

SAINT XAVIER UNIVERSITY - SCHEDULE OF BENEFITS

IN-NETWORK OUT-OF-NETWORK

Lifetime Maximum Medical Expense Benefit - Per Accident or Sickness	\$250,000	\$250,000
Deductible: Per Person – Per Policy Year	\$ 300	\$ 300

Student Health Center: The Deductible does not apply when covered services are received at the Student Health Center (SHC) 100% N/A

Prescription Drug Card (Express Scripts)- \$1,500 per Policy Year N/A N/A
 Generic Drug: \$15 co-payment
 Brand Name: \$25 co-payment

HOSPITAL INPATIENT COVERED SERVICES AND BENEFIT LIMITS

IN-NETWORK OUT-OF-NETWORK

(a) Hospital Room and Board and Hospital Miscellaneous: \$100 copay per confinement	80%	60%
(b) Surgical Treatment	80%	60%
(c) Anesthesia : 30% of Surgical Treatment	N/A	N/A
(d) Assistant Surgeon: 30% of Surgical Treatment	N/A	N/A
(e) Private Duty Nurse: Paid under (a)	80%	60%
(f) Physician Non-Surgical Visits: 1 visit per day; not paid the day of surgery	80%	60%
(g) Physiotherapy: 1 visit per day; Paid under (a)	80%	60%
(h) Maternity Benefits: Benefits paid the same as any Sickness	80%	60%
(i) Mental & Nervous Disorders: Benefits paid the same as any Sickness; up to \$10,000 per Policy Year; \$50 copay per confinement	80%	60%
(j) Substance Abuse: Benefits paid the same as any Sickness; up to \$10,000 per Policy year	80%	60%
(k) PreAdmission Testing	80%	60%

OUTPATIENT COVERED SERVICES AND BENEFIT LIMITS

IN-NETWORK OUT-OF-NETWORK

(a) Hospital Outpatient Surgical Miscellaneous: Day Surgery	80%	60%
(b) Surgical Treatment	80%	60%
(c) Anesthesia: 30% of Surgical Treatment	N/A	N/A
(d) Assistant Surgeon: 30% of Surgical Treatment	N/A	N/A
(e) Physician Non-Surgical Visits: 1 visit per day, not paid the day of surgery; \$20 copay per visit	80%	60%
(f) Physiotherapy: Includes occupational therapy; 1 visit per day, \$20 copay per visit; up to 10 visits	80%	60%
(g) Diagnostic X-rays, Radiology, and Laboratory Services: \$25 copay per visit; includes Ultrasound and Nuclear medicine, ECG, EEF and other Electronic Diagnostic procedures	80%	60%
(h) Hospital Emergency Room: \$100 copay per visit (waived if admitted)	80%	60%
(i) Maternity: Paid the same as any Sickness; includes Abortion if life threatening to mother	80%	60%
(j) Mental and Nervous Disorders: \$20 copay per visit; up to 20 visits per Policy Year	80%	60%
(k) Substance Abuse: \$20 copay per visit; up to 20 visits per Policy Year	80%	60%
(l) Prescription Drugs: 30 day supply per prescription; \$15 copay per Generic Drug; \$25 copay per Brand Drug; Refer to Prescription Drug Program through Express Scripts to \$1,500 per Policy Year	N/A	NA

OTHER COVERED SERVICES AND BENEFIT LIMITS

IN-NETWORK OUT-OF-NETWORK

(a) Ambulance: up to \$300	N/A	N/A
(b) Dental Treatment: Xray and treatment of dental injury to sound, natural teeth	80%	80%
(c) Orthopedic Appliances and Durable Medical Equipment: up to \$200 per Policy Year	80%	60%
(d) Motor Vehicle Injury: Benefits paid the same as any Injury	80%	60%
(e) Home Health Care: 40 visits per Policy Year; \$50 Deductible/Policy Year, up to maximum \$300 per Policy Year	80%	60%
(f) Consultant Physician: when requested by the attending Physician	80%	60%
(g) Well Child Care: includes immunizations and age appropriate screening tests; subject to Deductible	80%	60%
(h) Immunizations: when received at Student Health Services only; \$200 per Policy Year; \$10 copay per immunization	100%	N/A
(i) Wellness Benefit: up to \$300 per Policy Year; subject to Deductible	80%	60%
(j) Additional Benefits Mandated by State of Illinois: Breast Reconstruction following Mastectomy and Post Mastectomy Treatment Benefits	80%	60%
Cervical Pap and Prostate Cancer Tests Benefit	80%	60%
Diabetes Benefit	80%	60%
Mammography Examination Benefit	80%	60%
HPV Vaccine	80%	60%
Maternity and Postpartum Care Benefit	80%	60%
Temporomandibular Joint Disorder And Craniomandibular Disorder Benefit	80%	60%

ADDITIONAL PROGRAMS

OPTIONAL DENTAL, VISION AND PHARMACY DISCOUNT CARD See Details Page 20

A separate dental, vision and prescription drug discount plan is available on an optional basis and is subject to payment of an additional premium. Please call (800) 452-5772 to request plan details or visit our website at www.SaintXavierinsurance.com and click on Dental, Vision, & Pharmacy-Discount Card.

OPTIONAL DENTAL AND VISION INSURANCE PLAN

A separate dental insurance plan with optional vision coverage. Several benefit options to choose from, subject to additional premium. Please call (800) 452-5772 to request plan details or visit our website at www.SaintXavierInsurance.com and click on Dental & Vision Insurance Plan.

SCHOLASTIC EMERGENCY SERVICES (Travel Assistance) See Details Page 10

ASK MAYO CLINIC See Details Page 10

Note: These Additional Programs are not underwritten by Columbian Life Insurance Company.