Schedule of Benefits

Biola University

2026-319-1

METALLIC LEVEL - GOLD WITH ACTUARIAL VALUE OF 86.070%

Injury and Sickness Benefits

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

Deductible Preferred Provider	$400 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network Provider	$800 (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 Covered Medical Expenses incurred by an Insured Person as described in the Certificate of Coverage.

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 ground or 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.
- If an Insured is traveling for academic study abroad programs, business or pleasure, other services will be paid at the Out-of-Network 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

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Hospital Miscellaneous Expenses	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Routine Newborn Care	Based on setting where service is performed	Based on setting where service is performed
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)	$25 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. This review does not apply to Mental Illness Treatment or Substance Use Disorder Treatment.	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 100% 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 $40 Copay per prescription Tier 2 $75 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 ground or air ambulance expense shall not exceed the amount payable for Preferred Provider ground or 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:** $25 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:** $25 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.)	**Inpatient:** 80% of Allowed Amount after Deductible **Outpatient office visits:** $25 Copay per visit 100% of Allowed Amount not subject to Deductible **All other outpatient services:** Based on setting where service is performed	**Inpatient Room and Board:** $500 Copay per Hospital Confinement 60% of Allowed Amount not subject to Deductible **Inpatient:** 60% of Allowed Amount after Deductible **Outpatient office visits:** 60% of Allowed Amount after Deductible **All other outpatient services:** Based on setting where service is performed
Complications of Pregnancy	Based on setting where service is performed	Based on setting where service is performed
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	Based on setting where service is performed	Based on setting where service is performed
Diabetes Services See also Benefits for Diabetes in the Mandated Benefits Section of the Certificate.	Based on setting where service is performed	Based on setting where service is performed

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Home Health Care 100 visits maximum per Policy Year Separate visit limits apply to rehabilitative and Habilitative Services.	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
Skilled Nursing Facility	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Urgent Care Center	100% 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	Based on setting where service is performed	Based on setting where service is performed
Transplantation Services	Based on setting where service is performed	Based on setting where service is performed
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	Based on setting where service is performed	Based on setting where service is performed
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
Medical Supplies	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