

Schedule of Benefits

Biola University

2024-319-4

METALLIC LEVEL - GOLD WITH ACTUARIAL VALUE OF 85.600%

Injury and Sickness Benefits

No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)

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|---|---|
| Deductible Preferred Provider | \$300 (Per Insured Person, Per Policy Year) |
| Deductible Out-of-Network Provider | \$450 (Per Insured Person, Per Policy Year) |
| Coinsurance Preferred Provider | 80% except as noted below |
| Coinsurance Out-of-Network Provider | 60% except as noted below |
| Out-of-Pocket Maximum Preferred Provider | \$8,000 (Per Insured Person, Per Policy Year) |

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.

The **Preferred Provider** for this plan is UnitedHealthcare Options PPO.

Preferred Provider Benefits apply to Covered Medical Expenses that are provided by a Preferred Provider.

Out-of-Network Provider Benefits apply to Covered Medical Expenses that are provided by an Out-of-Network Provider. Refer to the *Preferred Provider and Out-of-Network Provider Information* section of the Certificate for information on reimbursement for Emergency Services provided by an Out-of-Network Provider, Covered Medical Expenses provided at Preferred Provider facilities at which, or as a result of which, the services are performed by an Out-of-Network Physician, and Air Ambulance transport provided by an Out-of-Network Provider. All other Covered Medical Expenses provided by an Out-of-Network Provider at a Preferred Provider facility will be paid at the Preferred Provider Benefit level.

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Any applicable Coinsurance, Copays, or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses and the amount benefits are reduced for failing to comply with Policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum.

Student Health Center Benefits: The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center or Counseling Center.

Out-of-Country Claims:

Covered Medical Expenses for services received outside the U.S. will be provided as follows:

- Emergency Services or urgently needed services when due to a Medical Emergency will be paid at the Preferred Provider Benefit level.

For all other treatment outside the United States, benefits are excluded.

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network Provider unless otherwise specifically stated. Please refer to the Medical Expense Benefits section of the Certificate of Coverage for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

| Inpatient | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|--|--|---|
| Room and Board Expense | 80% of Allowed Amount after Deductible | \$500 Copay per Hospital Confinement 60% of Allowed Amount not subject to Deductible |
| Intensive Care | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Hospital Miscellaneous Expenses | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |

| Inpatient | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|--|--|---|
| Routine Newborn Care | Paid as any other Sickness | Paid as any other Sickness |
| Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures. | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures. | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Anesthetist Services | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Private Duty Nurse's Services | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Physician's Visits | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Pre-admission Testing Payable within 7 working days prior to admission. | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |

| Outpatient | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|--|--|---|
| Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures. | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Day Surgery Miscellaneous | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures. | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Anesthetist Services | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Physician's Visits (Includes home visits) | \$20 Copay per visit 100% of Allowed Amount not subject to Deductible | 60% of Allowed Amount after Deductible |
| Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |

| Outpatient | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|---|--|---|
| Medical Emergency Expenses The Preferred Provider and Out-of-Network Provider Copay will be waived if admitted to the Hospital. | \$100 Copay per visit 80% of Allowed Amount not subject to Deductible | \$100 Copay per visit 80% of Allowed Amount not subject to Deductible (The Insured's expense shall not exceed the amount payable for Preferred Provider Medical Emergency Expenses.) |
| Diagnostic X-ray Services Benefits include CT scans, MRA scans, MRI scans, MRS scans, NC scans & PET scans. | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Radiation Therapy | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Laboratory Procedures Includes TB Testing that is not covered under Preventive Care Services. | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Tests & Procedures | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Injections | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Chemotherapy | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Prescription Drugs | UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy \$25 Copay per prescription Tier 1 \$35 Copay per prescription Tier 2 \$60 Copay per prescription Tier 3 up to a 31-day supply per prescription not subject to Deductible When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail Copay (up to 50% of the Prescription Drug Charge). UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply. | No Benefits |

| Other | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|--|---|--|
| Ambulance Services | 80% of Allowed Amount after Deductible | 80% of Allowed Amount after Deductible (The Insured's air ambulance expense shall not exceed the amount payable for Preferred Provider air ambulance services.) |
| Durable Medical Equipment See also Benefits for Prosthetic Devices for Speaking Post Laryngectomy in the Mandated Benefits Section of the Certificate. | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Consultant Physician Fees | \$40 Copay per visit 100% of Allowed Amount not subject to Deductible | 60% of Allowed Amount after Deductible |

| Other | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|---|--|--|
| Dental Treatment Benefits paid on Injury to Natural Teeth or as specifically provided in the Certificate only. | 80% of Allowed Amount after Deductible | 80% of Allowed Amount after Deductible |
| Mental Illness Treatment See Benefits for Mental Health and Substance Use Disorders in the Mandated Benefits Section of the Certificate. | Inpatient: 80% of Allowed Amount after Deductible Outpatient office visits: \$20 Copay per visit 100% of Allowed Amount not subject to Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: 80% of Allowed Amount after Deductible | Inpatient: 60% of Allowed Amount after Deductible Outpatient office visits: 60% of Allowed Amount after Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: 60% of Allowed Amount after Deductible |
| Substance Use Disorder Treatment See Benefits for Mental Health and Substance Use Disorders in the Mandated Benefits Section of the Certificate. | Inpatient: 80% of Allowed Amount after Deductible Outpatient office visits: \$20 Copay per visit 100% of Allowed Amount not subject to Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: 80% of Allowed Amount after Deductible | Inpatient: 60% of Allowed Amount after Deductible Outpatient office visits: 60% of Allowed Amount after Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: 60% of Allowed Amount after Deductible |
| Maternity (Routine pre-pregnancy, pre-natal, post-partum and inter-pregnancy office visits (office visits not related to Complications of Pregnancy) and all recommended preventive items and services related to pregnancy are provided under Preventive Care Services.) | Paid as any other Sickness | Paid as any other Sickness |
| Complications of Pregnancy | Paid as any other Sickness | Paid as any other Sickness |
| Preventive Care Services No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. See Preventive Care Services benefit in the Medical Expense Benefits section of the Certificate. | 100% of Allowed Amount not subject to Deductible | No Benefits |
| Reconstructive Breast Surgery Following Mastectomy | Paid as any other Sickness | Paid as any other Sickness |
| Diabetes Services See also Benefits for Diabetes in the Mandated Benefits Section of the Certificate. | Paid as any other Sickness | Paid as any other Sickness |
| Home Health Care 100 visits maximum per Policy Year | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Hospice Care | 80% of Allowed Amount after Deductible | 80% of Allowed Amount after Deductible |
| Inpatient Rehabilitation Facility | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |

| Other | Preferred Provider Benefits | Out-of-Network Provider Benefits |
|---|---|---|
| Skilled Nursing Facility 100 days maximum per Policy Year | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Urgent Care Center | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Hospital Outpatient Facility or Clinic | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Approved Clinical Trials | Paid as any other Sickness | Paid as any other Sickness |
| Transplantation Services | Paid as any other Sickness | Paid as any other Sickness |
| Pediatric Dental and Vision Services | See Pediatric Dental and Vision Services benefits | See Pediatric Dental and Vision Services benefits |
| Abortion and Abortion Related Services | 100% of Allowed Amount not subject to Deductible | 100% of Allowed Amount not subject to Deductible |
| Acupuncture Services | \$10 Copay per visit 100% of Allowed Amount not subject to Deductible | 60% of Allowed Amount after Deductible |
| Bariatric Surgery | Paid as any other Sickness | Paid as any other Sickness |
| Medical Foods See also Benefits for Phenylketonuria in the Mandated Benefits Section of the Certificate. | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Ostomy and Urological Supplies | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Vision Correction | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Hearing Aids | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |
| Autologous Blood Self-donated blood collection, testing, processing & storage for planned surgery. | 80% of Allowed Amount after Deductible | 80% of Allowed Amount after Deductible |
| Acne Treatment Benefit are limited to Physician visit charges and all ancillary charges except Prescription Drugs. Prescription Drugs for acne are covered under the Prescription Drug benefit. | 80% of Allowed Amount after Deductible | 60% of Allowed Amount after Deductible |