

2015–2016 Student Injury and Sickness Plan for George Fox University



Who is eligible to enroll?

All Undergraduate students and all full-time Graduate students are automatically enrolled in this Insurance plan at registration unless proof of comparable coverage is provided.

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 University 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 1-800-767-0700 or customerservice@uhcsr.com.

How much does the plan cost?

Rates	Annual 8/16/15 – 8/15/16	Fall 8/16/15 – 12/31/15	Spring/Summer 1/1/16 – 8/15/16
Student	\$1,722.00	\$650.00	\$1,075.00

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may, for example, cover your school's administrative costs associated with offering this health plan.

This plan is underwritten by UnitedHealthcare Insurance Company and is based on policy number 2015-441-1.
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	\$250 per Insured Person, Per Policy Year	\$500 per Insured Person, Per Policy Year
Out-of-Pocket Maximum <i>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.</i>	\$3,500 Per Insured Person, Per Policy Year	\$7,000 Per Insured Person, Per Policy Year
Coinsurance <i>All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copays as described in the plan brochure. NOTE: The Coinsurance percentage shown above is the Insured's responsibility. The remaining percentage is the amount the Company pays.</i>	20% of Preferred Allowance for Covered Medical Expenses	40% of Usual and Customary Charges for Covered Medical Expenses
Prescription Drugs <i>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.</i>	\$20 Copay for Tier 1 \$40 Copay for Tier 2 Up to a 31-day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP)	No Benefits
Preventive Care Services <i>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.</i>	0% of Preferred Allowance	No Benefits
The following services have per Service Copays/Deductibles <i>This list is not all inclusive. Please read the plan brochure for complete listing of Copays/Deductibles.</i>	Medical Emergency: \$100, waived if admitted to the hospital.	Medical Emergency: \$100, waived if admitted to the hospital.
Pediatric Dental and Vision Benefits	Refer to the plan brochure 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: <http://www.uhcsr.com/lookupredirect.aspx?delsys=52>

Online Services

UnitedHealthcare **StudentResources** 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.
2. Behavioral problems. Conceptual handicap. Developmental delay or disorder or mental retardation. Learning disabilities. Milieu therapy. Parent-child problems.
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.
 - Correct a scar or defect as a result of the treatment of an accidental Injury.
 - Correct a scar or defect of the head or neck as a result of a covered surgery.
 - Correct a functional disorder or impairment.
 - Treat or correct Congenital Conditions of a Newborn or adopted Infant.
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 abuse facilities for domiciliary or Custodial Care.
5. 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.
6. Elective Surgery or Elective Treatment.
7. Elective abortion.
8. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
9. Foot care for the following:
 - Flat foot conditions.
 - Supportive devices for the foot.
 - Fallen arches.
 - Routine foot care including the care, cutting and removal of corns, calluses, toenails.

This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
10. Health spa or similar facilities. Strengthening programs.
11. 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.
12. Hirsutism. Alopecia.
13. Hypnosis.
14. 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.
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 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. Methadone maintenance treatment for Substance Use Disorders.
20. Motor vehicle Injury.
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: hypodermic needles, syringes, 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, except for prescribed drugs for a particular Sickness (such as cancer) that have not been approved by the United States Food and Drug Administration when the Health Resources Commission has determined that the drug is recognized as effective for the treatment of that Sickness in publications that the Commission determines to be equivalent to: The American Hospital Formulary Services drug information, "Drug Facts and Comparisons", The United States Pharmacopoeia drug information, or other publications that have been identified by the United States Secretary of Health and Human

Services as authoritative; in the majority of relevant peer-reviewed medical literature; or by the United States Secretary of Health and Human Services.

- 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, except for the treatment of growth hormone deficiencies.
 - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
23. Reproductive/Infertility services including but not limited to the following:
- Procreative counseling.
 - Genetic counseling and genetic testing, except as specifically provided in policy.
 - Cryopreservation of reproductive materials. Storage of reproductive materials.
 - Fertility tests.
 - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
 - Premarital examinations.
 - Impotence, organic or otherwise.
 - Reversal of sterilization procedures.
 - Sexual reassignment surgery.
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 one pair of eyeglasses or contact lenses to correct a vision defect resulting from a severe medical or surgical condition.
26. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.
27. 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.
28. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the Student Health Fee.
29. 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.
30. Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping.
31. Speech therapy, except as specifically provided in the policy. Naturopathic services.
32. 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.
33. Supplies, except as specifically provided in the policy.
34. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
35. Treatment in a Government hospital, unless:
- There is a legal obligation for the Insured Person to pay for such treatment.
 - The treatment is provided by a Hospital owned or operated by the State of Oregon or any state approved community mental health program or community developmental disabilities program.
36. 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).
37. 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.



AMENDATORY NOTICE

It is hereby understood and agreed that the brochure to which this endorsement is attached is amended as follows:

I. The DEFINITIONS section is amended as follows:

1. The definition of **HABILITATIVE SERVICES** is removed in its entirety and replaced with the following:

HABILITATIVE SERVICES means services or devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or outpatient settings.

2. The definition of **MENTAL ILLNESS** is revised to include to remove the strike through text:

MENTAL ILLNESS means a Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. ~~The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense.~~ If not excluded or defined elsewhere in the policy, all mental health or psychiatric diagnoses are considered one Sickness.

3. The definition of **SUBSTANCE USE DISORDER** is revised to include the following underlined text:

SUBSTANCE USE DISORDER means a Sickness that is listed as an alcoholism and substance use disorder in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. ~~The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense.~~ If not excluded or defined elsewhere in the policy, all alcoholism and substance use disorders are considered one Sickness.

II. In the MANDATED BENEFITS section, the provision titled BENEFITS FOR PRESCRIPTION CONTRACEPTIVES AND SERVICES is revised to include the following underlined text:

BENEFITS FOR PRESCRIPTION CONTRACEPTIVES AND SERVICES

Benefits will be provided the same as any other Prescription Drug for prescription Contraceptives. Benefits will also be provided on the same basis as any other Sickness for outpatient consultations, examinations, procedures and medical services that are necessary to prescribe, dispense, deliver, distribute, administer or remove a prescription Contraceptive.

“Contraceptive” means a drug or device approved by the United States Food and Drug Administration to prevent pregnancy.

Prescription Contraceptives and services covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Prescription Contraceptives and services not covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be subject to all Preferred Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Prescription Contraceptives and services not covered by the Preventive Care Services Benefit and received from an Out-of-Network Provider shall be subject to all Out-of-Network Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

III. The introductory paragraph in the EXCLUSIONS AND LIMITATIONS section is revised to include the underlined text as shown below:

THIS POLICY DOES NOT INCLUDE A PRE-EXISTING CONDITION EXCLUSION.

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:

IV. The EXCLUSIONS AND LIMITATIONS section is amended as follows:

1. If all or any portion of the following Exclusion text appears in the policy, it is removed in its entirety:

Behavioral problems. Conceptual handicap. Developmental delay or disorder or mental retardation. Intensive behavioral therapies, such as applied behavioral analysis. Learning disabilities. Milieu therapy. Parent-child problems.

This notice takes effect and expires concurrently with the brochure to which it is attached, and is subject to all of the terms and conditions of the brochure not inconsistent therewith.

2. If all or any portion of the following Exclusion text appears in the policy, it is revised to include the underlined text as shown below:

Injury sustained while:

- Participating in any interscholastic, 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.

This exclusion does not apply to Emergency Services provided to stabilize an Insured with a Medical Emergency.

3. If all or any portion of the following Exclusion text appears in the policy, and it includes the last bullet text, then it is revised to include the underlined text as shown below:

Reproductive/Infertility services including but not limited to the following:

- Procreative counseling.
- Genetic counseling and genetic testing, except as specifically provided in policy.
- Cryopreservation of reproductive materials. Storage of reproductive materials.
- Fertility tests.
- Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
- Premarital examinations.
- Impotence, organic or otherwise.
- Reversal of sterilization procedures.
- i) Sexual reassignment surgery, unless Medically Necessary.

4. If all or any portion of the following Exclusion text appears in the policy, it is revised to include the underlined text as shown below:

Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping.

This exclusion does not apply to Emergency Services provided to stabilize an Insured with a Medical Emergency.

V. In the UNITEDHEALTHCARE PHARMACY (UHCP) PRESCRIPTION DRUG BENEFITS section, if the following Additional Exclusion text appears in the policy, it is revised to include the underlined text as shown below:

Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

This exclusion does not apply to over-the-counter contraceptives covered by the Preventive Care Services benefit, if prescribed by a Physician.

In all other respects, all policy provisions remain the same.

This notice takes effect and expires concurrently with the brochure to which it is attached, and is subject to all of the terms and conditions of the brochure not inconsistent therewith.