



2014–2015

Student Injury and Sickness Insurance Plan for American University

Who is eligible to enroll?

All full-time degree seeking, residential and international students with F-1 and J-1 visas enrolled at American University are required to carry health insurance coverage and are automatically enrolled in the health insurance plan unless a waiver is submitted before the established deadline. All students taking six or more credit hours and Optional Practical Training students are eligible to enroll in the Student Health Insurance Plan. Students whose status is considered full-time are also eligible for the Student Health Insurance Plan. Eligible students may also insure their Dependents. Eligible Dependents are the student's spouse and dependent children under 26 years of age.

Where can I get more information about the benefits available?

Please read the plan brochure to determine whether this plan is right before you enroll. The plan brochure 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 plan brochure are available from the University and may be viewed at www.uhcsr.com/american.

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.

What important deadlines should I be aware of?

Online waivers must be submitted by September 9, 2014.

How much does the plan cost?

| Rates | Annual 8/1/14 – 7/31/15 | Fall 8/1/14 – 12/31/14 | Spring/Summer 1/1/15 – 7/31/15 | Summer 5/1/15 – 7/31/15 |
|----------------|----------------------------|---------------------------|-----------------------------------|----------------------------|
| Student | \$ 1,815.00 | \$ 800.00 | \$ 1,075.00 | \$ 475.00 |
| Spouse | \$ 7,335.00 | \$ 3,068.00 | \$ 4,260.00 | \$ 1,850.00 |
| Each Child | \$ 4,285.00 | \$ 1,790.00 | \$ 2,490.00 | \$ 1,080.00 |
| All Children | \$ 7,431.00 | \$ 3,115.00 | \$ 4,316.00 | \$ 1,873.00 |
| All Dependents | \$14,752.00 | \$ 6,184.00 | \$ 8,568.00 | \$ 3,718.00 |

This plan is underwritten by UnitedHealthcare Insurance Company and is based on policy number 2014-101-1.

The Policy is a Non-Renewable One-Year Term Policy.

Highlights of the Coverage and Services offered by UnitedHealthcare StudentResources

| | Preferred Providers | Out-of-Network Providers |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| Overall Plan Maximum | There is no overall maximum dollar limit on the policy | |
| Plan Deductible | \$200 per Insured Person, per Policy Year | \$500 per Insured Person, per Policy Year |
| Out-of-Pocket Maximum <i>After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any applicable benefit maximums. Refer to the plan brochure for details about how the Out-of-Pocket Maximum applies.</i> | \$6,350 Per Insured Person, Per Policy Year \$12,700 For all Insureds in a Family, Per Policy Year | No Benefits |
| Coinsurance <i>All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copays as described in the plan brochure.</i> | 80% of Preferred Allowance for Covered Medical Expenses | 60% of Usual and Customary Charges for Covered Medical Expenses |
| Prescription Drugs <i>Mail order through UHCP at 2.5 times the retail copay up to a 90 day supply. (Prescriptions filled at the Student Health Center will be paid at 100% with a \$5.00 Copay for generic, \$20 Copay for brand.)</i> | \$10 Copay for Tier 1 \$35 Copay for Tier 2 \$50 Copay for Tier 3 Up to a 31-day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP) | 60% of Usual and Customary Charges \$10 Deductible for generic drugs \$35 Deductible for brand name drugs Up to a 31-day supply per prescription |
| Preventive Care Services <i>Including but not limited to: annual physicals, GYN exams, routine screenings and immunizations. No copay or Deductible when the services are received from a Preferred Provider. Please see www.healthcare.gov for complete details of the services provided for specific age and risk groups.</i> | 100% of Usual and Customary Charges | Usual and Customary Charges |
| The following services have per Service Copays/Deductibles <i>This list is not all inclusive. Please read the plan brochure for complete listing of Copays/Deductibles.</i> | Medical Emergency: \$150 | Medical Emergency: \$150 |
| Pediatric Dental and Vision Benefits | Refer to the plan brochure for details (age limits apply). | |
| FrontierMEDEX | Domestic Students are eligible for FrontierMEDEX services when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address. International Students are covered worldwide except in their home country. | |

Preferred Providers

The Preferred Provider Network for this plan is UnitedHealthcare Choice Plus. Preferred Providers can be found using the following link: <http://www.uhcsr.com/lookupredirect.aspx?delsys=52>

Online Services

UnitedHealthcare **StudentResources** Insureds have online access to their claims status, EOBs, ID Cards, network providers, correspondence and coverage account information by logging in to *My Account* at www.uhcsr.com/myaccount. To create an online account, select the "create My Account Now" link and follow the simple, onscreen directions. All you need is your 7-digit Insurance ID number or the email address on file. Insureds can also download our UHCSR Mobile App available on Google Play and Apple's App Store.

Exclusions and Limitations:

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

1. Behavioral problems. Developmental delay or disorder or mental retardation. Learning disabilities.
This exclusion does not apply to benefits specifically provided in the policy.
2. Cosmetic procedures, except reconstructive procedures to:
 - Correct an Injury or treat a Sickness for which benefits are otherwise payable under this policy. The primary result of the procedure is not a changed or improved physical appearance.
 - Treat or correct Congenital Conditions of a Newborn or adopted Infant.
3. Custodial Care.
 - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
 - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
4. Dental treatment, except:
 - For accidental Injury to Sound, Natural Teeth.
 - For treatment of cleft lip and cleft palate.
 - As specifically provided in the Schedule of Benefits.

This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
5. Elective Surgery or Elective Treatment.
6. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
7. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
This exclusion does not apply to:
 - Hearing defects or hearing loss as a result of an infection or Injury.
 - Hearing screenings specifically provided for in Benefits for Child Health Screening Services.
8. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy.
9. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
10. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance.
11. Injury sustained while:
 - Participating in any intercollegiate, or professional sport, contest or competition.
 - Traveling to or from such sport, contest or competition as a participant.
 - Participating in any practice or conditioning program for such sport, contest or competition.
12. Investigational services.
13. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
14. Prescription Drugs, services or supplies as follows:
 - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy.
 - Immunization agents, except as specifically provided in the policy. Biological sera.
 - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except as specifically provided in the policy.
 - Products used for cosmetic purposes.
 - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
 - Anorectics - drugs used for the purpose of weight control.
 - Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
 - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
15. Reproductive/Infertility services including but not limited to the following:
 - Procreative counseling.
 - Genetic counseling and genetic testing.
 - Cryopreservation of reproductive materials. Storage of reproductive materials.
 - Fertility tests, except to diagnose the underlying cause of infertility including testing and counseling.
 - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
 - Premarital examinations.
 - Impotence, organic or otherwise.
 - Female sterilization procedures, except as specifically provided in the policy.
 - Vasectomy.
 - Reversal of sterilization procedures.
16. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.
This exclusion does not apply as follows:
 - When due to a covered Injury or disease process.

- To benefits specifically provided in Pediatric Vision Services.
17. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.
 18. Preventive care services, except as specifically provided in the policy, including:
 - Routine physical examinations and routine testing.
 - Preventive testing or treatment.
 - Screening exams or testing in the absence of Injury or Sickness.
 19. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
 20. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis. This exclusion does not apply to benefits specifically provided in the policy.
 21. Supplies, except as specifically provided in the policy.
 22. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
 23. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
 24. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
 25. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat.





POLICY NUMBER: 2014-101-1

NOTICE:

The benefits contained within have been revised since publication. The revisions are included within the body of the document, and are summarized on the last page of the document for ease of reference.

NOC #2 - (7/9/14)

Removed "Temporomandibular joint dysfunction, except for surgical treatment" from exclusion #20.

NOC # 1- (6/11/14)

Removed the following text from the parenthetical under *Prescription Drugs on the Schedule of Benefits in the Policy Web Brochure: "and a \$45 Copay for non-formulary prescriptions.)"

After the removal of the text in the parenthetical, it should read as follows: "Prescriptions filled at the Student Health Center will be paid at 100% with a \$5.00 Copay for generic and a \$20 Copay for brand."