UMass Lowell
2014-2015 Student Health Insurance Plan
Schedule of Benefits

No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)
Deductible: $250 (Per Insured Person, Per Policy Year)
The 2014-2015 policy deductible is $250 per insured person, per policy year. Deductible must be paid each year before covered medical expenses are paid. Under Preventive Care Services, benefits are paid at 100% with no cost share (deductible) if services are rendered at an in-network provider and are billed with the appropriate diagnosis code, CPT code and are age and gender appropriate. For any benefits that have a service line co-pay, (example prescription) only the co-pay will apply, unless stated in the policy otherwise
Coinsurance – Preferred Providers: 80% except as noted below
Coinsurance – Out-of-Network: 65% except as noted below
Out-of-Pocket Maximum: $5,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum: $10,000 (For all Insured in a Family, Per Policy Year)

Inpatient	Preferred Provider	Out-of-Network
Room & Board Expense	Preferred Allowance	Usual and Customary Charges
Intensive Care	Preferred Allowance	Usual and Customary Charges
Hospital Miscellaneous Expenses	Preferred Allowance	Usual and Customary Charges
Routine Newborn Care See Benefits for Maternity, Childbirth, Well-Baby and Post-Partum Care	Paid as any other Sickness	Paid as any other Sickness
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures. The first procedure will be paid in accordance with our standard reimbursement policy.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Registered Nurse's Services	Preferred Allowance	Usual and Customary Charges
Physician Visit's	Preferred Allowance	Usual and Customary Charges
Pre-admission Testing Pre-admission testing must occur within 7 days prior to admission.	Paid Under Hospital Miscellaneous Expenses	Paid Under Hospital Miscellaneous Expenses
Outpatient	**Preferred Provider**	**Out-of-Network**
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures. The first procedure will be paid in accordance with our standard reimbursement policy.	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous Usual and Customary Charges for Day Surgery	Preferred Allowance	Usual and Customary Charges

Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index.		
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits The Policy Deductible does not apply.	100% of Preferred Allowance $30 Copay per visit	100% of Usual and Customary Charges $30 Deductible per visit
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. The Policy Deductible does not apply. See also Benefits for Cardiac Rehabilitation, Benefits for Treatment of Autism Spectrum Disorder, and Benefits for Treatment of Speech, Hearing and Language Disorders.	100% of Preferred Allowance $30 Copay per visit	100% of Usual and Customary Charges $30 Deductible per visit
Medical Emergency Expenses Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness. The Copay/per visit Deductible will be waived if admitted to the Hospital. The Policy Deductible does not apply.	100% of Preferred Allowance $150 Copay per visit	100% of Usual and Customary Charges $150 Deductible per visit
Diagnostic X-ray Services	Preferred Allowance	Usual and Customary Charges
Radiation Therapy	Preferred Allowance	Usual and Customary Charges
Laboratory Procedures	Preferred Allowance	Usual and Customary Charges
Tests & Procedures	Preferred Allowance	Usual and Customary Charges
Injections	Preferred Allowance	Usual and Customary Charges
Chemotherapy	Preferred Allowance	Usual and Customary Charges
Prescription Drugs and medicines lawfully obtainable only upon written prescription of a Physician	UnitedHealthcare Pharmacy (UHCP) $15 Copay per prescription for Tier 1 $30 Copay per prescription for Tier 2 $50 Copay per prescription for Tier 3 up to a 31 day supply per prescription Mail order Prescription Drugs through UHCP at 2 times the retail Copay up to a 90 day supply.	$15 Deductible per prescription for generic drugs $30 Deductible per prescription for brand name up to a 31 day supply per prescription
Other	**Preferred Provider**	**Out-of-Network**
Ambulance Services This service is subject to the Policy Deductible	100% of Preferred Allowance	100% of Usual and Customary Charges
Durable Medical Equipment See also Benefits for Prosthetic Devices and Repair	Preferred Allowance	Usual and Customary Charges
Consultant Physician Fees	Preferred Allowance	Usual and Customary Charges
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only.	Preferred Allowance	Usual and Customary Charges
Dental Treatment Benefits paid for removal of impacted wisdom teeth only.	Preferred Allowance	Usual and Customary Charges
Mental Illness Treatment See Benefits for Treatment of Mental Disorders	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment See Benefits for Treatment of Mental Disorders	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion	Preferred Allowance	Usual and Customary Charges
Maternity	Paid as any other Sickness	Paid as any other Sickness

See Benefits for Maternity, Childbirth, Well-Baby and Post-Partum Care		
Complications of Pregnancy See Benefits for Maternity, Childbirth, Well-Baby and Post-Partum Care	Paid as any other Sickness	Paid as any other Sickness
Preventive Care Services No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. See also Benefits for Cytologic Screening and Mammographic Examinations, Benefits for Maternity, Childbirth, Well-Baby and Post-Partum Care, Benefits for Hormone Replacement Therapy and Outpatient Contraceptive Services, and Benefits for Dependent Children Preventive Care	100% of Preferred Allowance	No Benefits
Reconstructive Breast Surgery Following Mastectomy See Benefits for Initial Prosthetic Devices and Reconstructive Surgery Incident to Mastectomy	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See Benefits for Treatment of Diabetes	Paid as any other Sickness	Paid as any other Sickness
High Cost Procedures The Policy Deductible does not apply.	100% of Preferred Allowance $100 Copay per procedure	80% of Usual and Customary Charges
Home Health Care See Benefits for Home Health Care	Preferred Allowance	Usual and Customary Charges
Hospice Care See Benefits for Hospice Care	Preferred Allowance	Usual and Customary Charges
Inpatient Rehabilitation Facility	Preferred Allowance	Usual and Customary Charges
Skilled Nursing Facility	Preferred Allowance	Usual and Customary Charges
Urgent Care Center	Preferred Allowance	Usual and Customary Charges
Hospital Outpatient Facility or Clinic	Preferred Allowance $20 Copay per visit	Usual and Customary Charges $20 Deductible per visit
Approved Clinical Trials See also Benefits for Qualified Clinical Trials for Treatment of Cancer	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Ostomy Supplies	Preferred Allowance	Usual and Customary Charges
Acupuncture	Preferred Allowance $20 Copay per visit	Usual and Customary Charges $20 Deductible per visit
Titers	100% of Preferred Allowance $20 Copay per visit	Usual and Customary Charges $20 Deductible per visit