Student Health Insurance

Benefits summary

Types of Coverage	Student Health Service/ Copayment Amounts	Network Benefits/Copayment	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.** If this Benefit Summary conflicts in any way with the Policy issued to the Enrolling Group, the Policy shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage. 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. Network Benefits are payable for Covered Health Services provided by or under the direction of your Network Physician.	**Annual Deductible:** No Annual Deductible. **Out-of-Pocket Maximum:** No Out-of-Pocket Maximum. **Annual Maximum Benefit:** The Maximum amount that we will pay for Benefits during the Policy Year. Combined Student Health Service, Network and non-Network: $250,000 per Covered Person. **Maximum Policy Benefit:** Combined Student Health Service, Network and non-Network $500,000 per Covered Person.	**Annual Deductible:** $400 per Covered Person per Policy Year, not to exceed $800 for all Covered Persons in a family. After you meet your deductible, the medical plan and you will share expenses. Your share is called coinsurance and is represented in a percentage amount. **Out-of-Pocket Maximum:** $4,000 per Covered Person per Policy Year, not to exceed $5,000 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. **Annual Maximum Benefit:** The Maximum amount that we will pay for Benefits during the Policy Year. Combined Student Health Service, Network and non-Network: $250,000 per Covered Person. **Maximum Policy Benefit:** Combined Student Health Service, Network and non-Network $500,000 per Covered Person.	**Annual Deductible:** $400 per Covered Person per Policy Year, not to exceed $800 for all Covered Persons in a family. After you meet your deductible, the medical plan and you will share expenses. Your share is called coinsurance and is represented in a percentage amount. **Out-of-Pocket Maximum:** $6,000 per Covered Person per Policy Year, not to exceed $8,000 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. **Annual Maximum Benefit:** The Maximum amount that we will pay for Benefits during the Policy Year. Combined Student Health Service, Network and non-Network: $250,000 per Covered Person. **Maximum Policy Benefit:** Combined Student Health Service, Network and non-Network $500,000 per Covered Person.
1. Ambulance Services Emergency only	Ground Transportation: Not Covered Air Transportation: Not Covered	Ground Transportation: 30% of Eligible Expenses[1] Air Transportation: 30% of Eligible Expenses[1]	Same as Network Benefit
2. Durable Medical Equipment (DME) Network and non-Network Benefits for DME are limited to $2,500 per Policy Year.	Covered at 100%	30% of Eligible Expenses[1]	40% of Eligible Expenses[1 2]
3. Emergency Health Services	Covered at 100%	$150 per visit	Same as Network Benefit Notification is required if results in an Inpatient Stay.
4. Eye Examinations Covered only at Student Health Service designated facility for one visit annually at a $20 Copayment.	Not Covered	Not Covered	Not Covered
5. Home Health Care Network and non-Network Benefits are limited to 60 visits for skilled care services per Policy Year.	Not Covered	30% of Eligible Expenses[1]	40% of Eligible Expenses[1 2]
6. Hospice Care	Not Covered	30% of Eligible Expenses[1]	40% of Eligible Expenses[1 2]

[1] After you've reached your deductible, coinsurance will apply. Coinsurance is the percentage amount.
[2] Prior Notification is required.

Benefits summary, continued

Types of Coverage	Student Health Service/ Copayment Amounts	Network Benefits/Copayment	Non-Network Benefits/ Copayment Amounts
7. Hospital - Inpatient Stay Services at UMH, UMHC, UMSCCC, ABLEH[3] will be covered at 90% of eligible expenses	Not Covered	30% of Eligible Expenses[1] 10% of Eligible Expenses[1]	40% of Eligible Expenses[1 2]
8. Maternity Services	Not Covered	Same as 7, 9, 10 and 11 Physician office visits for prenatal care covered at 100% after the first visit.	Same as 7, 9, 10 and 11[1] Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
9. Outpatient Surgery, Diagnostic and Therapeutic Services			
Outpatient Surgery Services at UMH, UMHC, UMSCCC, ABLEH[3] will be covered at 90% of eligible expenses.	Covered at 100%	30% of Eligible Expenses[1] 10% of Eligible Expenses[1]	40% of Eligible Expenses[1]
Outpatient Diagnostic Services	For lab and radiology/Xray: Covered at 100%	For lab and radiology/Xray: Covered at 100%	No Benefits for Preventive Care
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine Services at UMH, UMHC, UMSCCC, ABLEH[3] will be covered at 90% of eligible expenses.	Not Covered	30% of Eligible Expenses 10% of Eligible Expenses[1]	40% of Eligible Expenses[1]
Outpatient Therapeutic Treatments (dialysis, chemotherapy) Services at UMH, UMHC, UMSCCC, ABLEH[3] will be covered at 90% of eligible expenses.	Not Covered	30% of Eligible Expenses 10% of Eligible Expenses	40% of Eligible Expenses[1]
10. Physician's Office Services			
Preventive Care	Covered at 100%	$20 per Primary Care office visit $40 per Specialist office visit for services not available at the Student Health Service	40% of Eligible Expenses[1]
Sickness and Injury	Covered at 100%	$20 per Primary Care office visit $40 per Specialist office visit	40% of Eligible Expenses[1]
Injections Received in a Physician's Office when no other health service is received	Covered at 100%	$20 per visit	40% of Eligible Expenses[1]
11. Professional Fees for Surgical and Medical Services	Not Covered	30% of Eligible Expenses[1] 10% of Eligible Expenses[1] for services at UMH, UMHC, UMSCCC, ABLEH[3]	40% of Eligible Expenses[1]
12. Prosthetic Devices Network and non-Network Benefits for prosthetic devices are limited to $2,500 per Policy Year.	Not Covered	30% of Eligible Expenses[1]	40% of Eligible Expenses[1]

[1] After you've reached your deductible, coinsurance will apply. Coinsurance is the percentage amount.
[2] Prior Notification is required.
[3] UMH - University of Miami Hospital; UMHC - University of Miami Hospital & Clinics; UMSCCC - University of Miami Sylvester Comprehensive Cancer Center; ABLEH - Ann Bates Leach Eye Hospital.

Benefits summary, continued

Types of Coverage	Student Health Service/ Copayment Amounts	Network Benefits/Copayment	Non-Network Benefits/ Copayment Amounts
13. Reconstructive Procedures	Not Covered	Same as 7, 9, 10, 11 and 12[1]	Same as 7, 9, 10, 11 and 12[1]
14. Rehabilitation Services - Outpatient Therapy Network and non-Network Benefits are limited as follows: 15 visits of physical therapy; 15 visits of occupational therapy; 15 visits of speech therapy; 15 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per Policy Year. 15 additional visits will be covered for services necessary after surgery or IP hospitalization	Not Available	$20 per visit	40% of Eligible Expenses[1]
15. Skilled Nursing Facility/ Inpatient Rehabilitation Facility Services Network and non-Network Benefits are limited to 60 days per Policy Year.	Not Covered	30% of Eligible Expenses[1]	40% of Eligible Expenses[1 2]
16. Transplantation Services	Not Covered	30% of Eligible Expenses[1 2]	40% of Eligible Expenses[1 2]
17. Urgent Care Center Services	Not Covered	$50 per visit	40% of Eligible Expenses[1]
18. Elective Termination of Pregnancy	Not Covered	30% of Eligible Expenses[1] $500 max	40% of Eligible Expenses[1] $500 max
Additional Benefits			
Mental Health and Substance Abuse Services - Outpatient (Services provided by United Behavioral Health) Must receive prior authorization through the Mental Health/ Substance Abuse Designee for Network and non-Network Benefits.	Covered at 100% at the Student Health Services	$20 per visit[1]	40% of Eligible Expenses[1]
Mental Health and Substance Abuse Services - Inpatient and Intermediate (Services provided by United Behavioral Health) Must receive prior authorization through the Mental Health/ Substance Abuse Designee for Network and non-Network Benefits.	Not Covered	30% of Eligible Expenses[1]	40% of Eligible Expenses[1 2]
Spinal Treatment 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[1]

[1] After you've reached your deductible, coinsurance will apply. Coinsurance is the percentage amount.
[2] Prior Notification is required.

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. Non-injectable 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.

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. Testing and treatment for ADD and ADHD are not covered. Prescriptions for treatment of ADD and ADHD are covered under the prescription drug benefit.

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, body building, 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. Surgical breast reductions, augmentation, breast implants or breast prosthetic devices except as specifically provided in this policy.

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. NCAA sports exclusion
Injuries sustained while:

a. participating in any intercollegiate sport, contest, or competition,

b. traveling to or from such sport contest or competition as a participant,

c. while participating in any practice or conditioning program for such sport contest or competition.

Exclusions Continued

M. Pre-existing condition
Pre-existing conditions will apply for the first 6 months except for individuals who have been continuously insured under the school's insurance policy for at least 6 consecutive months. Credit will be given for the time the insured person was covered under a previous similar plan if the previous coverage was continuous to a date not more than 63 days prior to the insured person's effective date under this policy.

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

O. 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.

P. Transplants
Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1and 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.

Q. 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. 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.

R. 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.

S. 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 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.

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. 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; 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.

T. Preventive services
Preventive care services that are available at the Student Health Service will be excluded outside the Student Health Service.

U. Elective surgery
Complications resulting from complications of elective surgery are excluded.

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 60,000 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 myuhc.com. The online service offers the 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, Tier 3, or Tier 4. Please visit myuhc.com, or call the Customer Care number on your medical ID card to determine tier status.

Low cost generic medicines are available for a $4 copayment for a one month supply, or a $12 copayment for a three month supply at the Student Health Service Pharmacy only. More information is available at **miami.edu/student-health**.

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.

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.

	Student Health Service For up to a 31-day supply	**Retail Network Pharmacy** For up to a 31-day supply
Tier 1	$10	$20
Tier 2	$35	$45
Tier 3	$50	$65
Tier 4	$100	$100

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.

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.
- Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
- Drugs used to treat or cure baldness, anabolic steroids used for Body building, Anoretics-drugs used for the purpose of weight control.
- 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 except when dispensed at the Student Health Service Pharmacy.
- 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.