PLEASE NOTE:
THIS DOCUMENT HAS BEEN CHANGED. SEE THE BACK COVER FOR DETAILS

The rates have been updated per state requirements.

2014–2015

Student Injury and Sickness Insurance Plan for Eastern Virginia Medical School

Who is eligible to enroll?

All Eastern Virginia Medical School students who are registered and taking credit hours are required to participate in this plan on a hard-waiver basis. Eligible students may also insure their Dependents. Eligible Dependents are the student's spouse and dependent children under 26 years of age.

Where can I get more information about the benefits available?

Please read the plan brochure to determine whether this plan is right before you enroll. The plan brochure 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 plan brochure are available from the College and may be viewed at www.uhcsr.com/evms.

Who can answer questions I have about the plan?

If you have questions please contact Customer Service at 1-800-767-0700 or customerservice@uhcsr.com.

How much does the plan cost?

Rates	Annual 8/1/14 – 7/31/15	Fall 8/1/14 – 1/02/15	Spring 1/03/15 – 7/31/15
Student	$2,536.00	$1,269.00	$1,268.00
One Dependent	$2,536.00	$1,269.00	$1,268.00
All Dependents	$7,608.00	$3,289.00	$3,855.00

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 and is based on policy number 2014-193-1.
The Policy is a Non-Renewable One-Year Term Policy.

Highlights of the Coverage and Services offered by UnitedHealthcare **Student**Resources		
	Preferred Providers	**Out-of-Network Providers**
Overall Plan Maximum	There is no overall maximum dollar limit on the policy	
Plan Deductible	$250 per Insured Person, per Policy Year	$500 per Insured Person, per Policy Year
SHC Benefits	The Deductible will be waived for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center.	
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 brochure for details about how the Out-of-Pocket Maximum applies.*	$6,250 Per Insured Person, Per Policy Year and $12,500 For all Insureds in a Family, Per Policy Year	$10,000 Per Insured Person, Per Policy Year and $15,000 For all Insureds in a Family, Per Policy Year
Coinsurance *All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copays as described in the plan brochure.*	80% of Preferred Allowance for Covered Medical Expenses	50% of Usual and Customary Charges for Covered Medical Expenses
Prescription Drugs *Prescriptions must be filled at a UHCP network pharmacy.* *Mail order through UHCP at 2.5 times the retail copay up to a 90 day supply.*	$15 Copay for Tier 1 $30 Copay for Tier 2 Up to a 31-day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP)	No Benefits
Preventive Care Services *Including but not limited to: annual physicals, GYN exams, routine screenings and immunizations. No copay or Deductible when the services are received from a Preferred Provider. Please see www.healthcare.gov for complete details of the services provided for specific age and risk groups.*	100% of Preferred Allowance	No Benefits
Pediatric Dental and Vision Benefits	Refer to the plan brochure for details (age limits apply).	
FrontierMEDEX	Domestic Students are eligible for FrontierMEDEX services when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address. International Students are covered worldwide except in their home country.	

Preferred Providers

The Preferred Provider Network for this plan is UnitedHealthcare Options PPO. Preferred Providers can be found using the following link: http://www.uhcsr.com/lookupredirect.aspx?delsys=01

Online Services

UnitedHealthcare **Student**Resources Insureds have online access to their claims status, EOBs, ID Cards, network providers, correspondence and coverage account information by logging in to *My Account* at 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.

Other Coverage

Also available for Eastern Virginia Medical School students is a UnitedHealthcare Insurance Company fully insured Dental and Vision plan. To enroll go to www.uhcsr.com/evms.

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. Addiction, such as:
   - Caffeine addiction.
   - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
   - Codependency.
2. Biofeedback.
3. 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.
   - Treat or correct Congenital Conditions of an Adopted or Newborn.
4. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance use facilities for domiciliary or Custodial Care.
5. Dental treatment, except:
   - As provided in the Dental Treatment benefit.
   - As specifically provided in the Schedule of Benefits.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
6. Elective Surgery or Elective Treatment.
7. Foot care for the following:
   - Flat foot conditions.
   - Supportive devices for the foot.
   - Subluxations of the foot.
   - Fallen arches.
   - Weak feet.
   - Chronic foot strain.
   - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

   This exclusion does not apply to routine or preventive foot care for Insured Persons with diabetes.
8. Health spa or similar facilities. Strengthening programs.
9. 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 specifically provided in Benefits for Newborn Infant Hearing Screening.
10. Hypnosis.
11. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
12. Investigational services.
13. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.

14. Prescription Drugs, services or supplies as follows:
    - Therapeutic devices or appliances, including: 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.
    - 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, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, or Serophene.
    - Growth hormones.
    - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
15. Reproductive/Infertility services including but not limited to the following:
    - Procreative counseling.
    - Genetic counseling and genetic testing, except as specifically provided in Genetic Testing.
    - Cryopreservation of reproductive materials. Storage of reproductive materials.
    - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except to diagnose or treat the underlying cause of the infertility.
    - Premarital examinations.
    - Impotence, organic or otherwise.
    - Female sterilization procedures, except as specifically provided in the policy.
    - Vasectomy.
    - Reversal of sterilization procedures.
    - Sexual reassignment surgery.
16. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in Benefits for Clinical Trials for Treatment Studies on Cancer.
17. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.
    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 eyeglasses or contact lenses as described under Vision Correction in the policy.
18. Routine Adopted or Newborn Child Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.
19. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
20. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.
    This exclusion does not apply to:
    - Maxillary or mandibular frenectomy when not related to a dental procedure.
    - Alveolectomy related to tooth extraction.
    - Orthognathic surgery required to attain functional capacity.
    - Surgical services on the hard or soft tissue of the mouth for purposes not related to treat or help teeth and supporting structures.
    - Treatment of cleft lip, cleft palate, or ectodermal dysplasia.
21. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
22. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
23. 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).
24. Weight management. Weight reduction. Nutrition programs. Treatment for obesity. Surgery for removal of excess skin or fat.

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.

UnitedHealthcare
A UnitedHealth Group Company

POLICY NUMBER: 2014-193-1

NOTICE:
The benefits contained within have been revised since publication. The revisions are included within the body of the document, and are summarized on the last page of the document for ease of reference.

NOC#5
Rates have been changed per State requirements.

NOC2

- Removed Flight Exclusion, IC Sports Exclusion, Preventive Care Exclusion and Supplies Exclusion.
- Updated the following exclusion: Cosmetic Procedures; Custodial Care; Dental Treatment; Prescription Drug; Reproductive/Infertility; Research and Routine Adopted or Newborn Child.

NOC #1

No Changes Necessary to flyer.