UnitedHealthcare
University of Miami 2021 - 2022
Student Health Insurance *Plan 160 Modified*

Utilizing the Choice Plus Network

Access to high-quality, affordable health care is vital to academic success. UnitedHealthcare helps keep you 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 Service first. There are no copayments for Clinical Services received at the Student Health Service, other 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 Service 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[SM] 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 at the Student

Health Service.

Prenatal care is covered.

Routine check-ups are covered at the

Student Health Service.

Childhood immunizations are covered.

Mammograms are covered.

Student Health Insurance *Benefits Summary*

Types of Coverage	Tier 1: Student Health Service/UMC/UMHC/UMSCCC/ ABLEH / 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.** 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. *Prior Notification is required.	**Annual Deductible:** $300 per Covered Person per Policy Year. **Out-of-Pocket Maximum: :** $5,500 per Covered Person per Policy Year. The Out-of-Pocket Maximum does include the Annual Deductible, Copayments and Coinsurance. Prescription drug costs are also included in the Out-of –Pocket Maximum. **Annual Maximum Benefit:** Unlimited **Maximum Policy Benefit:** Unlimited	**Annual Deductible:** $300 per Covered Person per Policy Year. **Out-of-Pocket Maximum:** $5,500 per Covered Person per Policy Year. The Out-of-Pocket Maximum does include the Annual Deductible, Copayments and Coinsurance. Prescription drug costs are also included in the Out-of –Pocket Maximum. **Annual Maximum Benefit:** Unlimited **Maximum Policy Benefit:** Unlimited	**Annual Deductible:** $750 per Covered Person per Policy Year.. **Out-of-Pocket Maximum:** $6,000 per Covered Person per Policy Year. The Out-of-Pocket Maximum does include the Annual Deductible, Copayments and coinsurance. Prescription drug costs are also included in the Out-of –Pocket Maximum. **Annual Maximum Benefit:** Unlimited **Maximum Policy Benefit:** Unlimited
1. Ambulance Services - Emergency only	Ground Transportation: 10% of Eligible Expenses Air Transportation: 10% of Eligible Expenses	Ground Transportation: 30% of Eligible Expenses Air Transportation: 30% of Eligible Expenses	Same as Network Benefit
2. Durable Medical Equipment	Covered at 100% at SHS	30% of Eligible Expenses	*40% of Eligible Expenses *Prior notification is required when the cost is more than $1,000.
3. Emergency Health Services	$200 per visit	$200 per visit	Same as Network Benefit *Notification is required if results in an Inpatient Stay.
4. Eye Examinations For Student Health Center Benefits, eye exams are limited to one routine vision exam, including refraction, every Policy Year.	$20 per visit at SHS	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.	10% of Eligible Expenses	30% of Eligible Expenses	*40% of Eligible Expenses
6. Hospice Care	10% of Eligible Expenses	30% of Eligible Expenses	*40% of Eligible Expenses
7. Hospital - Inpatient Stay	10% of Eligible Expenses	30% of Eligible Expenses	*40% of Eligible Expenses
8. Maternity Services	Same as 7, 9, 10 and 11 No Copay, applies to Physician Office visits for prenatal care after the first visit.	Same as 7, 9, 10 and 11 No Copay, applies to Physician Office visits for prenatal care after the first visit.	Same as 7, 9, 10 and 11
9. Outpatient Surgery, Diagnostic and Therapeutic Services			
Outpatient Surgery	10% of Eligible Expenses	30% of Eligible Expenses	40% of Eligible Expenses
Outpatient Diagnostic Services	For lab and radiology/Xray: No Copayment	No Copayment	No Benefits for Preventive Care No Benefits for Preventive Care
Outpatient Diagnostic/Therapeutic Services -CT Scans, Pet Scans, MRI and Nuclear Medicine	10% of Eligible Expenses	30% of Eligible Expenses	40% of Eligible Expenses
Outpatient Therapeutic Treatments	10% of Eligible Expenses	30% of Eligible Expenses	40% of Eligible Expenses
10. Physician's Office Services -Preventive Care	Covered at 100% at SHS	Covered at 100%	40% of Eligible Expenses
-Sickness and Injury	Covered at 100% at SHS	$40 per visit/$40 per visit specialist	40% of Eligible Expenses
-Injections Received in a Physician's Office when no other health service is received.	Covered at 100% at SHS	$40 per visit	40% of Eligible Expenses

Types of Coverage	Tier 1: Student Health Service/UMC/UMHC/UMSCCC/ ABLEH / Copayment Amounts	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
11. Professional Fees for Surgical and Medical Services	10% of Eligible Expenses	30% of Eligible Expenses	40% of Eligible Expenses
12. Prosthetic Devices	10% of Eligible Expenses	30% of Eligible Expenses	40% of Eligible Expenses
13. Reconstructive Procedures	Same as 7, 9, 10, 11 and 12	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: 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. Benefits for Habilitative Services are subject to the limits as stated in the benefits section.	$20 per visit	$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.	10% of Eligible Expenses	30% of Eligible Expenses	*40% of Eligible Expenses
16. Transplantation Services	10% of Eligible Expenses	*30% of Eligible Expenses	*40% of Eligible Expenses
17. Urgent Care Center Services	$50 per visit	$50 per visit	40% of Eligible Expenses
18. Elective Termination of Pregnancy	10% of Eligible Expenses $500 max	30% of Eligible Expenses $500 max	40% of Eligible Expenses $500 max

Additional Benefits

Bones or Joints of the Jaw and Facial Region	Same as 7, 9, 10 and 11	Same as 7, 9, 10 and 11	Same as 7, 9, 10 and 11
Child Health Supervision Services Coverage from birth to age 16.	Same as 9, 10, 11 and 14 No Annual Deductible applies.	Same as 9, 10, 11 and 14 No Annual deductible applies.	Same as 9, 10, 11 and 14 No Annual Deductible applies.
Cleft Lip and Cleft Palate Treatment	Same as 7, 9, 10, 11 and 14	Same as 7, 9, 10, 11 and 14	Same as 7, 9, 10, 11 and 14
Dental Services - Anesthesia and Hospitalization	Same as 7, 9 and 11	Same as 7, 9 and 11	Same as 7, 9 and 11
Diabetes Treatment	Same as 2, 9, 10 and 11	Same as 2, 9, 10 and 11	Same as 2, 9, 10 and 11
Enteral Formulas	10% of Eligible Expenses	30% of Eligible Expenses	40% of Eligible Expenses
Mastectomy	Same as 7, 9, 10 and 11	Same as 7, 9, 10 and 11	Same as 7, 9, 10 and 11
Mental Health and Substance Abuse Services - Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee.	$20 per visit	$20 per visit	40% of Eligible Expenses
Mental Health and Substance Abuse Services - Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee for Network and non-Network Benefits.	10% of Eligible Expenses	30% of Eligible Expenses	*40% of Eligible Expenses
Osteoporosis Treatment	Same as 9, 10 and 11	Same as 9, 10 and 11	Same as 9, 10 and 11
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.	$20 per visit	$20 per visit	40% of Eligible Expenses

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, this exclusion does not apply to Cleft Lip/Cleft Palate as described in Section 2 of the COC and this exclusion does not apply to dental care as described in Bones or Joints of the Jaw and Facial Region and Dental Services - Anesthesia and Hospitalization as described in Section 2 of the COC, 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. This exclusion does not apply to Cleft Lip/Cleft Palate Treatment as described in Section 2 of the COC.

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, except bone marrow transplants and medically appropriate medications prescribed for the treatment of cancer, for a particular indication, if that drug is recognized for the treatment of that indication in a standard reference compendium or recommended in the medical literature. 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.

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. This exclusion does not apply to Enteral Formulas as decribed in Section 2 of the COC.

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.

M. Services Provided under Another Plan

Health services for which coverage is paid under arrangements required by federal, state or local law. This includes, but is not limited to, coverage paid by workers' compensation, no-fault automobile insurance or similar legislation. 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. 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 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; 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.

S. 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 partipating in any practice or conditioning program for such sport contest or competition.