2016–2017
Student Injury and Sickness Plan for University of Idaho International Students

Who is eligible to enroll?
All International students registered for classes are eligible and must be enrolled in the plan, unless proof of comparable coverage is provided.

Where can I get more information about the benefits available?
The certificate of coverage provides details of the coverage including costs, benefits, exclusions, and reductions or limitations and the terms under which the coverage may be continued in force. Copies of the certificate of coverage are available from the University and may be viewed at www.uidaho.edu/SHIP.

Who can answer questions I have about the plan?
If you have questions please contact Claims Administrator, AmeriBen at 1-800-953-1801.

How much does the plan cost?

<table>
<thead>
<tr>
<th>Rates</th>
<th>Fall 8/22/16 - 1/10/17</th>
<th>Spring/Summer 1/11/17 – 8/20/17</th>
<th>Summer 5/15/17 - 8/20/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$906.00</td>
<td>$906.00</td>
<td>$501.00</td>
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</tbody>
</table>

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

This plan is underwritten by UnitedHealthcare Insurance Company and is based on policy number 2016-353-4. The Policy is a Non-Renewable One-Year Term Policy.
# Highlights of the Coverage and Services offered by UnitedHealthcare Student Resources

**METALLIC LEVEL – SILVER WITH ACTUARIAL VALUE OF 73.866%**

<table>
<thead>
<tr>
<th>Overall Plan Maximum</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Deductible</strong></td>
<td>$500 per Insured Person, per Policy Year.</td>
<td>$1,000 per Insured Person, per Policy Year.</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>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.</td>
<td>$6,350 Per Insured Person, Per Policy Year</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>75% of Preferred Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Customary Charges for Covered Medical Expenses</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>Magellan Rx Management</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Mail order is available through Magellan RX Management for up to a 90 day supply at 3 times the 31 day supply retail Copay. Oral vaccines for typhoid are covered.</td>
<td>$30 Copay per prescription for generic drugs</td>
<td>$30 Copay per prescription for generic drugs</td>
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<tr>
<td></td>
<td>$60 Copay per prescription for formulary drugs</td>
<td>$60 Copay per prescription for formulary drugs</td>
</tr>
<tr>
<td></td>
<td>$100 Copay per prescription for non-formulary drugs up to a 30 day supply per prescription</td>
<td>$100 Copay per prescription for non-formulary drugs up to a 30 day supply per prescription</td>
</tr>
<tr>
<td>If a retail Magellan RX Management pharmacy agrees to the same rates, terms and requirements associated with dispensing a 90 day supply, then up to a consecutive 90 day supply of a Prescription Drug at 3 times the copay that applies to a 31 day supply per prescription.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td>100% of Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Including but not limited to: annual physicals, GYN exams, routine screenings and immunizations. No Copay or Deductible when the services are received from a Preferred Provider. Please see <a href="http://www.healthcare.gov/preventive-care-benefits/">www.healthcare.gov/preventive-care-benefits/</a> for complete details of the services provided for specific age and risk groups.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following services have per Service Copays/Deductibles</strong></td>
<td>Medical Emergency: $150 (In Lieu of policy Deductible, waived if admitted)</td>
<td>Medical Emergency: $150 (In Lieu of policy Deductible, waived if admitted)</td>
</tr>
<tr>
<td>This list is not all inclusive. Please read the plan certificate for complete listing of Copays/Deductibles.</td>
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<tr>
<td><strong>Pediatric Dental and Vision Benefits</strong></td>
<td>Refer to the plan certificate for details (age limits apply).</td>
<td></td>
</tr>
<tr>
<td><strong>UnitedHealthcare Global: Global Emergency Services</strong></td>
<td>International Students are covered worldwide except in their home country.</td>
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</tbody>
</table>
Preferred Providers
First Choice in the states of Idaho, Washington, and Montana and PHCS outside of those states.

Other Coverage
Accident coverage for Intercollegiate sports injury is provided under a separate policy, 2016-353-84.

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. Addiction, such as:
   - Caffeine addiction.
   - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
   - Codependency.


4. Cosmetic procedures, except reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under this policy. The primary result of the procedure is not a changed or improved physical appearance.
   - Treat or correct a Congenital Condition of a covered Dependent child.
   - Treat or correct Congenital Conditions of a Newborn Infant and Adopted Child.

5. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.

6. 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.

7. Elective Surgery or Elective Treatment.

8. Elective abortion, except to preserve the life of the female upon whom the abortion is performed.

9. Health spa or similar facilities. Strengthening programs.

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.


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. Injuries occurring during practice or play of curricular or competitive sports activities as a member of the school sponsored sports team.

15. Lipectomy.

16. 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, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, or Serophene.
   - Growth hormones, except to treat children with growth failure due to a pituitary disorder.
   - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

17. Reproductive/Infertility services including but not limited to the following:
   - Procreative counseling.
   - Genetic counseling and genetic testing.
   - Cryopreservation of reproductive materials. Storage of reproductive materials.
   - Fertility tests.
   - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
• Premarital examinations.
• Impotence, organic or otherwise.
• Female sterilization procedures, except as specifically provided in the policy.
• Vasectomy.
• Reversal of sterilization procedures.
• Sexual reassignment surgery.

18. Research or examinations relating to research studies, or any treatment for which the patient or the patient’s representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the policy for Approved Clinical Trials.

   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 cataract surgery which must be purchased within 90 days following surgery.

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. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia. Temporomandibular joint dysfunction. Deviated nasal septum, including submucous resection and/or other surgical correction thereof.

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. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.

26. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.

27. 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).

28. Treatment for obesity. Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically proved in the policy.

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.