PART IV
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS-INJURY
FLORIDA ATLANTIC UNIVERSITY - INTERCOLLEGIATE SPORTS PLAN
2013-34-18
INJURY ONLY BENEFITS

Maximum Benefit	**$90,000 (For Each Injury)**
Deductible	**$500 (For Each Injury)**
Coinsurance Preferred Providers	**80% except as noted below**
Coinsurance Out-of-Network	**70% except as noted below**

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.

The Policy provides benefits for the Covered Medical Expenses incurred by and Insured Person for loss due to a covered Injury up to the Maximum Benefit of $90,000 for each Injury.

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.

Eligible services at the Student Health Services (SHS) are covered at 100%, and the Deductible will be waived.

All benefit maximums are combined Preferred Provider and Out-of-Network, unless noted below. The benefits payable are as defined in and subject to all provisions of this policy and any riders or endorsements thereto. Benefits will be paid up to the Maximum Benefit for each service as scheduled below.

NOTE: No benefits will be paid for services designated as "No Benefits" in the Schedule.

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
(Specified surgery based on data provided by FAIR Health, Inc.) (Except Dental Surgery. See Other)		
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
(Specified surgery based on data provided by FAIR Health, Inc.) (Except Dental Surgery. See Other)		
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:	100% of Preferred Allowance $20 Copay per visit	Usual and Customary Charges
Physiotherapy:	100% of Preferred Allowance $10 Copay per visit	Usual and Customary Charges
(60 visits maximum Per Policy Year)(Spinal Treatment - 24 visits maximum Per Policy Year)(Benefits include diagnosis and related services.)(Medical Necessity review will be performed after the 12th visit per Injury.)		
Medical Emergency:	$100 Copay per visit 100% of Preferred Allowance	70% of Usual and Customary Charges $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 $10 Copay per visit	Usual and Customary Charges
Prescription Drugs:	No Benefits	No Benefits

Other	Preferred Provider	Out-of-Network Provider
Ambulance:	Preferred Allowance	80% of Usual and Customary Charges
Durable Medical Equipment:	Preferred Allowance	Usual and Customary Charges
($2,500 maximum (Per Policy Year))		
Consultant:	Preferred Allowance	Usual and Customary Charges
Dental:	80% of Usual and Customary Charges	80% of Usual and Customary Charges
($1,000 maximum (Per Policy Year)) (Injury to Sound, Natural Teeth only.)		
Home Health Care:	Preferred Allowance	Usual and Customary Charges
(60 visits maximum (Per Policy Year))		
Skilled Nursing Facility:	Preferred Allowance	Usual and Customary Charges
(60 days maximum (Per Policy Year)) (Total combined benefit with Inpatient Rehabilitation Facility benefits.)		
CAT Scan/MRI:	Preferred Allowance $100 Copay per visit	Usual and Customary Charges $100 Deductible per visit
Urgent Care Center:	100% of Preferred Allowance $50 Copay per visit	70% of Usual and Customary Charges
Inpatient Rehabilitation Facility:	Preferred Allowance	Usual and Customary Charges
(60 days maximum (Per Policy Year)) (Total combined benefit with Skilled Nursing Facility benefits.)		

SCHEDULE OF BENEFITS (Continued)
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MAJOR MEDICAL

Maximum Benefit **No Benefits**

CATASTROPHIC MEDICAL

Maximum Benefit **No Benefits**

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

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

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

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

*If benefit is designated, see endorsement attached.

PART VII

EXCLUSIONS AND LIMITATIONS

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

1. Acupuncture;
2. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy;
3. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
4. Elective Surgery or Elective Treatment, except cosmetic surgery made necessary as the result of a covered Injury or to correct a disorder of a normal bodily function;
5. Eye examinations, 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. Hearing examinations or hearing aids;
8. Hypnosis;
9. Preventive medicines or vaccines, except where required for treatment of a covered Injury;
10. Injury for which benefits are paid under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
11. Injury sustained while (a) participating in any interscholastic; high school; intramural; club, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
12. Investigational services;
13. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
14. Pre-existing Conditions, will apply for the first 6 months, except for individuals who have been continuously insured under the school's student insurance policy for at least 6 consecutive months. Credit will be given for the time the Insured was covered under a previous similar plan if the previous coverage was continuous to a date not more than 63 days prior to the Insured's Effective Date under this policy;
15. Prescription Drugs dispensed or purchased while not Hospital Confined; except as specifically provided under Benefits for Outpatient Services; or except when dispensed at the Student Health Center;
16. Screening exams or testing in the absence of Injury;
17. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
18. Sickness or disease in any form; over-exertion; fainting; or hernia, regardless of how caused;
19. Deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery;

20. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
21. Sleep disorders;
22. Supplies, except as specifically provided in the policy;
23. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
24. 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); and
25. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.