

Student Injury and Sickness Insurance Plan

Designed especially for the students of

University of South Florida Visiting Scholars



The University of South Florida is pleased to offer an Injury and Sickness Insurance Plan underwritten by UnitedHealthcare Insurance Company and serviced by Gallagher Student Health & Special Risk. All Visiting Scholars are eligible to participate in this plan. All J-1 Exchange Visitors and their accompanying dependents on J-2 visas are required to have health insurance coverage during their period of stay at USF and are eligible to participate in this plan.



How do I Enroll in the Plan?

Go to www.gallagherstudent.com/usf and under "Student Access" select "Forms and Applications"

Need more information? Please contact:

Gallagher Student Health & Special Risk
500 Victory Road
Quincy, MA 02171
1-617-769-6405 or
Toll free 1-877-539-3492
Email: USFStudent@gallagherstudent.com

If you have any questions, please contact Customer Service toll-free at 1-877-539-3492 or at USFStudent@gallagherstudent.com

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



Highlights of the Coverage and Services offered:

- There is no overall maximum dollar limit on the policy.
- \$200 Deductible for Preferred Providers Per Insured Person Per Policy Year, \$500 Deductible for Out of Network Providers Per Insured Person Per Policy Year.
- Covered Medical Expenses for Preferred Providers are payable at 80% of Preferred Allowance and Out of Network benefits are payable at 70% of Usual and Customary charges (all benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copays as described in the policy).
- Preferred Provider Out-of-Pocket Maximum of \$5,000 Per Insured Person and \$10,000 for all Insureds in a Family, Per Policy Year. Out-of-Network Out-of-Pocket maximum of \$10,000 Per Insured Person and \$20,000 for all Insureds in a Family, Per Policy Year. 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 certificate for details about how the Out-of-Pocket Maximum applies.
- Prescription Drug Benefits: \$15 Copay for Tier 1 / \$30 Copay for Tier 2 / \$50 Copay for Tier 3 up to a 31-day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP). Mail order through UHCP at 2.5 times the retail copay up to a 90 day supply. \$15 Deductible for generic drugs / \$30 Deductible for brand name up to a 31-day supply per Prescription at an Out-of-Network pharmacy.
- Refer to Plan certificate for details about pediatric dental and vision benefits. (Age limits apply.)
- Preventive Care Services which include, but are not limited to, annual physicals, GYN exams, routine screenings and immunizations are covered at 100% with no Copay or deductible only 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.
- Coverage available for eligible Dependents.
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>
- 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.
- Also available for University of South Florida students is a UnitedHealthcare Insurance Company fully insured Dental and Vision plan, to enroll go to www.uhcsr.com/usf.
- 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.

Rates	Annual	Monthly	Weekly
Scholar	\$2,473	\$207	\$48
Spouse/Domestic Partner	\$5,555	\$462	\$107
Each Child	\$4,075	\$339	\$79
All Children	\$4,980	\$414	\$97

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees include amounts which are paid to certain non-insurer vendors or consultants by, or at the direction of, your school.

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. Acupuncture.
2. Congenital Conditions, except as specifically provided for:
 - Habilitative Services.
 - Benefits for Newborn Infant, Adopted or Foster Child.
 - Benefits for Cleft Lip and Cleft Palate.
 - Reconstructive surgery to correct deformity caused by birth defects or growth defects.
3. Cosmetic procedures, or 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.
 - Correct deformity caused by birth defects or growth defects.
 - Treat or correct Congenital Conditions of a Newborn or adopted Infant.
4. Dental treatment, except:
 - For accidental Injury to Sound, Natural Teeth.

This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
5. Elective Surgery or Elective Treatment, except cosmetic surgery made necessary as the result of a covered Injury or to correct a disorder of a normal bodily function.
6. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
7. Health spa or similar facilities. Strengthening programs.
8. 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.
 - Benefits for Cleft Lip and Cleft Palate.
 - Benefits for Child Health Assurance.
9. Hirsutism. Alopecia.
10. Hypnosis.
11. Immunizations, except as specifically provided in the policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy.
12. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
13. 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.
 - While participating in any practice or conditioning program for such sport, contest or competition.
14. Lipectomy.
15. Participation in a riot or civil disorder. Commission of or attempt to commit a felony. Fighting, except in self-defense.
16. Prescription Drugs, services or supplies as follows[, except as specifically provided in the policy:
 - 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. Blood or blood products administered on an outpatient basis.
 - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs.
 - 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.
 - Growth hormones.
 - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
17. 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.
 - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except to diagnose or treat the underlying cause of the infertility.
 - Premarital examinations.
 - Impotence, organic or otherwise.
 - Reversal of sterilization procedures.
 - Sexual reassignment surgery.
18. 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.
 - To benefits specifically provided in Benefits for Newborn Infant, Adopted or Foster Child.
 - To benefits specifically provided in Benefits for Child Health Assurance.
19. Routine Newborn Infant Care and well-baby nursery and related Physician charges, except as specifically provided in the policy.
 20. 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.
 21. Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping.
 22. Speech therapy, except as specifically provided in Benefits for Cleft Lip and Cleft Palate. Or except as specifically provided in the policy. Naturopathic services.
 23. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.
 24. Supplies, except as specifically provided in the policy.
 25. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
 26. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
 27. 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).
 28. Weight management. Weight reduction. Nutrition programs. Treatment for obesity, surgery for removal of excess skin or fat

This plan is underwritten by UnitedHealthcare Insurance Company and serviced by Gallagher Student Health & Special Risk, and is based on policy 2014-363-2.

Please read the certificate of coverage to determine whether this plan is right for you before you enroll. The certificate of coverage provides details of the coverage including costs, benefits, exclusions, any reductions or limitations and the terms under which the coverage may be continued in force.

Copies of the certificate are available from the University, or may be viewed and downloaded at www.gallagherstudent.com