UIC International
STUDENT HEALTH INSURANCE PLAN

Insurance Definitions and How They Relate to Your Insurance Plan

	IN-NETWORK	OUT-OF-NETWORK
COVERED SERVICE The services, procedures, prescription medications, medical supplies/equipment that benefits are available for	Negotiated Rate	No Benefits
ALLOWED AMOUNT The maximum amount the insurance company will pay for a covered service.	Negotiated Rate	Unlimited
OUT OF POCKET MAXIMUM The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copays and coinsurance, your health insurance plan pays 100% of the costs of covered benefits.	$6,850	$6,850
MEDICAL PROVIDER • DOCTOR • HOSPITAL / EMERGENCY ROOM (ER) • SPECIALIST • URGENT CARE CENTER	Contracted with the insurance company to provide services for pre-negotiated rates. Typically, if you visit a physician or other provider within the network, the amount you will be responsible for paying will be less than if you go to an out-of-network provider. You can search for in-network providers at www.universityhealthplans.com/UIC by clicking on "Provider Search" from the left navigation menu.	Not contracted with the insurance company. Typically, if you visit a physician or other provider out of the network, the amount you will be responsible for paying will be more than if you go to an in-network provider.
COINSURANCE The percent you pay for covered services	20% of the allowed amount	40%
COPAY A fixed amount you pay for covered services. In-network copayments usually are less than out-of-network copayments.	Prescription Copays: Tier 1: $15 Tier 2: $30 Tier 3: $50	No Benefits
DEDUCTIBLE The amount you pay for covered services before the insurance company starts to pay.	$400	$400

Student Health Center Information

The UIC Student Health Center is considered part of the UI Hospital and Health Sciences System. The Student Health Center is considered an in-network provider and the will file medical claims on your behalf to the insurance company. You will not need to complete a claim form when seeking medical services from the Student Health Services Center. Claims will be paid at 100% and the plan deductible will be waived for covered services when treatment is rendered at the Student Health Services Center. Information about the Student Health Services Center can be found online at here.

The UIC Student Health Services Center is located at:

722 W. Maxwell St, 2nd Floor, Chicago, IL 60607
(312) 996-2901
516-877-6008 (fax)

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How to File a Medical Claim with Consolidated Health Plans (CHP)

In-Network Claim Process

If you visit an In-Network Cigna Preferred Provider, the provider must file a medical claim on your behalf. That is why most doctor offices and hospitals require you to provide your insurance ID card when you come in for a visit or procedure. Once billed, your insurance company will process the claims and reimburse your provider accordingly. If any part of your claim is not covered, you will be responsible for the balance as described in your explanation of benefits.

Out-of-Network Claims Process

If you visit an Out-of-Network (non-Cigna) provider who does not file a medical claim for you, you will need a claim form to submit for payment. You can obtain the claim form online at www.universityhealthplans.com/UIC. Attached is a sample claim form.

1. After you receive care, obtain a copy of the itemized medical bill(s) from your provider. KEEP A COPY OF THE ITEMIZED BILL(S) FOR YOUR RECORDS. The bill(s) must include:
    - Provider's name and address
    - Provider's Tax ID Number
    - Diagnosis
    - Date of Service
    - List of services received with procedure code(s)
    - Provider charges for each procedure
    - Copy of receipt if you have paid for the services

2. Complete **ALL** of the information on the claim form. KEEP A COPY OF YOUR COMPLETED CLAIM FORM FOR YOUR RECORDS.

3. Send the **signed** completed claim form along with copies of itemized bills and receipts, **as soon as reasonably possible,** to:

    Consolidated Health Plans
    2077 Roosevelt Avenue
    Springfield, MA 01104
    Fax (413)-733-4612

4. Please do not submit balance due, balance forward or past due statements for payment. Sending these types of statements will only delay payment.

5. It is your responsibility to provide all of the necessary information so that your claim can be quickly processed. If you have any questions call, Consolidated Health Plans at 800-633-7867 or email customer service at customerservice@consolidatedhealthplan.com.

CHP Consolidated Health Plans
A Berkshire Hathaway Company

Student Insurance Claim Form

Upon completion, send this form to:

Consolidated Health Plans, Inc.
2077 Roosevelt Ave
Springfield, MA 01104
Fax (413) 733 - 4612

School Name: ***UIC International***		
Student Name: ***Student Full Name***	**Member ID Number:** ***Student Insurance Member ID#*** ***(located on the insurance ID card)***	**Date of Birth:** ***Student DOB*** ***(mm/dd/yyyy)***
Student Address* **City** **State** **Zip** ***Student Local Mailing Address***		
Email: ***Student E-Mail Address***	**Telephone:** ***Student Telephone #*** ***(000-000-0000)***	

***Note: All address changes must be done through your plan sponsor.**

Is this claim for your dependent? ☐ YES ☐ NO

- Check YES if the claim is for your dependent

- Check NO if the claim if for yourself

Dependent's Name:_____ Date of Birth: _____

- If the Claim is for your dependent, print your dependent's name and DOB

Do you, your dependents, or your parents have any other insurance or medical plan that covers this condition? ☐ YES ☐ NO

- Check YES if you have other US health insurance to cover this condition

- Check NO if this insurance is your only US health insurance for this condition

If yes, please enter the name of the insurance company: _____

- If you answered YES above, print the name of the insurance company

1. **For an Annual/Routine Examination:** ☐ YES ☐ NO
2. **For an Illness/Prescription:**

- Check YES if you saw a physician or provider for an annual or routine exam (i.e., physical)

- Check NO if you saw a physician or provider for an illness (i.e., sick visit)

Please describe symptoms: _____

- Print your symptoms

Date of illness: _____

- Print the date of your illness

Date you first consulted a physician for this illness: _____

- Print the first date you contacted/consulted/saw a physician or provider for this illness

Have you ever sought treatment for this illness in the past: ☐ YES ☐ NO

- Check YES if you have ever been seen by a physician or provider for this illness in the past

- Check NO if you have never been seen by a physician or provider for this illness in the past

If yes, please describe past treatment and dates: _____

_____

_____

- If you answered YES above, print any past dates you were seen by a physician or provider for this illness and any treatments the physician/provider conducted to treat this illness

3. **For an Injury:**

Please describe how injury occurred: _____

_____

- If you saw a physician or provider because of an injury, briefly describe what happened to cause the injury.

Where did the injury occur (home, work, etc)_____

_____

- Print where you were when you were injured.

Date of injury: _____

- Print the date the injury occurred.

What body part was injury (include right or left if applicable)_____

- Print what was hurt in the injury (i.e., right hand, left knee, forehead, right shoulder, chin, lower back, etc.)

Was the injury a result of an auto accident? ☐ YES ☐ NO

- Check YES if the injury was because you were in an automobile accident

- Check NO if the injury was not because you were in an automobile accident

Were you injured while working on the job? ☐ YES ☐ NO

- Check YES if you were injured while you were at work

- Check NO if you were not injured while you were at work

Were you injured during practice or play of an intercollegiate sport? ☐ YES ☐ NO

- Check YES if you were injured while you were at practice or if you were engaging in an intercollegiate sport

- Check NO if you were not injured while you were at practice or if you were engaging in an intercollegiate sport

If yes, signature of athletic director: _____

- If you checked YES, please have the athletic director sign this line

Have you ever sought treatment for this injury in the past? ☐ YES ☐ NO

- Check YES if you have ever been seen by a physician or provider for this injury in the past

- Check NO if you have never been seen by a physician or provider for this injury in the past

If yes, please describe past treatment and dates: _____

- If you answered YES above, print any past dates you were seen by a physician or provider for this illness and any treatments the physician/provider conducted to treat this illness

Were you treated by Student Health Services and referred for this condition? ☐ YES ☐ NO

- Check YES if the Student Health Center treated your condition and referred you to another physician or provider

Seen by: _____

- If you checked YES above, list the physician or provider's name that you were referred to

If not referred, why? _____

- If you were not referred to another physician or provider, explain why here

I authorize any physician, hospital, company, employer or organization to release the medical history, treatments or benefits payable for this claim to Consolidated Health Plan or its payor for which it is an authorized plan administrator. A photocopy of this form shall be just a valid as the original. I authorize Consolidated Health Plans or its representatives to pay all bills in conjunction with this claim directly to the physician, hospital or other health care provider rendering service.

I certify that I have read all answers to this form, and to the best of my knowledge the information I have given is complete and true. Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty (not to exceed five thousand dollars in New York) and the stated value of the claim for each violation.

_____ _____

Signature of Claimant

- Sign your name on this line

Date

Print the date you completed this form on this line