

LA SIERRA UNIVERSITY SCHEDULE OF HEALTH CARE BENEFITS - JULY 1, 2006 - JUNE 30, 2007

MEDICAL DEDUCTIBLE:

DENTAL DEDUCTIBLE:

MEDICAL OUT OF POCKET MAXIMUM

(OOPM):

\$250 - INDIVIDUAL

\$0 - INDIVIDUAL

\$2,000 - INDIVIDUAL out of network-

\$4500

\$500 - FAMILY

\$0 - FAMILY

\$4,000 - FAMILY

out of network- \$7000

This is a summary of plan benefits. Please see full plan document for complete coverage. P:\healthcare/benefits summary.doc2007

*OOPM applies

COVERAGE CATEGORY	MAXIMUMS Co-Pay Amounts	IN NETWORK	OUT NETWORK
ALTERNATIVE THERAPIES Chiropractic Treatment (spinal manipulation only) Acupuncture Therapy Appropriate billing codes (CPT) must be included (Does not apply for dependents under age 10)	30 visits per plan year 18 visits per plan year	80%	65%
AMBULANCE		80%*	NA
DENTAL CARE Type A - Preventive Care Type B - Basic Restorative and Type C – Major Restorative	\$1,840.00/person \$5,520.00/family Per plan year	100% 80%	NA
DURABLE MEDICAL EQUIPMENT Charges above \$1,000 require prior authorization	\$8,000 payment limit Per plan year	80%*	65%
EMERGENCY/URGENT CARE \$50.00 deductible per Hospital Emergency Room visit	Does not apply to emergency room charges	80%*	NA
HEARING CARE	\$3,200 limit per plan year	80%*	NA
HOME HEALTH CARE Prior Authorization required to receive plan benefits	52 Visits per plan year (0-4 hrs = 1 visit)	80%*	65%
HOSPICE CARE Prior Authorization required to receive plan benefits		100% of charges	NA
INFERTILITY TREATMENTS Prior Authorization required to receive plan benefits	\$16,000.00 Lifetime Does not apply to Deductible and OOPM	80% with prior approval	65%
INPATIENT/OUTPATIENT HOSPITAL CARE OFFICE/AMBULATORY SURGICAL PROCEDURES		80%*	65%
MENTAL HEALTH BENEFITS Inpatient (Prior Authorization Required) Outpatient Treatment per 1 hr visit Acute Partial Hospitalization (Prior Authorization Required)	15 days per plan year \$20.00 co-pay per 30 visits per plan year 20 days per plan year	80%* 100% after co-pay 80%*	65% 65%
ORGAN/TISSUE TRANSPLANT Pre-authorization required to receive plan benefits		80%*	NA
ORTHODONTIC Maximum calculated at time of banding, Eligible to age 24	\$2,300.00 Lifetime/person	50%	NA
OUTPATIENT SERVICES		80%*	65%
OFFICE VISITS / PREVENTIVE HEALTH Does not apply to deductible, not included in OOPM Other Charges on same bill	\$20.00 co-pay	100% after co-pay 80%*	65% no co-pay
PRESCRIPTION DRUGS MAIL ORDER (90 – day supply) RETAIL (30 – day supply) or 20% co-pay	\$400.00 per person \$800.00 per family OOPM	Mail Order \$15.00 generic \$25.00 brand \$35 non-formulary	Retail \$12.00 generic \$18.00 brand \$25 non-formulary
REFRACTIVE EYE SURGERY Do not apply to deductible, not included in OOPM	\$2,400.00 lifetime	80%	NA
SUBSTANCE ABUSE / CHEMICAL DEPENDANCY Outpatient Treatment per 1 hr. visit (Prior Authorization Req.) In-Patient Treatment (Prior Authorization Required) Partial Hospitalization (Prior Authorization Required)	\$20.00 co-pay 30 visits per plan year 15 days per plan year 20 days per plan year	100% after co-pay 80%* 80%*	65%
TEMPOROMANDIBULAR DISORDERS (TMD) Covered under medical (not dental) provisions	Pre-authorization for treatment required CPT Required	80%*	NA
THERAPEUTIC SERVICES Physical Therapy/ Massage Therapy (Does not apply for dependents under the age of 10) Occupational Therapy (Prior Authorization Required) Speech Therapy (Prior Authorization Required)	30 visits per plan year for each category of therapy \$90.00 allowable per visit Appropriate billing codes CPT required	80%	65%
URGENT CARE CENTERS Other Charges on same bill	\$20.00 co-pay	100% after co-pay 80%	65%
VISION CARE Plan year deductible and OOPM do not apply Vision Therapy (Prior Authorization Required)	\$560.00 Maximum Payable per plan year CPT Required	80% 80%	NA