The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.campuscare.uic.edu. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.campuscare.uic.edu or call 1-312-996-4915 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.campuscare.uic.edu or call 1-312-996-4915 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from the provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	Not Covered	None
	Specialist visit	$15 copay/visit	Not Covered	Referral is required.
	Preventive care/ screening/ immunization	No charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not Covered	An order is required.
	Imaging (CT/PET scans, MRIs)	No charge	Not Covered	An order is required for some services.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.campuscare.uic.edu/pharmacy	Generic drugs	$10 copay/ prescription	$10 copay/prescription	Covers up to a 31-day supply per fill for all eligible retail pharmacy medications. Formulary contraceptives are subject to $0 copay. Mail order is not available.
	Preferred brand drugs	$20 copay/ prescription	$20 copay/prescription	Covers up to a 31-day supply per fill for all eligible retail pharmacy medications. Formulary contraceptives are subject to $0 copay. Mail order is not available.
	Non-preferred brand drugs	10% coinsurance, $40 copay/ prescription	10% coinsurance, $40 copay/prescription	Covers up to a 31-day supply per fill for all eligible retail pharmacy medications. Mail order is not available.
	Specialty drugs	10% coinsurance, $40 copay/ prescription	10% coinsurance, $40 copay/prescription	Covers up to a 31-day supply per fill for all eligible retail pharmacy medications. Mail order is not available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not Covered	Referral is required..
	Physician/surgeon fees	No charge	Not Covered	Referral is required.
If you need immediate medical attention	Emergency room care	$50 copay/visit	30% coinsurance, $50 copay/visit	If network hospital uses an out-of-network provider, Member will be responsible for the out-of-network coinsurance. Out-of-network visits must be approved.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Urgent care	$15 copay	Not Covered	A note must be made in the medical records from an network physician advising Member to utilize specified Urgent Care Centers.
If you have a hospital stay	Facility fee (e.g., hospital room)	$50 copay/day	30% coinsurance, $50 copay/day.	Preauthorization is required. Out-of-network stays must be approved
	Physician/surgeon fees	No charge	30% coinsurance, $50 copay/day.	If network hospital uses an out-of-network provider, Member will be responsible for the out-of-network coinsurance Referral is required. Out-of-network stays must be approved.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit	30% coinsurance,$50 copay/day.	Preauthorization is required. Out-of-network stays must be approved
	Inpatient services	$50 copay/day	30% coinsurance, $50 copay/day.	If network hospital uses an out-of-network provider, Member will be responsible for the out-of-network coinsurance Preauthorization is required. Out-of-network services must be approved.
If you are pregnant	Office visits	$15 copay/visit	Not Covered	Newborn services are only covered if added within 31 days of birth.
	Childbirth/delivery professional services	No Charge	30% coinsurance, $50 copay/day.	If network hospital uses an out-of-network provider, Member will be responsible for the out-of-network coinsurance. Newborn services are only covered if added within 31 days of birth
	Childbirth/delivery facility services	$50 copay/day	30% coinsurance, $50 copay/day.	Out-of-network services must be approved. Newborn services are only covered if added within 31 days of birth
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not Covered	Preauthorization is required.
	Rehabilitation services	$15 copay/visit	Not Covered	Preauthorization is required. PT out-patient: 40 visits/academic year OT/ST in-patient: 45 days/academic OT/ST out-patient: 20 visits/academic Spinal manipulation:15 visits/academic year
	Habilitation services	$15 copay/visit	Not Covered	Preauthorization is required. PT out-patient: 40 visits/academic year OT/ST in-patient: 45 days/academic OT/ST out-patient: 20 visits/academic year Spinal manipulation: 15 visits/academic year

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Skilled nursing care	10% coinsurance	Not Covered	Preauthorization is required.
	Durable medical equipment	10% coinsurance	Not Covered	Preauthorization is required.
	Hospice services	10% coinsurance	Not Covered	Referral is required. Bereavement counseling: 12 sessions/ academic year
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	One routine eye exam per academic year at network providers
	Children's glasses	10%-50% Discounted rate	Not Covered	Vision program through UHP
	Children's dental check-up	No charge	Not Covered	Dental program through UHP

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Emergency Care when traveling outside the U.S.
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic care
- Dental care (Adult)
- Hearing Aids
- Long term care
- Private-duty nursing

Your Rights to Continue Coverage: To be eligible to enroll in *CampusCare*, an individual must be a registered student of UIC or eligible fellow working under a T/32 or F/32 grant at UIC. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: cchealth@uic.edu or 312-996-4915.

* For more information about limitations and exceptions, see the plan or policy document at www.campuscare.uic.edu.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 312-996-4915 option 2
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 312-996-4915 option 2
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**312-996-4915 option 2
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 312-996-4915 option 2

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$100
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$240
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$240**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$0
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$60
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$600**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$50
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$70
Coinsurance	$
What isn't covered	
Limits or exclusions	$200
The total Mia would pay is	**$270**

The plan would be responsible for the other costs of these EXAMPLE covered services.