2015–2016
Student Injury and Sickness Plan for The Pennsylvania State University

Who is eligible to enroll?

All undergraduates taking 3 or more credit hours and graduates taking 1 or more credit hours or enrolled in a departmental 601, 610 or 611 course, non-graduate assistant/graduate fellow students, all Hershey Medical students, all graduate assistants and graduate fellows, visiting scholars, students enrolled in the intensive English communication program and students who participate in the Co-op work experience program as part of their required academic program are eligible to enroll in this insurance plan. All international students (F-1 and J-1 visa holders) are required to purchase this plan, unless proof of comparable coverage is furnished. Eligible students may also insure their Dependents. Eligible Dependents are the student's spouse or Domestic Partner and dependent children under 26 years of age. See the Definitions section of the Certificate for the specific requirements needed to meet Domestic Partner eligibility.

This plan is underwritten by UnitedHealthcare Insurance Company and is based on policy number 2015-547-1. The Policy is a Non-Renewable One-Year Term Policy.

How much does the plan cost?

2015-2016 Annual Rates	
Rates	8/10/15 – 8/9/16
Student	
Spouse	
Each Child	
All Children	
All Dependents	

Who can answer questions I have about the plan?

If you have questions please contact Customer Service at 1-800-505-4160 or customerservice@firstriskadvisors.com

What important deadlines should I be aware of?

Open Enrollment/Waiver Period Fall Deadline

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.firststudent.com

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.

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
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.*	$1,350 Per Insured Person, Per Policy Year $2,700 For all Insureds in a Family, Per Policy Year	There is no Out-of-Pocket Maximum for Out-of-Network benefits.
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.	70% of Usual and Customary Charges for Covered Medical Expenses.
Prescription Drugs *Mail order through UHCP at 2.5 times the retail Copay up to a 90 day supply*	50% Coinsurance Up to a 31-day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP)	50% Coinsurance up to a 31 day supply per prescription
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	80% 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.*	Medical Emergency: $150 Copay per visit	Medical Emergency: $150 Copay per visit
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. International Students are covered worldwide except in their home country.	

Preferred Providers

The Preferred Provider Network for this plan is UnitedHealthcare Choice Plus. Preferred Providers can be found using the following link: www.firststudent.com

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.firststudent.com. To create an online account, select the "My Account" 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 policy.
2. Behavioral problems. Conceptual handicap. Developmental delay or disorder or mental retardation. Intensive behavioral therapies, such as applied behavioral analysis, except as specifically provided in Benefits for Autism Spectrum Disorder. Learning disabilities. Milieu therapy. Parent-child problems.
   This exclusion does not apply to benefits specifically provided in the policy.
3. Circumcision.
4. Cosmetic procedures, except as specifically provided in the policy or 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 or to restore normal bodily function.
5. 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.
6. Dental treatment, except:
   - For removal of bony, impacted teeth.
   - As specifically provided in the Schedule of Benefits.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
7. Elective Surgery or Elective Treatment as defined in the policy. This exclusion does not apply to cosmetic surgery necessitated by a covered Injury.
8. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline, or chartered aircraft only while participating in a school sponsored intercollegiate sport activity.
9. Foot care for the following, except as specifically provided in the policy:
   - Flat foot conditions.
   - Supportive devices for 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 diabetes.
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 the policy.
11. Hypnosis.
12. 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.
13. Injury caused by, contributed to, or resulting from the Insured being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician.
14. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
15. Injury or Sickness outside the United States and its possessions when traveling for academic study abroad programs, business, or pleasure.
16. 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.
17. Investigational services.
18. Lipectomy.
19. Benefits which duplicate any benefits provided by the Pennsylvania Motor Vehicle Financial Responsibility Law.
20. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
21. Prescription Drugs, services or supplies as follows, except as specifically provided in the policy:

- Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy.
- Birth control and/or contraceptives, oral or other, whether medication or device, regardless of intended use; except as specifically provided in Preventive Care Services or 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.
- Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
- Growth hormones.
- Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

22. Reproductive/Infertility services including but not limited to the following, except as specifically provided in the policy:
    - Procreative counseling.
    - Genetic counseling and 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 surgically 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.
23. 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.
24. 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 benefits specifically provided in the policy.
25. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.
26. Preventive care services, 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.
27. Services provided normally without charge by the Health Service of the Policyholder.
28. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia. Temporomandibular joint dysfunction. 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. This exclusion does not apply to benefits specifically provided in the policy.
29. Sleep disorders, except as specifically provided in the policy.
30. Speech therapy, except as specifically provided in the policy. Naturopathic services.
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. Nutrition programs. 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 the policy.