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

Who is eligible to enroll?

All graduate assistants with assignments of 10 hours (0.25 FTE) or greater for the full semester in the Fall and/or Spring semesters, and who meet the minimum monthly stipend established by the Office of the Provost are required to have health insurance coverage and will be automatically enrolled in the Auburn University Graduate Student Group Health Plan (GSGHP). All non-assistantship graduate students are eligible to enroll voluntary basis. Eligible Dependents of students enrolled in the plan may participate in the plan on a voluntary basis. 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/auburn.

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.

How much does the plan cost?

Rates	Annual 8/16/15 – 8/15/16	Fall 8/16/15 – 2/15/16	Spring/Summer 2/16/16 – 8/15/16	Summer 5/16/16 – 8/15/16	Special Coverage Period 7/16/15 – 8/15/15
Student	$1,941.00	$976.00	$965.00	$488.00	$165.00
Spouse	$1,941.00	$976.00	$965.00	$488.00	$165.00
One Child	$1,941.00	$976.00	$965.00	$488.00	$165.00
Two or More Children	$3,848.00	$1,935.00	$1,913.00	$967.00	$327.00
Spouse + Two or More Children	$5,755.00	$2,894.00	$2,861.00	$1,466.00	$489.00

This plan is underwritten by UnitedHealthcare Insurance Company and is based on policy number 2015-38-2.
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	$250 per Insured Person, per Policy Year	$500 per Insured Person, 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.*	$6,350 Per Insured Person, Per Policy Year $12,700 For all Insureds in a Family, Per Policy Year	There is no Out-of-Pocket Maximum for Out-of-Network benefits.
Coinsurance *All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copays as described in the plan brochure.*	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Customary Charges for Covered Medical Expenses
Prescription Drugs *Mail order through UHCP at 2.5 times the retail Copay up to a 90 day supply.* *(**At AU Pharmacy Only:*** *$10 Copay per prescription for Tier 1* *$35 Copay per prescription for Tier 2* *$60 Copay per prescription for Tier 3* *up to a 31-day supply per prescription.)*	$20 Copay for Tier 1 $50 Copay for Tier 2 $75 Copay for Tier 3 Up to a 31-day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP)	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
Pediatric Dental and Vision Benefits	Refer to the plan brochure for details (age limits apply).	
UnitedHealthcare Global: Global Emergency Services	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 East Alabama Medical Center and 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. Acne.
2. Acupuncture.
3. Biofeedback.
4. Circumcision.
5. 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.
6. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
7. Elective Surgery or Elective Treatment.
8. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
9. Health spa or similar facilities. Strengthening programs.
10. 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.
11. Hirsutism. Alopecia.
12. Hypnosis.
13. 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.
14. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
15. 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.
16. 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.
17. Investigational services.
18. Lipectomy.
19. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
20. 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. 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.
21. 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.
- Female sterilization procedures, except as specifically provided in the policy.
- Vasectomy.
- Reversal of sterilization procedures.
- Sexual reassignment surgery.

22. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the policy.
23. 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 to replace the human lens function as a result of eye surgery or eye Injury or defect.
24. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.
25. 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.
26. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
27. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia. Temporomandibular joint dysfunction. 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.
28. Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping.
29. Naturopathic services.
30. Supplies, except as specifically provided in the policy.
31. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
32. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
33. 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).

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.