

# 2015–2016 Student Accident and Sickness Insurance Plan for Washington County Community College



## Who is eligible to enroll?

All registered full-time students and all registered international students with F-1 and J-1 visas are automatically enrolled in this insurance Plan at registration, unless proof of comparable coverage is furnished.

## 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.crossagency.com/wccc](http://www.crossagency.com/wccc).

## 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](mailto:customerservice@uhcsr.com) or Cross Insurance Agency at 1-800-537-6444 or [CollegeHealth@crossagency.com](mailto:CollegeHealth@crossagency.com).

## What important dates or deadlines should I be aware of?

Waiver forms must be submitted by September 14, 2015 for Annual and January 18, 2016 for Spring/Summer.

## How much does the plan cost?

Rates	Annual 8/1/15 – 7/31/16	Spring/Summer 1/1/16 – 7/31/16
Student	\$998.00	\$581.00

NOTE: The amounts stated above include a fee for the servicing agency charged by the school you are receiving coverage through.

This plan is underwritten by HPHC Insurance Company, an affiliate of Harvard Pilgrim Health Care Inc. and administered by UnitedHealthcare **StudentResources** and serviced by Cross Insurance Agency and is based on policy number 2015-202629-1.

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
<b>Overall Plan Maximum</b>	There is no overall maximum dollar limit on the policy	
<b>Plan Deductible</b>	\$4,500 Per Insured Person, Per Policy Year <i>(The Deductible will not be applied until the Company has paid \$2,500 in Covered Medical Expenses.)</i>	\$6,500 Per Insured Person, Per Policy Year <i>(The Deductible will not be applied until the Company has paid \$2,500 in Covered Medical Expenses.)</i>
<b>Out-of-Pocket Maximum</b> <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>	\$6,350 Per Insured Person, Per Policy Year	There is no Out-of-Pocket Maximum for Out-of-Network benefits
<b>Coinsurance</b> <i>All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copays as described in the plan brochure.</i>	80% of Preferred Allowance to \$2,500, Deductible applies after \$2,500, then 100% thereafter for Covered Medical Expenses	60% of Usual and Customary Charges to \$2,500, Deductible applies after \$2,500, then 80% thereafter for Covered Medical Expenses
<b>Prescription Drugs</b> <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 \$30 Copay for Tier 2 \$60 Copay for Tier 3 Up to a 31-day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP)	No Benefits
<b>Preventive Care Services</b> <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 <a href="http://www.healthcare.gov">www.healthcare.gov</a> for complete details of the services provided for specific age and risk groups.</i>	100% of Preferred Allowance	No Benefits
<b>The following services have per Service Copays/Deductibles</b> <i>This list is not all inclusive. Please read the plan brochure for complete listing of Copays/Deductibles.</i>	Medical Emergency: \$100 Copay, in addition to the Policy Deductible. The Copay will be waived if admitted to the Hospital.	Medical Emergency: \$100 Deductible, in addition to the Policy Deductible. The per visit Deductible will be waived if admitted to the Hospital.
<b>Pediatric Dental and Vision Benefits</b>	Refer to the plan brochure for details (age limits apply).	
<b>UnitedHealthcare Global: Global Emergency Services</b>	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 HPHC Insurance Company Network. Preferred Providers can be found using the following link: <https://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. Acne.
2. Acupuncture.
3. Learning disabilities.
4. Biofeedback.
5. Circumcision.
6. 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 Infant.
  - Correct port wine stains.
7. 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.
8. Elective Surgery or Elective Treatment.
9. Elective abortion.
10. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
11. Foot care for the following:
  - 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.
12. Hearing examinations. Hearing aids, except as specifically provided under the Benefits for 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.
13. Hirsutism. Alopecia.
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 caused by, contributed to, or resulting from the use of:
  - Any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician.
16. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
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. Lipectomy.
20. Participation in a riot or civil disorder. Commission of or attempt to commit a felony. Fighting.
21. 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 Benefits for Diabetes Treatment.
  - 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 as specifically provided in the Benefits for Off-Label Drug Use.
  - 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:
  - Procreative counseling.
  - Genetic counseling and genetic testing.
  - 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.
  - 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 one pair of eyeglasses or contact lenses to treat accommodative strabismus, cataracts, or aphakia.
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. Services covered or provided by the student health fee.
28. Nasal and sinus surgery, except for treatment of a covered Injury.
29. Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping.
30. Sleep disorders.
31. Speech therapy, except as specifically provided in the policy.
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. Suicide or attempted suicide while sane or insane (including drug overdose). Intentionally self-inflicted Injury.
34. Supplies, except as specifically provided in the policy.
35. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except:
- As specifically provided in the Benefits for Breast Cancer Treatment and Reconstructive Breast Surgery.
  - Medically Necessary surgery for gynecomastia.
  - As specifically provided in the policy.
36. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
37. 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).
38. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except morbid obesity for an Insured diagnosed as morbidly obese). 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 Harvard Pilgrim Health Care 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.**

