ESCONDIDO UNION SCHOOL DISTRICT

Consortium Custom Health Plan

PROFESSION SERVICES	In-Network Preferred Providers	Out-of-Network Providers
Visit to a physician, physician assistant or nurse practitioner	$15	30% after deductible
Routine physical examinations	$15	30% after deductible
Well-Women care, including pap smear and mammography	$15	30% after deductible
Well-baby/child care, including immunizations recommended by the American Academy of Pediatrics	$15	30% after deductible
Routine vision examinations for refractions (frames and lenses not included)	$15	30% after deductible
Specialist consultations (No referrals required)	$15	30% after deductible
Physician visit to hospital or skilled nursing facility	No charge	30% after deductible
Immunizations (except for occupational purposes)	$15	30% after deductible
Allergy testing	$15	30% after deductible
Allergy injection services/serum	$15	30% after deductible
Therapeutic injections	$15	30% after deductible
Surgeon or assistant surgeon	No charge	30% after deductible
Administration of anesthetics	No charge	30% after deductible
X-ray and laboratory procedures	No charge	30% after deductible
CT, SPECT, MRI, MUGA, and PET	No charge	30% after deductible
Outpatient rehabilitative Therapy (limited to 60 visits per calendar year)	$15	30% after deductible
Dental Services (when medically necessary to properly monitor, control or treat a severe medical condition when excluded dental services are being performed).	No charge	30% after deductible
CARE FOR CONDITIONS OF PREGNANCY (professional services only)	In-Network Preferred Providers	Out-of-Network Providers
Prenatal and postnatal office visit	Global Fees Required	
Normal delivery, Cesarean section. Includes newborn inpatient care.	No charge	30% after deductible
Complication of pregnancy, including medially necessary abortions	No charge	30% after deductible
Elective abortions (12-20 weeks only)	$15	30% after deductible
Genetic testing of fetus	No charge	30% after deductible
Circumcision of newborn	No charge	30% after deductible
FAMILY PLANNING	In-Network Preferred Providers	Out-of-Network Providers
Insertion / removal intra-uterine devices (IUD)	$15	30% after deductible
Removal of Norplant	$15	30% after deductible
Intra-uterine device	50% of cost	50% of cost
Depro-Provera injection	$15	30% after deductible
Depro-Provera medication (limited to 1 injection every 90 days)	$35	30% after deductible
Infertility services ***(limited to diagnostic testing only)***	No charge	30% after deductible
Sterilization of females (tubal ligation)	$100	30% after deductible
Sterilization of males (vasectomy)	$50	30% after deductible
Reversal of sterilization	Not Covered	Not Covered

OTHER SERVICES	In-Network Preferred Providers	Out-of-Network Providers
Ground and air ambulance (medically necessary services and supplies)	No charge	No charge
Durable medical equipment.	No charge	30% after deductible
Hearing aids (up to a $1,000 allowance/24 months)	No charge	30% after deductible
Prosthesis	No charge	30% after deductible
Blood, blood plasma, blood factors and blood derivatives	No charge	30% after deductible
Nuclear medicine	No charge	30% after deductible
Chemotherapy	No charge	30% after deductible
Renal dialysis	No charge	30% after deductible
Home health visit (limited to a maximum 100 visits per calendar year).	No charge	30% after deductible
Hospice care	No charge	30% after deductible
CHIROPRACTIC AND ACUPUNCTURE CARE	In-Network Preferred Providers	Out-of-Network Providers
Chiropractic services (limited to 30 visits per calendar year maximum)	$15	30% after deductible
Acupuncture services (limited to 30 visits per calendar year maximum)	$15	30% after deductible
HOSPITAL AND SKILLED NURSING FACILITY SERVICES	In-Network Preferred Providers	Out-of-Network Providers
Unlimited days of hospital care in a semi-private room or ICU with ancillary services	$200 per admission	30% after deductible
Confinement in skilled nursing facility	No charge	30% after deductible
Maternity care. Includes routine nursery charges	$200 per admission	30% after deductible
Outpatient surgery	No charge	30% after deductible
Outpatient services (except emergency room)	No charge	30% after deductible
EMERGENCY CARE/URGENTLY NEEDED CARE	In-Network Preferred Providers	Out-of-Network Providers
Use of emergency room (facility) Copay waived if admitted to hospital	$100	$100
Use of urgent care center (facility and professional services)	$15	30% after deductible
CALENDAR YEAR DEDUCTIBLE	In-Network Preferred Providers	Out-of-Network Providers
Per member / family maximum	None / None	$500 / $1,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	In-Network Preferred Providers	Out-of-Network Providers
Per member / family maximum	$1,000 / $3,000	$4,000 / $12,000

Calendar year deductible, prescription drug copayments, mental health/substance abuse copayments and non-covered services/supplies or any charge exceeding customary and reasonable do not apply towards the Calendar Year Out of Pocket Maximum

LIFETIME MAXIMUM BENEFIT	In-Network Preferred Providers	Out-of-Network Providers
Maximum lifetime benefit per member	$5,000,000	
RETAIL PRESCRIPTION DRUGS - THROUGH EXPRESS SCRIPTS RETAIL PHARMACIES		
For a 30 day supply - based on Express Scripts National Formulary		
Generic	$5	
Preferred brand	$10	
Non-preferred brand	$25	

MAIL ORDER PRESCRIPTION DRUGS - THROUGH EXPRESS SCRIPTS MAIL SERVICE		
For a 90 day supply - based on Express Scripts National Formulary		
Generic	$10	
Preferred brand	$20	
Non-preferred brand	$50	
MENTAL HEALTH AND SUBSTANCE ABUSE - PROVIDED THROUGH PACIFICARE BEHAVIORAL HEALTH	In-Network Preferred Providers	Out-of-Network Providers
Inpatient Mental Health		
Deductible	None	None
Per Admission fee	None	None
Inpatient, partial and day treatment	Covered at 100%	Emergency services and care only
Days determined on the following ratios:	30 days per calendar year	
Inpatient Treatment = 1 day	(combined with Chemical Dependency)	
Residential Treatment = 50% of 1 day		
Day Treatment = 33% of 1 day		
Inpatient Chemical Dependency		
Deductible	None	None
Per Admission fee	None	None
Inpatient, partial and day treatment (includes detox)	Covered at 100%	Emergency services and care only
Days determined on the following ratios:	30 days per calendar year	
Inpatient Treatment = 1 day	(combined with Chemical Dependency)	
Residential Treatment = 50% of 1 day	2 pretreatments per lifetime	
Day Treatment = 33% of 1 day		
Outpatient Mental Health and Chemical Dependency (maximum 52 in and out of network visits per calendar year)		(Out-of-network maximum of 20 visits)
Individual session	$10	All charges above $50 per visit
Group session	$5	All charges above $25 per visit
The visit limits and maximums do not apply to Severe Mental Illness diagnosis (SMI)		
ORGAN TRANSPLANT BENEFIT		
Organ transplants are covered under a fully insured carve out plan through AIG Life Insurance Company.	The program covers 100% of all in-network transplant related costs up to a $1,000,000 maximum. The AIG Transplant Network consists of 50+ world class transplant centers across the United States. Benefits include travel allowance for patient and companion of $10,000 per year. The $1,000,000 organ transplant maximum does not apply towards the health plan lifetime maximum.	

9/28/2006

In-Network Preferred Providers (PPO): Member is not responsible for any charge that is determined to exceed the PPO providers contracted fees.

Out-of-Network Providers: In addition to the copayment amount, member is responsible for any charge determined to be in excess of the customary and reasonable charge.

This outline of benefits does not create or confer any rights. It is a brief summary of the plan and is not to be accepted or construed as a substitute of the Master Plan. Benefits are paid based on eligible expenses.