

SCHEDULE OF BENEFITS

BENEFIT	UNIVERSITY HEALTH SERVICES (UHS) Primary Care only	NETWORK PROVIDERS with UHS Referral ¹	NON-NETWORK PROVIDERS OR IN-NETWORK WITHOUT A REFERRAL ²
Lifetime Aggregate Maximum	\$500,000 per Insured Student		
Deductible (per Plan Year)	Not Applicable	\$300 per Insured Student	\$300
Out-of-Pocket Maximum(per Plan Year)	Not Applicable	\$4,000 per Insured Student	\$4,000 per Insured Student
INPATIENT BENEFITS			
Inpatient Hospital Expense Benefit: Services include Hospital Room & Board Expense including the Intensive Care Unit Expense, Miscellaneous Hospital Expense, In Hospital Doctor Visit & Medical Expense, Consultant Expense & Pre-admission Test Expense	Not Applicable	80% of Preferred Allowance	60% of R & C Expense
Surgical Expense Benefit: Services include Surgery Expense, Anesthesia Expense, Assistant Surgeon Expense & Multiple Surgical Procedure Expense	Not Applicable	80% of Preferred Allowance	60% of R & C Expense

1 Network Providers are University Health Services, Health Alliance Hospitals, Christ Hospital, St. Elizabeth Healthcare, University of Cincinnati Physicians (specialists group) and Alliance Partners, REACH, Counseling Center, and Central Clinic. To obtain a Beech Street provider in the student's area—call their toll-free number—1-800-Beechst (1-800-233-2478); (9 am – 5 pm) or visit their website at www.BeechStreet.com. Referrals must be renewed EACH NEW ACADEMIC YEAR but are not required outside the Cincinnati area which includes the following zip code prefixes: 410, 450, 451, 452, and 470.

2 Coverage provided when care is received at Non-Network Providers or Network Providers with no UHS Referral is at 60% of the Reasonable and Customary Expense or Preferred Allowance. Referrals are not required for medical services rendered outside the Cincinnati area. The Cincinnati area includes the following zip code prefixes: 410, 450, 451, 452, and 470.

OUTPATIENT BENEFIT	UNIVERSITY HEALTH SERVICES (UHS) Primary Care only	NETWORK PROVIDERS with UHS Referral ¹	NON-NETWORK PROVIDERS OR IN-NETWORK WITHOUT A REFERRAL ²
Surgical Expense Benefit: Services include Surgery Expense, Anesthesia Expense, Assistant Surgeon Expense, & Multiple Surgical Procedure Expense	Not Applicable	80% of Preferred Allowance	60% of R & C Expense
Outpatient Expense Benefit: Services include hospital outpatient department, radiation therapy, chemotherapy, & other medically necessary treatments	Not Applicable	80% of Preferred Allowance	60% of R & C Expense
Doctor's Office Visit Expense Benefit	100% of Covered Charges	80% of Preferred Allowance	60% of R & C Expense
Diagnostic X-ray & Laboratory Expense Benefit	100% of Covered Charges	80% of Preferred Allowance	60% of R & C Expense
Emergency Room Expense Benefit (Follow-up care must be received at UHS)	Not Applicable	80% of Preferred Allowance	80% of R & C Expense
Dermatology Expense Benefit	100% of Covered Charges ³	80% of Preferred Allowance	60% of R & C Expense
Allergy Treatment Expense Benefit:	100% of Covered Charges Injections only	80% of Preferred Allowance	60% of R & C Expense
Physical & Occupational Therapy & Chiropractic Care Expense Benefit: Combined Maximum of \$750 per Policy Year	Not Applicable	80% of Preferred Allowance	60% of R & C Expense

³ Dermatology specimens sent to pathology are subject to the pre-existing exclusion clause and the Deductible.

MENTAL HEALTH & ALCOHOL & DRUG ABUSE BENEFITS	UNIVERSITY HEALTH SERVICES (UHS) Primary Care only	NETWORK PROVIDERS with UHS Referral ¹	NON-NETWORK PROVIDERS OR IN-NETWORK WITHOUT A REFERRAL ²
Inpatient Mental Health Expense Benefit ⁴	Not Applicable	80% of Preferred Allowance	60% of R & C Expense
Inpatient Alcohol & Drug Abuse Expense Benefit ⁵	Not Applicable	80% of Preferred Allowance	60% of R & C Expense
Outpatient Mental Health Benefit ⁶	Insurance pays \$48; Student's copay is any remaining cost above \$48	Insurance pays \$48; Student's copay is any remaining cost above \$48	Insurance pays \$36; Student's copay is any remaining cost above \$36
Outpatient Alcohol & Drug Abuse Expense Benefit ⁷	75% of Covered Charges up to a maximum of \$75 per week for Group Therapy; 50% of Covered Charges up to a maximum of \$75 per week for Individual Therapy	80% of Preferred Allowance	60% of R & C Expense

4 Inpatient Mental and Nervous Conditions Expense Benefit will be paid at \$250 per day for room and board expenses up to a combined maximum of \$15,000 per Insured Person per Policy Year for both Inpatient Mental and Nervous Conditions and Alcohol and Drug Abuse Expense Benefits.

5 Inpatient Alcohol and Drug Abuse Expense Benefit will be paid at \$250 per day for room and board expenses up to a combined maximum of \$15,000 per Insured Person per Policy Year for both Inpatient Mental and Nervous Conditions and Alcohol and Drug Abuse Expense Benefits.

6 Maximum number of visits is 30 per academic year. ADHD-LD Evaluation will be paid up to a maximum of \$400 per Policy Year.

7 We will pay up to a maximum of \$75 per week up to a maximum of \$800 per Policy Year.

ADDITIONAL BENEFITS	UNIVERSITY HEALTH SERVICES (UHS) Primary Care only	NETWORK PROVIDERS with UHS Referral ¹	NON-NETWORK PROVIDERS OR IN-NETWORK WITHOUT A REFERRAL ²
Accidental Dental Expense Benefit	Not Applicable	80% of Preferred Allowance	60% of R & C Expense
Ambulance Expense Benefit	Not Applicable	80% of Preferred Allowance	60% of R & C Expense
Cytologic Screening (Pap Smear) Expense Benefit	100% of Covered Charge	80% of Preferred Allowance	60% of R & C Expense
Diabetes Expense Benefit	Not Applicable	80% of Preferred Allowance	60% of R & C Expense
Durable Medical Equipment Expense Benefit	Not Applicable	80% of Preferred Allowance	60% of R & C Expense
Home Health Care Expense Benefit: Maximum of 40 visits per Policy Year	Not Applicable	80% of Preferred Allowance	60% of R & C Expense
Hospice Expense Benefit	Not Applicable	80% of Preferred Allowance	60% of R & C Expense
Mammographic Examination Expense Benefit	Not Applicable	80% of Preferred Allowance	60% of R & C Expense
Maternity Expense Benefit	Not Applicable	80% of Preferred Allowance	60% of R & C Expense
Prescription Drug Expense Benefit ⁸	\$10 Copay for Generic Prescriptions & \$30 Copay for Brand Name Prescriptions; Then We Pay 100% of Covered Charges up to a Maximum of \$1,000 per Plan Year	Not Applicable	80% of R & C Expense
Sickness Dental Expense Benefit (Extraction of Impacted Wisdom Teeth)	Not Applicable	80% of Preferred Allowance	60% of R & C Expense
Skilled Nursing Facility Expense Benefit: Maximum of 120 days per confinement	Not Applicable	80% of Preferred Allowance	60% of R & C Expense

⁸ Maximum 34-day supply filled per month