you pay to purchase your health insurance plan.

**Waiver:** Showing proof of adequate health care coverage in order to opt-out of the student health plan.

## EXCLUSIONS

The following is a partial list of services and supplies that are not covered. Your plan may contain exceptions to this list based on the plan design purchased.

For a full description of covered benefits and exclusions, please visit [saic.myahpcare.com](http://saic.myahpcare.com).

Certain services are not covered under this plan including but not limited to cosmetic surgery, procedures, supplies and appliances; Custodial Care; Expenses incurred for elective treatment or elective surgery except as specifically provided in the Plan; Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid; Hearing Exams; Preventive dental care, except as provided under "Pediatric dental care for Members under age 19" benefit Reversal of voluntary

## YOUR PLAN ALSO INCLUDES

### 24 HOUR NURSELINE

Experienced RNs are just a phone call away to help you figure out the best course of action for a non-emergency health concern. The 24/7 Nurse Advice Line provides a convenient, easy, and confidential way to get medical care advice.

Please call 800-299-0274 for more information.

### WORLDWIDE ASSISTANCE

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 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, go to [saic.myahpcare.com](http://saic.myahpcare.com).