PART V
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS-INJURY
UNIVERSITY OF CHICAGO - STUDENT PLAN
2016-451-81
INJURY ONLY BENEFITS

Maximum Benefit	**$25,000 (Per Insured Person, Per Policy Year)**
Deductible	**$0**
Coinsurance Preferred Providers	**90% except as noted below**
Coinsurance Out-of-Network	**70% except as noted below**

The Preferred Provider for this plan is Multiplan.

This policy provides benefits for injury sustained by an Insured Person while: 1) actually engaged, as an official representative of the Policyholder, in the play or practice of an intercollegiate sport under the direct supervision of a regularly employed coach or trainer of the Policyholder; or 2) actually being transported as a member of a group under the direct supervision of a duly delegated representative of the Policyholder for the purpose of participating in the play or practice of a scheduled intercollegiate sport.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider coinsurance levels of benefits subject to the Usual and Customary Charges. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

If care is rendered outside of the United States, Covered Medical expenses will be payable subject to all policy provisions, at 90% of billed charges.

PREFERRED PROVIDER SERVICES: Covered Medical Expenses incurred at a Preferred Provider will be paid at 90% of Preferred Allowance up to an Out-of-Pocket maximum of $1,500. After the Out-of-Pocket maximum has been reached, additional Covered Medical Expenses will be paid at 100% of Preferred Allowance up to the $25,000 Maximum Benefit.

OUT-OF-NETWORK SERVICES: Covered Medical Expenses incurred at an Out-of-Network Provider will be paid at 70% of Usual & Customary Charges up to an Out-of-Pocket maximum of $2,500. After the Out-of-Pocket maximum has been reached, additional Covered Medical Expenses will be paid at 100% of Usual & Customary Charges up to the $25,000 Maximum Benefit.

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
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

SCHEDULE OF BENEFITS *(Continued)*
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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	Usual and Customary Charges
Physiotherapy:	Preferred Allowance	Usual and Customary Charges
(Review of Medical Necessity will be performed after 12 visits per Injury.)		
Medical Emergency:	Preferred Allowance	90% of Usual and Customary Charges
	$100 Copay per visit	$100 Deductible per visit
X-rays:	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
Prescription Drugs:	No Benefits	No Benefits

Other	**Preferred Provider**	**Out-of-Network Provider**
Ambulance:	90% of Preferred Allowance	90% of Usual and Customary Charges
Durable Medical Equipment:	Preferred Allowance	Usual and Customary Charges
($1,000 maximum Per Policy Year)		
Consultant:	Preferred Allowance	Usual and Customary Charges
Dental:	90% of Actual Charges	90% of Actual Charges
($1,000 maximum Per Policy Year) (Benefits paid on Injury to Sound, Natural Teeth only)		
Home Health Care:	Preferred Allowance	Usual and Customary Charges

MAJOR MEDICAL
Maximum Benefit No Benefits

CATASTROPHIC MEDICAL
Maximum Benefit No Benefits

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

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

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

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

*If benefit is designated, see endorsement attached.

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:

Multiplan.

The availability of specific providers is subject to change without notice. Insured's should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-866-348-8472 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. Insured's may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

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 Hospital Expenses

PREFERRED HOSPITALS - Eligible inpatient Hospital expenses at a Preferred Hospital will be paid at the coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Call 1-866-348-8472 for information about Preferred Hospitals.

OUT-OF-NETWORK HOSPITALS - If care is provided at a Hospital that is not a Preferred Provider, eligible inpatient Hospital 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 Multiplan will be paid at the coinsurance percentages specified in the Schedule of Benefits 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 VII
EXCLUSIONS AND LIMITATIONS

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

1. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy;

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

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

4. Elective Surgery or Elective Treatment;

5. 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;

6. Foot care including: flat foot conditions, supportive devices for the foot, subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;

7. Health spa or similar facilities; strengthening programs;

8. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;

9. Alopecia;

10. Hypnosis;

11. Preventive medicines or vaccines, except where required for treatment of a covered Injury;

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

13. Investigational services;

14. Lipectomy;

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

16. Prescription Drugs dispensed or purchased while not Hospital Confined;

17. 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;

18. Routine physical examinations and routine testing; preventive testing or treatment;

19. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;

20. Speech therapy, except when a Medical Necessity due to Injury; naturopathic services;

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

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

23. 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).

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, or as soon as possible after the patient becomes lucid and able to communicate, 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.