

STUDENT ONLY - Schedule of Benefits

ITA Global Trust Ltd - Global Care Basic

2024-202907-91

Injury and Sickness Benefits

Policy Maximum Benefit	\$500,000 (For each Injury or Sickness)
Deductible Preferred Provider	\$100 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network Provider	\$500 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	80% except as noted below
Coinsurance Out-of-Network Provider	70% except as noted below

IMPORTANT: This Schedule of Benefits applies to the Named Insured (student) only. Refer to the Dependent Only – Schedule of Benefits for benefits that apply to covered Dependents.

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. If a Preferred Provider is not available in the Network Area, benefits will be paid for Covered Medical Expenses provided by an Out-of-Network Provider at the Preferred Provider Benefit level. "Network area" means the 50 mile radius around the local school campus the Named Insured is attending.

Out-of-Network Provider Benefits apply to Covered Medical Expenses that are provided by an Out-of-Network Provider.

Student Health Center Benefits: The Deductible and Copays will be waived and benefits will be paid at the Preferred Provider Benefit level when treatment is rendered at the Student Health Center.

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefits limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. All benefits are subject to the Policy Maximum Benefit, unless otherwise specifically stated. 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	\$100 Copay per Hospital Confinement Allowed Amount not subject to Deductible	\$100 Copay per Hospital Confinement Allowed Amount not subject to Deductible
Intensive Care	\$100 Copay per Hospital Confinement Allowed Amount not subject to Deductible	\$100 Copay per Hospital Confinement Allowed Amount not subject to Deductible
Hospital Miscellaneous Expenses Out-of-Network Physiotherapy is limited to 30 days maximum per Policy Year.	Allowed Amount after Deductible	Allowed Amount after Deductible
Routine Newborn Care	Paid as any other Sickness	Paid as any other Sickness

COL-19C (PY23) SOB PPO

1

NOTE: UnitedHealthcare reserves the right to adjust the terms of the policy (i) in the event of any changes in federal, state or other applicable legislation or regulation; (ii) in the event of any changes in Plan design required by the applicable state regulatory authority; and (iii) as otherwise permitted in the our policy.

Inpatient	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.	Allowed Amount after Deductible	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.	Allowed Amount after Deductible	Allowed Amount after Deductible
Anesthetist Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Registered Nurse's Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Physician's Visits	\$30 Copay per visit Allowed Amount not subject to Deductible	Allowed Amount after Deductible
Pre-admission Testing Payable within 7 working days prior to admission.	Allowed Amount after Deductible	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.	Allowed Amount after Deductible	Allowed Amount after Deductible
Day Surgery Miscellaneous	\$100 Copay per date of service Allowed Amount not subject to Deductible	\$100 Copay per date of service Allowed Amount not subject to 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.	Allowed Amount after Deductible	Allowed Amount after Deductible
Anesthetist Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Physician's Visits	\$30 Copay per visit Allowed Amount not subject to Deductible	Allowed Amount after Deductible
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	\$30 Copay per visit Allowed Amount not subject to Deductible	Allowed Amount after Deductible
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	\$300 Copay per visit Allowed Amount not subject to Deductible	\$300 Copay per visit 80% of Allowed Amount not subject to Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.		

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Diagnostic X-ray Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Radiation Therapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Laboratory Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Tests and Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Chemotherapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Prescription Drugs *See UHCP Prescription Drug Benefit Endorsement for additional information.	*UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy \$20 Copay per prescription Tier 1 30% Coinsurance per prescription Tier 2 45% Coinsurance per prescription Tier 3 up to a 31-day supply per prescription not subject to Deductible 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	Allowed Amount after Deductible	Allowed Amount after Deductible
Durable Medical Equipment \$1,000 maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible
Consultant Physician Fees	\$30 Copay per visit Allowed Amount not subject to Deductible	Allowed Amount after Deductible
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only. \$100 maximum per tooth \$500 maximum for each Injury	Allowed Amount after Deductible	80% of Allowed Amount after Deductible
Mental Illness Treatment	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment	Paid as any other Sickness	Paid as any other Sickness
Maternity	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion \$1,500 maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible
Preventive Care Services \$1,000 maximum per Policy Year	100% of Allowed Amount not subject to Deductible	No Benefits

COL-19C (PY23) SOB PPO

3

NOTE: UnitedHealthcare reserves the right to adjust the terms of the policy (i) in the event of any changes in federal, state or other applicable legislation or regulation; (ii) in the event of any changes in Plan design required by the applicable state regulatory authority; and (iii) as otherwise permitted in the our policy.

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider.		
Reconstructive Breast Surgery Following Mastectomy	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services	Paid as any other Sickness	Paid as any other Sickness
High Cost Procedures	\$200 Copay per visit Allowed Amount not subject to Deductible	\$200 Copay per visit Allowed Amount not subject to Deductible
Urgent Care Center	\$50 Copay per visit Allowed Amount not subject to Deductible	\$50 Copay per visit Allowed Amount not subject to Deductible
Hospital Outpatient Facility or Clinic	Allowed Amount after Deductible	Allowed Amount after Deductible
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Titers Benefits are limited to titers related to immunizations for the following: Polio Virus Immune status, Varicella-Zoster AB, IgG, Hepatitis B surf AB, MMR, Hep B, Hep A, Tdap, and Rubella.	Allowed Amount after Deductible	Allowed Amount after Deductible
Tuberculosis Screening and Testing Benefits are limited to TB Screening and Testing not covered under the Preventive Care Services Benefit.	100% of Allowed Amount after Deductible	Allowed Amount after Deductible

DEPENDENT ONLY - Schedule of Benefits

ITA Global Trust Ltd - Global Care Basic
2024-202907-91
Injury and Sickness Benefits

Policy Maximum Benefit	\$250,000 (Per Insured Person, Per Policy Year)
Deductible Preferred Provider	\$250 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network Provider	\$750 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	80% except as noted below
Coinsurance Out-of-Network Provider	70% except as noted below

IMPORTANT: This Schedule of Benefits applies to covered Dependents only. Refer to the Student Only – Schedule of Benefits for benefits that apply to the Named Insured.

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. If a Preferred Provider is not available in the Network Area, benefits will be paid for Covered Medical Expenses provided by an Out-of-Network Provider at the Preferred Provider Benefit level. "Network area" means the 50 mile radius around the local school campus the Named Insured is attending.

Out-of-Network Provider Benefits apply to Covered Medical Expenses that are provided by an Out-of-Network Provider.

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefits limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. All benefits are subject to the Policy Maximum Benefit, unless otherwise specifically stated. 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	\$500 Copay per Hospital Confinement 80% of Allowed Amount not subject to Deductible	\$3,000 maximum per day Allowed Amount after Deductible
Intensive Care	\$500 Copay per Hospital Confinement 80% of Allowed Amount not subject to Deductible	\$4,000 maximum per day Allowed Amount after Deductible
Hospital Miscellaneous Expenses \$1,000 maximum per day Physiotherapy is limited to 30 days maximum per Policy Year.	Allowed Amount after Deductible	Allowed Amount after Deductible
Routine Newborn Care \$5,000 maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible

Inpatient	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.	Allowed Amount after Deductible	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.	Allowed Amount after Deductible	Allowed Amount after Deductible
Anesthetist Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Registered Nurse's Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Physician's Visits \$50 maximum per visit 30 visits maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible
Pre-admission Testing Payable within 7 working days prior to admission.	Allowed Amount after Deductible	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.	Allowed Amount after Deductible	Allowed Amount after Deductible
Day Surgery Miscellaneous	\$100 Copay per date of service 80% of Allowed Amount not subject to Deductible	\$100 Copay per date of service 70% of Allowed Amount not subject to 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	Allowed Amount after Deductible	Allowed Amount after Deductible
Anesthetist Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Physician's Visits	\$50 maximum per visit Allowed Amount after Deductible	\$30 maximum per visit Allowed Amount after Deductible
Physiotherapy \$50 maximum per visit 12 visits maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible
Medical Emergency Expenses	\$200 Copay per visit 80% of Allowed Amount	\$200 Copay per visit 80% of Allowed Amount

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
The Copay will be waived if admitted to the Hospital. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.	not subject to Deductible	not subject to Deductible
Diagnostic X-ray Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Radiation Therapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Laboratory Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Tests and Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Chemotherapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Prescription Drugs *See UHCP Prescription Drug Benefit Endorsement for additional information.	*UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy \$20 Copay per prescription Tier 1 30% Coinsurance per prescription Tier 2 40% Coinsurance per prescription Tier 3 up to a 31-day supply per prescription not subject to Deductible 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	Allowed Amount after Deductible	Allowed Amount after Deductible
Durable Medical Equipment \$1,000 maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible
Consultant Physician Fees \$50 maximum per visit 30 visits maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only. \$100 maximum per tooth \$500 maximum for each Injury	Allowed Amount after Deductible	80% of Allowed Amount after Deductible
Mental Illness Treatment Inpatient – 30 days maximum per Policy Year Outpatient - \$75 maximum per visit 30 visits maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible
Substance Use Disorder Treatment	Allowed Amount	Allowed Amount

COL-19C (PY23) SOB PPO

7

NOTE: UnitedHealthcare reserves the right to adjust the terms of the policy (i) in the event of any changes in federal, state or other applicable legislation or regulation; (ii) in the event of any changes in Plan design required by the applicable state regulatory authority; and (iii) as otherwise permitted in the our policy.

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Inpatient – 30 days maximum per Policy Year Outpatient - \$75 maximum per visit 30 visits maximum per Policy Year	after Deductible	after Deductible
Maternity \$10,000 maximum per Policy Year Conception must occur after the Insured's effective date under this Policy.	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy \$10,000 maximum per Policy Year Conception must occur after the Insured's effective date under this Policy.	Paid as any other Sickness	Paid as any other Sickness

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Elective Abortion \$1,500 maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible
Preventive Care Services \$1,000 maximum per Policy Year No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider.	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	Paid as any other Sickness	Paid as any other Sickness
High Cost Procedures	\$200 Copay per visit 80% of Allowed Amount not subject to Deductible	\$200 Copay per visit 70% of Allowed Amount not subject to Deductible
Urgent Care Center	\$50 Copay per visit 80% of Allowed Amount not subject to Deductible	\$50 Copay per visit 70% of Allowed Amount not subject to Deductible
Hospital Outpatient Facility or Clinic	Allowed Amount after Deductible	Allowed Amount after Deductible
Transplantation Services \$10,000 maximum per Policy Year	Paid as any other Sickness	Paid as any other Sickness
Congenital Conditions \$20,000 Maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible

Exclusions and Limitations

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

1. Acne.
2. Acupuncture.
3. Addiction, such as:
 - Nicotine addiction, except as specifically provided in the Policy.
 - Caffeine addiction.
 - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
 - Codependency.
4. Biofeedback.
5. Injections.
6. Cosmetic procedures, except reconstructive procedures to correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy or for newborn or adopted children. The primary result of the procedure is not a changed or improved physical appearance.
7. Custodial Care.
 - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
 - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
8. Dental treatment, except:
 - For accidental Injury to Sound, Natural Teeth.
9. Elective Surgery or Elective Treatment.
10. Foot care for the following:
 - Routine foot care including the care, cutting and removal of corns, calluses, and bunions (except capsular or bone surgery).

This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
11. Health spa or similar facilities. Strengthening programs.
12. Home health care.
13. Hospice care.
14. Immunizations, except as specifically provided in the Policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the Policy.
15. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
16. Injury or Sickness inside the Insured's home country.
17. Injury or Sickness outside the United States and its possessions, except when traveling for academic study abroad programs, business, pleasure or to or from the Insured's home country.
18. Injury or Sickness when claims payment and/or coverage is prohibited by applicable law.
19. Injury sustained while:
 - Participating in any interscholastic, intercollegiate, or professional sport, contest or competition.
 - Traveling to or from such sport, contest or competition as a participant.
 - Participating in any practice or conditioning program for such sport, contest or competition.
20. Investigational services.
21. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
22. Pre-existing Conditions in excess of \$1,000. This exclusion will not be applied to individuals who have been continuously insured under the student insurance Policy for at least 6 consecutive months. The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under prior Creditable Coverage which provided benefits similar to this Policy provided the coverage was continuous to a date within 63 days prior to the Insured's effective date under this Policy.
23. Prescription Drugs, services or supplies as follows:
 - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.
 - Immunization agents, except as specifically provided in the Policy. Biological sera. Blood or blood products administered on an outpatient basis.
 - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs.

NOTE: UnitedHealthcare reserves the right to adjust the terms of the policy (i) in the event of any changes in federal, state or other applicable legislation or regulation; (ii) in the event of any changes in Plan design required by the applicable state regulatory authority; and (iii) as otherwise permitted in the our policy.

- Products used for cosmetic purposes.
 - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
 - Anorectics - drugs used for the purpose of weight control.
 - Fertility agents or sexual enhancement drugs.
 - Growth hormones.
 - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
24. Reproductive services for the following:
- Procreative counseling.
 - Genetic counseling and genetic testing.
 - Cryopreservation of reproductive materials. Storage of reproductive materials.
 - Fertility tests.
 - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
 - Premarital examinations.
 - Impotence, organic or otherwise.
 - Female sterilization procedures, except as specifically provided in the Policy.
 - Vasectomy.
 - Sexual reassignment surgery.
 - Reversal of sterilization procedures.
25. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study.
26. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems. This exclusion does not apply as follows:
- When due to a covered Injury or disease process.
27. Routine Newborn Infant Care, and well-baby nursery and related Physician charge, except as specifically provided in the Policy.
28. Preventive care services. Routine physical examinations and routine testing. Preventive testing or treatment. Screening exams or testing in the absence of Injury or Sickness. This exclusion does not apply to benefits specifically provided in the Policy.
29. Services provided normally without charge by the Health Service of the institution attended by the Insured or services covered or provided by a student health fee.
30. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.
31. Speech therapy, except as specifically provided in the Policy.
32. Supplies, except as specifically provided in the Policy.
33. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the Policy.
34. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
35. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
36. Weight management. Weight reduction. Nutrition programs. Treatment for obesity. Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the Policy.

NOTE: UnitedHealthcare reserves the right to adjust the terms of the policy (i) in the event of any changes in federal, state or other applicable legislation or regulation; (ii) in the event of any changes in Plan design required by the applicable state regulatory authority; and (iii) as otherwise permitted in the our policy.