Health care coverage that earns really high marks

United Healthcare
Thanks for considering UnitedHealthcare

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

Large national network
Our network is one of the largest in the nation, with 900,000+ doctors and 5,500+ hospitals. So, chances are your regular doctor already participates with us. It also means that wherever you are in the country, you’ll be able to find a network hospital and get the same benefit coverage level you find at home.

Benefit coverage wherever you travel
- 900,000+ physicians and health care professionals
- 5,500+ hospitals
- Large national pharmacy network
- 123,000+ counseling and mental health practitioners

Eligibility
All domestic students who are actively enrolled in 6 or more credit hours per semester, or considered full time (in a program requiring documentation of health insurance coverage; exceptions listed at miami.edu/student-health), must purchase the student insurance unless they show proof of comparable coverage. All international students, regardless of credit load, are required to be insured under the plan.

Medical students must be actively enrolled or on an authorized leave of absence to qualify for coverage under the policy. UnitedHealthcare maintains its right to investigate student status and attendance requirements have been met. If and whenever UnitedHealthcare discovers that the policy eligibility requirements have not been met, it may discontinue coverage and its only obligation is refund of premium.

Eligible medical students who do enroll also may insure their dependents at the time the student is first able to enroll in the plan (within 14 days of the start of the semester), except for a change in dependent status due to a life event. Eligible dependents are the spouse and children. Dependent eligibility expires concurrently with that of the insured medical student.

Effective and termination dates
Medical student coverage is as follows:

| Class of 2024 (MS2) NextGen All Tracks | June 28, 2021–June 30, 2022 |
| Class of 2025 (MS1) NextGen MD/MBA | July 12, 2021–June 30, 2022 |
| Class of 2025 (MS1) NextGen MD/MPH | June 28, 2021–June 30, 2022 |
| Class of 2025 (MS1) NextGen MD All Others | July 12, 2021–June 30, 2022 |
| MS 3-4 All Students | July 1, 2021–June 30, 2022 |

Coverage becomes effective on the first day of the period for which the premium is paid. Coverage terminates on that date or at the end of the period through which the premium is paid, whichever is earlier.

The Counseling Center
The Counseling Center offers a variety of services to students, including short-term psychotherapy, individual and group counseling, career and educational counseling and assessment services to assist students in their educational and career decisions. For appointments and more information, please call 305-284-5511.

How to enroll dependents
For questions about enrolling dependents of students, please contact Academic Health Plans (AHP) at 855-844-3001 or visit miami.myahpcare.com.
Information on automatic charge of insurance premium for medical students and waiver of insurance fee is available at miami.edu/student-health.

<table>
<thead>
<tr>
<th>Quick care options</th>
<th>Needs or symptoms</th>
<th>Freestanding ERs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Virtual Visits</strong></td>
<td>• Cold</td>
<td>Many people have been surprised by their bill after visiting a freestanding emergency room (FSER). FSERs, sometimes referred to as urgent centers, bill at ER rates (or higher) and can be $1,500 more than an urgent care center. Neither located in nor attached to a hospital, FSERs are able to treat similar conditions as an ER, but do not have an ER’s ability to admit patients.</td>
</tr>
<tr>
<td>Anywhere, anytime online doctor visits</td>
<td>• Flu</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Fever</td>
<td><strong>Ask before you enter:</strong></td>
</tr>
<tr>
<td></td>
<td>• Pink eye</td>
<td>• Is this an urgent care center or an ER?</td>
</tr>
<tr>
<td></td>
<td>• Sinus problems</td>
<td>• Is this facility a network provider?</td>
</tr>
<tr>
<td><strong>Convenience Care Clinic</strong></td>
<td>• Skin rash</td>
<td></td>
</tr>
<tr>
<td>Treatment that's nearby</td>
<td>• Flu shot</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Minor injuries</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Earache</td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care Center</strong></td>
<td>• Low back pain</td>
<td></td>
</tr>
<tr>
<td>Quicker after-hours care</td>
<td>• Respiratory (cough, pneumonia, asthma)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stomach (pain, vomiting, diarrhea)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Infections (skin, eye, ear/nose/throat, genital-urinary)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Minor injuries (burns, stitches, sprains, small fractures)</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Room (ER)</strong></td>
<td>• Chest pain</td>
<td></td>
</tr>
<tr>
<td>For serious immediate needs</td>
<td>• Shortness of breath</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Severe asthma attack</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Major burns</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Severe injuries</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Kidney stones</td>
<td></td>
</tr>
</tbody>
</table>
Summary of benefits – Medical student health plan

With this plan, you will receive the highest level of benefits when you seek care at UHealth facilities or with a network physician, facility or other health care professional.

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

Student Health Service

This benefit plan is designed to be used in conjunction with the services of the Student Health Service. To obtain the greatest level of benefits, you will need to use the services of the Student Health Service first, where treatment will be administered or a referral issued. Appointments are available at MyUHealthChart.com. However, in the case of a medical emergency, maternity, when away from campus or when the Student Health Service is closed, you can seek care directly from any doctor in the UnitedHealthcare network.

<table>
<thead>
<tr>
<th>Medical students</th>
<th>Total annual rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class of 2024 (MS2) Next Gen all tracks</td>
<td>$3,930</td>
</tr>
<tr>
<td>Class of 2025 (MS1) Next Gen MD/MPH Students</td>
<td>$3,930</td>
</tr>
<tr>
<td>Class of 2025 (MS1) Next Gen MD/MBA</td>
<td>$3,930</td>
</tr>
<tr>
<td>Class of 2025 (MS1) Next Gen MD all others</td>
<td>$3,930</td>
</tr>
<tr>
<td>MS 3-4 All Students</td>
<td>$3,930</td>
</tr>
<tr>
<td>Med Student on LOA</td>
<td>$4,052</td>
</tr>
<tr>
<td>Spouse</td>
<td>$4,052</td>
</tr>
<tr>
<td>Each Child</td>
<td>$4,052</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student coverage period</th>
<th>Effective date</th>
<th>Expiration date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class of 2024 (MS2) Next Gen all tracks</td>
<td>June 28, 2021</td>
<td>June 30, 2022</td>
</tr>
<tr>
<td>Class of 2025 (MS1) Next Gen MD/MPH Students</td>
<td>July 12, 2021</td>
<td>June 30, 2022</td>
</tr>
<tr>
<td>Class of 2025 (MS1) Next Gen MD/MBA</td>
<td>July 28, 2021</td>
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<td>June 30, 2022</td>
</tr>
<tr>
<td>MS 3-4 All Students</td>
<td>July 01, 2021</td>
<td>June 30, 2022</td>
</tr>
</tbody>
</table>

Get the most out of your benefits by registering for myuhc.com

When it comes to managing your health plan and making more informed decisions, simpler is better. With myuhc.com*, you have a personalized website that helps you access and manage your health plan. Use it to:

- Set up your account today
- Find and estimate costs for the network care you need
- See what’s covered and get information about preventive care
- View claim details and account balances
- Sign up for paperless delivery of your required plan communications

*myuhc.com is a personalized website.
Set up your account today

1. Go to myuhc.com
2. Click on Register now. You'll need your health plan ID card.
3. Follow the step-by-step instructions

Support to help you reach your wellness goals

Rally can help you get healthier, one small step at a time. Rally is designed to help you make changes to your daily routine, set smart goals and track your progress. You'll get personalized recommendations to help you move more, eat better and improve your health—and have fun doing it.

On Rally, you can take the Health Survey and instantly get your Rally Age—measure of your “health age”—to help assess your overall health.

Then, pick Missions to help you get your health on track. You can store your health history, connect with online communities and compete in fun challenges. Earn coins as you track and complete each mission, and then use them for a chance to win great prizes.

Sign up for Rally on myuhc.com.

What’s what (a short glossary of terms)

Copayment – A fixed dollar amount you pay when you receive certain types of network care.

Annual deductible – The amount you must pay before your medical plan pays.

Coinsurance – After you meet your deductible, the medical plan pays a percentage of the covered cost of some services and you pay the rest. Your share is called coinsurance.

Out-of-pocket limit – You share expenses until you reach a yearly limit on how much you have to pay.

Network vs. out-of-network – Network means you receive care from a doctor, specialist, hospital or other provider or facility that participates in a medical plan’s network. Out-of-network means you receive care from a provider who is not in the network. Your deductible, coinsurance limit and out-of-pocket costs are higher for out-of-network care.

Eligible expenses – The amount we will pay for covered health care services, incurred while the policy is in effect, are determined as stated below.

For network and Student Health Services benefits, eligible expenses are based on either of the following:

• When covered health services are received from network providers, eligible expenses are our contracted fee(s) with that provider
• When covered health services are received from out-of-network providers as a result of an emergency or as otherwise arranged by us, eligible expenses are billed charges unless a lower amount is negotiated

Other myuhc.com features:

• Print a temporary health plan ID card and request a permanent health plan ID card
• Find the cost of many different medical services in your area by using Find Care & Costs

Use UnitedHealthcare® app wherever you are

• Our UnitedHealthcare app provides instant access to critical health information — anytime, anywhere. Whether you want to find a physician near you or check the status of a claim, the UnitedHealthcare app is your go-to resource.

Important

When searching for a provider on myuhc.com, please select Find a Doctor. The name of your UnitedHealthcare plan is “Choice Plus.”
For out-of-network benefits, eligible expenses are based on the following applicable criteria, to the extent available, and in the order of priority as identified below:

1. Fee(s) we are able to negotiate with the provider, such as the Shared Savings Program
2. 100% of the published rates allowed by Medicare for the same or similar service
3. 50% of the billed charge

**Medical Student Health Plan**

**Utilizing the UnitedHealthcare network**

Access to affordable health care is vital to academic success. UnitedHealthcare helps keep you and your family healthier with extensive medical coverage options, including preventive care and emergency services. It is easier to get care and maintain your health with a Student Health Plan.

The UnitedHealthcare network gives you the freedom to see any physician or other health care professional from our network, including specialists. In order to make the most of your benefits, you should visit the Student Health Service or UHealth facilities. There are no copayments for services received at the Student Health Service. You will receive the highest level of benefits when you seek care at the Student Health Service or when referred to 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. However, you should know that care received from an out-of-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. The amount you are required to pay, which could be significant, does not apply to the out-of-pocket limit. We recommend that you ask out-of-network physicians or health care professionals for information about their billed charges before you receive care.

**Important benefits of your plan**

You have access to a network of physicians, facilities and other health care professionals, including specialists. Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care coordination services are available to help identify and prevent delays in care for those who might need specialized help. For out-of-network benefits, eligible expenses are based on the following applicable criteria, to the extent available, and in the order of priority as identified below:

- Emergencies are covered anywhere in the world
- Prenatal care is covered
- Routine checkups are covered. No student cost-share.
- Mammograms are covered
- Your plan utilizes the Choice Plus network. When searching for a provider on myuhc.com, please select **Find a Doctor**.

The name of your UnitedHealthcare plan is “Choice Plus.”
## Student Health Insurance

### Benefit Summary

<table>
<thead>
<tr>
<th>Types of coverage</th>
<th>Student Health Service*/ Copayment amounts</th>
<th>Network Benefits/ Copayment</th>
<th>Out-of-Network Benefits/ Copayment amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*Services only provided for student, not dependents</td>
<td>Annual Deductible: No Annual Deductible</td>
<td>Annual Deductible: $750 per Covered Person per Policy Year. 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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-Pocket Limit: No Out-of-Pocket Limit</td>
<td>Out-of-Pocket Limit: $8,000 per Covered Person per Policy Year. The Out-of-Pocket Limit does include the Annual Deductible, Copayments and Coinsurance. Prescription drug costs are also included in the Out-of-Pocket Limit.</td>
</tr>
</tbody>
</table>

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 COC.

Benefits are subject to day, visit and/or dollar limits. Such limits apply to the combined use of Benefits whether Network or Out-of-Network, except where mandated by state law.

Network benefits are payable for Covered Health Care Services provided by or under the direction of your Network physician.

1. **Ambulance Services**
   - Ground transportation: Not covered
   - Air transportation: Not covered

2. **Durable Medical Equipment (DME)**
   - Covered at 100% at Student Health Service

3. **Emergency Health Services**
   - Covered at 100%

4. **Eye Examinations**
   - Covered only at Student Health Service-designated facility for 1 visit annually at a $20 Copayment. For more information, call Student Health Service at 305-284-8100.

5. **Home Health Care**
   - Not covered

6. **Hospice Care**
   - Not covered

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continued
<table>
<thead>
<tr>
<th>Types of Coverage</th>
<th>Student Health Service*/ Copayment amounts</th>
<th>Network Benefits/ Copayment</th>
<th>Out-of-Network Benefits/ Copayment amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Hospital – Inpatient Stay</td>
<td>Not covered</td>
<td>30% of Eligible Expenses¹</td>
<td>40% of Eligible Expenses² * Services only provided for student, not dependents</td>
</tr>
<tr>
<td>8. Maternity Services</td>
<td>Not covered</td>
<td>Same as 7, 9, 10, 11 and 12.¹ Maternity not available at UHealth and therefore 10% of Eligible Expenses benefit not available. Physician office visits for prenatal care covered at 100% after the first visit.</td>
<td>Same as 7, 9, 10, 11 and 12.¹ Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section delivery.</td>
</tr>
<tr>
<td>9. Outpatient Surgery, Diagnostic and Therapeutic Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Diagnostic Services</td>
<td>For lab and radiology/X-ray: covered at 100%</td>
<td>For lab and radiology/X-ray: Covered at 100%</td>
<td>No Benefits for Preventive Care</td>
</tr>
<tr>
<td>Outpatient Diagnostic/ Therapeutic Services + CT Scans, Pet Scans, MRI and Nuclear Medicine</td>
<td>Not covered</td>
<td>30% of Eligible Expenses¹</td>
<td>40% of Eligible Expenses¹</td>
</tr>
<tr>
<td>Outpatient Therapeutic Treatments (Dialysis, Chemotherapy)</td>
<td>Not covered</td>
<td>30% of Eligible Expenses¹</td>
<td>40% of Eligible Expenses¹</td>
</tr>
<tr>
<td>10. Physician’s Office Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
<td>40% of Eligible Expenses¹</td>
</tr>
<tr>
<td>Sickness and Injury</td>
<td>Covered at 100%</td>
<td>$40 per Primary Care office visit</td>
<td>40% of Eligible Expenses¹</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$40 per Specialist office visit</td>
<td></td>
</tr>
<tr>
<td>Injections Received in a Physician’s Office When No Other Health Service Is Received</td>
<td>Covered at 100%</td>
<td>$40 per visit</td>
<td>40% of Eligible Expenses¹</td>
</tr>
<tr>
<td>11. Professional Fees for Surgical and Medical Services</td>
<td>Not covered</td>
<td>30% of Eligible Expenses¹</td>
<td>Same as 7, 9, 10, 11 and 12¹</td>
</tr>
<tr>
<td>12. Reconstructive Procedures</td>
<td>Not covered</td>
<td>Same as 7, 9, 10, 11 and 12¹</td>
<td>Same as 7, 9, 10, 11 and 12¹</td>
</tr>
<tr>
<td>13. Rehabilitation Services – Outpatient Therapy</td>
<td>Not covered</td>
<td>$20 per visit</td>
<td>40% of Eligible Expenses¹</td>
</tr>
<tr>
<td>Network and Out-of-Network Benefits are limited as follows:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 visits of physical therapy,</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>15 visits of occupational therapy,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 visits of speech therapy,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 visits of pulmonary rehabilitation and 36 visits of cardiac rehabilitation per Policy Year. Fifteen additional visits will be covered for services necessary after surgery or inpatient hospitalization.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Skilled Nursing Facility/ Inpatient Rehabilitation Facility Services</td>
<td>Not covered</td>
<td>30% of Eligible Expenses¹</td>
<td>40% of Eligible Expenses¹²</td>
</tr>
<tr>
<td>Network and Out-of-Network Benefits are limited to 60 days per Policy Year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Transplantation Services</td>
<td>Not covered</td>
<td>30% of Eligible Expenses¹</td>
<td>40% of Eligible Expenses¹²</td>
</tr>
<tr>
<td>Types of coverage</td>
<td>Student Health Service*/Copayment amounts</td>
<td>Network Benefits/Copayment</td>
<td>Out-of-Network Benefits/Copayment amounts</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>------------------------------------------</td>
<td>---------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>16. Urgent Care Center Services</td>
<td>Not covered</td>
<td>$50 per visit</td>
<td>40% of Eligible Expenses¹</td>
</tr>
<tr>
<td>17. Elective Termination of Pregnancy</td>
<td>Not covered</td>
<td>30% of Eligible Expenses¹</td>
<td>40% of Eligible Expenses¹</td>
</tr>
<tr>
<td>18. Virtual Visits</td>
<td>Telehealth Visits are available through Student Health Service. Covered at 100%</td>
<td>No Copayment</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Additional Benefits**

<table>
<thead>
<tr>
<th>Mental Health and Substance Disorder Services – Outpatient (Services Provided by United Behavioral Health)</th>
<th>Not covered</th>
<th>$20 per visit</th>
<th>40% of Eligible Expenses¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health and Substance Disorder Not Covered Services – Inpatient and Intermediate (Services provided by United Behavioral Health)</strong></td>
<td>Not covered</td>
<td>30% of Eligible Expenses¹</td>
<td>40% of Eligible Expenses¹</td>
</tr>
<tr>
<td><strong>Spinal Treatment</strong></td>
<td>Not available</td>
<td>$20 per visit</td>
<td>40% of Eligible Expenses¹</td>
</tr>
<tr>
<td>Benefits include diagnosis and related services, and are limited to 1 visit and treatment per day. Network and Out-of-Network Benefits are limited to 24 visits per Policy Year.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pediatric Vision Services (Benefits covered up to age 19)</th>
<th>Not covered</th>
<th>Please refer to your COC for specific coverage information.</th>
<th>Please refer to your COC for specific coverage information.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Dental Services (Benefits covered up to age 19)</td>
<td>Not covered</td>
<td>Please refer to your COC for specific coverage information.</td>
<td>Please refer to your COC for specific coverage information.</td>
</tr>
<tr>
<td>Transgender Services (hormone therapy, gender confirmation surgery and psychological support)</td>
<td>Covered; Please refer to your COC for specific coverage information.</td>
<td>Please refer to your COC for specific coverage information.</td>
<td>Please refer to your COC for specific coverage information.</td>
</tr>
</tbody>
</table>
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; hypnotherapy; massage therapy; aromatherapy; 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 devices or computers to assist in communication and speech.

C. Dental (For Pediatric Dental, see section S below)
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 supernumerary 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. Non-prescription medications: Non-prescription 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 pharmaceutical 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; hygiene 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 to prevent or protect against accidents 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, bandages, gauze and dressings; ostomy supplies, syringes and diabetic test strips. Orthotic appliances that straighten or reshape a body part (including cranial bandaging and some types of braces). Tubing and masks are not covered except when used with a Durable Medical Equipment as described in Section 1 and 2 of the COC.

H. Mental Health/Substance Disorder Services
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, neurologically-based disorders, and other disorders with a known physiological 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 Disorder Services Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha Acetylmethadol), Naltrexone 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. Enreal feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical appearance
Cosmetic Procedures including, but not limited to, pharmaceutical 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 freestanding 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 care 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 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 care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health care services while on active military duty.

N. Transplants
Health care services for organ or tissue transplants are excluded, except those specified as covered in Section 1 and 2 of the COC. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health care 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. This exclusion does not apply to Covered Students participating in a school-sponsored program outside of the United States. Benefits are provided to these Covered Students and their Enrolled Dependents for Covered Health Services as Out-of-Network Benefits, except for Emergency Health Services, which are provided as Network Benefits.

- 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 (For Pediatric Vision, see section T below)
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, eyeglasses 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.

continued
Q. Other exclusions
Health care services and supplies that do not meet the definition of a Covered Health Service see definition in Section 10 of the COG.

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 (including NCAA sports activities), 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 care 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 care 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 an Out-of-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.

Changes 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. Florida statutes require coverage for orthognathic surgery related to congenital and developmental deformities as well as conditions due to injury or condition.

Surgical treatment and nonsurgical treatment of obesity (including morbid obesity).

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

Growth hormone therapy; 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.

R. Elective Surgery
Complications resulting from complications of elective surgery are excluded.

S. Pediatric Dental Services
Benefits are not provided under Pediatric Dental Services for the following: Any Dental Service or Procedure not listed as a Covered Pediatric Dental Service. Dental Services that are not Necessary. Hospitalization or other facility charges. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.) Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental condition. Injury or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body. Any Dental Procedure not directly associated with dental condition. Any Dental Procedure not performed in a dental setting. Procedures that are considered to be Experimental or Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or 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 or Investigational or Unproven in the treatment of that particular condition. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit. Setting of facial bone fractures and any treatment associated with the dislocation of facial skeletal hard tissue. Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper- and lower-jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours’ notice. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through the Rider to the Policy. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person’s family, including spouse, brother, sister, parent or child. Foreign Services are not covered unless required as an Emergency. Fixed or removable prosthetic restoration procedures for complete oral rehabilitation or reconstruction. Procedures related to the reconstruction of a patient’s correct vertical dimension of occlusion (VDO). Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesi. Orthodontic coverage does not include the installation of a space maintainer; any treatment related to treatment of the temporomandibular joint. Any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the Plan.

T. Pediatric Vision Services
Benefits are not provided under Pediatric Vision Services for the following: Medical or surgical treatment for an eye condition that requires the services of a Physician and for which Benefits are available as stated in the COG. Non-prescription items (e.g., plano lenses). Replacement or repair of lenses and/or frames that have been lost or broken. Optional Lens Extras not listed in Vision Care Services. Missed appointment charges. Applicable sales tax charged on Vision Care Services.
Pharmacy management program
Plan 060

This UnitedHealthcare plan includes pharmacy services with choice, accessibility and value. While most pharmacies participate in our network, you should check before filling. Call your pharmacist, or visit myuhc.com to find locations of network retail neighborhood pharmacies by ZIP code.

Prescription order or refill and copayments

All covered prescription drug products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. Please visit myuhc.com, or call the number on your health plan ID card to find tier placement.

For a single copayment, you may get up to the covered supply amount. Some products are subject to supply limits.

Some prescriptions require prior authorization. This means your doctor will have to give us more information about why the drug is right for you before we will cover it.

Due to health care reform law, many contraceptives are covered 100%. Refer to myuhc.com for a more complete list.

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<tr>
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<th>On-campus Walgreens</th>
<th>Retail network pharmacy</th>
<th>Home delivery</th>
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Other important cost-sharing information

NOTE: If you purchase a Prescription Drug Product from an out-of-network pharmacy, you will have to pay the difference between the out-of-network and network price. This could be higher than your normal copay.
Pharmacy benefit exclusions

Exclusions from coverage are listed in the Certificate of the Rider. They include, but are not limited to:

- 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 unapproved.
- 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
- Fertility agents or sexual enhancement drugs, such as Parlodel®, Clomid, Profasi®, Serophene® or Viagra®
- Drugs used to treat or cure baldness, anabolic steroids used for body-building or anorectics-drugs used for the purpose of weight control
- Durable Medical Equipment (DME). 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
- 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 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 1 ingredient that requires a Prescription Order or Refill. Compounded drugs that contain at least 1 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)
Special help for chronic conditions

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

Privacy policy

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

Coverage while away from home

UnitedHealthcare contracts with 900,000+ doctors and 5,500+ hospitals nationwide. So, when you are traveling or visiting areas outside Miami, it is possible you will be in another UnitedHealthcare contracted network. As a result, if you need to access care while outside of Miami, you can call the toll-free number on your health plan ID card, or you can search our online provider directory at myuhc.com to identify network doctors or other health care professionals in the area you are visiting.

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

Global emergency medical assistance

Through participation in the Student Health Plan, you are eligible for global emergency medical assistance services when traveling 100 miles or more from your principal residence. Services are provided by UnitedHealthcare Global.

Services include evacuation, repatriation and return of mortal remains. Once you are ready to be released from the hospital, UnitedHealthcare Global will make arrangements to transport you to your residence or rehabilitation facility, with medical supervision, if necessary. More detailed information regarding this service can be obtained from UnitedHealthcare Global at 1-410-453-6330.

UnitedHealthcare Global is not travel or medical insurance, but a service provider for emergency medical assistance services. All medical costs incurred are subject to the policy limits of your health coverage.

Emergencies are covered anywhere in the world.
Claim procedure

In the event of injury or sickness:

1. When you receive services from network providers, they will file a claim for you.

2. When you receive services from an out-of-network provider who does not file a claim, you will need to fill out a claim form and mail it to the address below. You’ll also need to include all medical and hospital bills, along with the patient name, ID number on your health plan ID card, Social Security number, address and name of your university under which you are insured.

3. File the claim within 30 days of injury or first treatment for a sickness. Bills should be received by the company within 90 days of service. Bills submitted after 1 year will not be considered for payment, except in the case of legal capacity.

In the event there is a conflict of this brochure and the Master Policy, the Master Policy shall prevail. You can obtain a brochure or Certificate of Coverage at the Student Health Service.

Direct all claims and/or customer service inquiries to:
UnitedHealthcare Claims
P.O. Box 740800
Atlanta, GA 30374-0800
800-436-7709
Questions?

To reach a University of Miami Student Health Service provider, call 305-284-9100

After you’ve reached your deductible, coinsurance will apply. Coinsurance is the percentage amount. Eligible Expenses – the amount we will pay for Covered Health Services, incurred while the Policy is in effect, are determined as stated below. For Network and Student Health Service Benefits, Eligible Expenses are based on the following: • When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider. • When Covered Health Services are received from Out-of-network providers as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated for Out-of-network Benefits. Eligible Expenses are based on the following applicable criteria, to the extent available, and in the order of priority as identified below: 1. Fee(s) we are able to negotiate with the provider, such as the Shared Savings Program; 2. 110 percent of the published rates allowed by Medicare for the same or similar service; 3. 50 percent of the billed charge.

Prior Notification is required.

UHealth – University of Miami Hospital, UMB – University of Miami Hospital & Clinics, UMHCOC – University of Miami Sylvester Comprehensive Cancer Center, ABLEH – Ann Bates Leach Eye Hospital.

Immunizations required for travel are covered at the Student Health Service.

Virtual Visits are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life threatening medical conditions and should not be used in those circumstances. Services may not be available at all times or in all locations. Payment for Virtual Visit services does not cover pharmacy charges; members must pay for prescriptions (if any) separately. The Designated Virtual Visit Provider’s reduced rate for a virtual visit is subject to change at any time.

Disease Management programs and services may vary on a location-by-location basis and are subject to change with written notice. UnitedHealthcare does not guarantee availability of programs in all service areas and provider participation may vary. Certain terms may be excluded from coverage and other requirements or restrictions may apply. If you select a new provider or are assigned to a provider who does not participate in the Disease Management program, your participation in the program will be terminated.

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

All UnitedHealthcare members can access cost estimates online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under Find Care & Costs section.

Daily Health provides health and wellbeing information and support as part of your health plan. It does not provide medical advice or other health services, and is not a substitute for your doctor’s care. If you have specific health care needs, consult an appropriate health care professional. Participation in the health survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates.

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