2014–2015

Student Injury and Sickness Insurance Plan for Pace University

PLEASE NOTE:
THIS DOCUMENT HAS BEEN CHANGED. SEE THE BACK COVER FOR DETAILS

Who is eligible to enroll?

All full-time undergraduate student carrying 12 or more credits, full-time graduate students carrying 9 or more credits and all enrolled full-time law students are required to participate in this plan on a hard waiver basis. Part-time graduate, undergraduate and law students registered for 6 or more credit hours may participate in this plan on a voluntary basis. 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 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/pace.

Who can answer questions I have about the plan?

If you have questions please contact Customer Service at 1-800-331-1096.

What benefits are available at the Student Health Center?

Student Health Center Benefits: When the Student Health Center is accessible, an Insured student is recommended to seek services from the Pace University Health Center. Benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center. The Deductible will be waived for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center.

This plan is underwritten by UnitedHealthcare Insurance Company of New York and is based on policy number 2014-869-1.
The Policy is a Non-Renewable One-Year Term Policy.

Highlights of the Coverage and Services offered by UnitedHealthcare **Student**Resources		
	In-Network Member Cost-Share	**Out-of-Network Member Cost-Share**
Plan Deductible	$35 Per Member, per Plan Year	
Out-of-Pocket Limit *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.*	$6,350 Per Member, per Plan Year $12,700 For all Members in a Family, per Plan Year	
Coinsurance *All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copayments as described in the plan Certificate.*	10% of Allowed Amount[1] for Covered Expenses	35% of Allowed Amount[1] for Covered Expenses
Prescription Drugs *Mail order at 2 times the retail Copayment up to a 90 day supply.*	$15 Copayment per prescription for generic drugs $30 Copayment per prescription for brand name $50 Copayment per prescription for non-preferred brand name	Out-of-Network Prescription Drugs are not covered and you pay the full cost.
Preventive Care *Including but not limited to: annual physicals, GYN exams, routine screenings and immunizations. Please see https://www.healthcare.gov/what-are-my-preventive-care-benefits for complete details of the services provided for specific age and risk groups.*	Covered in full	No Benefits
The following services have per Service Copayments *This list is not all inclusive. Please read the plan Certificate for complete listing of Copayments.*	Office Visits: $20	No Copayments
Pediatric Dental and Vision Benefits	Refer to the plan Certificate of Coverage 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.	

[1]The Allowed Amount for Participating Providers is the amount we have negotiated with the Participating Providers. The Allowed Amount for Out-of-Network Non-Participating Providers will be determined on the Usual, Customary and Reasonable charge based on the 75th percentile of the Fair Health rate.

In-Network Benefits

In-Network benefits apply when your care is provided by Participating Providers in our UnitedHealthcare Options PPO network. Participating Providers can be found using the following link: http://www.uhcsr.com/lookupredirect.aspx?delsys=01

Online Services

UnitedHealthcare **Student**Resources Members 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. Members can also download our UHCSR Mobile App available on Google Play and Apple's App Store.

Exclusions and Limitations:

No coverage is available under the Certificate for:

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. 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.

D. 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 except as specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of this Certificate.

E. 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 the Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

F. 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).

G. 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.

H. 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.

I. 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.

J. 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).

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

L. No-Fault Automobile Insurance.
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

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 will 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.

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A UnitedHealth Group Company

POLICY NUMBER: 2014-869-1

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#1

1. Exclusion [J] for **Interscholastic Sports (Intercollegiate Sports)** and Exclusion [O] for **Professional Sports** were removed and all remaining items re-lettered. **These exclusions are not allowed in NY**