**PART V**
**SCHEDULE OF BENEFITS**
**MEDICAL EXPENSE BENEFITS**
**IHC-SP GLOBAL-GLOBAL CARE PLUS - STUDENT PLAN**
**2014-202817-91**
**INJURY AND SICKNESS BENEFITS**

| | |
|---|---|
| **Maximum Benefit** | **No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)** |
| **Deductible Preferred Provider** | **$100 (Per Insured Person, Per Policy Year)** |
| **Deductible Out-of-Network** | **$300 (Per Insured Person, Per Policy Year)** |
| **Coinsurance Preferred Provider** | **80% except as noted below** |
| **Coinsurance Out-of-Network** | **70% except as noted below** |
| **Out-of-Pocket Maximum Preferred Provider** | **$6,350 (Per Insured Person, Per Policy Year)** |
| **Out-of-Pocket Maximum Preferred Provider** | **$12,700 (For all Insureds in a Family, Per Policy Year)** |
| **Out-of-Pocket Maximum Out-of-Network** | **$8,000 (Per Insured Person, Per Policy Year)** |
| **Out-of-Pocket Maximum Out-of-Network** | **$16,000 (For all Insureds in a Family, Per Policy Year)** |

**Eligible students have a choice of insurance plans. Please review the benefits and make your selections carefully. You cannot upgrade coverage after the initial purchase for the policy year.**

The Preferred Provider for this plan is UnitedHealthcare Options PPO.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If a Preferred Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

**Out-of-Pocket Maximum:** After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits. The policy Deductible, Copays and per service Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses and the amount benefits are reduced for failing to comply with policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Out-of-Network per service Deductibles.

**Student Health Center Benefits:** The Preferred Provider Deductible will be waived when treatment is rendered at the SHC.

The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto. Benefits are subject to the policy Maximum Benefit unless otherwise specifically stated. Benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated.

| **Inpatient** | **Preferred Provider** | **Out-of-Network Provider** |
|---|---|---|
| **Room & Board:** | Preferred Allowance | Usual and Customary Charges |
| **Intensive Care:** | Preferred Allowance | Usual and Customary Charges |
| **Hospital Miscellaneous:** | Preferred Allowance | Usual and Customary Charges |
| **Routine Newborn Care:** | Paid as any other Sickness | Paid as any other Sickness |
| *(4 days Hospital Confinement expense maximum)* | | |
| **Physiotherapy:** | Preferred Allowance | Usual and Customary Charges |
| **Surgery:** | Preferred Allowance | Usual and Customary Charges |
| **Assistant Surgeon:** | Preferred Allowance | Usual and Customary Charges |
| **Anesthetist:** | Preferred Allowance | Usual and Customary Charges |
| **Registered Nurse's Services:** | Preferred Allowance | Usual and Customary Charges |
| **Physician's Visits:** | Preferred Allowance | Usual and Customary Charges |
| **Pre-admission Testing:** | Preferred Allowance | Usual and Customary Charges |

| Outpatient | Preferred Provider | Out-of-Network Provider |
|---|---|---|
| **Surgery:** | Preferred Allowance | Usual and Customary Charges |
| **Day Surgery Miscellaneous:** | Preferred Allowance | Usual and Customary Charges |
| *(Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index)* | | |
| **Assistant Surgeon:** | Preferred Allowance | Usual and Customary Charges |
| **Anesthetist:** | Preferred Allowance | Usual and Customary Charges |
| **Physician's Visits:** | Preferred Allowance<br>$25 Copay per visit | Usual and Customary Charges |
| **Physiotherapy:** | Preferred Allowance | Usual and Customary Charges |
| **Medical Emergency:** | Preferred Allowance<br>$200 Copay per visit | Usual and Customary Charges<br>$200 Deductible per visit |
| *(The Copay/per visit Deductible will be waived if admitted to the Hospital)* | | |
| **X-rays:** | Preferred Allowance | Usual and Customary Charges |
| **Radiation Therapy:** | Preferred Allowance | Usual and Customary Charges |
| **Laboratory:** | Preferred Allowance | Usual and Customary Charges |
| **Tests & Procedures:** | Preferred Allowance | Usual and Customary Charges |
| **Injections:** | Preferred Allowance | Usual and Customary Charges |
| **Chemotherapy:** | Preferred Allowance | Usual and Customary Charges |
| ***Prescription Drugs:** | UnitedHealthcare Pharmacy (UHCP)<br>$15 Copay per prescription for Tier 1<br>20% Coinsurance per prescription for Tier 2<br>30% Coinsurance per prescription for Tier 3<br>up to a 31 day supply per prescription | No Benefits |

| Other | | |
|---|---|---|
| **Ambulance:** | Preferred Allowance | Usual and Customary Charges |
| **Durable Medical Equipment:** | Preferred Allowance | Usual and Customary Charges |
| *($10,000 maximum (Per Policy Year))* | | |
| **Consultant:** | Preferred Allowance<br>$25 Copay per visit | Usual and Customary Charges |
| **Dental:** | 80% of Usual and Customary Charges | 80% of Usual and Customary Charges |
| *($100 maximum per tooth) ($500 maximum (Per Policy Year)) (Benefits paid on Injury to Sound, Natural Teeth only.)* | | |
| **Maternity:** | Paid as any other Sickness | Paid as any other Sickness |
| **Elective Abortion:** | Preferred Allowance | Usual and Customary Charges |
| *($1,500 maximum (Per Policy Year))* | | |
| **Complications of Pregnancy:** | Paid as any other Sickness | Paid as any other Sickness |
| **Repatriation:** | Benefits provided by FrontierMEDEX | Benefits provided by FrontierMEDEX |
| **Medical Evacuation:** | Benefits provided by FrontierMEDEX | Benefits provided by FrontierMEDEX |
| ***AD&D:** | Note Below | Note Below |
| *($1,250 - $5,000 maximum)* | | |
| **CAT Scan/MRI:** | Preferred Allowance<br>$150 Copay per visit | Usual and Customary Charges<br>$150 Deductible per visit |
| **Preventive Care Services:** | 100% of Preferred Allowance | No Benefits |
| **Diabetes Services:** | Paid as any other Sickness | Paid as any other Sickness |
| **Mental Illness Treatment:** | Paid as any other Sickness | Paid as any other Sickness |
| **Reconstructive Breast Surgery Following Mastectomy:** | Paid as any other Sickness | Paid as any other Sickness |
| **Substance Use Disorder Treatment:** | Paid as any other Sickness | Paid as any other Sickness |
| **Urgent Care Center:** | Preferred Allowance<br>$50 Copay per visit | Usual and Customary Charges<br>$50 Deductible per visit |

**MAJOR MEDICAL**

**Maximum Benefit** **No Benefits**

**CATASTROPHIC MEDICAL**

**Maximum Benefit** **No Benefits**

***SHC Referral Required: Yes ( ) No (X) Continuation Permitted: Yes ( ) No (X)**

***Pre-Admission Notification: Yes (X) No ( )**

**( ) 52 week Benefit Period or (X) Extension of Benefits**

**Other Insurance: (X) *Excess Insurance ( ) Excess Motor Vehicle ( ) Primary Insurance**

*If benefit is designated, see endorsement attached.

## PART VI
## PREFERRED PROVIDER INFORMATION

**"Preferred Providers"** are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. Preferred Providers in the local school area are:

UnitedHealthcare Options PPO.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-888-251-6253 and/or by asking the provider when making an appointment for services.

**"Preferred Allowance"** means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

**"Out of Network"** providers have not agreed to any prearranged fee schedules. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

**"Network Area"** means the 50 mile radius around the local school campus the Named Insured is attending.

Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid. The Company will pay according to the benefit limits in the Schedule of Benefits.

**Inpatient Expenses**

**PREFERRED PROVIDERS** – Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Options PPO United Behavioral Health (UBH) facilities. Call (888) 251-6253 for information about Preferred Hospitals.

**OUT-OF-NETWORK PROVIDERS** - If Inpatient care is not provided at a Preferred Provider, eligible Inpatient expenses will be paid according to the benefit limits in the Schedule of Benefits.

**Outpatient Hospital Expenses**

Preferred Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.

**Professional & Other Expenses**

Benefits for Covered Medical Expenses provided by UnitedHealthcare Options PPO will be paid at the Coinsurance percentages specified in the Schedule of Benefits or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

## PART IX
## EXCLUSIONS AND LIMITATIONS

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

1. Acne;

2. Acupuncture;

3. Addiction, such as: nicotine addiction, except as specifically provided in the policy; and caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency;

4. Biofeedback;

5. Congenital conditions, except as specifically provided for Newborn or adopted Infants;

6. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children;

7. Custodial Care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care; extended care in treatment or substance abuse facilities for domiciliary or Custodial Care;

8. Dental treatment, except for accidental Injury to Sound, Natural Teeth;

9. Elective Surgery or Elective Treatment;

10. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a covered Injury or disease process;

11. Routine foot care including the care, cutting and removal of corns, calluses, and bunions (except capsular or bone surgery);

12. Health spa or similar facilities; strengthening programs;

13. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;

14. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;

15. Injury or Sickness inside the Insured’s home country;

16. Injury or sickness outside the United States and its possessions, except when traveling for academic study abroad programs, business or pleasure, or to or from the Insured's home country;

17. Injury or Sickness when claims payment and/or coverage is prohibited by applicable law;

18. Injury sustained while (a) participating in any interscholastic, intercollegiate or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;

19. Investigational services;

20. Participation in a riot or civil disorder; commission of or attempt to commit a felony;

21. Prescription Drugs, services or supplies as follows:
    a) Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy;
    b) Immunization agents, except as specifically provided in the policy, biological sera, blood or blood products administered on an outpatient basis;
    c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
    d) Products used for cosmetic purposes;
    e) Drugs used to treat or cure baldness; anabolic steroids used for body building;
    f) Anorectics - drugs used for the purpose of weight control;
    g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
    h) Growth hormones; or
    i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

22. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;

23. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study;

24. Routine Newborn Infant Care, well-baby nursery and related Physician charges; in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery;

25. Preventive care services; routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;

26. Services provided normally without charge by the Health Service of the institution attended by the Insured; or services covered or provided by a student health fee;

27. Deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic purulent sinusitis; except as specifically provided in the policy;

28. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;

29. Supplies, except as specifically provided in the policy;

30. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;

31. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;

32. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and

33. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

# POLICY ENDORSEMENT

**In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:**

**EXCESS PROVISION**

No benefit of this policy is payable for any expense incurred for Injury or Sickness which is paid or payable by: 1) other valid and collectible insurance; or, 2) under an automobile insurance policy.

This Excess Provision will not be applied to the first $100 of medical expenses incurred.

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with policy provisions or requirements.

**This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.**

# POLICY ENDORSEMENT

**In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:**

## ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

**Loss of Life, Limb or Sight**

If such Injury shall independently of all other causes and within 180 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below.

Payment under this endorsement when added to payment under the "Basic Medical Expense Benefit" (and under Major Medical, if coverage is afforded under Major Medical) shall not exceed the policy Maximum Benefit.

**For Loss Of:**

| | |
|---|---|
| Life | $5,000 |
| Two or More Members | $5,000 |
| One Member | $2,500 |
| Thumb or Index Finger | $1,250 |

Member means hand, arm, foot, leg, or eye. Loss shall mean with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.

**This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.**

# POLICY ENDORSEMENT

**In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:**

**PRE-ADMISSION NOTIFICATION**

UnitedHealthcare should be notified of all Hospital Confinements prior to admission.

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.

2. **NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient's representative, Physician or Hospital should telephone 1-877-295-0720 within two working days of the admission to provide notification of any admission due to Medical Emergency.

UnitedHealthcare is open for Pre-Admission Notification calls from 8:00 a.m. to 6:00 p.m. C.S.T., Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling 1-877-295-0720.

**IMPORTANT:** Failure to follow the notification procedures will not affect benefits otherwise payable under the policy; however, pre-notification is not a guarantee that benefits will be paid.

**This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.**