GBG

Insurance Without Borders℠

SCHEDULE OF BENEFITS

CALIFORNIA PLAN (1500)

This is document is intended as a preview only. Please refer to the certificate of health coverage for complete plan details.

SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary outline of the benefits covered under this insurance Plan. The benefits are divided into two sections: Medical Expense Benefits, and Non-Medical Expense Benefits. Please read the Description of Benefits sections for full details. All benefits described are subject to the definitions, exclusions and provisions.

ELIGIBLE PERSONS

Eligible Person is an individual who meets all the requirements of one of the covered Classes shown below:

Class 1
A registered full time undergraduate or a graduate student attending classes who is a minimum age of 16 years and maximum of 40 years:

- Student must have a current passport and be travelling outside their Home Country; and
- Student must have a valid F, M, or Q visa. F1 visa holder on OPT are not eligible.

Class 2

- The spouse or domestic partner of a Class 1 Insured Person

Class 3

- The Dependent child(ren) of a Class 1 Insured Person

MEDICAL EXPENSE BENEFITS

The following Medical Expense Benefits are subject to the Insured Person's Deductible, Copayment, and Coinsurance amount. After satisfaction of the Deductible and applicable Copayments, 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	United Healthcare
Area of Coverage	Worldwide Basis Excluding Home Country
Maximum Benefit Payable per Period of Insurance	Unlimited
Lifetime Maximum	Unlimited
Individual Deductible per Period of Insurance	
•In-Network Provider	$1,500 per Insured Person, 2x Individual per family
•Out-of-Network Provider	$2,500 per Insured Person, 2x Individual per family

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

COPAYMENTS

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

• **Student Health Center Copayment**	$0
• **Physician Office Visit Copayment**	$25
• **Specialist Office Visit Copayment**	$50
• **Urgent Care Center Copayment**	$50
• **Hospital Copayment per Admission**	$250
• **Emergency Room Copayment** (waived if admitted)	$250 per Occurrence

Out-of-Pocket-Maximum per Period of Insurance

• In-Network	$6,350 per Individual/$12,000 Family
• Out-of-Network	Unlimited per Insured Person

The Deductible does apply to the Out-of-Pocket Maximum

Pre-Existing Condition Limitation (12 months Lookback Period)	**Student:** Pre-Existing Conditions are covered without a Waiting Period. **Dependents:** Pre-Existing Conditions are covered after a 24 months Waiting Period.

NOTE: Deductible and Copayment 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.

COVERED SERVICES AND BENEFIT LEVELS Subject to Deductible, Coinsurance, Copayment, 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 • Copayment applies	80% Preferred Allowance
Intensive Care/Cardiac Care	80% Preferred Allowance
Mental Health	80% Preferred Allowance
Inpatient Consultation/Visit by a Physician or Specialist	80% Preferred Allowance
Diagnostic Testing and Hospital Miscellaneous Expense	80% Preferred Allowance
Pre-Admission Testing • Within 3 working days prior to Admission	80% Preferred Allowance
Extended Care, Skilled Nursing Facility, and Inpatient Rehabilitation, Acupuncture • Maximum Benefit per Period of Insurance: 45 days • Must be confined to facility immediately following a hospital stay	80% Preferred Allowance

OUTPATIENT BENEFITS	
Physician Visit or Consultation by Specialist • Office visit Copayment applies • Urgent Care Center Copayment applies	80% Preferred Allowance
Diagnostic Testing • X-Ray and Laboratory • MRI, PET, and CT Scans	80% Preferred Allowance
Therapeutic Services, Physical Therapy, Chiropractic, Cardiac Rehab, Occupational Therapy, Vocational and Speech Therapy	80% Preferred Allowance
Mental Health • Office visit Copayment applies	80% Preferred Allowance
SURGICAL BENEFITS (INPATIENT/OUTPATIENT)	
Inpatient, Outpatient or Ambulatory Surgery Includes: • Surgeon's Fees • Out-of-network Assistant Surgeon or Anesthesiologist (up to 25% of Usual, Customary & Reasonable for surgery) • 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
EMERGENCY BENEFITS	
Emergency Room and Medical Services • Copayment waived, if admitted • 50% Coinsurance for non-emergency use	80% Preferred Allowance
Ambulance Services • Emergency local ground ambulance • Medical Emergency services regardless of network status will be paid at an in-network level	80% Preferred Allowance
Emergency Dental • Limited to accidental Injury of sound natural teeth sustained while covered • Maximum Benefit per Period of Insurance: $1,000, up to $250 per tooth	80% Preferred Allowance

MATERNITY CARE	
Normal delivery or Medically Necessary C-Section, pre-natal, post-natal care, and Complications of Pregnancy	80% Preferred Allowance
Elective Abortion	80% Preferred Allowance
OTHER BENEFITS (INPATIENT/OUTPATIENT)	
Preventive Care and Annual Exams • Newborn to12 months: 9 visit maximum • Child/Adult: Annual exams, immunizations • Child/Adult: Routine eye and hearing exams • In-Network or Student Health Center only • Deductible and Copayment does not apply	80% Preferred Allowance (Student Health Center payable at UCR)
Allergy Testing and Treatment • Allergy serum and injection • Office visit Copayment applies	80% Preferred Allowance
Cancer Care and Oncology	80% Preferred Allowance
Home Health Care	80% Preferred Allowance
Hospice Care	80% Preferred Allowance
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
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	80% UCR
Voluntary HIV Screening • During emergency room visit	100% Preferred Allowance
Durable Medical Equipment Reimbursement of rental up to the purchase price	80% UCR
Alcohol and Substance Abuse • Rehabilitative treatment only • Office visit Copayment applies	80% Preferred Allowance
Habilitative Services for the Treatment of Congenital or Genetic Birth Defects	80% Preferred Allowance

OTHER BENEFITS (INPATIENT/OUTPATIENT) (CONTINUED)	
Prescription Medications • Mail Order at 2.5 times the retail Copayment up to a 90-day supply • Up to 31-day supply per prescription • Includes contraceptives payable at 100%, Copayment does not apply • CVS/Caremark network pharmacy is required	$10 Copayment per prescription for Tier 1 $20 Copayment per prescription for Tier 2 $40 Copayment per prescription for Tier 3
Motor Vehicle Accident	80% Preferred Allowance
Sports and Other Activities • Injuries arising from Interscholastic, Intramural, Intercollegiate, and Club sports	80% Preferred Allowance
Pediatric Dental Benefits	See Schedule of Benefits below
Pediatric Vision Benefits	See Schedule of Benefits below
Passive War and Terrorism	Included

NON-MEDICAL EXPENSE BENEFITS

Non-Medical Expense Benefits do not accumulate towards the Medical Expense Maximum Benefit payable per Period of Insurance or toward the Lifetime Maximum.

ADDITIONAL BENEFITS	
Medical Evacuation and Repatriation • Maximum Benefit per Period of Insurance: $100,000	100%
Return of Mortal Remains • Maximum Benefit: $50,000	100%

PEDIATRIC VISION BENEFITS

The following Benefits are provided for covered vision services for Dependent Child.

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam	Once per year	50% UCR
Eyeglass Lenses • Single Vision • Bifocal • Trifocal • Lenticular	Once per year	50% UCR

Lens Extras	Once per year	
• Polycarbonate Lenses		100% UCR
• Standard scratch-resistant coating		100% UCR
• Oversized Lenses		100% UCR
Eyeglass Frames	Once per year	
• Eyeglass frames with a retail cost up to $130		50% UCR
• Eyeglass frames with a retail cost of $130-$160		50% UCR
• Eyeglass frames with a retail cost of $160-$200		50% UCR
• Eyeglass frames with a retail cost of $200-$250		50% UCR
Contact Lenses	Limited to a 12-month supply	
• Covered Contact Lens Selection		50% UCR
• Necessary Contact Lenses		50% UCR
Low Vision Services	Once every 24 months	
• Low Vision Testing		75% UCR
• Low Vision Therapy		75% UCR

PEDIATRIC DENTAL BENEFITS

The following Benefits are provided for covered dental services for Dependent Child.

Maximum Benefit per Period of Insurance	$1,000
Diagnostic Services: • Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 1 series of films per 12-months • Panorex Radiographs (Full Jaw X-Ray) or Complete Series • Radiographs (Full Set of X-Rays) Limited to 1 time per 36 months • Periodic Oral Evaluation (Checkup Exam) • Limited to 2 times per 12-months. Covered as a separate benefit only if no other services were performed during the visit other than X-rays.	100% UCR
Preventive Services: • Dental Prophylaxis (cleanings) Limited to 2 times per 12-months • Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis. • Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months • Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation	100% UCR
Minor Restorative Services, Endodontics, Periodontics, and Oral Surgery: • Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling. • Composite Resin Restorations (Tooth Colored Fillings) For Anterior (front) teeth only • Endodontics (Root Canal Therapy) • Periodontal Surgery Limited to one quadrant or site per 36 months per surgical area • Scaling and Root Planning (Deep Cleanings) Limited to 1 time per quadrant per 24 months • Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12-month period in conjunction with dental prophylaxis following active and adjunctive periodontal therapy, exclusive of gross debridement • Simple Extractions (simple tooth removal) Limited to 1 time per tooth of lifetime • Oral Surgery, including Surgical Extraction	75% UCR

Adjunctive Services: • General Services (including Dental Emergency treatment) • Covered as a separate benefit only if no other service was done during the visit other than X-rays • General anesthesia is covered when clinically necessary • Occlusal guards limited to 1 guard every 12-months	
Major Restorative Services: Replacement to complete dentures, fixed, or removable partial dentures, crowns, inlays, or onlays previously submitted for payment is limited to 1 time per 60-months from initial or supplemental placement. • Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60-months. Covered only when silver fillings cannot restore the tooth. • Fixed Prosthetics (bridges) Limited to 1 time per 60-months. Covered only when a filling cannot restore the tooth. • Removable Prosthetics (Full or partial dentures) Limited to 1 per 60-months. No additional allowances for precision or semi-precision attachments • Relining and Rebasing Dentures Limited to repairs or adjustments performed more than 12-months after the initial insertion. Limited to 1 per 6-months.	50% UCR
Medically Necessary Orthodontics Lifetime Maximum Benefit	$1,000
Medically Necessary Orthodontics: Benefits are provided for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy, or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefit are not available for comprehensive orthodontic and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be Pre-Authorized. Orthodontic services include, but not limited to: • Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be Medically Necessary.	50% UCR