2011 - 2012

# HEALTH CARE WITH A DIFFERENCE

STUDENT HEALTH PLAN | WRIGHT STATE UNIVERSITY BOONSHOFT SCHOOL OF MEDICINE

# Thank you for considering UnitedHealthcare as your provider of health benefit coverage.

We know you want the best benefit coverage with the fewest obstacles between you and your health care. Here are some of the ways becoming a UnitedHealthcare member can help.

## A really big network

Our network is one of the largest in the nation, with more than **626,000 doctors** and **5,035 hospitals**. So chances are your regular doctor already participates with us. It also means that wherever you're at in the country, you'll be able to find a network hospital and get the same benefit coverage level you find at home. Your **benefits travel with you**.

## With a nationwide network, your benefit coverage travels with you:

- **626,000 doctors**
- **5,035 hospitals**
- **60,000 pharmacies**
- **57,000 counseling and mental health practitioners**

## Eligibility

The Wright State University Boonshoft School of Medicine recognizes the need for a comprehensive medical insurance program for medical students. That is why we are pleased to present this UnitedHealthcare program to you, in conjunction with Collegiate Risk Management. This program has been tailored to meet the specific needs of students within the medical school.

Coverage is available to eligible full-time medical students. Students must complete all the necessary enrollment forms to be covered under the plan. Spouses and unmarried dependent children under age 25 are also eligible for coverage under the Program Plan. If there is a need to make changes after the initial enrollment, such as adding a dependent, a new enrollment form must be completed.

Students electing not to participate in the Wright State University Boonshoft School of Medicine insurance program, may do so if they have equivalent group coverage through a parental or spousal plan.

Eligible students who do enroll also may insure their dependents at the time the student is first able to enroll in the plan (within 14 days of the start of the semester), except for

### UnitedHealthcare Choice Plus

With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms.

a change in dependent status due to a life event. Eligible dependents are the spouse and their children under age 25 who are not self-supporting, who live with the insured or who are full-time or part-time students. Dependent eligibility expires concurrently with that of the insured student.

## Plan year

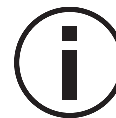
The plan year starts on July 1, 2011 and runs until June 30, 2012. Dependent coverage will not be effective prior to that of the insured student or extend beyond that of the insured student. Refunds of premiums are allowed only upon entry into the U.S. Armed Forces.

## Extension of benefits after termination

The coverage provided under the policy ceases on the termination date. However, if an insured is totally disabled on the termination date from a covered injury or sickness for which benefits are payable before the termination date, covered medical expenses for such injury or sickness will continue to be paid as long as the condition continues but not to exceed 12 months after the termination date.

If an insured is pregnant on the termination date and the conception occurred while covered under this policy, covered medical expenses for such pregnancy will continue to be paid through the term of the pregnancy.

The total payments made in respect of the insured for such condition both before and after the termination date will never exceed the maximum benefit. After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.



### Information on services offered

For information about services offered, please visit **www.collegiaterisk.com**, type "wright" in the box for the school name and click submit. Then, follow the links for Medical Students.

### Find in-network dental and vision providers

To find in-network dental and vision providers, please visit **www.myuhcdental.com** and **www.myuhcvision.com**.

# Summary of Benefits – UnitedHealthcare Choice Plus.

With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms.

You also may choose to seek care outside the network. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible, copayment and coinsurance. In addition, if you choose to seek care outside the network, UnitedHealthcare only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the out-of-pocket maximum. We recommend that you ask the non-network physician or health care professional about their billed charges before you receive care.

| Monthly Breakdown of Rates | Monthly Rates | Dental Services | Vision Services |
|---|---|---|---|
| Student | $208.00 | $33.41 | $6.05 |
| Student & Spouse | $610.00 | $63.74 | $11.14 |
| Student & Child | $417.00 | $63.74 | $11.67 |
| Children | $629.00 | $63.74 | $11.67 |
| Student, Spouse & Child | $819.00 | $111.05 | $17.47 |
| Student, Spouse & Children | $1,031.00 | $111.05 | $17.47 |
| **Student Coverage Periods** | | | |
| | | Effective Date | Expiration Date |
| Annual | | 7/1/2011 | 6/30/2012 |

# Better manage your benefit plan

When you become a member, your main tool for managing your benefit plan is myuhc.com. Once you've enrolled, just register to access your personal plan information. A few clicks and you can search the directory for a network doctor or hospital in your area. You also can see what services are covered and how much you'll pay for a copayment and deductible.*

## Health planning tools: Get well, stay well

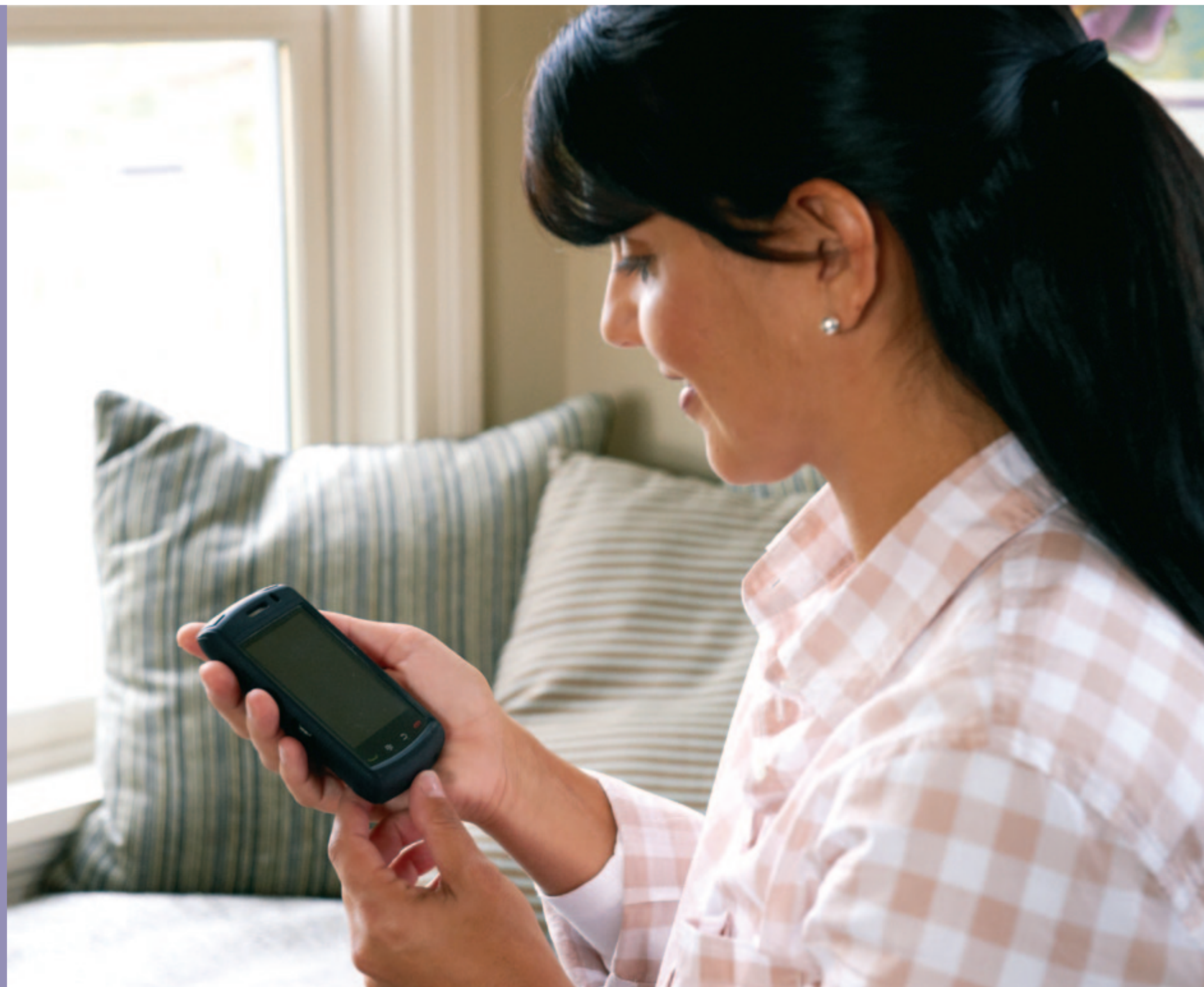
You may be surprised to know that as a member, you get more than just benefit coverage. On myuhc.com, you also have a wealth of online tools, information and programs to help you obtain and maintain good health. These are just some of the ways you can start achieving your wellness goals:

- **Gauge** your health status by taking a Personal Health Assessment.
- **Manage** your health and wellness with the Personal Health Record.
- **Choose** from several health improvement tools to begin your healthy journey.
- **Receive** discounts on thousands of wellness products and services.
- **Keep track** of your progress with personal journaling and other wellness tools.
- **Learn** healthy tips and trivia with wellness quizzes and games.
- **Read up** on health topics in our vast libraries of health and wellness articles.

* Check your benefit plan documents to verify your coverage levels.

### Other myuhc.com features

- Track your claims to see when they are paid
- Create an emergency medical wallet card
- Find the cost of many different medical services in your area by using the Treatment Cost Estimator



# UnitedHealthcare Student Health Insurance Plan 159

**Wright State University Boonshoft Medical School**

## Utilizing the Choice Plus network

Access to high-quality, affordable health care is vital to academic success. UnitedHealthcare helps keep you and your family healthy with comprehensive medical coverage options, including preventive care and emergency services. It is easy to get care and maintain your health with a UnitedHealthcare Student Health Benefit Plan.

The Choice Plus plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. In order to make the most of your Benefits, you should visit the Student Health Center first. Some Benefits may have a Copayment. You will receive the highest level of Benefits when you seek care from a Network Physician, facility or other health care professional if services at the Student Health Center are either not covered or not available. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-Network Physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, UnitedHealthcare only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-Network Physician or health care professional for information about their billed charges *before you receive care.*

## Some of the important benefits of your plan:

You have access to a Network of Physicians, facilities and other health care professionals, including specialists, without designating a primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care Coordination℠ services are available to help identify and prevent delays in care for those who might need specialized help.

- Emergencies are covered anywhere in the world.
- Pap smears are covered.
- Prenatal care is covered.
- Routine check-ups are covered.
- Childhood immunizations are covered.
- Mammograms are covered.

### Need a real voice when you have health questions?

With **NurseLine℠ services**, you can call to speak with an experienced registered nurse anytime, day or night. Ask health-related questions about anything from illnesses, to treating a burn, to the possible side effects of medications. You also can get help with finding the right doctor or hospital and understanding possible treatment options with Treatment Decision Support.

To access NurseLine services, call the toll free telephone number on your member ID card.

**Notice:** If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and Hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the Coordination of Benefits section, and compare them with the rules of any other plan that covers you or your family.

Blanket Student Health Insurance - Non-Renewable

Benefits are underwritten by United Healthcare Insurance Company. OHXGT15905

# Student Health Insurance

## Benefits summary

| Types of Coverage Amounts | Student Health Center / Copayment Amounts | Network Benefits / Copayment Amounts | Non-Network Benefits / Copayment Amounts |
|---|---|---|---|
| This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage (COC) that will be made available upon enrolling in the Plan.**<br><br>If this Benefit Summary conflicts in any way with the Policy issued to the Enrolling Group, the Policy shall prevail.<br><br>Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.<br><br>Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether Network or non-Network, except where mandated by state law.<br><br>Network Benefits are payable for Covered Health Services provided by or under the direction of your Network Physician.<br><br>*Prior Notification is required. | **Annual Deductible:**<br>$200 per Covered Person per Policy Year, not to exceed $200 for all Covered Persons in a family.<br><br>**Out-of-Pocket Maximum:**<br>No Out-of-Pocket Maximum.<br><br>**Annual Maximum Benefit:**<br>The Maximum amount that we will pay for Benefits during the Policy Year. Combined Student Health Service, Network and non-Network: $200,000 per Covered Person.<br><br>**Maximum Policy Benefit:**<br>Combined Student Health Center, Network and non-Network $800,000 per Covered Person. | **Annual Deductible:**<br>$250 per Covered Person per Policy Year, not to exceed $500 for all Covered Persons in a family.<br><br>**Out-of-Pocket Maximum:**<br>$5,000 per Covered Person per Policy Year, not to exceed $6,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC.<br><br>**Annual Maximum Benefit:**<br>The Maximum amount that we will pay for Benefits during the Policy Year. Combined Student Health Center, Network and non-Network: $200,000 per Covered Person.<br><br>**Maximum Policy Benefit:**<br>Combined Student Health Center, Network and non-Network $800,000 per Covered Person. | **Annual Deductible:**<br>$500 per Covered Person per Policy Year, not to exceed $1000 for all Covered Persons in a family.<br><br>**Out-of-Pocket Maximum:**<br>$10,000 per Covered Person per Policy Year, not to exceed $12,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC.<br><br>**Annual Maximum Benefit:**<br>The Maximum amount that we will pay for Benefits during the Policy Year. Combined Student Health Service, Network and non-Network: $200,000 per Covered Person.<br><br>**Maximum Policy Benefit:**<br>Combined Student Health Service, Network and non-Network $800,000 per Covered Person. |
| **1. Ambulance Services**<br>Emergency only | Ground Transportation:<br>Not Covered<br><br>Air Transportation:<br>Not Covered | Ground Transportation:<br>20% of Eligible Expenses<br><br>Air Transportation:<br>20% of Eligible Expenses | Same as Network Benefit |
| **2. Durable Medical Equipment**<br>Network and non-Network Benefits for Durable Medical Equipment are limited to $2,500 per Policy Year. | No Copayment | 20% of Eligible Expenses | *40% of Eligible Expenses<br><br>*Prior notification is required when the cost is more than $1,000. |
| **3. Emergency Health Services** | No Copayment | $250 per visit | Same as Network Benefit<br><br>*Notification is required if results in an Inpatient Stay. |
| **5. Home Health Care**<br>Network and non-Network Benefits are limited to 60 visits for skilled care services per Policy Year. | Not Covered | 20% of Eligible Expenses | *40% of Eligible Expenses |
| **6. Hospice Care** | Not Covered | 20% of Eligible Expenses | *40% of Eligible Expenses |
| **7. Hospital - Inpatient Stay** | Not Covered | 20% of Eligible Expenses | *40% of Eligible Expenses |
| **8. Maternity Services** | Not Covered | Same as 5, 7, 9, 10 and 11<br>No Copayment, applies to Physician Office visits for prenatal care after the first visit. | Same as 5, 7, 9, 10 and 11<br>*Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. |

## Benefits summary continued

| Types of Coverage Amounts | Student Health Center / Copayment Amounts | Network Benefits / Copayment Amounts | Non-Network Benefits / Copayment Amounts |
|---|---|---|---|
| **9. Outpatient Surgery, Diagnostic and Therapeutic Services** | | | |
| Outpatient Surgery | No Copayment | 20% of Eligible Expenses | 40% of Eligible Expenses |
| Outpatient Diagnostic Services | For lab and radiology/Xray: No Copayment | No Copayment | 40% of Eligible Expenses |
| | For diagnostic mammography testing: No Copayment | No Copayment | 40% of Eligible Expenses |
| Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine | Not Covered | 20% of Eligible Expenses | 40% of Eligible Expenses |
| Outpatient Therapeutic Treatments | Not Covered | 20% of Eligible Expenses | 40% of Eligible Expenses |
| **10. Physician's Office Services** | | | |
| Preventive Care | No Copayment | No Copayment | 40% of Eligible Expenses |
| Sickness and Injury | No Copayment | $20 per visit | 40% of Eligible Expenses |
| Injections Received in a Physician's Office when no other health service is received | No Copayment | $20 per visit | 40% of Eligible Expenses |
| Any combination of Network and non-Network Benefits for Child Health Supervision Services are limited to $500 for Enrolled Dependent children from birth to age one and $150 for Enrolled Dependent children from age one to age nine per Policy Year. | | | |
| **11. Professional Fees for Surgical and Medical Services** | Not Covered | 20% of Eligible Expenses | 40% of Eligible Expenses |
| **12. Prosthetic Devices** Network and non-Network Benefits for prosthetic devices are limited to $2,500 per Policy Year. | Not Covered | 20% of Eligible Expenses | 40% of Eligible Expenses |
| **13. Reconstructive Procedures** | Not Covered | Same as 7, 9, 10, 11 and 12 | *Same as 7, 9, 10, 11 and 12 |
| **14. Rehabilitation Services - Outpatient Therapy** Network and non-Network Benefits are limited as follows: 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per Policy Year. | Not Copayment | $20 per visit | 40% of Eligible Expenses |
| **15. Skilled Nursing Facility/ Inpatient Rehabilitation Facility Services** Network and non-Network Benefits are limited to 60 days per Policy Year. | Not Covered | 20% of Eligible Expenses | *40% of Eligible Expenses |
| **16. Transplantation Services** | Not Covered | *20% of Eligible Expenses | *40% of Eligible Expenses Benefits are limited to $30,000 per transplant. |
| **17. Urgent Care Center Services** | Not Covered | $50 per visit | 40% of Eligible Expenses |

## Benefits summary, continued

| Additional Benefits | | | |
|---|---|---|---|
| **Alcoholism Services**<br>Must receive prior authorization through the Mental Health/Substance Abuse Designee. Any combination of Network and non-Network Benefits for alcoholism services provided on an outpatient, inpatient or intermediate basis is limited to $550 per Policy Year. | **For Outpatient Alcoholism Services:**<br>0% of Eligible Expenses<br><br>**For Inpatient or Intermediate Alcoholism Services:**<br>Not Covered | **For Outpatient Alcoholism Services:**<br>20% of Eligible Expenses<br><br>**For Inpatient or Intermediate Alcoholism Services:**<br>20% of Eligible Expenses | **For Outpatient Alcoholism Services:**<br>40% of Eligible Expenses<br><br>**For Inpatient or Intermediate Alcoholism Services:**<br>40% of Eligible Expenses |
| **Cytologic Screening and Screening Mammography**<br>Benefits for Screening Mammography performed within the state of Ohio shall not exceed one hundred thirty percent of the lowest Medicare reimbursement rate in Ohio for Screening Mammography or a component of Screening Mammography. | Same as 9, 10 and 11 | Same as 9, 10 and 11 | Same as 9, 10 and 11 |
| **Mental Health and Substance Abuse Services - Outpatient**<br>Must receive prior authorization through the Mental Health/Substance Abuse Designee. Any combination of Network and non-Network Benefits for outpatient Mental Health Services is limited to 20 visits per Policy Year. | No Copayment | 20% of Eligible Expenses | 40% of Eligible Expenses |
| **Mental Health and Substance Abuse Services - Inpatient and Intermediate**<br>Must receive prior authorization through the Mental Health/Substance Abuse Designee. Any combination of Network and non-Network Benefits for inpatient or intermediate Mental Health Services is limited to 30 days per Policy Year. | Not Covered | 20% of Eligible Expenses | *40% of Eligible Expenses |
| **Spinal Treatment**<br>Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network and non-Network Benefits are limited to 24 visits per Policy Year. | Not Covered | $20 per visit | 40% of Eligible Expenses |
| **Substance Abuse Services - Outpatient**<br>Must receive prior authorization through the Mental Health/Substance Abuse Designee. Any combination of Network and non-Network Benefits for outpatient Substance Abuse Services is limited to 20 visits per Policy Year. These Benefit limits are in addition to Benefits provided as described under Alcoholism Services. | No Copayment | 20% of Eligible Expenses | 40% of Eligible Expenses |
| **Substance Abuse Services - Inpatient and Intermediate**<br>Must receive prior authorization through the Mental Health/Substance Abuse Designee. Any combination of Network and non-Network Benefits for inpatient and intermediate Substance Abuse Services is limited to 30 days per Policy Year. These Benefit limits are in addition to Benefits provided as described under Alcoholism Services. | No Covered | 20% of Eligible Expenses | 40% of Eligible Expenses |

# **Exclusions** - UnitedHealthcare Insurance Company

*Except as may be specifically provided in Section 1 and 2 of the Certificate of Coverage (COC) or through a Rider to the Policy, the following are not covered:*

**A. Alternative Treatments**
Acupressure; hypnotism; rolfing; massage therapy; aroma therapy; acupuncture; and other forms of alternative treatment.

**B. Comfort or Convenience**
Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

**C. Dental**
There is no coverage for dental care, preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

**D. Drugs**
Prescription drug products for outpatient use that are filled by a prescription order or refill. Self- injectable medications. Noninjectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

**E. Experimental, Investigational or Unproven Services**
Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition. Refer to External Independent Review for Terminal Conditions in Section 6 of the COC for exceptions to this exclusion.

**F. Foot Care**
Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

**G. Medical Supplies and Appliances**
Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes and diabetic test strips. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 and 2 of the COC.

**H. Mental Health/Substance Abuse**
Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgment of the Mental Health/ Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 3 of the COC.

**I. Nutrition**
Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

**J. Physical Appearance**
Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.) Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

**K. Providers**
Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 3 of the COC (this exclusion does not apply to mammography testing).

**L. Reproduction**
Health services and associated expenses for infertility treatments. Surrogate parenting. The reversal of voluntary sterilization.

## Exclusions Continued

**M. Services Provided under Another Plan**
Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

**N. Transplants**
Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 and 2 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs. Any multiple organ transplant not listed as a Covered Health Service in Section 1 and 2 of the COC.

**O. Travel**
Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion (Emergency ambulance transportation is a Covered Health Service as described in Section 2 of the COC). Transportation expenses resulting from a medical or commercial transfer from a medical facility in a foreign country to a medical facility in the United States.

**P. Vision and Hearing**
Purchase cost of eye glasses, contact lenses, or hearing aids. Routine vision exams, including refraction, to determine vision impairment and the need for corrective lenses. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

**Q. Other Exclusions**
Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the COC.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Policy, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received after the date your coverage under the Policy ends, including health services for medical conditions arising prior to the date your coverage under the Policy ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.

In the event that a non-Network provider waives Copayments and/ or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer, or as necessary to safeguard a Covered Person's health due to a non-dental physiological impairment. Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Surgical removal of excess skin and tissue resulting from weight loss.

Abdominoplasty.

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring. Custodial Care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, autism or Congenital Anomaly.

This summary of Benefits is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to the Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Certificate of Coverage, the Certificate of Coverage prevails. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.

# Pharmacy management program Plan 060

UnitedHealthcare's pharmacy management program provides clinical pharmacy services that promote choice, accessibility and value. The program offers a broad network of pharmacies (more than 56,000 nationwide) to provide convenient access to medications.

While most pharmacies participate in our network, you should check first. Call your pharmacist or visit our online pharmacy service at www.myuhc.com. The online service offers you home delivery of prescriptions, ability to view personal benefit coverage, access to health and well-being information, and even locations of network retail neighborhood pharmacies by ZIP code.

## Copayment per prescription order or refill

Your Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Please access **www.myuhc.com** through the Internet, or call the Customer Service number on your ID card to determine tier status.

For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits. You are responsible for paying the lower of the applicable Copayment or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment or the Home Delivery Pharmacy's Prescription Drug Cost.

Also note that some Prescription Drug Products require that you notify us in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

| | **Retail Network Pharmacy** For up to a 31-day supply | **Home Delivery Network Pharmacy** For up to a 90-day supply | **Retail Non-Network Pharmacy** For up to a 31-day supply |
|---|---|---|---|
| Tier 1 | $20 | $50 | $20 |
| Tier 2 | $40 | $100 | $40 |
| Tier 3 | $80 | $200 | $80 |

### Other important cost sharing information

NOTE: If you purchase a Prescription Drug Product from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug Product dispensed by a Network Pharmacy.

| | |
|---|---|
| **Annual Drug Deductible** | No Annual Drug Deductible. |
| **Out-of-Pocket Drug Maximum** | No Out-of-Pocket Drug Maximum. |
| **Annual Maximum Benefit** | $1,600 per Covered Person per Policy Year, not to exceed $3,200 for all Covered Persons in a family. |

**Check the pharmacy in your network**

While most pharmacies participate in our network, you should check first. Call your pharmacist or visit our online pharmacy service at **www.myuhc.com**.

# Exclusions

*Exclusions from coverage listed in the Certificate apply also to this Rider. In addition, the following exclusions apply:*

- Coverage for Prescription Drug Products for the amount dispensed (days supply or quantity limit) which exceeds the supply limit.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility. Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression and other weight loss products.
- A specialty medication Prescription Drug Product (such as immunizations and allergy serum) which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging of Prescription Drug Products
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products when prescribed to treat infertility.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.
- Prescription Drug Products for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.
- New Prescription Drug Products and/or new dosage forms until the date they are reviewed by our Prescription Drug List Management Committee. Growth hormone therapy for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

This summary of Benefits is intended only to highlight your Benefits for outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all your outpatient prescription drug expenses. Please refer to your Outpatient Prescription Drug Rider and the Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage prevail. Capitalized terms in the Benefit Summary are defined in the Outpatient Prescription Drug Rider and/or Certificate of Coverage.

## Special help for chronic conditions

A range of resources is available if you develop a chronic health condition. Disease management programs help you better control common conditions such as asthma or diabetes. Specialized resources can help if you are affected by a transplant, cancer or congenital heart disease — from choosing the right medical center to finding a nearby hotel when you have treatment.

## Privacy policy

We know that your privacy is important to you, and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling Customer Care at **1-800-436-7709** or by visiting **myuhc.com.**

## Coverage while away from home

UnitedHealthcare contracts with more than 626,000 doctors and 5,035 hospitals nationwide. Therefore, when you are traveling or visiting areas outside Dayton, it is possible you will be in another UnitedHealthcare contracted network. As a result, if you need to access care while outside of Dayton, you can contact the Customer Care toll-free number on your ID card, or you can search our online provider directory at **myuhc.com** to identify network doctors or other health care professionals in the area.

When you use UnitedHealthcare doctors or other health care professionals outside of Dayton, you will receive reimbursement at your network level of benefits. Enrolled individuals receive network-level benefits for emergency care that meets the "prudent layperson" definition, whether they receive care from a network or non-network doctor or other health care professionals.

### How to find mental health and substance abuse services

Through United Behavioral Health, you will have access to more than 57,000 practitioners for personal, confidential counseling. You also can visit **www.liveandworkwell.com** for information on mental health and substance abuse services. This site also links to the United Behavioral Health Preventive Health Program for exclusive resources and information on major depression disorders, alcohol abuse and attention deficit hyperactivity disorder.

## Claim procedure:

In the event of injury or sickness you should:

1. Report to the Student Health Service or infirmary for treatment or referral, or when not in school, to the nearest physician or hospital.

2. If the provider does not file a claim, you will need to fill out a claim form and mail to the address below along with all medical and hospital bills, along with the patient name, ID number on your member ID Card, Social Security number, address and name of your university under which you are insured.

3. File the claim within 30 days of injury or first treatment for a sickness. Bills should be received by the company within 180 days of service. Bills submitted after one year will not be considered for payment except in the case of legal capacity.

In the event there is a conflict of this brochure and the Master Policy, the Master Policy shall prevail. You can obtain a brochure at the Health Center, at the Wright State Boonshoft School of Medicine or by logging onto www.collegiaterisk.com or by calling 1-800-922-3420. The Certificate of Coverage is on file with the school and a copy may be obtained by logging onto the Collegiate Risk website above.

Direct all claims and/or customer service inquiries to:

**UnitedHealthcare Claims**
**PO Box 30555**
**Salt Lake City, UT 84130-0555**

### Customer Care staff

Customer Care staff available by calling **1-800-436-7709.** For eligibility questions or any additional help needed, call Collegiate Risk at **1-800-922-3420.**

# Dental plan

Custom Passive PPO P7905

## Voluntary options PPO/covered dental services

| | Non-Orthodontics | | Orthodontics | |
|---|---|---|---|---|
| | Network | Non-Network | Network | Non-Network |
| **Individual Annual Calendar Year Deductible** | $50 | $50 | $0 | $0 |
| **Family Annual Calendar Year Deductible** | $150 | $150 | $0 | $0 |
| **Maximum** (the sum of all Network and Non-Network benefits will not exceed annual maximum) | $1500 per person per Calendar Year | $1500 per person per Calendar Year | $1000 per person per Lifetime | $1000 per person per Lifetime |
| **New enrollee's waiting period:** | Network: 12 months Major / 12 months Ortho | | Non-Network: 12 months Major / 12 months Ortho | |
| **Annual deductible applies to preventive and diagnostic services** | | | No (In Network) No (Out Network) | |
| **Annual deductible applies to orthodontic services** | | | No | |
| **Orthodontic eligibility requirement** | | | Child (up to age 19) | |

| Covered Services* | Network Plan Pays** | Non-Network Plan Pays*** | Benefit Guidelines |
|---|---|---|---|
| **Diagnostic Services** | | | |
| Periodic Oral Evaluation | 100% | 100% | Limited to 2 times per consecutive 12 months. |
| Radiographs | 100% | 100% | Bite-wing: Limited to 1 series of films per Calendar Year. |
| Complete/Panorex: Limited to 1 time per consecutive 36 months. | | | |
| Lab and Other Diagnostic Tests | 100% | 100% | |
| **Preventive Services** | | | |
| Prophylaxis (Cleanings) | 100% | 100% | Limited to 2 times per consecutive 12 months. |
| Fluoride Treatment (Preventive) | 100% | 100% | Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months. |
| Sealants | 100% | 100% | Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months. |
| Space Maintainers | 100% | 100% | For Covered Persons under the age of 16 years, limited to 1 per consecutive 60 months. |
| **Basic Services** | | | |
| Restorations (Amalgams or Composite) | 80% | 80% | Multiple restorations on one surface will be treated as a single filling. |
| General Services (incl. Emergency Treatment) | 80% | 80% | Palliative Treatment: Covered as a separate benefit only if no other service was done during the visit other than X-rays. General Anesthesia: When clinically necessary. |
| Simple Extractions | 80% | 80% | Limited to 1 time per tooth per lifetime. |
| Oral Surgery (includes surgical extractions) | 80% | 80% | |
| Periodontics | 80% | 80% | Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area.<br>Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months.<br>Periodontal Maintenance: Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement. |
| Endodontics | 80% | 80% | |
| **Major Services** | | | |
| Inlays/Onlays/Crowns | 50% | 50% | Limited to 1 time per tooth per consecutive 60 months. |
| Dentures and other Removable Prosthetics | 50% | 50% | Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. |
| Fixed Partial Dentures (Bridges) | 50% | 50% | Once per tooth per consecutive 60 months. |
| **Orthodontic Services** | | | |
| Diagnose or correct misalignment of the teeth or bite | 50% | 50% | Course of treatment is typically 24 months, with the initial payment at banding of 20% and remaining payment spread over the course of the treatment |

# Dental exclusions and limitations

## General limitations

**Periodic oral evaluation**
Limited to 2 times per consecutive 12 months.

**Complete series or panorex radiographs**
Limited to one time per consecutive 36 months. Exception to this limit will be made for Paronex Radiograph if taken for diagnosis of molars, Cysts or neoplasms

**Bitewing radiographs**
Limited to 1 series of films per Calendar Year

**Extraoral radiographs**
Limited to 2 films per Calendar Year

**Dental prophylaxis**
Limited to 2 times per consecutive 12 months.

**Fluoride treatments**
Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

**Sealants**
Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.

**Space maintainers**
Limited to Covered Persons under the age of 16 years. Limited to 1 per consecutive 60 months. Benefit includes all adjustment within 6 months of installation

**Restorations**
Multiple restorations on 1 surface will be treated as a single filling.

**Pin retention**
Limited to 2 pins per tooth; not covered in addition to cast restoration.

**Inlays and onlays**
Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

**Crowns**
Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

**Post and cores**
Covered only for teeth that have had root canal therapy.

**Sedative fillings**
Covered as a separate benefit only if no other service, other than x-rays and exam were performed on the same tooth during the visit.

**Scaling and root planing**
Limited to 1 time per quadrant per consecutive 24 months.

**Periodontal maintenance**
Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

**Full dentures**
Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

**Partial dentures**
Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

**Relining and rebasing dentures**
Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

**Repairs to full dentures, partial dentures, bridges**
Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 time per consecutive 6 months.

**Palliative treatment**
Covered as a separate benefit only if no other service, other than exam and radiographs, were performed on the same tooth during the visit.

**Occlusal guards**
Limited to 1 guard every consecutive 36 months and only if prescribe to control habitual grinding.

**Full mouth debridment**
Limited to 1 time every consecutive 36 months.

**General anesthesia**
Covered only when clinically necessary.

**Osseous grafts**
Limited to 1 per quadrant or site per consecutive 36 months.

**Periodontal surgery**
Hard tissue and soft tissue periodontal surgery are limited to 1 per quadrant or site per consecutive 36 months per surgical area

**Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays**
Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

This plan includes a roll-over maximum benefit. Some of the unused portion of your annual maximum may be available in future periods.

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

**The network percentage of benefits is based on the discounted fees negotiated with the provider.

***The non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.

The Prenatal Dental Care and Oral Cancer Screening programs are covered under this plan.

The material contained in the table on page 8 is for informational purposes only and is not an offer of coverage. Please note that this table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

## Dental general exclusions

**The following are not covered:**

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the policy.
10. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
12. Foreign services are not covered unless required as an Emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been covered under the policy for 12 continuous months.
15. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Placement of dental implants, implants-supported abutments and prostheses. (Not applicable for plans with implants)
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
22. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue
23. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint. (Not Applicable for Plans with TMJ).
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia
25. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
26. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
27. Occlusal guard used as safety items or to affect performance primarily in sports-related activities
28. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
29. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

# UnitedHealthcare Vision℠

UnitedHealthcare Vision has been trusted for more than 40 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

**Copays for in-network services**

| | |
|---|---|
| Comprehensive Exam | $10.00 |
| Materials | $25.00 |

**Benefit Frequency**

| | |
|---|---|
| Comprehensive Exam | 12 months |
| Spectacle Lenses | 12 months |
| Frames | 24 months |
| Contact Lenses (in lieu of eye glasses) | 12 months |

**Out of Network Reimbursement**

Network Copays do not apply

| | |
|---|---|
| Comprehensive Exam | Up to $40 |
| Lenses | |
| Single Vision | Up to $40 |
| Bifocal | Up to $60 |
| Trifocal | Up to $80 |
| Lenticular | Up to $80 |
| Frames | Up to $45 |
| Contact Lenses in lieu of eyeglasses | |
| Elective | Up to $105 |
| Necessary[1] | Up to $210 |

You do not need to submit a claim for In-Network benefits. However, you must submit a claim to UnitedHealthcare Vision for benefit reimbursement for Out-of-Network services.

**Covered in Full (after applicable copays) In-Network Benefits:**

Comprehensive Exam

Lenses
- Standard Single Vision
- Standard Lined Bifocal
- Standard Lined Trifocal
- Standard Lenticular Lenses

Contact Lenses *(in lieu of eyeglasses)*
- Elective
- Necessary[1]

Frame

Lens Options
- Standard Scratch Resistant Coating

**Frame Benefit**

Private Practice Provider
- $50 wholesale allowance (approximate retail value of $120-$150)

Retail Chain Provider
- $130 retail frame allowance

**Network Contact Lens Benefit**

Covered-in-full contact lenses in lieu of eyeglasses. The covered-in-full contact lens benefit at network providers includes fitting/evaluation, contacts, and two follow-up visits (after $25 copay). For those who choose disposable lenses, up to 4 boxes are included when obtained from a network provider.

**Additional Materials Discount Program**

UnitedHealthcare Vision now offers an Additional Materials Discount Program. At a participating network provider you will receive a 20% discount on an additional pair of eyeglasses or contact lenses.[2]

## UnitedHealthcare Vision℠

| | |
|---|---|
| Copays Exam | $ 10.00 |
| Materials | $ 25.00 |

**Frequency**

| | |
|---|---|
| Exams | 12 Months |
| Lenses | 12 Months |
| Frames | 24 Months |
| Contacts *(Contacts are in lieu of lenses and frames)* | 12 Months |

*This card does not guarantee eligibility and benefits*

## Sample illustration of savings

| Cost | Student Only | Student + Spouse | Student + Child(ren) | Student + Family[3] |
|---|---|---|---|---|
| Monthly Premium | $6.05 | $11.14 | $11.67 | $17.47 |
| Annual Premium | $72.60 | $133.68 | $140.04 | $209.64 |
| Approx. Pre-tax Savings (20%)[4] | $14.52 | $26.74 | $28.01 | $41.93 |
| Annual Tax-Adjusted Premium | $58.08 | $106.94 | $112.03 | $167.71 |
| Plus Copays | $35.00 | $70.00 | $105.00 | $140.00 |
| **Total Cost to Student** | **$93.08** | **$176.94** | **$217.03** | **$307.71** |

| Vision Plan | Exam and Materials Covered by UnitedHealthcare Vision | Estimated Cost Without a Vision Plan[5] | Less Employee Cost | Total Savings with UnitedHealthcare Vision |
|---|---|---|---|---|
| Student Only | Exam, Single Vision, & Covered-in-full frames | $275.00 | $93.08 | $181.92 |
| Student + One | Exam, Single Vision, & Covered-in-full frames | $550.00 | $176.94 | $373.06 |
| Student + Child(ren) | Exam, Single Vision, & Covered-in-full frames | $825.00 | $217.03 | $607.97 |
| Student + Family[3] | Exam, Single Vision, & Covered-in-full frames | $1,100.00 | $217.03 | $882.97 |

[1] Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming reimbursement that UnitedHealthcare Vision will make before you purchase such contacts.

[2] Once all of your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare Vision shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers may offer this discount. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.

[3] For purposes of this sample calculation, Employee + Family is calculated with four (4) members. Employee + Children is calcualted with three (3) members.

[4] Actual tax savings will depend upon your individual tax bracket.

[5] Approximate retail value illustrated: Exam & Refraction ($65), Single Vision Lenses ($80), and Frames ($130). Average retail costs may vary by provider.

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document. Please consult the applicable policy/certificate of coverage for a full description of benefits, including exclusions and limitations.

### For More Information

Customer Service:........................ 1.800.638.3120
Monday through Friday: .......... 8:00 a.m. - 11:00 p.m. ET
Saturday: ......................... 9:00 a.m. - 6:30 p.m. ET
Provider Locator: ........................ 1.800.839.3242
TDD for the hearing impaired: .............1.800.524.3157

### Submit Out-of-Network Claims to:

UnitedHealthcare Vision Claims Department
P.O. Box 30978
Salt Lake City, UT 84130
For more information about your UnitedHealthcare Vision plan, visit **www.myuhcspecialtybenefits.com**, or call Customer Service.

### Important to Remember:

- Benefits available every 12 or 24 months (depending on the benefit frequency), based on last date of service.
- Your $105 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is $30, you will have $75 towards the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store. If you choose disposable contacts, you may receive up to 4 boxes of disposable contacts(depending on prescription). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.

UnitedHealthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser correction providers. Call 1-888-563-4497 or visit www.uhclasik.com.

- Lens Options such as progressive lenses, polycarbonate lenses, tints and anti-reflective coating may be available at a discount.
- Out of Network Reimbursement: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address:

  UnitedHealthcare Vision, Inc.
  Attn. Claim Dept. P.O. Box 30978
  Salt Lake City, UT 84130

**The following services and materials are excluded from coverage under the Policy:** Post cataract lenses; Non-prescription items; Medical or surgical treatment for eye disease that requires the services of a physician; Worker's Compensation services or materials; Services or materials that the patient, without cost, obtains from any governmental organization or program; Services or materials that are not specifically covered by the Policy; Replacement or repair of lenses and/or frames that have been lost or broken; Cosmetic extras, except as stated in the Policy's Table of Benefits.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

UnitedHealthcare Vision coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06 and associated COC form number VCOC.INT.06.TX.

Insurance coverage provided by or through: United HealthCare Insurance Company, United HealthCare Insurance Company of New York, or their affiliates.

Health care professional availability for certain services may be dependent on licensure, scope of practice restrictions or other requirements in the state. Therefore, some services may not be included in the program due to state regulations.

The UnitedHealthcare Student Health Plan and/or Health Discount Program may not be available in all states or for all group sizes. The Healthy Pregnancy Program follows national practice standards from the Institute for Clinical Systems Improvement. Insurance coverage is provided by or through: United HealthCare Insurance Company.

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