Student Injury and Sickness Insurance Plan for Hebrew College

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

Who is eligible to enroll?

All eligible registered students taking credit hours are required to enroll in the plan on a Hard Waiver basis. Eligible Dependents of students enrolled in the Student Health Insurance plan may participate in the plan on a voluntary basis. 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 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 College and may be viewed at www.uhcsr.com.

Who can answer questions I have about the plan?

If you have questions please contact Customer Service at 1-800-977-4698 or customerservice@uhcsr.com.

How much does the plan cost?

Rates	Annual 9/1/14 – 8/31/15	Fall 9/1/14 – 1/31/15	Spring/Summer 2/1/15 – 8/31/15	Summer 7/1/15 – 8/31/15
Student	$1,693.00	$724.00	$1,002.00	$293.00
Spouse	$4,659.00	$1,991.00	$2,758.00	$807.00
All Children	$3,288.00	$1,405.00	$1,947.00	$570.00
All Dependents	$7,948.00	$3,397.00	$4,705.00	$1,377.00

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 HPHC Insurance Company, an affiliate of Harvard Pilgrim Health Care, Inc. and administered by UnitedHealthcare **Student**Resources and is based on policy number 2014-202853-61.
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	$500 per Insured Person, Per Policy Year	$1,000 per Insured Person, per Policy Year
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.*	$5,000 Per Insured Person, Per Policy Year $10,000 For all Insureds in a Family, Per Policy Year	$10,000 Per Insured Person, Per Policy Year $20,000 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 certificate.*	75% of Preferred Allowance for Covered Medical Expenses	55% of Usual and Customary Charges for Covered Medical Expenses
Prescription Drugs and medicines lawfully obtainable only upon written prescription of a Physician *Mail order through UHCP at 2.5 times the retail copay up to a 90 day supply.*	$10 Copay for Tier 1 $40 Copay for Tier 2 $60 Copay for Tier 3 Up to a 31-day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP)	$10 Deductible per prescription for generic drugs $40 Deductible per prescription for brand name drugs
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
The following services have per Service Copays/Deductibles *This list is not all inclusive. Please read the plan certificate for complete listing of Copays/Deductibles.*	Physician's Visits: $25 per visit Medical Emergency: $150 per visit The copay will be waived if admitted to the Hospital	Medical Emergency: $150 per visit The per visit Deductible will be waived if admitted to the Hospital
Pediatric Dental and Vision Benefits	Refer to the plan certificate 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 HPHC Insurance Company Network. Preferred Providers can be found using the following link: http://www.uhcsr.com/lookupredirect.aspx?delsys=67

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.
3. 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 abuse facilities for domiciliary or Custodial Care.
4. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.
   - As described under Dental Treatment in the policy.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
5. Elective Surgery or Elective Treatment.
6. Elective abortion.
7. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
8. 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 preventive foot care for Insured Persons with systemic circulatory diseases such as diabetes.
9. Health spa or similar facilities. Strengthening programs.
10. 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 Treatment of Speech, Hearing and Language Disorders.
11. Hirsutism.
12. Hypnosis.
13. 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.
14. Injury caused by, contributed to, or resulting from the use of:
    - Intoxicants.
    - Hallucinogenics.
    - Illegal drugs.
    - Any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician.
15. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
16. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance.
17. 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.
18. Investigational services.
19. Learning disabilities testing, including diagnostic testing of learning disabilities.
20. Lipectomy.
21. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.

22. 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. 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.
    - Sexual enhancement drugs, such as Viagra.
    - Growth hormones.
    - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
23. Reproductive services for the following, except as specifically provided in Benefits for Infertility:
    - Procreative counseling.
    - Genetic testing.
    - Impotence, organic or otherwise.
    - Reversal of sterilization procedures.
24. 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 the policy.
25. 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 contact lenses to treat keratoconus.
26. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care.
27. Preventive care services, except as specifically provided in the Preventive Care Services benefit or 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.
28. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
29. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis
30. Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping.
31. 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.
32. Supplies, except as specifically provided in the policy.
33. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
34. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
35. 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).
36. Weight management. Weight reduction. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in Weight Loss Programs.

Harvard Pilgrim Health Care

NOTE: The information contained herein is a summary of certain benefits which are offered under a student health insurance policy issued by Harvard Pilgrim Health Care. 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 Harvard Pilgrim Health Care 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: 2014-201739-61

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#1

SUMMARY BROCHURE:

1. Exclusions and Limitations section – revised the following exclusions per below:

Exclusion #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.
- ~~[Treat or correct Congenital Conditions of a Newborn or Adopted Infant.]]~~

Exclusion #8 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 preventive foot care for Insured Persons with systemic circulatory diseases such as diabetes.

Exclusion #23 Reproductive services for the following, except as specifically provided in Benefits for Infertility:

- Procreative counseling.
- Genetic testing.
- ~~[Cryopreservation of reproductive materials.] [Storage of reproductive materials.]~~
- Impotence, organic or otherwise.
- Reversal of sterilization procedures.
- ~~[Sexual reassignment surgery.]]~~

Exclusion #27 Preventive care services, except as specifically provided in the Preventive Care Services benefit or 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.

Exclusion #36 Weight management. Weight reduction. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in Weight Loss Programs.

2. changed RX OON from no benefits to $10 deductible for generic/$40 deductible for brand.