

## **GRADUATE STUDENT**

# **HEALTH INSURANCE PROGRAM 2009-2010 SCHOOL YEAR**

## **Choice of 2 Medical Plans Now Available To**

### **Pacific Northwest University of Health Sciences**

- 1) Osteopathic Medical Students**
- 2) Associate Members**

## **HIGHLIGHTS**

- ▲ Acceptance is Guaranteed**
- ▲ Medical Plan Rx Card – UnitedHealthcare Network Pharmacies  
Copays for Plan 1 (Policy 2009-202364-1) – \$15 Tier 1/\$25 Tier 2**
- ▲ Medical Plan Doctor Office Visit Copay - \$25 (Plan 1)**
- ▲ Medical Plan PPO Network – UnitedHealthcare Options PPO**

**On Line Enrollment Available – [www.somainsurance.com](http://www.somainsurance.com)**

# GRADUATE STUDENT HEALTH INSURANCE PROGRAM

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**Any Questions On  
The PNWU College Health Plan  
Call Toll-Free  
800-349-1039  
8:00 A.M. - 5:00 P.M.  
Central Standard Time**

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**For Administrative forms and claim information, go to the Health Insurance Website  
[www.somainsurance.com](http://www.somainsurance.com)**



# IMPORTANT INFORMATION ON THE GRADUATE STUDENT MEDICAL INSURANCE PLANS

The Graduate Student Health Insurance Plan offers two medical insurance alternatives, in addition to a dental and vision insurance option.

**PLEASE NOTE:** After the deductible, the accident and sickness (medical) insurance plan has an 80%/60% co-insurance feature, however, we would like to call your attention to the maximum limits on the following charges for the Co-Pay and High Deductible Plan, also outlined on pages 4 and 5 in this brochure. **The deductible for the Plan 1 Co-Pay Plan does not apply to 1) Prescription Drugs which has a \$15 tier 1/\$25 tier 2 co-pay subject to the \$600 maximum per policy year; 2) Wellness Benefits; 3) Doctor Office Visit. Under Plan 2 (High Deductible) - a \$2,000 deductible for Preferred Providers and \$4,000 deductible for Out-of-Network must be satisfied before the plan pays any covered charges.**

	Plan 1 – “Form No. COL-06-WA (Rev 08) (202364-1)” Co-Pay Plan		Plan 2 – “Form No. COL-06-WA (Rev 08) (202364-2)” High Deductible Plan (HDHP)	
	Preferred Provider	Out-of-Network	Preferred Provider	Out-of-Network
<b>Deductible</b> In Patient Covered Charges	\$250	\$500	\$2,000	\$4,000
1. Hospital Expense	80%/ \$1,500 max per day	60%/ \$1,500 max per day	80%	60%
2. Doctor’s Fee for subsequent Surgical Procedure performed at same operative sessions	50% of primary	50% of primary	80% of primary	60% of primary
3. Psychotherapy	\$25 per day / 3 days maximum	\$25 per day / 3 days maximum	80%	60%
4. Pre-Admission Testing	\$1,500 max	\$1,500 max	80%	60%
<b>Out-Patient Benefit Max</b>	80%	60%		
1. Day Surgery	\$1,500 max	\$1,500 max	80%	60%
2. Out Patient Miscellaneous	\$2,000 max	\$2,000 max		
3. Injections	\$1,500 max	\$1,500 max	80%	60%
4. Prescription Drugs (Per Policy Year)	\$600 max	No Benefits	80%/\$2,500 max	80%/\$2,500 max
5. Durable Medical Equipment	\$1,500 max	80% /\$1,500 max	80%	80%
6. Psychotherapy	\$1,500 max	\$1,500 max	80%	60%
7. Physiotherapy	\$50 per visit / 10 day maximum	\$50 per visit / 10 day maximum	80%	60%

This plan issued to PNWU is a one year non-renewable term policy. This policy is excess to any other insurance policy you may have. No benefit of this policy is payable for any expense incurred for Injury or Sickness which is paid or payable by other valid and collectible insurance. This excess provision will not be applied to the first \$100 of medical expenses incurred. Benefits are provided as mandated by the State of Washington.

## HOW TO APPLY

- 1) Turn to Page 9 for How To Apply Instructions (Rates are outlined on Page 10).
- 2) The enrollment form on Page 11 must be completed and signed.
- 3) Members who wish to pay monthly must complete the Monthly Automatic Pay Plan form on Page 12.

**We urge you to carefully review the insurance plans described in this booklet on Pages 4-6. If you have any questions or need any assistance, please call our experienced insurance administrator toll-free at 1-800-349-1039.**

**SCHEDULE OF BENEFITS SUMMARY FOR 2009-2010  
POLICY YEAR (Will Not Exceed Usual & Customary Charges)**

**Plan 1 - Co-Pay Plan (2009-202364-1)**

SICKNESS AND INJURY BENEFITS (all benefit maximums are combined Preferred Providers/Out-of-Network unless otherwise noted)	Preferred Provider	Out-of-Network
Aggregate Lifetime Maximum.....	No Lifetime Maximum	
Policy Year Aggregate Maximum Amount Per Sickness/Injury.....	\$100,000	
Deductible Per Insured Person (09/01/09 - 08/31/10).....	\$250 Policy Year	\$500 Policy Year
Coinsurance - Preferred Provider – 80% ; Out-of-Network - 60%.....	80%*	60%*
Maximum Out-of-Pocket (Does Not Include Deductible)..... After the Insured has incurred \$9,750 out-of-pocket, this plan pays for 100% of Preferred Allowance for Preferred Providers and 100% of Usual & Customary Charges for Out-of-Network Providers for covered medical expenses. Does not include per service copays or deductibles. Per service benefit maximums still apply.	\$9,750	\$9,750
<b>Covered Charges - Inpatient Benefits</b> 1. Room & Board /Hospital Miscellaneous - \$1,500 Aggregate max per day..... 2. Intensive Care..... 3. Routine Newborn Care ..... 4. Physiotherapy ..... 5. Surgery..... 6. Asst Surgeon (Secondary Assistant Surgeon Fees are paid at 50% of Primary)..... 7. Anesthetist..... 8. Registered Nurse's Services..... 9. Physician's Visits..... 10. Pre-admission Testing: - \$1,500 Maximum..... 11. Psychotherapy (as mandated by Washington).....	1. Preferred Allowance 2. Paid under R&B/ Hosp. Misc. 3. Paid as any other Sickness 4. Paid under R&B /Hosp. Misc. 5. Preferred Allowance 6. Preferred Allowance 7. 25% of Surgery Allowance 8. Preferred Allowance 9. Preferred Allowance 10. Preferred Allowance 11. Preferred Allowance \$25 per day/3 days max	1. Usual & Customary Charges 2. Paid under R&B/ Hosp. Misc. 3. Paid as any other Sickness 4. Paid under R&B /Hosp. Misc. 5. Usual & Customary Charges 6. Usual & Customary Charges 7. 25% of Surgery Allowance 8. Usual & Customary Charges 9. Usual & Customary Charges 10. Usual & Customary Charges 11. Usual & Customary Charges/ \$25 per day/3 days max
<b>Covered Charges - Outpatient Benefits</b> 1. Surgery..... 2. Day Surgery Miscellaneous - \$1,500 max..... 3. Assistant Surgeon (Secondary Assistant Surgeon Fees are paid at 50% of Primary)..... 4. Anesthetist..... 5. Physician's Visits ..... 6. Physiotherapy. - \$50 max per visit/10 visit max..... 7. Outpatient Miscellaneous Benefits - \$2,000 max..... 8. Medical Emergency..... 9. X-Rays & Laboratory..... 10. Radiation Therapy..... 11. Tests & Procedures..... 12. Injections. - \$1,500 max..... 13. Chemotherapy..... 14. Psychotherapy - \$1,500 max (as mandated by Washington)..... 15. Prescription Drugs (up to a \$600 maximum per policy year), (after a \$15 tier 1/\$25 tier 2 Copay per prescription/31 day supply)	1. Preferred Allowance 2. Preferred Allowance 3. Preferred Allowance 4. 25% of Surgery Allowance 5. Paid under Outpatient Misc./ \$25 copay per visit 6. Preferred Allowance 7. Preferred Allowance 8. Preferred Allowance 9. Paid under Outpatient Misc. 10. Paid under Outpatient Misc. 11. Paid under Outpatient Misc. 12. Preferred Allowance 13. Paid under Outpatient Misc. 14. Preferred Allowance 15. \$15 copay tier 1/\$25 tier 2 when utilizing the United Healthcare Network Pharmacy (UHPS)	1. Usual & Customary Charges 2. Usual & Customary Charges 3. Usual & Customary Charges 4. 25% of Surgery Allowance 5. Paid under Outpatient Misc./ \$25 deductible per visit 6. Usual & Customary Charges 7. Usual & Customary Charges 8. 80% of Usual & Customary Charges 9. Paid under Outpatient Misc. 10. Paid under Outpatient Misc. 11. Paid under Outpatient Misc. 12. Usual & Customary Charges 13. Paid under Outpatient Misc. 14. Usual & Customary Charges 15. No Benefits - Prescriptions Are only covered if filled at a Network Pharmacy
<b>Covered Charges - Other Benefits</b> 1. Ambulance - \$200 max..... 2. Durable Medical Equipment.- \$1,500 max..... 3. Dental (Benefits for injury to Sound Natural Teeth only) - \$500 max..... 4. Consultant..... 5. Needle Stick/Face Splash as a result of course work..... 6. Alcoholism./Chemical Dependency as mandated by Washington (\$14,500 max per any consecutive 24 months) 7. Maternity..... 8. Elective Abortion..... 9. Complications of Pregnancy..... 10. Repatriation..... 11. Medical Evacuation..... 12. AD&D..... 13. Intercollegiate Sports..... 14. Home Health Care..... 15. Cat Scan/MRI..... 16. Other Special Coverages - \$150 max Per Policy Year..... Wellness expense for the Insured and Dependents over the age of 18. Benefits include one examination/routine physical and one HIV/syphilis test each Policy Year, includes pre/post test counseling. For men, routine physical examination includes the office visit charge and a Gonorrhea/Chlamydia test, a hemoglobin and urine test. For women, examination includes the office visit charge, pap smear, gonorrhea, Chlamydia test, hemocult for women over the age of 50, a hemoglobin and urine test. (Not subject to the Policy Year deductible.)	1. Preferred Allowance 2. Preferred Allowance 3. 80% of Usual & Customary 4. Preferred Allowance 5. Paid as any other Injury or Sickness 6. Paid as any other Sickness 7. Paid as any other Sickness 8. No Benefits 9. Paid as any other Sickness 10. Benefits provided by Scholastic Emergency Services, Inc. 11. Benefits provided by Scholastic Emergency Services, Inc. 12. \$5,000 - \$10,000 max 13. No Benefits 14. Preferred Allowance 15. Outpatient Miscellaneous 16. Preferred Allowance	1. 80% of Usual & Customary Charges 2. 80% of Usual & Customary Charges 3. 80% of Usual & Customary 4. Usual & Customary Charges 5. Paid as any other Injury or Sickness 6. Paid as any other Sickness 7. Paid as any other Sickness 8. No Benefits 9. Paid as any other Sickness 10. Benefits provided by Scholastic Emergency Services, Inc. 11. Benefits provided by Scholastic Emergency Services, Inc. 12. \$5,000 - \$10,000 max 13. No Benefits 14. Usual & Customary Charges 15. Outpatient Miscellaneous 16. Usual & Customary Charges

\*Except as otherwise specified

**SCHEDULE OF BENEFITS SUMMARY FOR 2009-2010  
POLICY YEAR (Will Not Exceed Usual & Customary Charges)**

**Plan 2 - High Deductible Health Plan (HDHP)  
(2009-202364-2)**

SICKNESS AND INJURY BENEFITS	Preferred Provider	Out-of-Network
Aggregate Lifetime Maximum.....	No Lifetime maximum	
Policy Year Aggregate Maximum Amount Per Sickness/Injury.....	\$100,000	
Deductible Per Insured Person (09/01/ 09 - 08/31/10).....	\$2,000 Policy Year	\$4,000 Policy Year
Coinsurance.....	80%*	60%*
<b>Maximum Out-of-Pocket (Does Not Include Deductible).....</b> <b>After the Insured has incurred \$8,000 out-of-pocket expenses, this plan pays for 100%</b> <b>of Preferred Allowance for Preferred Providers and 80% of Usual &amp; Customary</b> <b>Charges for Out-of-Network Providers for covered medical expenses.</b>	\$8,000	\$8,000
<b>Covered Charges - Inpatient Benefits</b> 1. Room & Board /Hospital Miscellaneous..... 2. Intensive Care..... 3. Routine Newborn Care ..... 4. Physiotherapy ..... 5. Surgery..... 6. Assistant Surgeon (Secondary Assistant Surgeon Fees are paid at 50% of Primary)..... 7. Anesthetist..... 8. Registered Nurse..... 9. Physician's Visits..... 10. Pre-admission Testing..... 11. Psychotherapy (as mandated by Washington).....	1. Preferred Allowance 2. Paid under R&B/Hosp. Misc. 3. Paid as any other Sickness 4. Paid under R&B/Hosp. Misc . 5. Preferred Allowance 6. Preferred Allowance 7. 25% of Surgery Allowance 8. Preferred Allowance 9. Preferred Allowance 10. Preferred Allowance 11. Preferred Allowance	1. Usual & Customary Charges 2. Paid under R&B/Hosp. Misc. 3. Paid as any other Sickness 4. Paid under R&Bd/Hosp Misc . 5. Usual & Customary Charges 6. Usual & Customary Charges 7. 25% of Surgery Allowance 8. Usual & Customary Charges 9. Usual & Customary Charges 10. Usual & Customary Charges 11. Usual & Customary Charges
<b>Covered Charges - Outpatient Benefits</b> 1. Surgery..... 2. Day Surgery Miscellaneous..... 3. Assistant Surgeon (Secondary Assistant Surgeon Fees are paid at 50% of Primary)..... 4. Anesthetist..... 5. Physician's Visit ..... 6. Physiotherapy..... 7. Medical Emergency..... 8. X-Rays & Laboratory..... 9. Radiation Therapy..... 10. Tests & Procedures..... 11. Injections..... 12. Chemotherapy..... 13. Psychotherapy...(as mandated by Washington)..... 14. Prescription Drugs (up to a \$2,500 maximum Per Policy Year).....	1. Preferred Allowance 2. Preferred Allowance 3. Preferred Allowance 4. 25% of Surgery Allowance 5. Preferred Allowance 6. Preferred Allowance 7. Preferred Allowance 8. Preferred Allowance 9. Preferred Allowance 10. Preferred Allowance 11. Preferred Allowance 12. Preferred Allowance 13. Preferred Allowance 14. 80% of Usual & Customary Charges	1. Usual & Customary Charges 2. Usual & Customary Charges 3. Usual & Customary Charges 4. 25% of Surgery Allowance 5. Usual & Customary Charges 6. Usual & Customary Charges 7. 80% of Usual & Customary 8. Usual & Customary Charges 9. Usual & Customary Charges 10. Usual & Customary Charges 11. Usual & Customary Charges 12. Usual & Customary Charges 13. Usual & Customary Charges 14. 80% of Usual & Customary Charges
<b>Covered Charges - Other Benefits</b> 1. Ambulance..... 2. Durable Medical Equipment..... 3. Dental (Benefits for injury to Sound - Natural Teeth only)..... 4. Consultant..... 5. Needle Stick/Face Splash as a result of course work..... 6. Alcoholism/Chemical Dependency as mandated by Washington (\$14,500 max per any consecutive 24 month period) ..... 7. Maternity ..... 8. Elective Abortion..... 9. Complications of Pregnancy..... 10. Repatriation..... 11. Medical Evacuation..... 12. AD&D..... 13. Intercollegiate Sports..... 14. Home Health Care..... 15. CAT Scan/MRI..... 16. Wellness Benefit..... Wellness expense for the Insured and Dependents over the age of 18. Benefits include one examination/routine physical and one HIV/syphilis test each Policy Year, includes pre/ post test counseling. For men, routine physical examination includes the office visit charge, Gonorrhea/Chlamydia test, a hemoglobin and urine test. For women, examination includes the office visit charge, pap smear, Gonorrhea and Chlamydia test, hemocult for women over the age of 50, a hemoglobin and urine test.	1. Preferred Allowance 2. Preferred Allowance 3. 80% of Usual & Customary Charges 4. Preferred Allowance 5. Paid as any other Injury or Sickness 6. Paid as any other Sickness 7. Paid as any Other Sickness 8. No Benefits 9. Paid as any Other Sickness 10. Benefits provided by Scholastic Emergency Services, Inc. 11. Benefits Provided by Scholastic Emergency Services, Inc. 12. \$5,000-\$10,000 max 13. No Benefits 14. Preferred Allowance 15. Preferred Allowance 16. Preferred Allowance *Except as otherwise specified	1. 80% of Usual & Customary Charges 2. 80% of Usual & Customary Charges 3. 80% of Usual & Customary Charges 4. Usual & Customary Charges 5. Paid as any other Injury or Sickness 6. Paid as any other Sickness 7. Paid as any Other Sickness 8. No Benefits 9. Paid as any Other Sickness 10. Benefits provided by Scholastic Emergency Services, Inc. 11. Benefits Provided by Scholastic Emergency Services, Inc. 12. \$5,000-\$10,00 max 13. No Benefits 14. Usual & Customary Charges 15. Usual & Customary Charges 16. Usual & Customary Charges

## PRESCRIPTION DRUG CARD

### Plan 1 - Co-Pay Plan Only

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Network Pharmacy. Benefits are subject to supply limits (up to 31 days) and copayments that vary depending on which tier of the PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

You are responsible for paying the applicable copayments. Your copayment is determined by the tier to which the Prescription Drug is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access [www.uhcsr.com](http://www.uhcsr.com) or call 877-417-7345 or the customer service number on your ID card for the most up-to-date tier status.

\$15 copay per prescription order or refill for a **Tier 1** Prescription Drug  
\$25 copay per prescription order or refill for a **Tier 2** Prescription Drug  
Mail order prescription drugs are available at 2.5 times the retail copay up to a 90 day supply  
Your maximum allowed benefit is \$600 per policy year.

Please present your ID card to the network pharmacy when the prescription is filled. If you do not use a network pharmacy, you will be responsible for paying the full cost for the prescription.

If you do not present the card, you will need to pay the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or network pharmacies, please visit [www.uhcsr.com](http://www.uhcsr.com) and log in to your online account or call 877-417-7345 or the customer service number on your ID card.

#### **Additional Exclusions in addition to the policy Exclusions and Limitations, the following Exclusions apply:**

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-2).
4. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as required by state mandate.

## MEDICAL PLAN ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFIT

### **ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFIT**

Loss of Life/Dismemberment (two or more members).....	\$10,000
Loss of One Member *.....	\$5,000

\* Member means hand, arm, foot, leg or eye

**This brochure is not a contract of insurance. Terms and conditions of coverage and benefits are set forth in the Policy. These plans are underwritten by UnitedHealthcare Insurance Company (Medical), based on Policy Form COL-06-WA (REV 08) (202364-1) and COL-06-WA (REV 08) (202364-2)**

**Mass Marketing Insurance Consultants, Inc. specializes in developing and marketing insurance programs for members of professional and trade associations and is the health insurance broker and consultant on the Graduate Student Insurance Program.**

Only available to residents of Washington

## MEDICAL EXCLUSIONS

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:

1. Learning Disabilities;
2. Biofeedback;
3. Circumcision;
4. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children; removal of warts, non-malignant moles and lesions;
5. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
6. Elective Surgery or Elective Treatment;
7. Elective abortion;
8. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a disease process;
9. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
10. Hirsutism;
11. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury;
12. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
13. Injury sustained while (a) participating in any interscholastic, club, intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
14. Organ transplants, including organ donation;
15. \* Pre-existing Conditions for a 3 month period, except for individuals who have been insured under another similar health plan for at least 3 months immediately prior to becoming an Insured under this policy. Credit will be given for the period of time an Insured was covered under the immediately preceding health plan for periods less than the 3 month period;
16. Prescription Drugs, services or supplies as follows, except as specifically provided in the policy:
  - (a) Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Benefits for Diabetes;
  - (b) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;

- (c) Products used for cosmetic purposes;
  - (d) Drugs used to treat or cure baldness, anabolic steroids used for body building;
  - (e) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
  - (f) Growth hormones; or
  - (g) 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: family planning; fertility tests; infertility (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; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
  18. Routine Newborn Infant Care, well-baby nursery and related Physician charges except as specifically provided in the policy;
  19. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the Policy;
  20. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
  21. 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; nasal and sinus surgery;
  22. Sleep disorders;
  23. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
  24. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy;
  25. 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); and
  27. Weight management, weight reduction, nutrition programs/ treatment for obesity, surgery for removal of excess skin or fat, and treatment of eating disorders such as bulimia and anorexia.. Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.
- \* the time the Insured was covered under previous creditable coverage will be credited if previous coverage was continuous to a date not more than 63 days prior to the Insured's effective date of this coverage.

## HOW THE GRADUATE STUDENT HEALTH PLAN WORKS...

### **The Graduate Student Medical Insurance Plan is a Preferred Provider Organization (PPO) Managed Care Health Plan.**

A PPO provides incentives for members to receive care from network doctors, but also covers a percentage of costs if a patient goes outside the network. **The Managed Care Network for the Graduate Student Medical Insurance Plan is UnitedHealthcare Options PPO Network.** The doctors and other health care providers who belong to UnitedHealthcare Options PPO Network are called Preferred Providers. They include general practitioners and internists as well as specialists, hospitals, and other health care facilities. UnitedHealthcare Options PPO Network has Preferred Providers located locally as well as nationally.

**To find a Preferred Provider, you can use UnitedHealthcare Options PPO Network's online service at [www.myuhc.com](http://www.myuhc.com).** You can find out whether a specific provider belongs to UnitedHealthcare Options PPO or find Preferred Providers practicing in your area.

Using UnitedHealthcare Options PPO Network's Preferred Providers will save you money because Preferred Providers agree to accept negotiated fees that may be lower than what Non-Preferred Providers would charge. UnitedHealthcare Options Preferred Providers do not charge more than the negotiated fee for a given service. For Non-Preferred Providers, the Graduate Student Plan pays benefits for usual and customary charges only. If a Non-Preferred Provider charges more than the usual and customary charge allowance, you must pay the difference.

**PRE-EXISTING CONDITION** means 1) the existence of symptoms within the 3 months immediately prior to the Insured's Effective Date under the policy; or, 2) any condition which is diagnosed, treated or recommended for treatment within the 3 months immediately prior to the Insured's Effective Date under the policy.

#### **Arranged By:**

Mass Marketing Insurance Consultants, Inc.  
14616 John Humphrey Drive  
Orland Park, IL 60462  
1-800-349-1039

#### **Underwritten By:**

**Medical**  
UnitedHealthcare Insurance Company  
P.O. Box 809025  
Dallas, TX 75380-9025

## HOW TO APPLY

Enroll On-Line at [www.somainsurance.com](http://www.somainsurance.com)

Or

- 1) Complete and Sign the Enrollment form on Page 11. Applicants who choose the credit card or check -o-matic method of payment must also complete the Monthly Automatic Enrollment Form (Page 12).
- 2) Payment Options (Refer to Premiums On Page 10)

### Applicants Who Wish To Have Their Monthly Premiums Charged To Their Credit Card

- a) Complete the Enrollment Form (Page 11) and Monthly Automatic Enrollment Form (Page 12)
- b) Do not send any payment - premium will be charged to your MasterCard or VISA Credit Card

### Applicants Who Wish To Have Their Monthly Premiums Debited From a Checking Account

- a) Complete the Enrollment Form (Page 11) and Monthly Automatic Enrollment Form (Page 12)
- b) Send 2 checks; 1st check equal to the monthly payment payable to Mass Marketing Insurance Consultants, Inc. and the 2nd check marked "void" and unsigned.

Send enrollment form, check(s), and Monthly Automatic Pay Plan form (if applicable) to:  
Graduate Student Health Insurance Plan • P.O. Box 95 • Orland Park, IL 60462

## MOST FREQUENTLY ASKED QUESTIONS ABOUT THE GRADUATE STUDENT COLLEGE HEALTH INSURANCE PLAN

- 1) **Can I switch plans during the school year?**  
No - the plan you enroll in cannot be changed until September 1, 2010.
- 2) **Is there a pre-existing condition limitation under the Graduate Student Insurance program?**  
Yes. Pre-existing Conditions are not covered for the first 3 months following an Insured Person's effective Date of coverage. However, the time an Insured Person was covered under previous creditable coverage will be credited if previous coverage was continuous to a date not more than 63 days before the Effective Date of this coverage.  
A Pre -existing Condition means: 1) the existence of symptoms within the 3 months immediately prior to the Insured's effective date under the policy or 2) any condition which is diagnosed treated or recommended for treatment within the 3 months immediately prior to the Insured's effective date under the Policy. The pre-existing condition limitation does not apply to the dental/vision option.
- 3) **How do I get reimbursed for expenses?**  
**Medical** - You must complete a claim form and send it along with your medical bills to UnitedHealthcare Insurance Company. It is your responsibility to file a claim and provide written notice of your claim within 90 days from the date of any treatment. (UnitedHealthcare Insurance Company, P.O. Box 809025, Dallas, TX 75380-9025).
- 4) **Do I need to inform the insurance company in advance of any hospitalization?**  
No pre-certification is required but pre-admission notification is recommended prior to planned admissions or emergency admissions.
- 5) **When will my coverage become effective?**  
The effective date will be the 1st of the month if the enrollment form is received by the Administrator between the 1st and 15th of any month. If the postmark date of the enrollment form is between the 16<sup>th</sup> and 31st of any month, your effective date will be the first of the following month.

## PREMIUM RATES

### MONTHLY PREMIUM

	Medical Plan	
	Plan 1 Co-Pay Plan	Plan 2 High Deductible (HDHP)
<b>Student Only</b> Under Age 30 Age 30 & Over	(\$164) (\$195)	(\$98) (\$116)
<b>Spouse Only</b> Under Age 30 Age 30 & Over (Based on Student's Age)	(\$354) (\$426)	(\$198) (\$237)
<b>Child(ren)</b> Under Age 30 Age 30 & Over	(\$262) (\$262)	(\$159) (\$159)

### PAYMENT OPTIONS

#### Applicants Who Wish To Have Their Monthly Premiums Charged To Their Credit Card

- 1) Complete the Enrollment Form (Page 11) and Monthly Automatic Enrollment Form (Page 12)
- 2) Do not send any payment - premium will be charged to your MasterCard or VISA Credit Card
- 3) You may wish to enroll on line - [www.somainsurance.com](http://www.somainsurance.com)

#### Applicants Who Wish To Have Their Monthly Premiums Debited From a Checking Account

- 1) Complete the Enrollment Form (Page 11) and Monthly Automatic Enrollment Form (Page 12)
- 2) Send 2 checks; 1st check equal to the monthly payment payable to Mass Marketing Insurance Consultants, Inc. and the 2nd check marked "void" and unsigned.

**DIRECT BILL OPTION AVAILABLE – CALL 1-800-349-1039**

