

**LA SIERRA UNIVERSITY STUDENT HEALTH PLAN
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I. LA SIERRA UNIVERSITY STUDENT HEALTH PLAN

A. What It Is

This Plan is a University-sponsored health care plan. This Plan will only provide coverage on an excess basis, which means that all medical expenses must first be submitted to any other available source of health care coverage. This Plan provides a broad range of medical coverage for you. It includes coverage for hospital care, surgery, emergency care and more. Details of this coverage are explained on the following pages. To be eligible for reimbursement under the provision of the Plan, expenses must be incurred while coverage is in effect. Expenses incurred before your Plan coverage becomes effective or after your Plan coverage has terminated will not be covered.

This Plan follows an annual plan year from September 1 to August 31. This period includes summer quarter, fall quarter, winter quarter, and spring quarter. **Summer quarter has limitations.** Students taking 8 units or more and have paid the health plan fee have access to the same student health plan which is provided during Fall/Winter/Spring Quarters. Part-time summer students taking less than 8 units, accepted students working full-time on campus during the summer or registered residents of the Universities housing may purchase basic campus health coverage. Basic campus health services are limited to: on campus office visits, in-stock medications, and limited laboratory tests.

B. What It Does

This Plan covers usual, reasonable and customary charges of the covered services and supplies outlined in the following pages which meet all of the following tests:

- They are medically necessary;
- They represent a commonly accepted form of treatment and meet professionally recognized national standards of quality; and
- They are recognized as generally accepted by the American medical community.

The reasonable and customary charges will be determined using guidelines established by Medical Data Research (MDR).

When allowable expenses are submitted and approved, the Plan will pay according to the Schedule of Benefits (see Page 16). If you have other coverage, this Plan will only provide coverage on an excess basis, and supplement any other medical plans which provide benefits to the student.

In addition to any other limitations stated in this Plan, there is a limit of \$5,000 per person, per year, for the aggregate medical expenses covered under this plan.

II. ELIGIBILITY

A. Benefits to You

Eligible students receive the benefits of the Student Health Service, hospital and surgical coverage, accidental death or dismemberment coverage, as described in this brochure.

ELIGIBLE STUDENT DEFINED: A student is eligible for the Student Health Plan if the student is ALL of the following:

1. Attending La Sierra University as a graduate or undergraduate; and
2. Enrolled in 8 units or more per quarter for which La Sierra University is receiving tuition, excluding "in Progress," "Employee Tuition Benefit," "Audit" units, and "Continuing education credit".
3. Paid the quarterly Student Health Plan fee.

B. Enrollment

Every student must have on file a Student Health Plan Enrollment Form before any medical claims can be accepted for payment.

IT IS THE RESPONSIBILITY OF THE STUDENT TO SEE THIS FORM IS COMPLETED AND TURNED IN TO THE STUDENT HEALTH SERVICE AND THAT IT IS KEPT UPDATED WHEN ELIGIBILITY CHANGES OCCUR.

When applying for coverage under the Plan, it is necessary that accurate and complete information be given. If relevant information is misstated, or not disclosed, coverage will be adjusted as necessary based upon the correct information, and the student will be obligated to refund to the Plan any benefit payment incorrectly received.

C. Effective Date of Coverage

The eligible student's coverage will become effective on the day of the actual school registration if registration is within one week of the beginning of the quarter, or up to one week prior to registration if the student is residing on campus.

The termination date for all plans will be graduation day or the last day of the final examinations for any quarter, unless a student is enrolled for the following quarter as an eligible student, or has purchased coverage for the following quarter.

(COVERAGE FOR ALL MEDICAL CONDITIONS INCURRED DURING THE COVERAGE PERIOD WILL END 30 DAYS AFTER TERMINATION.)

III. CLAIM PROCESSING PROCEDURES

All claims for benefits will be processed through Adventist Risk Management, Inc. and submitted to:

ADVENTIST RISK MANAGEMENT, INC
P O BOX 8007
RIVERSIDE CA 92515-8007
PHONE 909-353-6825
FAX 909-353-6848

IV. MEDICAL BENEFITS

A. Covered Services and Expenses

Under the Student Health Plan all primary care medical services and referrals for specialty services must be provided through the Student Health Service who provides the following services to eligible students:

1. Physician available for examination or treatment (by appointment); and
2. Medical Personnel working under the direction of physicians.

Services are provided, at no cost to the student, through the Student Health Service. Hours are from 8:00 a.m. to 12:00 noon and 1:00 p.m. to 5:00 p.m. Monday through Thursday and from 8:00 a.m. to 12:00 noon Friday. Closed holidays. Hours are subject to change. After hours on call medical team can be reached through Campus Security (ext. 2222).

B. Outpatient Referrals

When the medical needs of an eligible student are outside the services provided by Student Health Service, the student may, at the discretion of the Health Service Physician, be referred to a specialist. The Plan will provide coverage for these referrals as outlined in the Schedule of Benefits. Should the student refuse treatment at Student Health Service, any medical bills incurred for the problem for which treatment was refused will not be covered under the Student Health Plan. There will be no direct provider payment or reimbursement for medical care unless there has been a **PRIOR REFERRAL OR PRIOR APPROVAL** by Student Health Service. Psychiatric/counseling referrals must be made by the health service physicians or the counseling center on campus.

C. Hospitalization and Surgery

EMERGENCY ADMISSIONS: In the case of an emergency, follow the doctor's advice and seek appropriate medical care.

1. Covered Services and Expenses

Hospitalization is covered only when medically necessary. Services are subject to maximums, if any, listed in the Schedule of Benefits, and apply to the following areas:

- Inpatient surgical and anesthesia charges;
- Miscellaneous hospital expenses;
- Outpatient surgery charges for authorized procedures requiring general, spinal, or nerve block anesthesia;
- Semi-private room; and
- Reasonable and customary inpatient physician fees

2. Weekend Admissions

No benefits will be payable for weekend hospitalizations (Friday p.m. Saturday, Sunday) unless admission is required because of any emergency, or if surgery is being performed the following day.

3. Outpatient Surgery

In order to encourage outpatient surgery, the Plan will cover outpatient surgical procedures requiring general, spinal or nerve block anesthesia the same as inpatient hospital services the procedure must be performed in an outpatient surgical facility.

An outpatient surgical facility is an ambulatory or freestanding surgical center, the outpatient department of a hospital, or a facility which meets the definition of Outpatient Surgical Facility on page 13. If an office or other facility does not meet the definition requirement, any professional surgical charges will be covered as regular outpatient medical services and surgical facility charges will not be covered.

4. Limitations

- Cosmetic procedures limited to reconstruction due to illness or injuries sustained by an individual while covered by this Plan;
- In-patient psychiatric care and treatment of drug-abuse and/or alcoholism will be covered subject to limitations (see Schedule of Benefits);
- Isolation or private room will be covered if it is essential due to the patient's severely compromised defenses against infection, or due to a contagious disease, or because a private room is otherwise necessary to protect the patient's life; and
- Room rate for inpatient is limited to semi-private (if you voluntarily elect to occupy a private room instead of a semi-private room, you pay the difference in cost between the private room rate and the hospital's most common semi-private room rate).

5. Exclusions

- Charges that would not have been made if no coverage existed under this Plan, or charges the student is required to pay;
- Elective abortions;
- Experimental medicine, drug, or treatment;

- Long-term convalescent hospital or nursing home care;
- Personal convenience items while hospitalized;
- Reversal of voluntary or surgically induced infertility;
- Surgical procedures for changing gender identity;
- Treatment of callouses, corns, bunions, or toenails by surgical incision, except for the removal of nail roots or the treatment of foot related vascular or metabolic disorders;
- Treatment for work-related illness or injury;
- Weekend admissions unless for emergency or next-day surgery; and
- Weight management and/or surgery.

D. Obstetrics

1. Covered Services and Expenses

Under this Plan, pregnancy-related expenses are covered in the same way as medical expenses for illness or injury. Medical expenses for childbirth, miscarriage, or abortion are subject to all limitations, exclusions, and required authorizations contained in the Plan, including limitations for pre-existing conditions. Charges incurred before your coverage is effective or after your coverage terminated will not be covered.

2. Exclusions

- Charges that would not have been made if no coverage existed under this Plan or charges the student is required to pay;
- Elective abortions;
- In-vitro fertilization, artificial insemination and embryo transfers;
- Prenatal classes and parent training courses; and
- Services and supplies not certified as necessary by a licensed health care professional and/or physician.

E. Counseling Services

La Sierra University makes available to its students a free counseling service through the Counseling Center. This counseling service is not a part of the Student Health Plan, but is available as needed.

If additional counseling services are needed, they must be referred by the Counseling Center or Student Health Services. These services are covered as outlined in the Schedule of Benefits page 18.

F. Emergency Service

In the event of an emergency illness or accident, the Student Health Service is closed; the student should obtain medical care at the nearest appropriate medical facility available. EMERGENCY SERVICES are those required for the alleviation of severe pain, or the diagnosis and treatment of unforeseen medical conditions which if not treated would lead to disability, dysfunction, or death.

G. Accidental Death and Dismemberment

If an eligible student suffers an accidental death or an accidental dismemberment within 180 days from the date of an accident which occurred during his eligibility, this plan will pay, in addition to any other benefits, one of the following amounts for the corresponding loss.

Accidental Death	\$1,000
Accidental Loss of	
Both hands, Feet or Eyes	\$1,000
One Hand and One Foot	\$1,000
Hand or Foot and One Eye	\$1,000
Either Hand or Foot	\$ 500
Sight of One Eye	\$ 500

Only one of the amounts specified, the largest, will be paid for a loss resulting from any one accident, and shall be in addition to any other indemnity payable for such accident. Loss of hand or hands, or a foot or feet shall mean actual severance through or above the wrist or wrists, or the ankle or ankles, and the loss of sight of an eye or eyes shall mean the irrecoverable loss of the entire sight thereof.

H. Ambulance Services

Ambulance services for a life-threatening illness (such as heart attack, bleeding, severe breathing difficulties, unconsciousness, etc.) or accident will be covered at 80% subject to a maximum payment of \$250.

V. EXCLUSIONS TO THE STUDENT HEALTH PLAN

The Student Health Plan does not provide coverage for the following charges:

- Abortions or attempt thereof unless for medical reasons
- Acupuncture
- Allergies, congenital, or pre-existent conditions
- Any dental work, or x-rays, unless there shall have been an injury to a sound tooth. See Schedule of Benefits
- Charges that would not have been made if no coverage existed under the Plan or charges the student is required to pay
- Chiropractic treatment
- Convalescent (long-term) hospital or nursing home care
- Cosmetic procedures
- Durable medical equipment
- Elective surgery, except for cosmetic reconstruction necessary due to illness or injury sustained while an eligible student
- Experimental procedures
- Eyeglasses, contact lenses, or eye examinations or treatment where no accident or sickness was involved
- Hearing aids
- Injury or illness as a result of air travel, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline, or as a result of school-sponsored flying in private aircraft
- Injury or illness through war or any act of war, riot, or civil disturbance, or for any medical condition contracted while in the military, naval, or air service of any country
- Injury or sickness covered under any workers' compensation or occupational disease act or law
- Injury sustained in the participation, the practice, or the play of trampoline, skydiving activities, hand-gliding, or kiting
- Injury sustained in the participation, the practice, or the play of "intercollegiate Sports" or "Club Sports".
- Intentionally self-inflicted injuries or for injuries sustained while committing a crime
- In-vitro fertilization, artificial insemination and embryo transfers.
- Learning disability treatment for behavioral or learning problems
- Outpatient counseling or psychiatric treatment or for nervous, mental, or emotional disorder or disease, except as outlined in the Counseling Service section of this brochure.
- Personal convenience items, while hospitalized.
- Prescription drugs, except drugs available through La Sierra University Student Health Service.
- Preventive medicines, serums, vaccines and shots or injections.
- Reversal of voluntary or surgically induced infertility.

- Routine physical examinations/services.
- School requirements such as x-rays, lab work, or other tests.
- Services and supplies not certified as necessary by a licensed health care professional and/or physician.
- Services or expenses incurred prior to the date coverage is in force or after the date coverage terminates.
- Services or supplies provided more than twelve (12) months prior to the date the charges were submitted to the Plan for payment.
- Services provided by unlicensed counselors.
- Special shoes or other devices or appliance for the treatment of bunions, corns, callouses, toenails, or similar condition of the feet.
- Surgery, treatment, or drugs for changing gender identity.
- Temporomandibular joint (TMJ) disease treatment and repair, unless the condition was caused by a specific accident which occurred during the coverage period.
- Treatment of callouses, corns, bunions, or toenails by surgical incision, except for the removal of nail roots or treatment of foot related vascular or metabolic disorders.
- Treatment of other than cystic acne.
- Weight management and/or surgery.

VI. PRE-EXISTING CONDITIONS

A pre-existing injury or sickness is one that manifested itself in such a manner as would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the covered student's date of enrollment in the Student Health Plan.

For a covered student who has been continuously covered under this plan and a previously qualifying health plan for a period of not less than six months pre-existing conditions will not apply and benefits will be paid to the limits of the plan.

VII. EFFECTS OF OTHER BENEFIT COVERAGE

A. Coordination of Benefits

In calculating benefits to you from the Plan, payments you might receive from other sources, such as auto medical payment insurance and other group health plans, are taken into account. This coordination of benefits is common practice in health care plans and its primary purpose is to keep costs down for all consumers. Coordination of benefits is done to make certain that payments from all plans do not exceed 100% of covered expenses. For this reason, it is important you report coverage under any other insurance policy or health plan any time you submit a claim.

"Other plan" means any other plan of medical expense coverage provided by:

- Group insurance or any other arrangement of coverage for individuals in a group (including group service plan contracts or prepayment plan), whether or not the plan is insured; or
- Automobile medical payments insurance, uninsured motorists insurance or “no-fault” automobile reparations insurance which is required by “no-fault” law. The first \$2,000 of medical expenses arising from a motor vehicle or motorcycle (on or off-road) accident is excluded from this Plan, except where limiting state laws prevail.

Whenever a claimant is covered by more than one insurance, group health, or other plan, the “primary plan” always pays first. When this Plan is the primary plan, it will pay the benefits shown in this booklet. When this Plan is the secondary plan, it will pay the Plan benefits up to the balance of covered expenses not paid by the primary plan.

B. Excess Coverage

The Student Health Service Plan is an EXCESS MEDICAL PLAN AND SHALL ONLY SUPPLEMENT OTHER MEDICAL PLANS WHICH PROVIDE BENEFITS TO THE STUDENTS. The student shall first obtain payment or reimbursement from any and all other medical plans which provide benefits for the student and only thereafter submit bill for direct provider payment or reimbursement for any remaining portion not covered by the other plan/s.

Since many health plans (such as HMO’s) do not pay any medical bills unless their utilization review requirements are met, and since they are considered primary to the Student Health Plan, it is necessary that students follow their primary plan rules rather than those in this booklet.

C. Right of Recovery

The Plan reserves the right to recover from any insurer, provider, organization, or any other person any portion of any payment made under this Plan which is in excess of covered benefits under the provisions of this Plan.

If you receive benefits under this Plan, as the result of any of those benefits from the party that caused the injury or from any other person, entity, or organization that is obligated by law or contract to compensate you for the injury, including your automobile insurer under your medical payments or uninsured motorists coverage. In other words, the Plan subrogates or substitutes for you and assumes your rights to seek recovery from the negligent party or the person, entity, or organization that is obligated to compensate you. If you make a claim or file an action against that person, entity, or organization, benefits payable under this Plan must be included in the claim or action, and when the claim or action is settled, or otherwise finally adjudicated you must reimburse the Plan for the benefits provided. You are obligated to avoid doing anything that would prejudice the Plan’s rights of subrogation and reimbursement, and you may be required to sign and deliver documents to evidence or secure those rights.

VIII. CLAIMS

A. Filing a Claim

Generally, all claims for a benefit payment should be filed promptly. A claim must be submitted within 90 days after an illness or accident has occurred in order to be paid.

It is important for you to observe carefully the time frame for filing claims. Submit requests for payment as soon as you receive invoices or receipts. This way providers can be paid promptly and your records can be kept as up-to-date as possible.

B. How to File a Claim

The procedure for filing a claim is as follow:

1. Obtain a claim form from the Student Health Service.
2. Complete all appropriate sections of the claim form. It is important that you carefully complete the claim form. If you omit needed information, benefit payment could be delayed.
 - Separate claim forms must be submitted for each incident.
3. Provide proof for reimbursement. For your claims to be complete, you must provide proof of expense (paid receipt or canceled check). Original bills from providers are accepted, if they are on the letterhead of the provider or on a claim form containing the following information:
 - Name of patient
 - Date of service, treatment, or purchase
 - Type of treatment
 - Diagnosis
 - Each item for which you are charged
 - Amount of charge
 - Amount paid by subscriber
 - Provider's Federal Tax Identification Number

➤ NOTE: Non-itemized receipts or billings are not acceptable.

4. Submit original bills and claim forms to Adventist Risk Management, Inc. at:

Adventist Risk Management, Inc.
P O Box 8007
Riverside CA 92515-8007
Phone 951-354-6825
Fax 951-354-6848

Original medical expense bills must be submitted to Adventist Risk Management, Inc. and cannot be returned. If you cannot submit original bills because you have already submitted them to another plan which is the "primary plan," (see "Effects of Other Benefit Coverage," page 8.) Adventist Risk Management will accept photocopies of these bills.

5. Keep records of your claims. If you want to maintain personal records, be certain to keep copies of each medical bill you submit and each Explanation of Benefits Information Form you receive.

NOTE: If you believe your claim was incorrectly processed you may request a review.

C. How Claims are Paid

Claims are processed after Adventist Risk Management, Inc receives the complete, necessary written proof to support your claim.

Non-itemized receipts are not acceptable proofs of expense. When filing a claim for benefits under the Plan, it is necessary that accurate and complete information be given. If relevant information is misstated or not disclosed, the benefit payments will be recalculated based upon the correct information and you will be obligated to refund the Plan any overpayments received.

IX. OTHER PLAN INFORMATION

A. Plan Limits

The Student Health Plan has a total aggregate Plan limit of \$5,000 per person per year.

B. General Information

The benefits of the Student Health Plan are provided for illnesses and accidents only and are subject to all of the following:

1. Only for those benefits specifically enumerated in the Plan;
2. To the extent that the specific benefits do not exceed the individually listed maximums;
3. Only when not otherwise excluded by the EXCLUSIONS TO THE STUDENT HEALTH PLAN (Section V);
4. Only after the use of benefits from any other medical plan with benefits available to the student; and

Note: The time you were covered under this plan may count as creditable coverage under State and Federal Law if you leave this plan and go to an employer's plan within 63 days thereafter. You are eligible to receive a certification regarding the periods you were covered. Please contact the Plan Administrator when you need such certification.

X. SELECTED DEFINITIONS

ACCIDENTAL INJURY: a sudden and unforeseen event, definite as to time and place, causing injury to the physical structure of the body resulting from an external agent or trauma (as opposed to harm resulting from disease), happening involuntarily or as the result of a voluntary act entailing unforeseen consequences.

BENEFIT YEAR: the Plan follows an annual year from September 1 to August 31.

COSMETIC PROCEDURE: a procedure performed solely for the improvement of a covered person's appearance, rather than for the improvement or restoration of bodily function.

DOCTOR: a doctor either in the United State or in a foreign country may be any of the following who renders services within the recognized scope of his/her practice.

- Physician licensed to practice medicine and/or surgery
- Licensed osteopath
- Certified or registered psychologist (licensed by the State)

EMERGENCY SERVICES: those services required for the alleviation of severe pain, or the diagnosis and treatment of unforeseen medical conditions which if not treated would lead to disability, dysfunction, or death.

HOSPITAL: an institution which meets fully every one of the following tests:

- It is accredited by the Joint Commission on Accreditation of Hospitals;
- It is eligible to receive payments under Medicare;
- It is accredited by the government or other authority accrediting hospitals in a foreign country;
- It is primarily engaged in providing, for compensation and on an inpatient basis, facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons under the supervision of a staff of physicians;
- It continuously provides 24-hour registered nursing (RN) service; and
- It is not, other than incidentally, a place for rest for the aged, for drug addicts, for alcoholics, or a nursing home, or a facility providing custodial, educational, or rehabilitative care.

ILLNESS: a bodily disorder, disease, physical sickness, mental infirmity, or functional nervous disorder of a covered person. A recurrent illness will be considered an illness. Concurrent illnesses will be considered one illness unless the concurrent illnesses are totally unrelated. All such disorders existing simultaneously, which are due to the same or related causes, shall be considered one illness.

INCURRED EXPENSES: those services and supplies rendered to a covered person. Such expenses shall be considered to have occurred at the time or date the service or supply is actually provided.

INPATIENT: refers to the classification of a covered person when that person is admitted to a hospital or hospice facility for treatment, and charges are made for room and board to the covered person, as a result of such treatment.

MEDICALLY NECESSARY: health care services, supplies, or treatment which are appropriate and consistent with the diagnosis and which, in accordance with generally accepted/medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

OUTPATIENT: refers to the classification of a covered person when that covered person receives medical care, treatment, services, or supplies at a clinic, a physician's office or at a hospital, if not a registered bed-patient at the hospital.

OUTPATIENT SURGICAL FACILITY: a facility which meets all of the following requirements:

- Meet licensing standards;
- Is set up, equipped, and run to provide general surgery;
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recover period;
- Has at least one certified anesthesiologist at the site when surgery requires general or spinal anesthesia performed and during the recover period;
- Has at least two operating rooms and one recovery room;
- Provides, or arranges with a medical facility in the area for diagnostic x-ray and lab services needed in connection with surgery;
- Provides, in the operating and recover rooms, full-time skilled nursing services directed by a registered nurse, and
- Is equipped with and has trained staff to handle medical emergencies. It must have:
 - A physician trained in cardiopulmonary resuscitation
 - A defibrillator

- A tracheotomy set
- A blood volume expander

REASONABLE AND CUSTOMARY: refers to the designation of a charge as being the usual charge made by a physician or other provider of services supplies, medication, or equipment that does not exceed the general level of charges made by other providers rendering or furnishing such care to treatment within the same area. The term "area" in the definition means a county or such other area as is necessary to obtain a representative cross-section of such charges. Due consideration will be given to the nature and severity of the conditions being treated and any medical complications or unusual circumstances which require additional time, skill, or expertise.

NOTES:

XI. SCHEDULE OF BENEFITS

There is a limit of \$5,000 per person, per year, for the aggregate medical expenses covered under this plan.

MEDICAL COVERAGE

Hospitalization and Surgery

Semi-private Room and Board
Intensive Care Room and Board
Miscellaneous Expense
Surgery
Anesthesia
Obstetrics (in-patient care)
Inpatient Professional Fees

Inpatient Coverage

Inpatient Cost

80%

Inpatient psychiatric care and/or treatment for drug abuse and alcoholism will be covered at 80% subject to an aggregate maximum of 7 days inpatient treatment per school year and a total lifetime benefit of \$10,000 per individual.

Obstetrics

Refer to the Hospitalization and Surgery Section, and to the Medical Outpatient Service Section for the applicable percentage amounts.

	Annual Maximum <u>Benefit Paid</u>	Coverage <u>Percentage</u>
<u>Medical Outpatient Service</u>		
Office Visits and Consultation	R&C	80%
Laboratory and x-ray services	R&C	80%
Nonsurgical Medical Services & Testing	R&C	80%
Obstetrics (outpatient care)	R&C	80%
Obstetrics (inpatient care)	R&C	80%
Hospital Outpatient Services	R&C	80%
Outpatient Surgery Charges	R&C	80%
(For surgery requiring general or nerve block anesthesia)		
Physical Therapy	\$500	80%
<u>Psychiatric Outpatient Care/Counseling</u>		
Counseling/Psychiatric Referral	\$1,000	80% of up to \$50/visit
Alcohol and/or Drug Rehabilitation	\$1,000	80% of up to \$50/visit
<u>Accident</u> Emergency treatment of accidental injury is covered at 80% injury to a sound tooth will be covered at 80% to a limit of \$500.		
<u>Ambulance</u>		
Ambulance	\$250/trip	80%
(Covered for life-threatening conditions only)		