SCHEDULE OF BENEFITS

	IN-NETWORK	OUT-OF-NETWORK
Policy Year Maximum Benefit	Unlimited	Unlimited
Deductible - per person, per condition; additional deductibles and copays may apply	$250	$500
Insurer Percentage - plan pays	80% of Preferred Allowance (PA)	60% of Reasonable & Customary (R&C)
Out-of-Pocket Maximum - per policy year, applies to in-network only; deductibles, copays (including Rx) and coinsurance paid by insured contribute toward the out-of-pocket maximum; once this maximum is met, the plan pays in-network eligible expenses at 100% of PA	$6,350 per person $12,700 Family See page 10	None
Student Health Benefits	100% Charges Incurred; in-network deductible and copay waived; see page 9	
INPATIENT		
Room & Board (paid at the daily semi-private room rate)	80% of PA	60% of R&C
Intensive Care	80% of PA	60% of R&C
Hospital Miscellaneous includes meals and prescribed diets, diagnostic imaging, laboratory, pharmaceuticals administered while an inpatient, use of operating room, anesthesia, therapeutic services, supplies, dressings, blood and blood plasma, oxygen, radiation therapy, chemotherapy, miscellaneous items used in association with a surgical or non-surgical event, preadmission testing - **$500 copay per confinement**	80% of PA	60% of R&C
Inpatient Rehabilitation (includes physical therapy and chiropractic care) - **limited to 30 visits per policy year**	80% of PA	60% of R&C
Physician Visits - 1 visit per day; physician visit not paid same day as surgery	80% of PA	60% of R&C
Consulting Physician - 1 visit per day	80% of PA	60% of R&C
Skilled Nursing and Sub-Acute Care Facilities	80% of PA	60% of R&C
SURGERY BENEFITS (INPATIENT AND OUTPATIENT)		
Surgeon's Fees	80% of PA	60% of R&C
Assistant Surgeon	25% of Surgeon's Payment	25% of Surgeon's Payment
Anesthesia Services	25% of Surgeon's Payment	25% of Surgeon's Payment
Outpatient Surgical Miscellaneous (includes facility fee, supplies, drugs, diagnostic imaging, x-rays, laboratory and other miscellaneous items used with surgical event) - **$500 copay per surgical event**	80% of PA	60% of R&C
General Anesthesia for Dental Services	80% of PA	60% of R&C
Reconstructive Surgery	80% of PA	60% of R&C
Organ Transplant Surgery	80% of PA	60% of R&C

When multiple surgeries are performed through the same incision at the same operative session, the plan pays an amount not to exceed the benefit for the most expensive procedure being performed.
When multiple surgeries are performed through one or more incisions at the same operative session, the plan pays an amount not to exceed the benefit for the most expensive procedure being performed. The benefit for the primary or most expensive procedure or less expensive procedure is 50% of the benefit otherwise payable for each subsequent procedure

SCHEDULE OF BENEFITS Continued	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT		
Wellness/Preventive & Immunizations (only services listed on page 19, includes STD screenings) - plan deductible and copay are waived	100% of PA	No Benefit
Physician Office Visits (includes specialist/consultants) - 1 visit per day, not paid same day as surgery, **$40 copay per visit**	80% of PA	60% of R&C
Diagnostic Imaging and X-ray Services	80% of PA	60% of R&C
PET Scan, CT Scan, and MRI - $500 copay per procedure	80% of PA	60% of R&C
Infusion or Injections (performed in health care facility or physician office)	80% of PA	60% of R&C
Laboratory Services	80% of PA	60% of R&C
Chemotherapy and Radiation Therapy	80% of PA	60% of R&C
Medical Emergency Room (visit to the emergency room for treatment of an emergency condition) – **$200 copay per visit,** waived if admitted, in-network deductible applies	80% of PA	80% of R&C
Urgent Care Facility (non-emergency services) - **$200 copay per visit**, waived if admitted	80% of PA	80% of R&C
Emergency Medical Transportation Services	80% of PA	80% of R&C
OTHER SERVICES (INPATIENT AND OUTPATIENT)		
Prescription Drugs insured will need to file a claim for reimbursement; 30-day supply per prescription; copays do not apply to generic contraceptives and preventive/wellness prescriptions; one copay per 30-day supply	80% of R&C after: $25 copay per generic drug $50 copay per brand drug	80% of R&C after: $25 copay per generic drug $50 copay per brand drug
Allergy Testing & Treatment (includes testing/injections/treatment)	80% of PA	60% of R&C
Diabetes Treatment and Education	80% of PA	60% of R&C
Durable Medical Equipment/Prosthetic Appliances - $100 copay per prescription	80% of PA	60% of R&C
Rehabilitative and Habilititative Care (includes physical therapy and chiropractic care) - 1 visit per day; **limited to 30 visits each per policy year**	80% of PA	60% of R&C
Rehabilitative and Habilitative Care (includes occupational, and speech therapy) - 1 visit per day	80% of PA	60% of R&C
Home Health Care	80% of PA	60% of R&C
Hospice	80% of PA	60% of R&C
Dental Injury (treatment due to injury to sound, natural teeth within 12 months of injury; does not include damage from biting or chewing) – **limited to $3,000 per dental injury**	80% of PA	60% of R&C
Private Duty Nurse	80% of PA	60% of R&C
Club and Intramural Sports	Paid as any other Injury	
Maternity Services (including but not limited to: pre and post natal care, hospital services, diagnostic services at physician office and routine newborn care and inpatient newborn care)	Paid as any other Sickness	

SCHEDULE OF BENEFITS Continued	IN-NETWORK	OUT-OF-NETWORK

Pediatric Dental (coverage for insureds up to age 19) - includes coverage for preventive & diagnostic, basic restorative, major, and *medically necessary* orthodontia services. Waiting periods and other limitations may apply. Pre-authorization may be required for major and orthodontic care. Benefits are subject to the medical deductible and out-of-pocket maximum. Please see policy for details on coverage. Medically Necessary Orthodontics means the patient must have a severe and handicapping malocclusion. This means the child's condition must be severe enough to impact their ability to function such as having trouble eating and/or speaking.

Routine Vision Exam – (coverage for insured up to age 19). Includes 1 pair of glasses (lenses and frames) per policy year or contact lenses (in lieu of eyeglasses)	100% up to $150; 50% thereafter.
Treatment Outside United States	60% of Actual Charge

MENTAL HEALTH AND ALCOHOLISM OR DRUG ABUSE	
Inpatient for Mental Conditions	Paid as any other Sickness
Outpatient for Mental Conditions	Paid as any other Sickness
Inpatient for Alcoholism/Drug Abuse	Paid as any other Sickness
Outpatient for Alcoholism/Drug Abuse	Paid as any other Sickness

OTHER SCHEDULED BENEFITS

*STUDENT HEALTH SERVICES (SHS)

When non-emergency care is needed, students are strongly encouraged to use the Student Health Services, first. If the clinic does not provide the care needed, they can provide the student with information to make informed health care decisions. The following benefits are available when a student receives covered services at the SHS:

- Benefits for covered services are payable at 100% of charges incurred.
- The in-network deductible and copay are waived.

BENEFITS MANDATED BY THE STATE OF INDIANA

The Policy pays benefits in accordance with any applicable Indiana law. Mandates are listed below. Description of the mandates can be found in the Master Policy. Benefits may be subject to deductibles, coinsurance, limitations, or exclusions.

- Colorectal Cancer Examinations and Laboratory Tests
- Mammography Coverage
- Prostate Cancer Screening

ADDITIONAL PROGRAMS

***GLOBAL EMERGENCY SERVICES** (Travel Assistance) .....see details on page 14-15
****ASK MAYO CLINIC*** (Nurse Line) .....see details on page 15

***Note: These additional programs are not underwritten by Nationwide Life Insurance Company, but provided by independent vendors and are included if students participate in the insurance plan.**