

Student Health Insurance

Benefits summary

Types of Coverage	Student Health Service/ Copayment Amounts	Network Benefits/Copayment	Non-Network Benefits/ Copayment Amounts
<p>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.</p> <p>If this Benefit Summary conflicts in any way with the Policy issued to the Enrolling Group, the Policy shall prevail.</p> <p>Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.</p> <p>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.</p> <p>Network Benefits are payable for Covered Health Services provided by or under the direction of your Network Physician.</p>	<p>Annual Deductible: No Annual Deductible.</p> <p>Out-of-Pocket Maximum: No Out-of-Pocket Maximum.</p>	<p>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.</p> <p>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</p>	<p>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.</p> <p>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.</p>
<p>1. Ambulance Services Emergency only</p>	<p>Ground Transportation: Not Covered</p> <p>Air Transportation: Not Covered</p>	<p>Ground Transportation: 30% of Eligible Expenses¹</p> <p>Air Transportation: 30% of Eligible Expenses¹</p>	<p>Same as Network Benefit</p>
<p>2. Durable Medical Equipment (DME)</p>	<p>Covered at 100%</p>	<p>30% of Eligible Expenses¹</p>	<p>40% of Eligible Expenses^{1,2}</p>
<p>3. Emergency Health Services</p>	<p>Covered at 100%</p>	<p>\$150 per visit</p>	<p>Same as Network Benefit</p> <p>Notification is required if results in an Inpatient Stay.</p>
<p>4. Eye Examinations</p>	<p>Covered only at Student Health Service designated facility for one visit annually at a \$20 Copayment.</p>	<p>Not Covered</p>	<p>Not Covered</p>
<p>5. Home Health Care Network and non-Network Benefits are limited to 60 visits for skilled care services per Policy Year.</p>	<p>Not Covered</p>	<p>30% of Eligible Expenses¹</p>	<p>40% of Eligible Expenses^{1,2}</p>
<p>6. Hospice Care</p>	<p>Not Covered</p>	<p>30% of Eligible Expenses¹</p>	<p>40% of Eligible Expenses^{1,2}</p>
<p>¹ 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 either of the following:</p> <ul style="list-style-type: none"> • 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 non-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. <p>For Non-Network Benefits, Eligible Expenses are based on the following applicable criteria, to the extent available, and in the order of priority as identified below:</p> <ol style="list-style-type: none"> 1. Fee(s) we are able to negotiate with the provider, such as the Shared Savings Program; 2. 110% of the published rates allowed by Medicare for the same or similar service; 3. 50% of the billed charge. <p>² Prior Notification is required.</p>			

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 Maternity not available at UM facilities and therefore 10% of Eligible Expenses benefit not available. 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%	Covered at 100%	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. Reconstructive Procedures	Not Covered	Same as 7, 9, 10, 11 and 12 ¹	Same as 7, 9, 10, 11 and 12 ¹

¹ 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 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 non-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 Non-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% of the published rates allowed by Medicare for the same or similar service;
3. 50% of the billed charge.

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. 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
14. 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}
15. Transplantation Services	Not Covered	30% of Eligible Expenses ^{1,2}	40% of Eligible Expenses ^{1,2}
16. Urgent Care Center Services	Not Covered	\$50 per visit	40% of Eligible Expenses ¹
17. 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
Pediatric Vision Services (Benefits covered up to age 19)	Not Covered	Please refer to your COC for specific coverage information	Please refer to your COC for specific coverage information
Pediatric Dental Services (Benefits covered up to age 19)	Not Covered	Please refer to your COC for specific coverage information	Please refer to your COC for specific coverage information
<p>¹ 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 either of the following:</p> <ul style="list-style-type: none"> • 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 non-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. <p>For Non-Network Benefits, Eligible Expenses are based on the following applicable criteria, to the extent available, and in the order of priority as identified below:</p> <ol style="list-style-type: none"> 1. Fee(s) we are able to negotiate with the provider, such as the Shared Savings Program; 2. 110% of the published rates allowed by Medicare for the same or similar service; 3. 50% of the billed charge. <p>² Prior Notification is required.</p>			

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; hypnosis; 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 (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 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 use

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 interior 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. 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 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.

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.

Exclusions Continued

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 (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, 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. Florida statutes require coverage for orthagnathic surgery related to congenital and developmental deformities as well as conditions due to injury or disease.

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.

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 disease, 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 disease. Any Dental Procedure not performed in a dental setting. Procedures that are considered to be Experimental or Investigational or Unproven Services. 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 bony 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 prosthodontic 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 anesthesia. 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 eye disease which requires the services of a Physician and for which Benefits are available as stated in the COC. 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.

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.

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

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 health plan ID card to determine tier status.

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.

Due to Health Care Reform law, Oral Contraceptive Pills placed in the UnitedHealthcare Tier 1 Formulary will be covered at 100%.

	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 nonprescribed 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.

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 can 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 nonpublic personal information. We do not disclose any nonpublic 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 ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling Customer Care at **1-800-436-7709** or by visiting **myuhc.com**.

Coverage while away from home

UnitedHealthcare contracts with 757,843 doctors and 5,671 hospitals nationwide. Therefore, 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 contact the Customer Care 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 non-network doctor or other health care professionals.

How to find mental health and substance use services

Through United Behavioral Health, you will have access to more than 57,000 practitioners for personal, confidential counseling. You also can visit **www.liveandworkwell.com** for information on mental health and substance use services. This site links to the United Behavioral Health Preventive Health Program for exclusive resources and information on major depression disorders, alcohol abuse and attention deficit hyperactivity disorder.

Experienced specialists are available who can talk with you about your situation any time, day or night.



Worldwide assistance: Global emergency medical assistance



Through participation in UnitedHealthcare's Student Plan, you are eligible for global emergency medical assistance services when traveling 100 miles or more from your principal residence. Services are provided by Worldwide Assistance Services, Inc.

Services include evacuation, repatriation and return of mortal remains. Once you are ready to be released from the hospital, Worldwide Assistance 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 Worldwide Assistance at **1-800-898-3344**.

Worldwide Assistance 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.

Customer care

Customer Care is
available by calling
1-800-436-7709

Claim procedure:

In the event of injury or sickness:

- 1** Report to the Student Health Service or infirmary for treatment or referral, or when not in school, to the nearest physician or hospital.
- 2** If the provider does not file a claim, you will need to fill out a claim form and mail to the address below along with 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 180 days of service. Bills submitted after one 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 care inquiries to:

UnitedHealthcare Claims
P.O. Box 740800
Atlanta, GA 30374-0800
1-800-436-7709

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

NurseLineSM is for informational purposes only. Nurses cannot diagnose problems or recommend specific treatment and are not a substitute for your doctor's care. NurseLine services are not an insurance program and may be discontinued 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 items 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. Self-Funded or Self-Insured Plans (ASO) covered persons may have an additional premium cost. Please check with your employer.

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.

The UnitedHealthcare Student Health Plan and/or Health Discount Program may not be available in all states or for all group sizes.

All UnitedHealthcare members can access a cost estimator online tool at myuhc.com. Depending on your specific benefit plan and the ZIP code that is entered, either the myHealthcare Cost Estimator or the Treatment Cost Estimator will be available. A mobile version of myHealthcare Cost Estimator is available in the Health4Me mobile app, and additional ZIP codes and procedures will be added soon. This tool is not intended to be a guarantee of your costs or benefits. Your actual costs and/or benefits may vary. When accessing the tool, please refer to the Terms and Conditions of Use and Why Your Costs May Vary sections for further information regarding cost estimates. Refer to your health plan coverage document for information regarding your specific benefits.

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