2014-2015

Student Injury and Sickness Insurance Plan

Designed especially for the students of

Wright State University

All Boonshoft School of Medicine full-time students taking courses are eligible and must participate in the plan unless proof of comparable coverage is submitted.

**PLEASE NOTE:
THIS DOCUMENT HAS BEEN CHANGED. SEE THE BACK COVER FOR DETAILS**

If you have any questions, please contact Customer Service at 1-800-767-0700, or visit our website at www.uhcsr.com.

This Policy is a Non-Renewable One-Year Term Policy.

UnitedHealthcare®

Highlights of the Coverage and Services offered by UnitedHealthcare StudentResources are:

- There is no overall maximum dollar limit on the policy.
- $1,500 Deductible for Preferred Providers Per Insured Person, Per Policy Year and a $3,000 Deductible for Preferred Providers For all Insureds in a Family, Per Policy Year, $3,000 Deductible for Out of Network Providers Per Insured Person, Per Policy Year and a $6,000 Deductible for Out of Network Providers For all Insureds in a Family, Per Policy Year.
- Covered Medical Expenses for Preferred Providers are payable at 80% of Preferred Allowance and Out of Network benefits are payable at 60% of Usual and Customary charges (all benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copays as described in the policy).
- Preferred Provider Out-of-Pocket Maximum of $5,000 Per Insured Person, Per Policy Year and $10,000 For all Insureds in a Family, Per Policy Year. Out-of-Network Out-of-Pocket maximum of $10,000 Per Insured Person, Per Policy Year and $22,000 For all Insureds in a Family, Per Policy Year. 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.
- Prescription Drug Benefits: $15 Copay for Tier 1 / $30 Copay for Tier 2 / $45 Copay for Tier 3 up to a 31-day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP). Mail order through UHCP at 2.5 times the retail copay up to a 90 day supply. $15 Deductible for generic drugs / $30 Deductible for brand name up to a 31-day supply per Prescription at an Out-of-Network pharmacy.
- Refer to Plan brochure for details about pediatric dental and vision benefits. (Age limits apply.)
- Preventive Care Services which include, but are not limited to, annual physicals, GYN exams, routine screenings and immunizations are covered at 100% with no Copay or deductible only 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.
- Coverage available for eligible Dependents.
- The Preferred Provider Network for this plan is UnitedHealthcare Choice Plus. Preferred Providers can be found using the following link,
- Choice Plus http://www.uhcsr.com/lookupredirect.aspx?delsys=52
- FrontierMEDEX – Domestic Students are eligible for FrontierMEDEX 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.
- 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.

Rates	Annual 7/01/14 - 6/30/15	Fall 7/01/14 - 12/31/14	Spring/Summer 1/01/15 - 6/30/15
Student	$1,964	$990	$974
Spouse	$5,061	$2,551	$2,510
All Children	$3,231	$1,629	$1,602
All Dependents	$8,291	$4,180	$4,111

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. Addiction, such as:
   - Caffeine addiction.
   - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
   - Codependency.
4. Developmental delay or disorder or mental retardation. Learning disabilities.
5. Congenital Conditions, except as specifically provided for:
   - Habilitative Services.
   - Newborn or adopted Infants.
   - Intraoccular lens implantation for the treatment of aphakia
   - Reconstructive surgery to correct the following: 1) hemangiomas and port wine stains of the head and neck area for Insureds ages 18 and younger; 2) limb deformities such as club hand, club foot, syndactyly, polydactyly and macrodactylia; 3) Otoplasty when performed to improve hearing when ear or ears are absent or deformed; 4) tongue release for diagnosis of tongue-tied; 5) skull deformity caused by Congenital Conditions such as Crouzon's disease; 6) cleft lip; and 7) cleft palate.
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.
   - Correct the following: 1) hemangiomas and port wine stains of the head and neck area for Insureds ages 18 and younger; 2) limb deformities such as club hand, club foot, syndactyly, polydactyly and macrodactylia; 3) Otoplasty when performed to improve hearing when ear or ears are absent or deformed; 4) tongue release for diagnosis of tongue-tied; 5) skull deformity caused by Congenital Conditions such as Crouzon's disease; 6) cleft lip; and 7) cleft palate.
   - Treat or correct Congenital Conditions of a Newborn or adopted Infant.
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. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
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.
11. Hirsutism. Alopecia.
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 or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
14. 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.
15. Lipectomy.
16. Participation in a riot or civil disorder. Commission of or attempt to commit a felony. Fighting.

17. 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. 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 for children born small for gestational age.
    - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
18. 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.
    - Reversal of sterilization procedures.
    - Sexual reassignment surgery.
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 the first pair of eyeglasses or contact lenses following intraocular lens implantation for the treatment of cataracts or aphakia or to replace the function of the human lens for conditions caused by cataract surgery or Injury.
20. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.
21. 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.
22. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
23. 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.
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. Supplies, except as specifically provided in the policy.
26. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
27. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
28. 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).

This plan is underwritten by UnitedHealthcare Insurance Company and is based on policy 2014-212-22.

Please read the plan brochure to determine whether this plan is right for you before you enroll. The plan brochure provides details of the coverage including costs, benefits, exclusions, any reductions or limitations and the terms under which the coverage may be continued in force.

Copies of the brochure are available from the University, or may be viewed and downloaded at www.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 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.

UnitedHealthcare
A UnitedHealth Group Company

POLICY NUMBER: 2014-212-22

NOTICE:
The benefits contained within have been revised since publication. The revisions are included within the body of the document, and are summarized on the last page of the document for ease of reference.

NOC#2

- Removed the following exclusion: "Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping."

NOC#1 - 7/21/14

Changed Preferred Provider Out-of-Pocket Family Maximum from $11,000, to $10,000.