



Meridian Benefits Consulting offers affordable

International Student Injury and Sickness Insurance Plans

Underwritten by Student Resources (SPC) Ltd., a United Health Group Company

To

The Pennsylvania State University Students

Choose from these 2 plans that satisfy the Penn State Mandatory Insurance Requirements

Global Care Preferred 2015-2016 Policy 2015-202818-91	Global Care Plus 2015-2016 Policy 2015-202817-91
Monthly Rate (3 Month Minimum)	Monthly Rate (3 Month Minimum)
Student 24 and Under \$ 85.50	Student 24 and Under \$ 75
Student 25-30 \$119.10	Student 25-30 \$104.70
Student 31-40 \$203.10	Student 31-40 \$186.60
Student 41 + \$432.90	Student 41 + \$380.10
Spouse \$390.60	Spouse \$390.60
Each Child \$255.60	Each Child \$255.60
\$50 Deductible for Preferred Providers	\$100 Deductible for Preferred Providers
\$300 Deductible for Out of Network Providers	\$300 Deductible for Out of Network Providers
Covered Medical Expenses: Coinsurance Preferred Provider: 90% Coinsurance Out of Network : 70% UCR *Please visit your booklet for further detail	Covered Medical Expenses: Coinsurance Preferred Provider: 80% Coinsurance Out of Network: 70% UCR *Please visit your booklet for further detail
Out-of-Pocket Maximum: <u>Preferred Provider</u> \$5,000 Per Insured Person \$10,000 For all insured Family <u>Out Of Network</u> \$7,000 Per Insured Person \$14,000 For all Insured Family *Please visit your booklet for further detail	Out-of-Pocket Maximum: <u>Preferred Provider</u> \$6,350 Per Insured Person \$12,700 For all Insured Family <u>Out Of Network</u> \$8,000 Per Insured Person \$16,000 For all Insured Family *Please visit your booklet for further detail.
Prescription Drug Benefits: \$15 Copay for Tier 1 \$30 Copay for Tier 2 \$50 Copay for Tier 3 Up to a 31-day supply per prescription filled. *Prescriptions must be filled at a UnitedHealthcare Network Pharmacy (UHP) Mail order through UHCP at 2.5 times the retail copay.	Prescription Drug Benefits: \$15 Copay for Tier 1 20% Coinsurance for Tier 2 30% Coinsurance for Tier 3 Up to a 31-day supply per prescription filled. *Prescriptions must be filled at a UnitedHealthcare Pharmacy (UHCP) Mail order through UHCP at 2.5 times the retail copay.



Physician Visit: \$20 Copay/visit	Physician Visit: \$25 Copay/visit
Medical Emergency: Preferred Provider - \$150 Copay per visit Out-of-Network Provider - \$150 deductible per visit (waived if admitted)	Medical Emergency: Preferred Provider - \$200 Copay per visit Out-of-Network Provider - \$200 deductible per visit (waived if admitted)
Consultant: \$20 Copay per visit	Consultant: \$25 Copay per visit
CAT Scan/MRI: Preferred Provider - \$100 Copay per visit Out-of-Network Provider - \$100 Deductible per visit	CAT Scan/MRI: Preferred Provider - \$150 Copay per visit Out-of-Network Provider - \$150 Deductible per visit
Dental: 90% of Usual and Customary Charges \$250 max per tooth \$1000 max per policy year Benefits paid on Injury to Sound, Natural Teeth only	Dental: 80% of Usual and Customary Charges \$100 max per tooth \$500 max per policy year Benefits paid on Injury to Sound, Natural Teeth only

* This is only a benefit outline. Please refer to the Summary of Benefits for full benefit descriptions.