



SCHEDULE OF BENEFITS

CALIFORNIA PLAN (500)

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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 \$500 per Insured Person, 2x Individual per family
- Out-of-Network Provider \$1,500 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	80% Preferred Allowance
• Copayment applies	
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	80% Preferred Allowance
• Within 3 working days prior to Admission	
Extended Care, Skilled Nursing Facility, and Inpatient Rehabilitation, Acupuncture	80% Preferred Allowance
• Maximum Benefit per Period of Insurance: 45 days	
• Must be confined to facility immediately following a hospital stay	

OUTPATIENT BENEFITS

Physician Visit or Consultation by Specialist

- Office visit Copayment applies 80% Preferred Allowance
- Urgent Care Center Copayment applies

Diagnostic Testing

- X-Ray and Laboratory 80% Preferred Allowance
- MRI, PET, and CT Scans

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 80% Preferred Allowance
- 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.

EMERGENCY BENEFITS

Emergency Room and Medical Services

- Copayment waived, if admitted 80% Preferred Allowance
- 50% Coinsurance for non-emergency use

Ambulance Services

- Emergency local ground ambulance 80% Preferred Allowance
- Medical Emergency services regardless of network status will be paid at an in-network level

Emergency Dental

- Limited to accidental Injury of sound natural teeth sustained while covered 80% Preferred Allowance
- Maximum Benefit per Period of Insurance: \$1,000, up to \$250 per tooth

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 to 12 months: 9 visit maximum
- Child/Adult: Annual exams, immunizations 80% Preferred Allowance
- Child/Adult: Routine eye and hearing exams (Student Health Center payable at UCR)
- In-Network or Student Health Center only
- Deductible and Copayment does not apply

Allergy Testing and Treatment

- Allergy serum and injection 80% Preferred Allowance
- Office visit Copayment applies

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. 80% Preferred Allowance
- Institute of Excellence required in the U.S.

No benefits when an Out-of-Network Provider is used

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 80% Preferred Allowance
- Office visit Copayment applies

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 \$10 Copayment per prescription for Tier 1
- Up to 31-day supply per prescription \$20 Copayment per prescription for Tier 2
- Includes contraceptives payable at 100%, Copayment does not apply \$40 Copayment per prescription for Tier 3
- CVS/Caremark network pharmacy is required

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 100%

- Maximum Benefit per Period of Insurance: \$100,000

Return of Mortal Remains 100%

- Maximum Benefit: \$50,000

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	Once per year	
<ul style="list-style-type: none"> • Single Vision • Bifocal • Trifocal • Lenticular 		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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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

<p>Adjunctive Services:</p> <ul style="list-style-type: none"> • 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 	
<p>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.</p> <ul style="list-style-type: none"> • 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 Rebased Dentures Limited to repairs or adjustments performed more than 12-months after the initial insertion. Limited to 1 per 6-months. 	50% UCR
<p>Medically Necessary Orthodontics Lifetime Maximum Benefit</p>	\$1,000
<p>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.</p> <p>All orthodontic treatment must be Pre-Authorized. Orthodontic services include, but not limited to:</p> <ul style="list-style-type: none"> • 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