ifs insurance for STUDENTS FutureHealth

SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary outline of the benefits covered under this insurance plan. All benefits described are subject to the definitions, exclusions and provisions. The following benefits are subject to the Plan Participant's Deductible, Copayment, and Coinsurance amount. After satisfaction of the Deductible, the Insurer will pay eligible benefits set forth in this Schedule at the specified Plan Coinsurance and Reimbursement Level.

GENERAL FEATURES AND PLAN SPECIFICATIONS	
U.S. Provider Network	UnitedHealthcare
Area of Coverage	Worldwide, excluding Home Country
Maximum Benefit Payable per Period of Insurance	Unlimited
Lifetime Maximum	Unlimited
Individual Deductible per Plan Participant per Period of Insurance[1] • In-Network Provider • Out-of-Network Provider	 $250 $1,000
Outpatient Office Visit Copayment[2] • In-Network and Out-of-Network Providers • Not including Student Health Center	 $25
Emergency Room Copayment[2] • In-Network and Out-of-Network Providers • Waived if admitted	 $200 per Occurrence
Urgent Care Center[2] • In-Network and Out-of-Network Providers	 $50 Copayment per Occurrence
Advanced Medical Imaging Copayment (per test) • In-Network and Out-of-Network Providers	 $250
Out-of-Pocket-Maximum • In-Network and Out-of-Network Providers	 Unlimited
Pre-Existing Conditions	Student: Pre-Existing Conditions are covered without a waiting period

Note: All Deductibles and Copayments will be waived when treatment is rendered at the Student Health Center. Benefits will be paid at the In-Network Coinsurance percentage, subject to Usual, Customary and Reasonable charges.

[1] The Deductible for In-Network does not accrue towards the Out-of-Network Deductible.

[2] Copayments do not apply to the Deductible or the Out-of-Pocket Maximum.

COVERED SERVICES AND BENEFIT LEVELS Subject to Deductible, Coinsurance, and Maximum Benefit per Period of Insurance.	WHAT THE INSURANCE PLAN COVERS The following Coinsurance applies for In-Network Providers in the U.S. or for expenses incurred outside the U.S. (if available). Coinsurance reduces to 70% UCR when Out-of-Network Providers in the U.S. are used.
HOSPITALIZATION AND INPATIENT BENEFITS	
Accommodations including semi-private room	80% Preferred Allowance
Intensive Care/Cardiac Care	80% Preferred Allowance
Inpatient Consultation by a Physician or Specialist	80% Preferred Allowance
Hospital Miscellaneous Expenses	80% Preferred Allowance
Pre-Admission Testing • Payable within 3 working days prior to admission	80% Preferred Allowance
Extended Care/Inpatient Rehabilitation • Maximum Benefit per Period of Insurance: 45 days • Must be confined to facility immediately following a hospital stay	80% Preferred Allowance
Registered Nurse's Services • Private Duty Nursing Care	80% Preferred Allowance
OUTPATIENT BENEFITS	
Physician Visit/Consultation by Specialist • Primary Care Physician or Specialist • $25 Copayment per visit (In-Network and Out-of-Network)	80% Preferred Allowance
Diagnostic Testing • X-Ray and Laboratory • MRI, PET, and CT Scans • $250 Copayment per visit (In-Network and Out-of-Network) for MRI, PET, and CT Scans	80% Preferred Allowance
Therapeutic Services, Physical Therapy, Manipulative, Cardiac Rehab, Vocational and Speech Therapy • Maximum Benefit per Period of Insurance: 12 visits per Injury/Illness	80% Preferred Allowance

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SURGICAL BENEFITS (INPATIENT/OUTPATIENT)	
Inpatient, Outpatient or Ambulatory Surgery **Includes:** • Surgeon's Fees • Anesthesiologist • Facility fees • Laboratory tests • Medications and dressings • Other medical services and supplies Note: when 2 or more procedures are performed through the same incision, the Maximum Benefit will not exceed 50% of the 2nd procedure, and 50% of all subsequent procedures.	80% Preferred Allowance
EMERGENCIES	
Emergency Room and Medical Services • $200 Copayment waived, if admitted (In-Network and Out-of-Network)	80% Preferred Allowance
Ambulance Services • Emergency Local Ground Ambulance • Out-of-Network reimbursed at 80%	80% Preferred Allowance
Emergency Dental • Limited to accidental Injury of sound natural teeth sustained while covered • In-Network and Out-of-Network • Maximum Benefit per Period of Insurance: $1,000	80% Preferred Allowance up to $250 per tooth
MATERNITY CARE	
Normal delivery or Medically Necessary C-Section, prenatal, postnatal care and complications of pregnancy	80% Preferred Allowance
OTHER BENEFITS (INPATIENT/OUTPATIENT)	
Mental Health • To treat a covered diagnosis • $25 Copayment per Outpatient visit (In-Network and Out-of-Network)	80% Preferred Allowance
Urgent Care • $50 Copayment per visit (In-Network and Out-of-Network) • All services rendered during the visit will be paid as specified in the Schedule of Benefits	80% Preferred Allowance

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OTHER BENEFITS (INPATIENT/OUTPATIENT) (CONTINUED)	
Voluntary HIV Screening • During Emergency Room visit	100% Preferred Allowance
Elective Abortion • Maximum Benefit per Period of Insurance: $750	80% Preferred Allowance
Preventive Care and Annual Exams • 0-12 months: Exam, immunizations • Child/Adult: Annual Exam, immunizations • Deductible does not apply • No benefits if an Out-of-Network Provider is used	100% Preferred Allowance
Chemotherapy, Radiotherapy	80% Preferred Allowance
Diabetic Medical Supplies • Includes Insulin Pumps and associated supplies • Outpatient self-management training, education, and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered health care professionals. • Maximum Benefit per period of Insurance: $10,000	80% Preferred Allowance
Durable Medical Equipment • Reimbursement of rental up to purchase price • Maximum Benefit per Period of Insurance: $5,000	80% Preferred Allowance
Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency Virus (HIV +) , AIDS Related Complex (ARC), Sexually transmitted diseases and all related conditions	80% Preferred Allowance
Alcohol and Substance Abuse • Institutions specializing in or primarily treating substance use disorders are not covered	80% Preferred Allowance
Motor Vehicle Accident • $25 Copayment per visit (In-Network and Out-of-Network)	80% Preferred Allowance
Sports Activities • Injuries arising from leisure and intramural sports	80% Preferred Allowance

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OTHER BENEFITS (INPATIENT/OUTPATIENT) (CONTINUED)	
Transplant Services (Human Organ, Bone Marrow, Stem Cell) • Expenses for Donor are not covered. • Institute of Excellence required in the U.S. • No benefits when an Out-of-Network Provider is used	80% Preferred Allowance
Prescription Medications • Mail order through CVS/Caremark at 2.5 times the retail Copayment up to a 90-day supply • Includes contraceptives • CVS/Caremark network pharmacy is required. • No benefits when a non-CVS pharmacy is used.	$20 Copayment per prescription for Tier 1 $40 Copayment per prescription for Tier 2 $60 Copayment per prescription for Tier 3 (up to a 31-day supply per prescription)
Medical Evacuation/Repatriation	100%
Repatriation of Remains	100%
War and Terrorism	Included

ACCIDENTAL DEATH AND DISMEMBERMENT

ACCIDENTAL DEATH AND DISMEMBERMENT	
Principal Sum for Primary Plan Participant	$5,000
Time Period for Loss	90 days
Loss of:	**Benefit:**
Accidental Death	$5,000
Two or More Members [3]	$5,000
One Member	$2,500

[3] **Member** means hand, arm, foot, leg, or eye.