2015–2016 Student Injury and Sickness Plan for Purdue University (Graduate Students)

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

Who is eligible to enroll?

All graduate teaching or research assistants and graduate administrative staff employed .5 FTE or more are eligible and may participate in this plan on a voluntary basis. Eligible students may also insure their Dependents. Eligible Dependents are the student's spouse or same-sex Domestic Partners and dependent children under 26 years of age. See the Definitions section of the Brochure for the specific requirements needed to meet Domestic Partner eligibility.

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/purdue.

Who can answer questions I have about the plan?

If you have questions please contact Customer Service at 1-888-224-4754 or customerservice@uhcsr.com.

This plan is underwritten by UnitedHealthcare Insurance Company and is based on policy number 2015-261-3.
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	$400 per Insured Person, per Policy Year and $400 for all Insureds in a Family, per Policy Year
Out-of-Pocket Maximum *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.*	$1,500 Per Insured Person, Per Policy Year and $3,000 For all Insureds in a Family, Per Policy Year	$3,000 Per Insured Person, Per Policy Year and $7,000 For all Insureds in a Family, Per Policy Year
Coinsurance *All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copays as described in the plan brochure.*	90% of Preferred Allowance for Covered Medical Expenses	70% of Usual and Customary Charges for Covered Medical Expenses
Prescription Drugs *Mail order through UHCP at 2 times the retail copay up to a 90 day supply.*	(A $10 Copay for generic prescriptions and a $20 Copay for brand name prescriptions applies to each covered prescription filled at the Purdue Pharmacy. When the Purdue Pharmacy is used, the plan will pay 100% above the Copay. When you do not use the Purdue Pharmacy, prescriptions must be filled at a UHCP participating pharmacy. Copay: greater of $20 Copay for Tier 1 prescriptions and $40 Copay for Tier 2 prescriptions or 30% Coinsurance up to a 31 day supply per prescription. Includes acne and allergy medications, and pre-natal vitamins.) (Mail order Prescription Drugs through UHCP at 2 times the retail Copay up to a 90 supply.)	No Benefits
Preventive Care Services *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.*	100% of Preferred Allowance	No Benefits
The following services have per Service Copays/Deductibles *This list is not all inclusive. Please read the plan brochure for complete listing of Copays/Deductibles. Copays for services at PUSH are $15 per visit.*	Medical Emergency: $50 Copay per visit (Waived if admitted to the Hospital)	Medical Emergency: $50 Deductible per visit (Waived if admitted to the Hospital)
Pediatric Dental and Vision Benefits	Refer to the plan brochure for details (age limits apply).	
UnitedHealthcare Global	Domestic Students are eligible for UnitedHealthcare Global services when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address.	

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 **Student**Resources 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. Acupuncture.
2. Learning Disabilities.
   This exclusion does not apply to benefits specifically provided in the policy.
3. 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.
   - Correct hemangiomas and port wine stain of the head and neck area for Insureds 18 and under.
   - Correct limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia.
   - Improve hearing by directing sound in the ear canal through Otoplasty, when ear or ears are absent or deformed from Injury, surgery, disease, or Congenital Condition.
   - Perform tongue release for diagnosis of tongue-tied.
   - Treat or correct Congenital Conditions that cause skull deformity such as Crouzon's disease.
   - Correct cleft lip and cleft palate.
4. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.
   - As described under Dental Treatment in the policy.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
5. Elective Surgery or Elective Treatment.
6. Elective abortion.
7. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
8. Foot care for the following:
   - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

   This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
9. 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.
10. Hirsutism. Alopecia.
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 interscholastic, 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.

14. Participation in a riot or civil disorder. Commission of or attempt to commit a felony. Fighting.
15. 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.
    - 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.
16. Reproductive/Infertility services including but not limited to the following, except as specifically provided in the policy:
    - 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.
    - Premarital examinations.
    - Impotence, organic or otherwise.
    - Reversal of sterilization procedures.
    - Sexual reassignment surgery.
17. 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 one pair of eyeglasses or contact lenses following a covered Surgery or accidental Injury when they replace the function of the human lens.
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. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis. This exclusion does not apply to Newborn Infants.
21. Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping.
22. Sleep disorders.
23. Supplies, except as specifically provided in the policy.
24. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
25. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
26. 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).
27. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except morbid obesity). Surgery for removal of excess skin or fat.

NOTE: 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. The information contained herein is a summary of certain benefits which are offered under a student health insurance policy issued by UnitedHealthcare and does not constitute a promise of coverage. Benefits and rates under any Student policy are subject to state and federal requirements and review. Company reserves the right to make any changes necessary to meet such requirements.

UnitedHealthcare®

POLICY NUMBER: 2015-261-3

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#5

Prescription Drugs exclusion: deleted "Blood or blood products administered on an outpatient basis." from 2nd bullet point.

NOC#4

No change needed

NOC#3

No change needed

NOC#2

Changed the RX Line Item From: (A $10 Copay for generic prescriptions and a $20 Copay for brand name prescriptions applies to each covered prescription filled at the Purdue Pharmacy. When the Purdue Pharmacy is used, the plan will pay 100% above the Copay. When you do not use the Purdue Pharmacy, prescriptions must be filled at a UHCP participating pharmacy. Copay: greater of $20 Copay for Tier 1 prescriptions and $40 Copay for Tier 2 prescriptions or 30% Coinsurance up to a $1,000 Coinsurance maximum then Copay: greater of $20 Copay for Tier 1 prescriptions and $40 Copay for Tier 2 prescriptions or 10% Coinsurance up to a 31 day supply per prescription. Includes acne and allergy medications, and pre-natal vitamins.) (Mail order Prescription Drugs through UHCP at 2 times the retail Copay up to a 90 supply.) (The $1,000 coinsurance maximum is still subject to the overall policy Out-of-Pocket maximum.)

To: (A $10 Copay for generic prescriptions and a $20 Copay for brand name prescriptions applies to each covered prescription filled at the Purdue Pharmacy. When the Purdue Pharmacy is used, the plan will pay 100% above the Copay. When you do not use the Purdue Pharmacy, prescriptions must be filled at a UHCP participating pharmacy. Copay: greater of $20 Copay for Tier 1 prescriptions and $40 Copay for Tier 2 prescriptions or 30% Coinsurance up to a 31 day supply per prescription. Includes acne and allergy medications, and pre-natal vitamins.) (Mail order Prescription Drugs through UHCP at 2 times the retail Copay up to a 90 supply.)

NOC#1

No Change needed.