PART VI

SCHEDULE OF BENEFITS

MEDICAL EXPENSE BENEFITS-INJURY

COLORADO SCHOOL OF MINES - INTERCOLLEGIATE SPORTS PLAN 2016-4059-8

INJURY ONLY BENEFITS

Maximum Benefit \$90,000 (For Each Injury)

Deductible Out-of-Network \$1,000 (Per Insured Person) (Per Policy Year)

Coinsurance Preferred Providers 90% except as noted below Coinsurance Out-of-Network 70% except as noted below

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.

The Preferred Provider for this plan is Multiplan.

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 level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

Copays and Per Service Deductibles: All Copays and per service Deductibles specified in the Schedule of Benefits are in addition to the policy Deductible.

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
	\$250 Copay per visit	\$750 Deductible per visit
Intensive Care:	Preferred Allowance	Usual and Customary Charges
Hospital Miscellaneous:	Paid under Room & Board	Paid under Room & Board
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) MEDICAL EXPENSE BENEFITS-INJURY COLORADO SCHOOL OF MINES - INTERCOLLEGIATE SPORTS PLAN 2016-4059-8 INJURY ONLY BENEFITS

\$200 Copay per trip (Benefit includes air ambulance payable at 90% of Preferred Allowance in-network / 70% of Usual and Customary Charges out-of-network. Limited to \$5,000 maximum Per Policy Year.) Durable Medical Equipment: Preferred Allowance Usual and Customary Charges (\$5,000 maximum (Per Policy Year) (Exception: See Benefits for Prosthetic Devices) Consultant: 100% of Preferred Allowance Usual and Customary Charges \$25 Copay per visit \$25 Deductible per visit Dental: Preferred Allowance 90% of Usual and Customary Charges (Injury to Sound, Natural Teeth only.) Urgent Care Center: Preferred Allowance Usual and Customary Charges	Outpatient	Preferred Provider	Out-of-Network Provider
\$250 Copay per visit \$750 Deductible per visit (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: 100% of Preferred Allowance Usual and Customary Charges Physiotherapy: Preferred Allowance Usual and Customary Charges \$25 Copay per visit \$25 Deductible per visit (40 visits maximum Per Policy Year) Medical Emergency: Preferred Allowance Usual and Customary Charges \$100 Copay per visit \$100 Deductible per visit (The Copay/per visit Deductible will be waived if admitted to the Hospital.) X-rays: Preferred Allowance Usual and Customary Charges Laboratory: Preferred Allowance Usual and Customary Charges Prescription Drugs: No Benefits No Benefits Other Ambulance: 100% of Preferred Allowance in-network / 70% of Usual and Customary Charges Prescription Drugs: Preferred Allowance in-network / 70% of Usual and Customary Charges out-of-network. Limited to \$5,000 maximum Per Policy Year.) Durable Medical Equipment: Preferred Allowance Usual and Customary Charges (Exception: See Benefits for Prosthetic Devices) Consultant: 100% of Preferred Allowance Usual and Customary Charges \$25 Copay per visit \$25 Deductible per visit Dental: Preferred Allowance Preferred Allowance Usual and Customary Charges	Surgery:	Preferred Allowance	Usual and Customary Charges
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 $\textbf{SHC Referral Required: } Yes () No (X) \\ \textbf{Conversion Permitted: } Yes () No (X)$

Pre Admission Notification: Yes () No (X)

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

Other Insurance: (X) *Coordination of Benefits (X) Excess Motor Vehicle () Primary Insurance

^{*}If benefit is designated, see endorsement attached.