2015–2016
Student Injury and Sickness Plan for Florida (Medical Students)

Who is eligible to enroll?
All Medical Students are required to purchase this plan or show proof of comparable coverage. Eligible students may also insure their Dependents. Eligible Dependents are the student’s 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.

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 costs, 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.gallagherstudent.com/fiu-medicine.

Who can answer questions I have about the plan?
If you have questions please contact Customer Service at 1-877-498-5468 or FIUStudent@gallagherstudent.com.

What important dates or deadlines should I be aware of?
Annual/Fall enrollment deadline is September 17, 2015. Spring/Summer enrollment deadline is February 1, 2016.

How much does the plan cost?

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$2,508</td>
<td>$2,403</td>
<td>$1,005</td>
<td>$900</td>
<td>$1,503</td>
</tr>
<tr>
<td>Spouse</td>
<td>$2,508</td>
<td>$2,403</td>
<td>$1,005</td>
<td>$900</td>
<td>$1,503</td>
</tr>
<tr>
<td>One Child</td>
<td>$2,508</td>
<td>$2,403</td>
<td>$1,005</td>
<td>$900</td>
<td>$1,503</td>
</tr>
<tr>
<td>Two or More Children</td>
<td>$5,016</td>
<td>$4,806</td>
<td>$2,010</td>
<td>$1,800</td>
<td>$3,006</td>
</tr>
<tr>
<td>Spouse +Two or More Children</td>
<td>$7,524</td>
<td>$7,209</td>
<td>$3,015</td>
<td>$2,700</td>
<td>$4,509</td>
</tr>
</tbody>
</table>

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.

This plan is underwritten by UnitedHealthcare Insurance Company, serviced by Gallagher Student Health & Special Risk, and is based on policy number 2015-667-2. The Policy is a Non-Renewable One-Year Term Policy.
### Highlights of the Coverage and Services offered by UnitedHealthcare Student Resources

<table>
<thead>
<tr>
<th>Overall Plan Maximum</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Plan Maximum</td>
<td>There is no overall maximum dollar limit on the policy</td>
<td></td>
</tr>
<tr>
<td>Plan Deductible</td>
<td>$200 per Insured Person, per Policy Year</td>
<td>$500 per Insured Person, per Policy Year</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$5,000 Per Insured Person, Per Policy Year. $10,000 For all Insureds in a Family, Per Policy Year</td>
<td>$10,000 Per Insured Person, Per Policy Year. $20,000 For all Insureds in a Family, Per Policy Year</td>
</tr>
</tbody>
</table>

**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 certificate for details about how the Out-of-Pocket Maximum applies.*

<table>
<thead>
<tr>
<th>Coinsurance</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coinsurance</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Customary Charges for Covered Medical Expenses</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drugs</td>
<td>$15 Copay for Tier 1</td>
<td>$15 Deductible per prescription for generic drugs</td>
</tr>
<tr>
<td></td>
<td>$30 Copay for Tier 2</td>
<td>$30 Deductible per prescription for brand name</td>
</tr>
<tr>
<td></td>
<td>$50 Copay for Tier 3</td>
<td>Up to a 31-day supply per prescription</td>
</tr>
<tr>
<td></td>
<td>Up to a 31-day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventive Care Services</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care Services</td>
<td>100% of Preferred Allowance</td>
<td>No Benefits</td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The following services have per Service Copays/Deductibles</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following services have per Service Copays/Deductibles</td>
<td>Physician’s Visits: $30</td>
<td>Medical Emergency: $100</td>
</tr>
<tr>
<td>This list is not all inclusive. Please read the plan certificate for complete listing of Copays/Deductibles.</td>
<td>Lab: $30</td>
<td>(The Deductible will be waived if admitted to the Hospital.)</td>
</tr>
<tr>
<td>This list is not all inclusive. Please read the plan certificate for complete listing of Copays/Deductibles.</td>
<td>X-rays: $30</td>
<td></td>
</tr>
<tr>
<td>This list is not all inclusive. Please read the plan certificate for complete listing of Copays/Deductibles.</td>
<td>Medical Emergency: $100</td>
<td></td>
</tr>
<tr>
<td>This list is not all inclusive. Please read the plan certificate for complete listing of Copays/Deductibles.</td>
<td>(The Copay per visit will be waived if admitted to the Hospital.)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pediatric Dental and Vision Benefits</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Dental and Vision Benefits</td>
<td>Refer to the plan certificate for details (age limits apply).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UnitedHealthcare Global: Global Emergency Services</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Global: Global Emergency Services</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

**Preferred Providers**

The Preferred Provider Network for this plan is UnitedHealthcare Choice Plus. Preferred Providers can be found using the following link: [www.uhcsr.com/ChoicePlus](http://www.uhcsr.com/ChoicePlus)

**Online Services**

UnitedHealthcare Student Resources Insureds have online access to their claims status, EOBs, network providers, correspondence and coverage account information by logging in to My Account at [www.uhcsr.com/myaccount](http://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.
Also available for School students is a UnitedHealthcare Insurance Company fully insured Dental plan. To enroll go to www.uhcsr.com.

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. 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.
   - Correct deformity caused by birth defects or growth defects.
   - Treat or correct Congenital Conditions of a Newborn or adopted Infant.
3. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.
   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
4. 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.
5. Elective abortion.
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.
   - Benefits for Newborn Infant, Adopted or Foster Child.
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 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.
   - 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:
   - 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.
• Premarital examinations.
• Impotence, organic or otherwise.
• Reversal of sterilization procedures.
• Sexual reassignment surgery.

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 charge, 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.


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).


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 may 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.
Need more information? Please contact:
Gallagher Student Health & Special Risk
500 Victory Road
Quincy, MA 02171
Toll free 1-877-498-5468
Email: FIUSTudent@gallagherstudent.com

For the online waiver form, please visit our website at www.gallagherstudent.com/fiu-medicine, click on “Medical Student Direct Pay Enroll” and follow the online instructions.