REVIEWING PLAN BENEFITS

SCHEDULE OF BENEFITS – TABLE 1

	Limits Individual Insured	Limits Spouse	Limits Dependent Child(ren)
MEDICAL EXPENSES			
Coverage Year Limit	$100,000	$100,000	$100,000
Coverage Year Deductible	$100 per Coverage Year	$100 per Coverage Year	$100 per Coverage Year
Coverage Year Out-of-Pocket Limit The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services, subject to the limits and provisions of this Certificate	After the Covered Person reaches a $5,000 Out-of-pocket Limit per Coverage Year, the Insurer pays the Allowed Amount at 100% and up to the applicable maximums in the Tables 2 and 3. Deductibles, Copayments, Prescription Drug Copayments and amounts above the maximums do not apply toward the Out-of-pocket Limit.	After the Covered Person reaches a $5,000 Out-of-pocket Limit per Coverage Year, the Insurer pays the Allowed Amount at 100% and up to the applicable maximums in the Tables 2 and 3. Deductibles, Copayments, Prescription Drug Copayments and amounts above the maximums do not apply toward the Out-of-pocket Limit.	After the Covered Person reaches a $5,000 Out-of-pocket Limit per Coverage Year, the Insurer pays the Allowed Amount at 100% and up to the applicable maximums in the Tables 2 and 3. Deductibles, Copayments, Prescription Drug Copayments and amounts above the maximums do not apply toward the Out-of-pocket Limit.
EMERGENCY TRANSPORTATION SERVICES			
Emergency Medical Evacuation	Maximum Benefit up to $100,000 per Coverage Year	Maximum Benefit up to $100,000 per Coverage Year	Maximum Benefit up to $100,000 per Coverage Year
Emergency Family Travel Arrangements	Maximum Benefit up to $1,500 per Coverage Year	Maximum Benefit up to $1,500 per Coverage Year	Maximum Benefit up to $1,500 per Coverage Year
Repatriation of Mortal Remains	Maximum Benefit up to $50,000 per Coverage Year	Maximum Benefit up to $50,000 per Coverage Year	Maximum Benefit up to $50,000 per Coverage Year
OTHER COVERAGES			
Accidental Death & Dismemberment	Maximum Benefit: Principal Sum up to $10,000	Maximum Benefit: Principal Sum up to $5,000	Maximum Benefit: Principal Sum up to $1,000

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REVIEWING PLAN BENEFITS

SCHEDULE OF BENEFITS – TABLE 2
MEDICAL EXPENSE BENEFITS

MEDICAL EXPENSES	Participating Provider+	Non-Participating Provider
Physician Office Visits*	After the Deductible is satisfied, 80% of the Allowed Amount after a $35 Copayment per visit	After the Deductible is satisfied, 60% of the Allowed Amount
Treatment at an Urgent Care Facility	After the Deductible is satisfied, 80% of the Allowed Amount after a $50 Copayment per visit	After the Deductible is satisfied, 60% of the Allowed Amount
Hospital and Physician Outpatient Services Pre-Certification May be Required	After the Deductible is satisfied, 80% of the Allowed Amount after a $50 Copayment per visit	After the Deductible is satisfied, 60% of the Allowed Amount
Inpatient Hospital Services Pre-Certification May be Required	After the Deductible is satisfied, 80% of the Allowed Amount after a $50 Copayment per visit	After the Deductible is satisfied, 60% of the Allowed Amount
Emergency Hospital Services	After the Deductible is satisfied, 80% of the Allowed Amount after a $200 Copayment per visit. If admitted to Hospital, then 100% of Copayment Waived	After the Deductible is satisfied, 60% of the Allowed Amount

+Payment of Covered Medical Expenses for Participating Providers is based on the Allowed Amount. Participating Providers have agreed to accept the Allowed Amount as payment in full.

*All Physician Visit Copayments and Deductibles for an Injury or Sickness are waived for treatment received at Recognized Student Health Center.

If a Covered Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.

If a Covered Person incurs Covered Medical Expenses for services or supplies that are not of the type provided by any Preferred Provider, these Covered Medical Expenses will be treated as if they had been incurred at a Preferred Provider.

SCHEDULE OF BENEFITS
TABLE 3
MEDICAL EXPENSE BENEFITS

The benefits listed below are subject to coverage maximums, Deductible, Coinsurance, and Copayments listed in Tables 1 & 2 above.

MEDICAL EXPENSES	Covered Person
Maternity Care for a Covered Pregnancy Pre-Certification May be Required	Allowed Amount
Complications of Pregnancy	Allowed Amount
Inpatient treatment of mental and nervous disorders including substance abuse Pre-Certification May be Required	Allowed Amount
Outpatient treatment of mental and nervous disorders including substance abuse	Allowed Amount
Treatment of specified therapies, including acupuncture and Physiotherapy Pre-Certification May be Required	Allowed Amount up to 20 visits per Coverage Year on an Outpatient basis

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MEDICAL EXPENSES	Covered Person
Routine Preventive Care Services	Allowed Amount up to a Coverage Year Maximum of $500
Annual cervical cytology screening for women 18 and older	Allowed Amount
Low dose mammography screening, one baseline mammogram and one mammogram per year	Allowed Amount
Colorectal cancer screenings	Allowed Amount
Diabetic Supplies/Education	Allowed Amount
Prostate screening tests	Allowed Amount
Child Preventive and Primary Care Services	Allowed Amount
Breast Reconstruction due to Mastectomy	Allowed Amount
Repairs to sound, natural teeth required due to an Injury	Allowed Amount up to $500 per Coverage Year maximum
Medical treatment of Injuries sustained as a result of a covered motor vehicle accident	Allowed Amount up to $10,000 Maximum per Injury or Sickness
Outpatient prescription drugs including oral contraceptives and devices	70% of actual charge up to a maximum of $2,500 per Coverage Year. Limited to a 31 day supply for initial fill or refill

GENERAL CERTIFICATE EXCLUSIONS

Unless specifically provided for elsewhere under the Certificate, the Certificate does not cover loss caused by or resulting from, nor is any premium charged for, any of the following:

1. Expenses incurred in excess of Reasonable Expenses.
2. Services or supplies that the Insurer considers to be Experimental or Investigative.
3. Expenses incurred prior to the beginning of the current Period of Coverage or after the end of the current Period of Coverage except as described in Covered General Medical Expenses and Limitations and Extension of Benefits.
4. Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health, unless otherwise noted.
5. Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or Injury, unless otherwise noted.
6. Surgery for the correction of refractive error and services and prescriptions for eye examinations, eyeglasses or contact lenses or hearing aids, except when Medically Necessary for the Treatment of an Injury.
7. Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
8. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, except as specifically provided for in the Certificate.
9. Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the Certificate and performed while the Certificate is in effect.
10. For diagnostic investigation or medical treatment for reproductive services, infertility, fertility, or for male or female voluntary sterilization procedures, or the reversal male or female voluntary sterilization procedures.
11. Expenses incurred for, or related to, sex change surgery.
12. Organ or tissue transplant.
13. Participating in an illegal occupation or committing or attempting to commit a felony.
14. While traveling against the advice of a Physician, while on a waiting list for a specific treatment, or when traveling for the purpose of obtaining medical treatment.
15. The diagnosis or treatment of Congenital Conditions, except for a newborn child insured under the Certificate.

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16. Expenses incurred within the Covered Person's Home Country.
17. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extraction's of teeth, TMJ dysfunction or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia, unless otherwise noted.
18. Expenses incurred in connection with weak, strained or flat feet, corns or calluses.
19. Diagnosis and treatment of acne.
20. Diagnosis and treatment of sleep disorders.
21. Expenses incurred for, or related to, services, treatment, education testing, or training related to learning disabilities or developmental delays.
22. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.
23. Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.
24. Expenses incurred for any services rendered by a family member or a Covered Person's immediate family or a person who lives in the Covered Person's home.
25. Unless specifically provided for elsewhere under the Certificate, the cost of treatment or services that are provided normally without charge by the Member's Student Health Center, covered or provided by the student health fee, rendered by a person employed by the Member, including team Doctor and trainers or any other service performed at no cost.
26. Loss due to an act of war; service in the armed forces of any country or international authority and Participation in a Riot or Civil Commotion.
27. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.
28. Loss arising from
    a. participating in any intercollegiate/interscholastic or professional sports, contest or competition;
    b. participating in any club sport competition, contest or competition;
    c. Racing or speed contests;
    d. SCUBA diving, sky diving, mountaineering (where ropes or other climbing gear is customarily used), ultra-light aircraft, parasailing, sailplaning/gliders, hang gliding, parachuting, or bungee jumping.
29. Medical Treatment Benefits provision for loss due to or arising from a motor vehicle Accident if the Covered Person operated the vehicle without a proper license in the jurisdiction where the Accident occurred.
30. Under the Accidental Death and Dismemberment provision, for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.
31. Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
32. Orthopedic shoes (except when joined to braces) or shoe inserts, including orthotics.
33. Routine hearing tests except as provided under Preventive and Primary Care.
34. Expense covered under any Other Plan.
35. To the extent that such payments would be prohibited by law.

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