



# 2026 – 2027

## Student Health Insurance Plan

### University of Richmond

#### Who can enroll?

All international students on non-immigrant visas at the University of Richmond, regardless of credit hours taken, and visiting scholars are required to purchase this plan on a mandatory basis.

All degree seeking undergraduate students who are registered for and taking three and a half or more units, and all degree seeking graduate students who are registered for and taking nine or more credit hours are automatically enrolled in the insurance plan at registration and the premium for coverage added to their tuition billing, unless proof of comparable coverage is furnished.

The student (Named Insured, as defined in the Certificate) must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the eligibility requirements that the student actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.

The eligibility date for Dependents of the Named Insured shall be determined in accordance with the following:

1. If a Named Insured has Dependents on the date he or she is eligible for insurance.
2. If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
  - a. On the date the Named Insured acquires a legal spouse.
  - b. On the date the Named Insured acquires a dependent child who is within the limits of a dependent child set forth in the Definitions section of the Certificate.

Dependent eligibility expires concurrently with that of the Named Insured.

#### Coverage periods, plan cost and deadline dates

|                                 | Annual               | Spring/Summer        |
|---------------------------------|----------------------|----------------------|
| Coverage dates                  | 8/1/2026 – 7/31/2027 | 1/1/2027 – 7/31/2027 |
| Student                         | \$2,540.00           | \$1,475.00           |
| Spouse                          | \$2,540.00           | \$1,475.00           |
| One Child                       | \$2,540.00           | \$1,475.00           |
| Two or More Children            | \$5,080.00           | \$2,950.00           |
| Spouse and Two or More Children | \$7,620.00           | \$4,425.00           |

Rates are subject to regulatory approval and may change.  
26COL5328-1443-1

| Plan resources at your fingertips                                                                                       |                                                               |
|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| View benefits, submit a claim and download your ID card via My Account                                                  | <a href="https://uhcsr.com/myaccount">uhcsr.com/myaccount</a> |
| Find an in-network provider                                                                                             | Choice Plus                                                   |
| Find a prescription drug provider                                                                                       | Optum Rx                                                      |
| Value-added benefits and services (Student Assist <sup>1</sup> , HealthiestYou <sup>2</sup> , UHC Global <sup>3</sup> ) | <a href="https://uhcsr.com/myaccount">uhcsr.com/myaccount</a> |
| If you need language assistance:                                                                                        | Language Assistance                                           |

## Plan highlights

**Metallic Level: Platinum with actuarial value of 90.860%**

**Student Health Center Benefits:** The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at or referred by the SHC for the following services: Laboratory services at SHC and Laboratory services referred to LabCorp. Policy Exclusions and Limitations do not apply.

| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Preferred Providers                                                                                                                                                                                                 | Out-of-Network Providers                                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overall Plan Maximum</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>There is no overall maximum dollar limit on the Policy</b>                                                                                                                                                       |                                                                                                                                                                 |
| <b>Plan Deductible</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | \$250 Per Insured Person, per Policy Year                                                                                                                                                                           | \$600 Per Insured Person, per Policy Year                                                                                                                       |
| <b>Out-of-Pocket Maximum</b><br>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.                                                                                                                                                                                                                                                           | \$6,350 Per Insured Person, Per Policy Year<br>\$12,700 For all Insureds in a Family, Per Policy Year                                                                                                               | There is no Out-of- Pocket Maximum for Out-of-Network benefits.                                                                                                 |
| <b>Coinsurance</b><br>All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copays as described in the plan certificate.                                                                                                                                                                                                                                                                                                                                                                                           | 90% of Allowed Amount for Covered Medical Expenses                                                                                                                                                                  | 70% of Allowed Amount for Covered Medical Expenses                                                                                                              |
| <b>Prescription Drugs</b><br>UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90 day supply.<br>For insulin drugs the total amount of Deductible, Copayments or Coinsurance shall not exceed \$50 for an individual prescription of up to a 30-day supply.<br>Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy for insulin drugs the total amount of Deductible, Copayments or Coinsurance shall not exceed \$150 for an individual prescription of up to a 90-day supply. | \$10 Copay for Tier 1<br>\$20 Copay for Tier 2<br>\$40 Copay for Tier 3<br>Up to a 31-day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP) Retail Network Pharmacy<br>not subject to Deductible | \$20 Copay for generic drugs<br>\$40 Copay for brand name drugs<br>Up to a 31-day supply per prescription<br>100% of billed charge<br>not subject to Deductible |
| <b>Preventive Care Services</b><br>Including but not limited to: annual physicals, GYN exams, routine screenings and immunizations. No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit <a href="http://www.healthcare.gov/preventive-care-benefits/">www.healthcare.gov/preventive-care-benefits/</a> for a complete list of the services provided for specific age and risk groups.                                                                                                      | 100% of Allowed Amount                                                                                                                                                                                              | Allowed Amount after Deductible                                                                                                                                 |
| <b>The following services have per service copays</b><br>This list is not all inclusive. Please read the plan certificate for complete listing of copays.                                                                                                                                                                                                                                                                                                                                                                                                           | Physician's Visits: \$25<br>not subject to Deductible<br><br>Medical Emergency: \$150<br>not subject to Deductible                                                                                                  | Physician's Visits: \$25<br>not subject to Deductible<br><br>Medical Emergency: \$150<br>not subject to Deductible                                              |

## Questions about your plan?

Contact Customer Service at **1-800-505-4160** or at [customerservice@uhcsr.com](mailto:customerservice@uhcsr.com)

<sup>1</sup>Student Assist services are provided through OptumHealth Behavioral Solutions and OptumHealth Care Solutions, UnitedHealth Group companies. The Student Assist is not a substitute for medical attention. If you have an emergency medical condition, you should call 911 or your local emergency services number. <sup>2</sup>HealthiestYou and the HealthiestYou logo are trademarks of Teladoc Health, Inc., and may not be used without written permission. HealthiestYou does not replace the primary care physician. HealthiestYou does not guarantee that a prescription will be written. HealthiestYou operates subject to state regulation and may not be available in certain states. HealthiestYou does not prescribe DEA-controlled substances, non-therapeutic drugs and certain other drugs that may be harmful because of their potential for abuse. HealthiestYou physicians reserve the right to deny care for potential misuse of services. <sup>3</sup>Non-Insurance Travel Assistance services are provided by or through United Healthcare Services, Inc., and affiliates under the UnitedHealthcare Global brand. © 2026 United HealthCare Services, Inc. All Rights Reserved. The written materials contained in this document are a confidential property of UnitedHealth Group. Do not distribute or reproduce any materials without the express written consent of UnitedHealth Group. This plan is underwritten by UnitedHealthcare Insurance Company and is based on policy 2026-1443-1. For further details of the coverage including costs, benefits, exclusions, any reductions or limitations and the terms under which the coverage may be continued in force, please refer to [uhcsr.com](http://uhcsr.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 does 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. The rates referenced are applicable to the plan design. UnitedHealthcare Student Resources may require to change the rates and/ or the plan design to comply with federal or state laws, regulations, or direction.