

Use this worksheet to compare your insurance plan to the OSU International Plan. If you do not have a summary of coverage your insurance company can complete and sign it to verify your plan's coverage.

	OSU International Plan	Your Coverage
Student only plan cost per term	\$272 per term X 3 terms of coverage (fall, winter, spring, and summer)	
Total Yearly Cost	\$816 Annually	
Maximum per year	\$250,000 per accident or condition	
Deductible: Off campus On Campus	Off campus: One time \$50 per accident or condition On Campus: None	
Preventive Services	Not covered except women's annual exam, mammogram, and MMR if required by law	
Office Visits	Off Campus: 100% at Preferred Providers after deductible paid On campus: 100%	
Outpatient Lab & X-ray	Off Campus: 100% at Preferred Providers after deductible paid On campus: 100%	
Hospital Room & Board	Off Campus: 100% at Preferred Providers after deductible paid On campus: 100%	
Physical Therapy	Off Campus: 100% at Preferred Providers after deductible paid On campus: 100%	
Mental Health and Substance Abuse	Outpatient: 100% up to \$70 maximum for each visit on campus, or at Preferred Provider after deductible paid. \$1000 max each year Inpatient (In Hospital): 100% for first 10 days at Preferred Provider after deductible paid. 100% for day 11-45 if approved.	
Prescription Drugs	On Campus: 70% Off Campus: 70% at Preferred Provider after deductible is met. Claims must be submitted through OSU Insurance Office.	
Emergency Room	Off Campus: Off Campus: 100% at Preferred Providers after deductible and \$50 Co-pay paid On campus: 100%	
Miscellaneous		
Pregnancy	Off Campus: 100% at Preferred Providers after deductible paid On campus: 100%	
Repatriation of Remains	Included. Your plan must have \$7,500 coverage minimum	
Medical Evacuation	Included. Your plan must have \$10,000 minimum	
Pre-existing conditions	Must be continuously enrolled in the plan for 6 months before coverage would begin for any condition treated or diagnosed before insurance start date, if you were not otherwise insured before the insurance start date.	

By signing below I confirm _____ is currently
Student Name
provided with health benefits stated in the "Your Coverage" section above.

Coverage begin date: _____ Coverage end date: _____

Signature of Authorized Company Official _____

Printed Name of Authorized Company Official _____

Insurance Company Name _____

Address _____

Phone _____ Fax _____