Indiana State University
More. From day one.

STUDENT HEALTH INSURANCE PLAN
SCHEDULE OF BENEFITS 2012-2013

INJURY AND SICKNESS BENEFITS COVERAGE: $100,000 PER POLICY YEAR

When your covered Injury or Sickness requires treatment by a Physician or Hospital, the policy will provide benefits while your coverage is in force for the percentage shown of the PPO negotiated fee for covered services received from a Preferred Provider, or the percentage shown of the Reasonable and Customary Charges (R&C) incurred for covered services received from a Non-Preferred Provider, or as scheduled below, **up to a Policy Year Maximum Benefit of $100,000**. Eligible expenses are subject to $250 Deductible per person, per Policy Year. Benefits will not be provided for services which are not listed in the Medical Benefits Schedule or the Master Policy.

COVERED SERVICES	IN NETWORK (Preferred Provider)	OUT OF NETWORK (Non-Preferred Provider)
I. INPATIENT		
a. HOSPITAL ROOM AND BOARD AND HOSPITAL MISCELLANEOUS (semi-private room rate including general nursing care)	80%	60%
b. SURGICAL TREATMENT	80%	60%
c. ANESTHETIST AND ASSISTANT SURGEON	80%	60%
d. PHYSICIAN'S NON-SURGICAL VISITS 1 visit per day, not paid day of surgery	80%	60%
e. MENTAL AND NERVOUS DISORDERS $50 copay per confinement	80%	60%
f. SUBSTANCE ABUSE $50 copay per confinement	80%	60%
g. PRE-ADMISSION TESTING	80%	60%
II. OUTPATIENT		
a. HOSPITAL OUTPATIENT SURGICAL MISCELLANEOUS	80%	60%
b. SURGICAL TREATMENT	80%	60%
c. ANESTHETIST AND ASSISTANT SURGEON	80%	60%
d. PHYSICIAN'S NON-SURGICAL VISITS 1 visit per day, not paid day of surgery $10 copay per visit; plus an additional $15 deductible applies per visit.	80%	60%
e. PHYSIOTHERAPY 1 visit per day, $25 copay per visit	80%	60%
f. HOSPITAL EMERGENCY ROOM (copay is waived if admitted) $100 copay per visit	80%	60%
g. DIAGNOSTIC X-RAY AND LAB SERVICES	80%	60%
h. MENTAL AND NERVOUS DISORDERS $25 copay per visit	80%	60%
i. SUBSTANCE ABUSE $25 copay per visit	80%	60%
j. PRESCRIPTION DRUGS: 30 day supply per prescription; not subject to deductible; (refer to the Medco Prescription Drug Card)	100% $15 copay per Generic Drug; $25 copay per Brand Drug	No Benefit
III. OTHER		
a. AMBULANCE SERVICES (professional ground service)	80%	60%
b. ORTHOPEDIC BRACES AND DURABLE MEDICAL EQUIPMENT	80%	80%
c. HIGH COST PROCEDURE (CAT Scans and MRI)	80%	60%
d. CONSULTANT PHYSICIAN (when requested by the attending physician) after $25 copay per visit	80%	60%
e. DENTAL TREATMENT (Injury to sound, natural teeth, includes X-rays, does not include biting or chewing injuries) up to $1,000/Policy Year	80%	80%
f. WELL BABY CARE (immunizations and screening tests)*	100%	60%
g. MATERNITY BENEFITS	Same as any Sickness	Same as any Sickness
h. MOTOR VEHICLE INJURY	Same as any Injury	Same as any Injury
i. IMMUNIZATIONS*	100%	60%
j. WELL CARE*	100%	60%

* In accordance with PPACA guidelines illustrated at www.healthcare.gov, deductibles and co-pays do not apply.