Who is eligible to enroll?

All full-time and all medical students without documented alternate health insurance in place and a completed online waiver are required to purchase this insurance plan on a mandatory basis. Eligible students may also insure their Dependents. Eligible Dependents are the student’s spouse or domestic partner and dependent children under 26 years of age. See the Who is Covered section of the Certificate of Coverage for the specific requirements needed to meet domestic partner eligibility.

Where can I get more information about the benefits available?

Please read the certificate of coverage to determine whether this plan is right before you enroll. The certificate of coverage provides details of the coverage including costs, benefits, exclusions, and reductions or limitations and the terms under which the coverage may be continued in force. Copies of the certificate of coverage are available from the University and may be viewed at www.uhcsr.com. This plan is underwritten by UnitedHealthcare Insurance Company of New York and is based on policy number 2018-892-1. The Policy is a Non-Renewable One-Year Term Policy.

Who can answer questions I have about the plan?

If you have questions please contact Customer Service at 1-800-767-0700 or customerservice@uhcsr.com.

Highlights of Coverage offered by UnitedHealthcare StudentResources

Coverage Dates and Plan Cost

<table>
<thead>
<tr>
<th>Rates</th>
<th>Annual 8/16/18 to 8/15/19</th>
<th>Fall 8/16/18 to 1/15/19</th>
<th>Spring/Summer 1/16/19 to 8/15/19</th>
<th>Summer 5/16/19 to 8/15/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$3,335.50</td>
<td>$1,411.25</td>
<td>$1,944.25</td>
<td>$861.25</td>
</tr>
<tr>
<td>Spouse</td>
<td>$3,335.50</td>
<td>$1,411.25</td>
<td>$1,944.25</td>
<td>$861.25</td>
</tr>
<tr>
<td>One Child</td>
<td>$3,335.50</td>
<td>$1,411.25</td>
<td>$1,944.25</td>
<td>$861.25</td>
</tr>
<tr>
<td>Two or More Children</td>
<td>$6,711.00</td>
<td>$2,822.50</td>
<td>$3,888.50</td>
<td>$1,722.50</td>
</tr>
<tr>
<td>Spouse and Two or More Children</td>
<td>$10,066.50</td>
<td>$4,233.75</td>
<td>$5,832.75</td>
<td>$2,583.75</td>
</tr>
</tbody>
</table>

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may, for example, cover your school’s administrative costs associated with offering this health plan.

The Member must meet the eligibility requirements each time a premium payment is made. To avoid a lapse in coverage, the Member’s premium must be received within 30 days after the coverage expiration date. It is the Member’s responsibility to make timely premium payments to avoid a lapse in coverage.
### Highlights of the Student Health Insurance Plan Benefits

**METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 84.750%**

#### In-Network Benefits
In-Network benefits apply when your care is provided by Participating Providers in our UnitedHealthcare Choice Options PPO network. Participating Providers can be found using the following link:

[UHC Options PPO](#)

<table>
<thead>
<tr>
<th>Overall Plan Maximum</th>
<th>In Network Participating Provider Cost-Share</th>
<th>Out-of-Network Non-Participating Provider Member Cost-Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Plan Maximum</td>
<td>There is no overall maximum dollar limit on the policy</td>
<td></td>
</tr>
<tr>
<td>Plan Deductible</td>
<td>$200 Per Member, Per Plan Year</td>
<td>$400 Per Member, Per Plan Year</td>
</tr>
<tr>
<td>Out-of-Pocket Limit</td>
<td>After the Out-of-Pocket Limit has been satisfied, Covered Expenses will be paid at 100% for the remainder of the Plan Year subject to any applicable benefit maximums. Refer to the plan Certificate for details about how the Out-of-Pocket Limit applies.</td>
<td>$3,000 Per Member, Per Plan Year $9,000 For all Members in a Family, Per Plan Year $6,000 Per Member, Per Plan Year $18,000 For all Members in a Family, Per Plan Year</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>20% of Allowed Amount(^1) for Covered Expenses</td>
<td>50% of Allowed Amount(^1) for Covered Expenses</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>$30 Copayment for Tier 1 $50 Copayment for Tier 2 $50 Copayment for Tier 3</td>
<td>$30 Copayment for Generic Drugs $50 Copayment for Brand Name Drugs Up to a 30 day supply per prescription</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>Covered in full</td>
<td>30% of Allowed Amount(^1)</td>
</tr>
<tr>
<td>The following services have per Service Copayments</td>
<td>Office Visits: $35 Laboratory Procedures: $0 Diagnostic X-rays: $0 Emergency Care in an Emergency Department: $100</td>
<td>Office Visits: $35 Laboratory Procedures: $15 Diagnostic X-rays: $0 Emergency Care in an Emergency Department: $100</td>
</tr>
<tr>
<td>Pediatric Dental and Vision Benefits</td>
<td>Refer to the plan Certificate of Coverage for details (age limits apply).</td>
<td></td>
</tr>
</tbody>
</table>

\(^1\)The Allowed Amount for Preferred and Participating Providers is the amount we have negotiated with the Preferred and Participating Providers. The Allowed Amount for Non-Participating Providers will be determined on the Usual, Customary and Reasonable charge using the lesser of: 1) the 80th percentile of the Fair Health rate; 2) the facility or provider's charge; or 3) a rate based on information provided by a third-party vendor. We reserve the right to negotiate a lower rate with Non-Participating Providers.
Exclusions and Limitations

No coverage is available under this Certificate for the following:

A. Aviation.
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or transportation. “Custodial care” means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Conversion Therapy.
We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for any individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

D. Cosmetic Services.
We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

E. Dental Services.
We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of this Certificate.

F. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, or when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

G. Felony Participation.
We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

H. Foot Care.
We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.
I. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

J. Medically Necessary.
In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

K. Medicare or Other Governmental Program.
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

L. Military Service.
We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

M. Services Not Listed.
We do not Cover services that are not listed in this Certificate as being Covered.

N. Services Provided by a Family Member.
We do not Cover services performed by a member of the covered person’s immediate family. “Immediate family” shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

O. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

P. Services With No Charge.
We do not Cover services for which no charge is normally made.

Q. Vision Services.
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Pediatric Vision Care section of this Certificate.

R. War.
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

S. Workers’ Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers’ Compensation, employers’ liability or occupational disease law.

UnitedHealthcare Global: Global Emergency Services

If you are a student insured with this insurance plan, you and your insured spouse, Domestic Partner and insured minor child(ren) are eligible for UnitedHealthcare Global Emergency Services. The requirements to receive these services are as follows:

International Students (whose Home Country is not the United States), insured spouse, Domestic Partner and insured minor child(ren): you are eligible to receive UnitedHealthcare Global services worldwide, except in your Home Country.

Domestic Students (whose Home Country is the United States), insured spouse, Domestic Partner and insured minor child(ren): you are eligible for UnitedHealthcare Global services when 100 miles or more away from your campus address or 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

The Assistance and Evacuation Benefits are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All services must be arranged and provided by UnitedHealthcare Global; any services not arranged by UnitedHealthcare Global will not be considered for payment. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center. UnitedHealthcare Global will then take the appropriate action to assist you and monitor your care until the situation is resolved.
Key Assistance Benefits include:
- Emergency Medical Evacuation
- Dispatch of Doctors/Specialists
- Medical Repatriation
- Transportation After Stabilization
- Transportation to Join a Hospitalized Member
- Return of Minor Children
- Repatriation of Remains

To access benefits please refer to the phone number on the back of your ID Card or access My Account and select My Benefits/Additional Benefits/UHC Global Emergency Services.

When calling the UnitedHealthcare Global Operations Center, please be prepared to provide:
- Caller’s name, telephone and (if possible) fax number, and relationship to the patient;
- Patient’s name, age, sex, and UnitedHealthcare Global ID Number as listed on the back of your Medical ID Card
- Description of the patient’s condition;
- Name, location, and telephone number of hospital, if applicable;
- Name and telephone number of the attending physician; and
- Information of where the physician can be immediately reached.

All medical expenses related to hospitalization and treatment costs incurred should be submitted to UnitedHealthcare Insurance Company of New York for consideration and are subject to all Policy benefits, provisions, limitations, and exclusions. All assistance and evacuation benefits must be arranged and provided by UnitedHealthcare Global. Claims for reimbursement of services not provided by UnitedHealthcare Global will not be accepted. A full description of the benefits may be found in your certificate of coverage.

NOTE: The information contained herein is a summary of certain benefits which are offered under a student health insurance policy issued by UnitedHealthcare. This document is a summary only and may not contain a full or complete recitation of the benefits and restrictions/exclusions associated with the relevant policy of insurance. This document is not an insurance policy document and your receipt of this document does not constitute the issuance or delivery of a policy of insurance. Neither you nor UnitedHealthcare has any rights or responsibilities associated with your receipt of this document. Changes in federal, state or other applicable legislation or regulation or changes in Plan design required by the applicable state regulatory authority may result in differences between this summary and the actual policy of insurance.
NON-DISCRIMINATION NOTICE

UnitedHealthcare StudentResources does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
United HealthCare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf


Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)


We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 1-866-260-2723.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

請注意: 如果您說中文 (Chinese), 我們免費為您提供語言協助服務。請致電：1-866-260-2723.


setState:'تشديد: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-260-2723.'

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisyè sevis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-260-2723.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-260-2723.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。1-866-260-2723 にお電話ください。
कृपा ध्यान दें: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-260-2723

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-260-2723.

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-260-2723.

DÍÍ BAA’ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yánil'ti'go, saad bee áka'aníd'a'wo'ígíí, t'áá jiik'eh, bee ná'ahóó'ti'. T'áá shoodi kohji' 1-866-260-2723 hodíilnih.

Díí yánil’ti’go, saad bee áka'aníd'a'wo'ígíí, t'áá jiik'eh, bee ná'ahóó'ti'. T'áá shoodi kohji' 1-866-260-2723 hodíilnih.