OLD DOMINION UNIVERSITY

2015–2016 Domestic Graduate Student Injury and Sickness Plan for Old Dominion University

Who is eligible to enroll?

Degree seeking domestic graduate students enrolled in courses at Old Dominion University's main campus or one of the higher education centers are eligible to enroll. Graduate assistants being paid $5,000 or more per semester are eligible to enroll as subsidized graduate assistants. All other eligible graduate students may enroll as nonsubsidized graduate students. 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 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 University and may be viewed at www.uhcsr.com./odu.

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.

What important dates or deadlines should I be aware of?

Deadline for all Subsidized and Non-Subsidized Graduate Students is September 30, 2015 for Fall 2015 and February 15, 2016 for Spring 2016 semester.

How much does the plan cost?

Rates	Annual 8/1/15 – 7/31/16	Fall 8/1/15 – 12/31/15	Spring/Summer 1/1/16 – 7/31/16
Student	$1,695.00	$709.00	$986.00
Spouse	$1,695.00	$709.00	$986.00
One Child	$1,695.00	$709.00	$986.00
Two or more Children	$3,390.00	$1,418.00	$1,972.00
Spouse and 2 or more Children	$5,085.00	$2,127.00	$2,958.00

This plan is underwritten by UnitedHealthcare Insurance Company and is based on policy number 2015-284-1.
This plan is subject to regulation by the Virginia Department of Health and the Bureau of Insurance.
The Policy is a Non-Renewable One-Year Term Policy.

Highlights of the Coverage and Services offered by UnitedHealthcare StudentResources		
	Preferred Providers	**Out-of-Network Providers**
Overall Plan Maximum	There is no overall maximum dollar limit on the policy	
Plan Deductible	$150 per Insured Person, per Policy Year	$400 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.*	$4,000 Per Insured Person, Per Policy Year $8,000 For all Insureds in a Family, Per Policy Year	$7,000 Per Insured Person, Per Policy Year $14,000 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.*	90% 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.*	$21 Copay for Tier 1 $25 Copay for Tier 2 $25 Copay for Tier 3 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	100% of Usual and Customary Charges
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: $20 Copay per visit Medical Emergency: $100 Copay per visit (waived if admitted to the Hospital.)	Physician's Visits: $20 Deductible per visit Medical Emergency: $100 Copay per visit (waived if admitted to the Hospital.)
Pediatric Dental and Vision Benefits	Refer to the plan certificate for details (age limits apply).	
UnitedHealthcare Global: Global Emergency Services	Domestic Students are eligible for UnitedHealthcare Global services when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address.	

Preferred Providers

The Preferred Provider Network for this plan is UnitedHealthcare Choice Plus. Preferred Providers can be found using the following link: http://www.uhcsr.com/lookupredirect.aspx?delsys=52

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.

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, except as specifically provided in the Schedule of Benefits.
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 an Adopted or Newborn Child.
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 use facilities for domiciliary or Custodial Care.
4. 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.
5. Elective Surgery or Elective Treatment.
6. Health spa or similar facilities. Strengthening programs.
7. 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.
8. Hirsutism. Alopecia.
9. Hypnosis.
10. Immunizations for work.
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. Injury or Sickness outside the United States and its possessions, except for a Medical Emergency when traveling for academic study abroad programs.
13. Investigational services.
14. Lipectomy.
15. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
16. 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.
17. 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.

18. 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.
19. 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.
20. Routine Adopted or Newborn Child Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.
21. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
22. 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.
23. Naturopathic services.
24. 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.
25. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
26. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
27. 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).
28. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat.

NOTE: 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. The information contained herein is a summary of certain benefits which are offered under a student health insurance policy issued by UnitedHealthcare and does not constitute a promise of coverage. Benefits and rates under any Student policy are subject to state and federal requirements and review. Company reserves the right to make any changes necessary to meet such requirements.