



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.uhcsr.com/fsu](http://www.uhcsr.com/fsu) or by calling 1-800-767-0700.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Select Providers <b>\$0</b> (Person) Preferred Providers <b>\$500</b> (Person) Out of Network <b>\$1,000</b> (Person) Doesn't apply to preferred provider preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan documents to see if the <u>deductible</u> starts over. See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. Dental Pediatric <b>\$500</b> , Consultant Physician Fees <b>\$40</b> Ded per visit, Medical Emergency Expenses <b>\$350</b> Ded per visit. There are other <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. Preferred Providers <b>\$6,350</b> (Person) Preferred Providers <b>\$12,700</b> (Family) Out of Network <b>\$15,000</b> (Person)	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of <u>preferred providers</u> , see <a href="http://www.uhcsr.com/fsu">www.uhcsr.com/fsu</a> or call 1-800-767-0700.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-767-0700 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance (Coins)** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible (ded)**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use preferred **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use a Select Provider	Your Cost if You Use a Preferred Provider	Your Cost if You Use an Out of Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 Copay per visit	\$20 Copay per visit The Policy Ded does not apply.	30% Coins \$20 Ded per visit	May not apply when related to surgery or Physiotherapy.
	Specialist visit	\$20 Copay per visit	\$20 Copay per visit The Policy Ded does not apply.	30% Coins \$20 Ded per visit	May not apply when related to surgery or Physiotherapy.
	Other practitioner office visit	\$20 Copay per visit	\$20 Copay per visit The Policy Ded does not apply.	30% Coins \$20 Ded per visit	—————none—————
	Preventive care/screening/immunization	No Charge	No Charge	30% Coins	Includes preventive health services specified in the health care reform law or benefits provided as mandated by state law.

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Common Medical Event	Services You May Need	Your Cost if You Use a Select Provider	Your Cost if You Use a Preferred Provider	Your Cost if You Use an Out of Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	The Policy Ded does not apply.	30% Coins	_____none_____
	Imaging (CT/PET scans, MRIs)	No Charge	High Cost Procedures: 20% Coins Tests & Procedures: 20% Coins High Cost Procedures: The Policy Ded does not apply. Tests & Procedures: \$40 Copay per visit	30% Coins	_____none_____
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.uhcsr.com/pdl">www.uhcsr.com/pdl</a>	Tier 1 - Your Lowest-Cost Option	Not Covered	\$20 Copay per prescription for Tier 1	Not Covered	Preferred Providers: up to a 31 day supply per prescription Preferred Providers: (Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply.) You may need to obtain certain specialty drugs from a pharmacy designated by us.
	Tier 2 - Your Midrange-Cost Option	Not Covered	\$50 Copay per prescription for Tier 2	Not Covered	
	Tier 3 - Your Highest-Cost Option	Not Covered	Same as Tier 2	Not Covered	
	Tier 4 - Additional High-Cost Option	Not	Not	Not	

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Common Medical Event	Services You May Need	Your Cost if You Use a Select Provider	Your Cost if You Use a Preferred Provider	Your Cost if You Use an Out of Network Provider	Limitations & Exceptions
		Applicable	Applicable	Applicable	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No Charge	20% Coins	30% Coins	—————none—————
	Physician/surgeon fees	No Charge	20% Coins	30% Coins	—————none—————
<b>If you need immediate medical attention</b>	Emergency room services	Not Covered	20% Coins \$350 Copay per visit	20% Coins \$350 Ded per visit	May be limited to use of emergency room and supplies. Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness. The Copay/per visit Ded is in addition to the Policy Ded and will be waived if admitted to the Hospital.
	Emergency medical transportation	Not Covered	20% Coins	20% Coins	—————none—————
	Urgent care	No Charge	\$50 Copay per visit The Policy Ded does not apply.	30% Coins \$50 Ded per visit	May be limited to facility fees.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not Covered	20% Coins	30% Coins	—————none—————
	Physician/surgeon fee	Not Covered	20% Coins	30% Coins	—————none—————
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$20 Copay per visit	\$20 Copay per visit The Policy Ded does not apply.	30% Coins \$20 Ded per visit	—————none—————
	Mental/Behavioral health inpatient services	Not Covered	20% Coins	30% Coins	—————none—————
	Substance use disorder outpatient services	\$20 Copay per visit	\$20 Copay per visit The Policy	30% Coins \$20 Ded per visit	—————none—————

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Common Medical Event	Services You May Need	Your Cost if You Use a Select Provider	Your Cost if You Use a Preferred Provider	Your Cost if You Use an Out of Network Provider	Limitations & Exceptions
			Ded does not apply.		
	Substance use disorder inpatient services	Not Covered	20% Coins	30% Coins	—————none—————
If you are pregnant	Prenatal and postnatal care	Not Covered	\$20 Copay per visit The Policy Ded does not apply.	30% Coins \$20 Ded per visit	No cost share for preventive health services specified in the health care reform law when provided by a Preferred Provider
	Delivery and all inpatient services	Not Covered	20% Coins	30% Coins	—————none—————
If you need help recovering or have other special health needs	Home health care	Not Covered	20% Coins	30% Coins	—————none—————
	Rehabilitation services	Inpatient Rehabilitation Facility: Not Covered	Inpatient Rehabilitation Facility: 20% Coins Physiotherapy: \$20 Copay per visit Physiotherapy: The Policy Ded does not apply.	Physiotherapy: 30% Coins Inpatient Rehabilitation Facility: 30% Coins Physiotherapy: \$20 Ded per visit	All Suppliers: Inpatient: 21 days maximum (Per Policy Year)
	Habilitation services	No Charge	\$20 Copay per visit The Policy Ded does not apply.	30% Coins \$20 Ded per visit	—————none—————
	Skilled nursing care	Not Covered	20% Coins	30% Coins	All Suppliers: 60 days maximum (Per Policy Year)

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Common Medical Event	Services You May Need	Your Cost if You Use a Select Provider	Your Cost if You Use a Preferred Provider	Your Cost if You Use an Out of Network Provider	Limitations & Exceptions
	Durable medical equipment	No Charge	20% Coins	30% Coins	—————none—————
	Hospice service	Not Covered	20% Coins	30% Coins	—————none—————
If your child needs dental or eye care	Eye exam	Not Covered	\$20 Copay	50% Coins	See your plan's Pediatric Vision Benefit Details. Age limits apply.
	Glasses	Not Covered	Lens: \$40 Copay Frames: Tiered Copays from no charge to 40% based on retail cost.	50% Coins	See your plan's Pediatric Vision Benefit Details. Age limits apply.
	Dental check-up	Not Covered	50% Coins	50% Coins	See your plan's Pediatric Dental Benefit Details. Age limits apply.

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## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Dental care (Adult) except as noted in the policy
- Long-term care
- Routine foot care except as noted in the policy
- Bariatric surgery
- Hearing aids except as noted in the policy
- Non-emergency care when traveling outside the U.S. except as noted in the policy
- Weight loss programs
- Cosmetic surgery except as noted in the policy
- Infertility treatment
- Routine eye care (Adult) except as noted in the policy

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Private-duty nursing

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### Your Rights to Continue Coverage:

If you lose your status as an eligible student under your Student Health Insurance Coverage, Federal and State laws may allow you to continue your health coverage for a limited period of time. Any such rights will be limited in duration and will require you to pay a **premium**. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the insurer at 1-800-767-0700. You may also contact your state insurance department at Florida Department of Financial Services at 1-877-693-5236 or visit <http://www.myfloridacfo.com/>.

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Florida Department of Financial Services at 1-877-693-5236 or visit <http://www.myfloridacfo.com/>.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-767-0700.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-767-0700.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-767-0700.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-767-0700.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,900
- Patient pays \$1,640

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$500
Copays	\$40
Coinsurance	\$900
Limits or exclusions	\$200
<b>Total</b>	<b>\$1,640</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,620
- Patient pays \$1,780

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$500
Copays	\$1,000
Coinsurance	\$200
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,780</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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## NON-DISCRIMINATION NOTICE

UnitedHealthcare StudentResources does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator  
UnitedHealthcare StudentResources  
PO Box 809025  
Dallas, Texas 75380-9025

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free **1-800-368-1019, 800-537-7697** (TDD)

**Mail:** U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We also provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

## LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 1-866-260-2723.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：1-866-260-2723。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-260-2723.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-260-2723.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру 1-866-260-2723.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-260-2723.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-260-2723.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-260-2723.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniłmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-260-2723.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-260-2723.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-260-2723.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-260-2723 an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。1-866-260-2723 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-866-260-2723 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-260-2723

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**កម្ពុជា(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទ ទៅលេខ 1-866-260-2723។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-260-2723.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjí' 1-866-260-2723 hodílnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-260-2723.