



**2025- 2026**

# Student Health Insurance Plan University of Missouri – Science & Technology

## Who can enroll?

### Domestic

- All enrolled in-person and online degree-seeking undergraduate students taking a minimum of six credit hours per semester are eligible to enroll in the plan.
- Enrolled graduate students, those holding assistantships, and students participating in internships or other practical training programs also are eligible to enroll in the plan. Please reach out to the school for further details.

### International

- Enrollment in this plan is mandatory and automatic for non-immigrant international students in F1 or J1 status.
- All non-immigrant international students, scholars and Optional Practical Training/Academic Training (OPT) participants holding F or J visas are eligible for this coverage.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse or Domestic Partner and dependent children under 26 years of age. See the Definitions section of the Certificate for the specific requirements needed to meet Domestic Partner eligibility.

## Plan resources at your fingertips

Domestic Students Only:  
Enroll coverage



[uhcsr.com](https://uhcsr.com)

View benefits, submit a claim and download your ID card via My Account

[uhcsr.com/myaccount](https://uhcsr.com/myaccount)

Find an in-network provider

[Choice Plus](#)

Find a prescription drug provider

[Optum Rx](#)

Value-added benefits and services (Student Assist<sup>1</sup>, HealthiestYou<sup>2</sup>, UHC Global<sup>3</sup>)

[uhcsr.com/myaccount](https://uhcsr.com/myaccount)

If you need language assistance:

[Language Assistance](#)

Student Health Center

<https://studenthealth.mst.edu/>

## Coverage periods, plan cost and deadline dates

### Domestic

|                              | Annual                | Fall                | Spring/Summer       |
|------------------------------|-----------------------|---------------------|---------------------|
| Enrollment Deadlines         | 09/05/2025            | 09/05/2025          | 02/06/2026          |
| Coverage dates               | 08/15/25 – 08/14/2026 | 08/15/25 - 01/14/26 | 01/15/26 - 08/14/26 |
| Student                      | \$2,654.00            | \$1,112.00          | \$1,542.00          |
| Student and Spouse           | \$5,308.00            | \$2,224.00          | \$3,084.00          |
| Student and Children         | \$5,308.00            | \$2,224.00          | \$3,084.00          |
| Student, Spouse and Children | \$7,962.00            | \$3,336.00          | \$4,626.00          |

### International

|                              | Annual              | Fall                | Spring/Summer       |
|------------------------------|---------------------|---------------------|---------------------|
| Enrollment Deadlines         | 09/05/2025          | 09/05/2025          | 02/06/2026          |
| Coverage dates               | 08/01/25 - 07/31/26 | 08/01/25 - 12/31/25 | 01/01/26 - 07/31/26 |
| Student                      | \$2,654.00          | \$1,112.00          | \$1,542.00          |
| Student and Spouse           | \$5,308.00          | \$2,224.00          | \$3,084.00          |
| Student and Children         | \$5,308.00          | \$2,224.00          | \$3,084.00          |
| Student, Spouse and Children | \$7,962.00          | \$3,336.00          | \$4,626.00          |

# Plan highlights

**Metallic Level: Gold with actuarial value of 83.660%**

**Student Health Referral:** Get treated at Student Health Services first. If a referral is needed to an outside provider your deductible will be waived. You will still be responsible for any applicable copays and coinsurance.

| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Preferred Providers                                                                                                                                                                                              | Out-of-Network Providers                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overall Plan Maximum</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           | There is no overall maximum dollar limit on the Policy                                                                                                                                                           |                                                                                                                                                    |
| <b>Plan Deductible</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                | \$400 Per Insured Person, per Policy Year                                                                                                                                                                        | \$800 Per Insured Person, per Policy Year                                                                                                          |
| <b>Out-of-Pocket Maximum</b><br><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 certificate for details about how the Out-of-Pocket Maximum applies.</i>                                                                                                                                                      | \$7,500 Per Insured Person, Per Policy Year<br>\$15,000 For all Insureds in a Family, Per Policy Year                                                                                                            | There is no Out-of-Pocket Maximum for Out-of-Network benefits.                                                                                     |
| <b>Coinsurance</b><br><i>All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copays as described in the plan certificate.</i>                                                                                                                                                                                                                                                                                      | 80% of Allowed Amount for Covered Medical Expenses                                                                                                                                                               | 50% of Allowed Amount for Covered Medical Expenses                                                                                                 |
| <b>Prescription Drugs</b><br><i>UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90 day supply.</i>                                                                                                                                                                                                                                                                                                 | \$15 Copay for Tier 1<br>\$50 Copay for Tier 2<br>\$75 Copay for Tier 3<br>Up to a 31-day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP) Retail Network Pharmacy not subject to Deductible | \$15 Copay for generic drugs<br>\$50 Copay for brand name drugs<br>Up to a 31-day supply per prescription<br>50% of billed charge after Deductible |
| <b>Preventive Care Services</b><br><i>Including but not limited to: annual physicals, GYN exams, routine screenings and immunizations. No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit <a href="http://www.healthcare.gov/preventive-care-benefits/">www.healthcare.gov/preventive-care-benefits/</a> for a complete list of the services provided for specific age and risk groups.</i> | 100% of Allowed Amount                                                                                                                                                                                           | 70% of Allowed Amount after Deductible                                                                                                             |
| <b>The following services have per service copays</b><br><i>This list is not all inclusive. Please read the plan certificate for complete listing of copays.</i>                                                                                                                                                                                                                                                                                                      | Physician's Visits: \$20 after Deductible<br><br>Consultant Visits: \$40 after Deductible<br><br>Medical Emergency: \$200 after Deductible                                                                       | Medical Emergency: \$200 after Deductible                                                                                                          |

Questions about your plan?

Contact Customer Service at 1-833-789-8649 or at customerservice@uhcsr.com

<sup>1</sup>Student Assist services are provided through OptumHealth Behavioral Solutions and OptumHealth Care Solutions, UnitedHealth Group companies. The Student Assist is not a substitute for medical attention. If you have an emergency medical condition, you should call 911 or your local emergency services number. <sup>2</sup>HealthiestYou and the HealthiestYou logo are trademarks of Teladoc Health, Inc., and may not be used without written permission. HealthiestYou does not replace the primary care physician. HealthiestYou does not guarantee that a prescription will be written. HealthiestYou operates subject to state regulation and may not be available in certain states. HealthiestYou does not prescribe DEA-controlled substances, nontherapeutic drugs and certain other drugs that may be harmful because of their potential for abuse. HealthiestYou physicians reserve the right to deny care for potential misuse of services. <sup>3</sup>Non-Insurance Travel Assistance services are provided by or through United Healthcare Services, Inc., and affiliates under the UnitedHealthcare Global brand. © 2025 United HealthCare Services, Inc. All Rights Reserved. The written materials contained in this document are a confidential property of UnitedHealth Group. Do not distribute or reproduce any materials without the express written consent of UnitedHealth Group. This plan is underwritten by UnitedHealthcare Insurance Company and is based on policy 2025-724-1. For further details of the coverage including costs, benefits, exclusions, any reductions or limitations and the terms under which the coverage may be continued in force, please refer to uhcsr.com.

NOTE: The information contained herein is a summary of certain benefits which are offered under a student health insurance Policy issued by UnitedHealthcare. This document is a summary only and does not contain a full or complete recitation of the benefits and restrictions/exclusions associated with the relevant Policy of insurance. 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. Neither you nor UnitedHealthcare has any rights or responsibilities associated with your receipt of this document. Changes in federal, state or other applicable legislation or regulation or changes in Plan design required by the applicable state regulatory authority may result in differences between this summary and the actual Policy of insurance. Benefits and rates described herein are subject to regulatory approval and may change.

