SCHEDULE OF BENEFITS

SANTA MARGARITA CATHOLIC HIGH SCHOOL

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 student attending a recognized K-12 institution who is a minimum of 5 years and a maximum of 20 years. Student must have a current passport and be travelling outside their Home County; and student must have a valid F1 visa type.

MEDICAL EXPENSE BENEFITS

The following Medical Expense Benefits are subject to the Plan Participant'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
Home Country Coverage	$500 per Period of Insurance
Maximum Benefit Payable per Period of Insurance • Benefits incurred outside of the U.S. are limited to a maximum of $1,500 per Period of Insurance	Unlimited
Lifetime Maximum	Unlimited
Individual Deductible[1] • In-Network Provider • Out-of-Network Provider	 $0 $500
Office Visit Copayment[2] • In-Network • Out-of-Network	 $20 $50
Emergency Room Copayment[2] (waived if admitted)	$ 300 per Occurrence
Out-of-Pocket-Maximum[3]	None Unlimited if an Out-of-Network Provider in the U.S. is used
Pre-Existing Condition Limitation (12-months Lookback Period)	Pre-Existing conditions are covered after a 6-months a Waiting Period

[1] The Deductible for In-Network does not accrue towards the Out-of-Network Deductible.
[2] Copayments do not apply to the Deductible or the Out-of-Pocket Maximum.
[3] The Deductible does not apply to the Out-of-Pocket Maximum.

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 80% UCR when Out-of-Network Providers in the U.S. are used.
HOSPITALIZATION AND INPATIENT BENEFITS	
Accommodations including semi-private room	100% Preferred Allowance
Intensive Care/Cardiac Care	100% Preferred Allowance
Inpatient Consultation by a Physician or Specialist	100% Preferred Allowance
Hospital Miscellaneous Expenses	100% Preferred Allowance
Pre-Admission Testing	100% Preferred Allowance
OUTPATIENT BENEFITS	
Physician Visit/Consultation by Specialist • $20 Copayment Physician/Specialist • $20 Copayment Urgent Care Center • $50 Copayment (Out-of-Network Providers)	100% Preferred Allowance
Diagnostic Testing • X-Ray and Laboratory • MRI, PET, and CT Scans • Office visit Copayment applies when testing is done outside an office visit	100% Preferred Allowance
Therapeutic Services, Physical Therapy, Chiropractic, Occupational Therapy, Vocational and Speech Therapy • Maximum Benefit per Period of Insurance: 12 visits per Injury/Illness • Office visit Copayment applies	100% 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, Reasonable, & Customary for surgery) • Facility fees • Laboratory tests • Medications and dressings • Other medical services and supplies	100% Preferred Allowance

EMERGENCIES	
Emergency Room and Medical Services • $300 Copayment waived, if admitted	100% Preferred Allowance
Ambulance Services • Emergency local ground ambulance • Out-of-Network reimbursed at 100%	100% Preferred Allowance
Emergency Dental • Limited to accidental Injury of sound natural teeth sustained while covered • Maximum Benefit per Period of Insurance: $1,000	100% Preferred Allowance up to $250 per tooth
OTHER BENEFITS (INPATIENT/OUTPATIENT)	
Mental Health • To treat a covered diagnosis • Inpatient Maximum Benefit per Period of Insurance: 30 days • Outpatient Maximum Benefit per Period of Insurance: 40 visits • Office visit Copayment applies	100% Preferred Allowance
Preventive Care and Annual Exams • In-Network or Student Health Center only • Age-appropriate immunizations • One exam, limited to Maximum Benefit per Period of Insurance: $600	100% Preferred Allowance
Chemotherapy, Radiotherapy	100% Preferred Allowance
Home Health Care • Maximum Benefit per Period of Insurance: 100 days	100% Preferred Allowance
Diabetic Medical Supplies • Includes Insulin Pumps and associated supplies	100% UCR
Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency Virus (HIV+), AIDS Related Complex (ARC), Sexually transmitted diseases and all related conditions	100% Preferred Allowance

OTHER BENEFITS (INPATIENT/OUTPATIENT) (CONTINUED)	
Durable Medical Equipment • Reimbursement of rental up to the purchase price • Maximum Benefit per Period of Insurance: $10,000	100% UCR
Alcohol and Substance Abuse • Inpatient Maximum Benefit per Period of Insurance: 30 days • Outpatient Maximum Benefit per Period of Insurance: 40 visits • Office visit Copayment applies	100% Preferred Allowance
Prescription Medications • Up to 31-day supply per prescription • CVS/Caremark network pharmacy is required • Maximum Benefit per Period of Insurance: $2,000	100% of charges
Sports Activities • Injuries arising from Interscholastic, Intramural, and Club sports • Maximum Benefit per Period of Insurance: $10,000	100% Preferred Allowance
Passive War and Terrorism	Included

NON-MEDICAL EXPENSE BENEFITS[4]

Compassionate Care Visit • Maximum Benefit per Period of Insurance: $1,000	100%
Medical Evacuation and Repatriation • Maximum Benefit per Period of Insurance: $300,000	100%
Return of Mortal Remains • Maximum Benefit: $50,000	100%
Passport Recovery • Maximum Benefit per Period of Insurance: up to $750	100%
Lost Baggage • Expense reimbursement due to flight delays • $100 Deductible applies • Maximum Benefit per Period of Insurance: $500	100% up to $200 per item

[4] Non-Medical Expense Benefits do not accumulate towards the Medical Expense Maximum Benefit Payable per Period of Insurance or toward the Lifetime Maximum

ACCIDENTAL DEATH AND DISMEMBERMENT

Principal Sum for Primary Plan Participant	$30,000
Time Period for Loss	90 days from the date of the covered Accident
Loss of:	**Benefit: Percentage of Principal Sum**
Accidental Death	100%
Loss of Both Hands or Feet, or Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand or Foot and Entire Sight of One Eye	100%
Loss of One Hand or Foot	50%
Loss of Sight of One Eye	50%