



2023-2024 Student Health Insurance Plan for State University of New York

Who is eligible to enroll?

All international students and scholars, all students and scholars traveling abroad on approved SUNY academic programs and exchanges, and students participating in Optional Practical Training programs are eligible and must be enrolled in the plan, with the exception of those who meet the SUNY specified mandatory enrollment exemptions. Eligible Dependents of students enrolled in the plan may enroll on a voluntary basis. Eligible Dependents are the student's spouse or domestic partner and dependent children under 26 years of age. See the Who is Covered section of the Certificate of Coverage 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 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.uhcsr.com. This plan is underwritten by UnitedHealthcare Insurance Company of New York and is based on policy number 2023-203415-41. The Policy is a Non-Renewable One-Year Term Policy.

Who can answer questions I have about the plan?

If you have questions please contact Customer Service at 1-888-714-6544 or customerservice@uhcsr.com.

Highlights of Coverage offered by UnitedHealthcare StudentResources

Coverage Dates, Plan Costs and Premium Rates

The Total Cost of the plan noted below includes premium and fees.

Total Plan Cost and Coverage Dates	Annual 8-15-23 to 8-14-24	Fall 8-15-23 to 1-14-24	Spring 1-15-24 to 6-14-24	Spring/Summer 1-15-24 to 8-14-24	Summer 5-15-24 to 8-14-24
Student	\$2,568.28	\$1,073.63	\$1,066.61	\$1,494.65	\$645.58
Spouse	\$2,320.00	\$969.84	\$963.50	\$1,350.16	\$583.17
One Child	\$2,320.00	\$969.84	\$963.50	\$1,350.16	\$583.17
Two or More Children	\$4,640.00	\$1,939.68	\$1,927.00	\$2,700.32	\$1,166.34
Spouse and Two or More Children	\$6,960.00	\$2,909.52	\$2,890.50	\$4,050.48	\$1,749.51

See the information below for the breakdown of premium and fees.

Premium Rates*	Annual Premium**	Fall Premium**	Spring Premium**	Spring/Summer Premium**	Summer Premium**
Student	\$2,317.62	\$968.85	\$962.51	\$1,348.77	\$582.57
Spouse	\$2,317.62	\$968.85	\$962.51	\$1,348.77	\$582.57
One Child	\$2,317.62	\$968.85	\$962.51	\$1,348.77	\$582.57
Two or More Children	\$4,635.24	\$1,937.70	\$1,925.02	\$2,697.54	\$1,165.14
Spouse and Two or More Children	\$6,952.86	\$2,906.55	\$2,887.53	\$4,046.31	\$1,747.71

*The premium is for the insurance coverage underwritten by UnitedHealthcare Insurance Company of New York and does not include the following fees:

- Annual **Service fee of \$2.38 for UHC Global administration of the Assistance and Evacuation Benefits.
- Annual **Administrative fee of \$248.28 charged by the school you are receiving coverage through which may, for example, cover your school's administrative costs associated with offering this health plan.

**Note: Fees are prorated for the coverage dates other than annual.

The Member must meet the eligibility requirements each time a premium payment is made. To avoid a lapse in coverage, the Member's premium must be received within 30 days after the coverage expiration date. It is the Member's responsibility to make timely premium payments to avoid a lapse in coverage.

Highlights of the Student Health Insurance Plan Benefits

METALLIC LEVEL – PLATINUM WITH ACTUARIAL VALUE OF 96.180%

In-Network Benefits

In-Network benefits apply when your care is provided by Participating Providers in our UnitedHealthcare Options PPO network. Participating Providers can be found using the following link: [UHC Options PPO](#).

In-Network Preferred Provider Benefits

In-Network Preferred Provider benefits apply when your care is provided by the Student Health Center.

	In-Network Preferred Provider Member Cost-Share	In Network Participating Provider Member Cost-Share	Out-of-Network Non-Participating Provider Member Cost-Share
Overall Plan Maximum	There is no overall maximum dollar limit on the policy		
Plan Deductible	\$0 Per Member, Per Plan Year	\$200 Per Member, Per Plan Year	\$400 Per Member, Per Plan Year
Out-of-Pocket Limit <i>After the Out-of-Pocket Limit has been satisfied, Covered Expenses will be paid at 100% for the remainder of the Plan Year subject to any applicable benefit maximums. Refer to the plan Certificate for details about how the Out-of-Pocket Limit applies.</i>	\$7,350 Per Member, Per Plan Year \$14,700 For all Members in a Family, Per Plan Year	\$7,350 Per Member, Per Plan Year \$14,700 For all Members in a Family, Per Plan Year	\$14,700 Per Member, Per Plan Year \$28,400 For all Members in a Family, Per Plan Year
Coinsurance <i>All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copayments as described in the plan Certificate.</i>	0% of Allowed Amount ¹ for Covered Expenses	0% of Allowed Amount ¹ for Covered Expenses	10% of Allowed Amount ¹ for Covered Expenses

Prescription Drugs <i>UHCP Mail Order Network Pharmacy or Maintenance Drugs from a Designated Retail Pharmacy at 2.5 times the retail Copay up to a 90-day supply</i>	\$10 Copayment for Generic Drug	\$10 Copayment for Tier 1 not subject to Deductible	\$10 Copayment for Generic Drugs then 10% Coinsurance not subject to Deductible
	\$20 Copayment for Brand Name Drug	\$20 Copayment for Tier 2 not subject to Deductible	\$30 Copayment for Brand Name Drugs then 10% Coinsurance not subject to Deductible
	Up to a 30-day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP)	\$20 Copayment for Tier 3 not subject to Deductible Up to a 30-day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP)	Up to a 30-day supply per prescription
Preventive Care <i>Including but not limited to: annual physicals, GYN exams, routine screenings and immunizations. Please see https://www.healthcare.gov/preventive-care-benefits/ for complete details of the services provided for specific age and risk groups.</i>	Covered in full	Covered in full	10% of Allowed Amount ¹ after Deductible ¹
The following services have per service Copayments <i>This list is not all inclusive. Please read the plan Certificate for complete listing of Copayments.</i>	Covered in full	Office Visits: 0% Coinsurance after Deductible	Office Visits: \$50 Copayment then 10% Coinsurance after Deductible
Outpatient Mental Health Care/Substance Use Disorder Services, except Emergency Services and Prescription Drugs	Office Visits: Covered in full	Office Visits: 0% Coinsurance after Deductible	Office Visits: \$50 Copayment then 10% Coinsurance after Deductible
	Other Outpatient Services: Covered in full	Other Outpatient Services: 0% Coinsurance after Deductible	Other Outpatient Services: 10% Coinsurance after Deductible
Pediatric Dental and Vision Benefits	Refer to the plan Certificate of Coverage for details (age limits apply).		

¹The Allowed Amount for Preferred and Participating Providers is the amount we have negotiated with the Preferred and Participating Providers. The Allowed Amount for Non-Participating Providers will be the lesser of: 1) the Medicare amount; 2) the amount based on cost information from the Centers for Medicare and Medicaid services; 3) The facility or provider's charge; 4) a rate based on information provided by a third-party vendor; or 5) The amount negotiated with the Provider. We reserve the right to negotiate a lower rate with Non-Participating Providers.

Exclusions and Limitations

No coverage is available under this Certificate for the following:

A. Aviation.

We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.

We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Conversion Therapy.

We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

D. Cosmetic Services.

We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

E. Dental Services.

We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of this Certificate.

F. Experimental or Investigational Treatment.

We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

G. Felony Participation.

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

H. Foot Care.

We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

I. Government Facility.

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

J. Medically Necessary.

In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

K. Medicare or Other Governmental Program.

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

L. Military Service.

We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

M. No-Fault Automobile Insurance.

We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

N. Services Not Listed.

We do not Cover services that are not listed in this Certificate as being Covered.

O. Services Provided by a Family Member.

We do not Cover services performed by a covered person's immediate family member. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

P. Services Separately Billed by Hospital Employees.

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Q. Services With No Charge.

We do not Cover services for which no charge is normally made.

R. Vision Services.

We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Pediatric Vision Care section of this Certificate.

S. War.

We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

T. Workers' Compensation.

We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

Highlights of Assistance and Evacuation Benefits

Medical Evacuation and Repatriation

If you are a student insured with this insurance plan, you and your insured Spouse and insured Child(ren) are eligible for Medical Evacuation and Repatriation Benefits. The requirements to receive these services are as follows:

An international Student (whose Home Country is not the United States), and their insured Spouse and insured Child(ren): you are eligible to receive Medical Evacuation and Repatriation Benefits worldwide, except in your home country.

The Medical Evacuation and Repatriation Benefits and related services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center. UnitedHealthcare Global will then take the appropriate action to assist you and monitor your care until the situation is resolved.

Key Assistance Benefits include:

- Emergency Medical Evacuation
- Dispatch of Doctors/Specialists
- Medical Repatriation
- Transportation After Stabilization
- Transportation to Join a Hospitalized Insured Person
- Return of Minor Children
- Repatriation of Mortal Remains

Check your certificate of coverage for details, descriptions and program exclusions and limitations.

Highlights of Services offered by UnitedHealthcare Student Resources

Healthiest You: 24/7 Doctor Access

Starting on the effective date of your coverage under the student insurance plan, you have 24/7 access to medical advice through HealthiestYou, a national telehealth service.* By visiting www.telehealth4students.com, you have access to board-certified physicians via phone and/or video, where permitted. This service is especially helpful for minor illnesses, such as allergies, sore throat, earache, pink eye, etc. Based on the condition being treated, the doctor can also prescribe certain medications, saving you a trip to the doctor's office. Using HealthiestYou can save you money and time, while avoiding costly trips to a doctor's office, urgent care facility, or emergency room. As a Member with Student Resources, there is no consultation fee for this service.* Every call with a HealthiestYou doctor is covered 100% during your policy period. You can learn more about this benefit and how to use it in My Account.

This service is meant to complement your Student Health Center. If possible, we encourage you to visit your Student Health Center first before using this service.

HealthiestYou is not health insurance. HealthiestYou is designed to complement, and not replace, the care you receive from your primary care physician. HealthiestYou physicians are an independent network of doctors who advise, diagnose, and prescribe at their own discretion. HealthiestYou physicians provide cross coverage and operate subject to state regulations. Physicians in the independent network do not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. HealthiestYou does not guarantee that a prescription will be written. Services may vary by state.

*Available to Member students and their covered Dependents; age restrictions may apply. If you call prior to your effective date of your coverage under the insurance plan, you will be charged a service fee before being connected to a board-certified physician.

HealthiestYou: Virtual Counselor Access

Starting on the effective date of your coverage under the student insurance plan, you have access to mental health providers through a national virtual counseling service.* Psychiatrists, psychologists and licensed therapists are available to you through a variety of communication methods, including phone and video.

When you sign up, you'll complete a questionnaire, choose your provider and select a date and time for your appointment. Appointments are available 7 days a week. Visits are secure, discreet and confidential, and you have ongoing support with the same provider.

As a Member with Student Resources, there is no consultation fee for this service. Every communication with a provider is covered 100% during your policy period.

*Available to Member students and their covered Dependents; age restrictions may apply, depending on your state.

24/7 Student Support

Members have immediate access to the Student Assistance Program, a service that coordinates counseling services offered by Master's Licensed Clinicians who can provide Members with someone to talk to when everyday issues become overwhelming. More information about these counseling services is available by logging into My Account at www.uhcsr.com/MyAccount.

This Summary Brochure is based on Policy #2023-203415-41.

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.

NON-DISCRIMINATION NOTICE

UnitedHealthcare Student Resources 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
United HealthCare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

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 other 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.

