TDIC Insurance Solutions
Anthem Blue Cross PPO Plus Plan for Pacific School of Dentistry Students
Summary of Benefits-2008

In addition to dollar and percentage copays, insured persons are responsible for deductibles, as described below.
Please review the deductible information to know if a deductible applies to a specific covered service.
Insured persons are also responsible for all costs over the plan maximums.
Plan maximums and other important information appear in *italics*.

Explanation of Covered Expense
Plan payments apply to the lesser of the charges billed by the provider or the following:
PPO Providers—PPO negotiated rates. Members are not responsible for the difference between the provider's usual charges & the negotiated amount.
Non-PPO Providers & Other Health Care Providers *(includes those not represented in the PPO provider network)*—The customary & reasonable charge for professional services or the reasonable charge for institutional services.

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the allowed amount & actual charges, as well as any deductible & percentage copay.

Calendar year deductible	$2,000/member; maximum of two separate deductibles/family
Deductible for non-Anthem Blue Cross PPO hospital, residential treatment center or ambulatory surgery center if services not preauthorized	$500/admission *(waived for emergency admission)*
Annual Out of Pocket Maximum	$8,000/insured person/year

The following do not apply toward the annual out of pocket maximum: deductibles listed above; dollar copays; percentage copays for mental or nervous disorders & substance abuse; non-covered expense. After the plan has paid $8,000 in benefits for covered expense incurred by an insured person, the insured person no longer pays percentage copays for the remainder of the year. The insured person, however, remains responsible for the deductibles listed above; dollar copays; percentage copays for mental or nervous disorders & substance abuse, & for costs in excess of the covered expense when using non-PPO & Other Health Care providers.

Lifetime Maximum	$5,000,000/member

Covered Services	**PPO: Per Insured Person Copay**	**Non-PPO: Per Insured Person Copay**
Hospital Medical Services *(preauthorization required; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	20%	30%[1]
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	30%[1]
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	20%	30% *(limited to $350 per day)*
Skilled Nursing Facility *(preauthorization required)*		
➢ Semi-private room, services & supplies *(medical conditions & severe mental disorders limited to 120 days/calendar year)*	20%	30%
Hospice Care		
➢ Inpatient or outpatient services for members with up to six months life expectancy, and family bereavement counseling services.	20%[2]	
Home Health Care *(preauthorization required)*		
➢ Services & supplies from a home health agency *(limited to 120 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	20%	30%

[1]For California facilities, a discount applies if the facility has a contract with Blue Cross for fee-for-service business.
[2]These providers are not represented in the Blue Cross PPO network.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Home Infusion Therapy *(preauthorization required)* ➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	40% *(limited to $600/day)*
Physician Medical Services		
➢ Office & home visits	$20/visit *(deductible waived)*	30%
➢ Hospital & skilled nursing facility visits	20%	30%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	30%
Diagnostic X-ray & Lab *(including mammograms Pap smears & prostate cancer screenings)*	No copay *(deductible waived)*	30%
Well Baby & Well-Child Care for Dependent Children		
➢ Routine physical examinations *(birth through age six)*	$25/exam	30% *(benefits limited to $20/exam)*
➢ Immunizations *(birth through age six)* & immunizations for Hepatitis B & Varicella Zoster (Chicken Pox) *(ages 7 through 18)*	$25/immunization	30% *(benefits limited to $12/immunization)*
Preventive Care for Members Ages Seven and Older		
➢ Routine physical exams, immunizations, vision & hearing screenings. *(limited to $250 max/calendar year)*	$25/visit	Not covered
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(limited to 12 visits/calendar year; additional visits may be authorized)*	20%	30% *(benefits limited to $25/visit)*
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	20%	30%[1] *(benefits limited to $25/visit)*
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	20%[1]
Pregnancy & Maternity Care *(services cover subscriber, spouse & dependent daughters)*		
➢ Physician office visits	$20/visit *(deductible waived)*	30%
➢ Prescription drug for elective abortion *(mifepristone)*	20%	30%
Normal delivery, cesarean section, complications of pregnancy & abortion *(newborn routine nursery care covered when natural mother is subscriber or spouse)*		
➢ Inpatient physician services	20%	30%
➢ Hospital & ancillary services	20%	30%[2]
Organ & Tissue Transplants *(preauthorization required; specified organ transplants covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	20%	
➢ Physician office visits *(including specialists and consultants)*	$20/visit *(deductible waived)*	
➢ Transplant travel expense for an authorized, specified transplant at a COE *(recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days)*	No copay *(deductible waived)*	

[1]Professional services that may be available from Blue Cross PPO network providers, but would usually be available from providers whose specialties are not represented in the Blue Cross PPO network, are payable at the higher reimbursement level of the plan.
[2]For California facilities, a discount applies if the facility has a contract with Blue Cross for fee-for-service business.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	20%	30%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; & the first pair of contact lenses or eyeglasses when required as a result of eye surgery *(limited to $2,000/calendar year; no limitation for prostheses following a mastectomy or prosthetic devices following a laryngectomy)*	20% if billed by PPO Provider 30% if billed by non-PPO Provider 20% if billed by supplier	
Durable Medical Equipment		
➢ Rental or purchase of DME, dialysis equipment & supplies, & therapeutic shoes & inserts for members with diabetes *(limited to $2,000/calendar year)*	20%	30%
Related Outpatient Medical Services & Supplies[1]		
➢ Ground or air ambulance transportation, services & disposable supplies	20%[1]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%[1]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery; limited to $100/procedure)*	20%[1]	
Emergency Care		
➢ Emergency room services & supplies	20%	20%[2]
➢ Inpatient hospital services & supplies	20%	20%[2] first 48 hours; 30%[2] after 48 hours *(unless insured can't be moved safely)*
➢ Ambulatory surgical center services & supplies	20%	20%
➢ Physician services	20%	20%
Mental or Nervous Disorders		
➢ Facility-based care *(benefits limited to 30 days per calendar year; preauthorization required; waived for emergency admissions)*	20%[3]	30%[2, 3]
➢ Inpatient or outpatient physician visits *(benefits limited to,30 days/calendar year for a combined inpatient/outpatient maximum)*	20%[3]	30%[3]
Substance Abuse		
➢ Facility-based care *(benefits limited to 30 days per calendar year; preauthorization required; waived for emergency admissions)*	20%	30%[2]
➢ Inpatient or outpatient physician visits *(benefits limited to $50/visit,30 days/calendar year for a combined inpatient/outpatient maximum)*	20%	30%
Prescription Drugs *(outpatient prescriptions only)*		
Participating Retail Pharmacy - *30 day supply*		
➢ Generic drugs	$5	
➢ Brand name drugs	$15	
Mail Service - *60 day supply*		
➢ Generic drugs	$5	
➢ Brand name drugs	$15	
Non-participating Pharmacies - *30 day supply*		
➢ Within California maximum	Insured person pays the above copay *plus* 50% of the amount allowed & costs in excess of the maximum amount	
➢ Outside California	Costs in excess of the covered expense	

[1]These providers are not represented in the Anthem Blue Cross PPO network.

[2]For California facilities, a discount applies if the facility has a contract with Anthem Blue Cross for fee-for-service business.

[3]These exclusions, copays and benefit maximums do not apply to severe mental disorders, including schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, bulimia, and serious emotional disturbances of children as defined in California state law (other than primary substance abuse or developmental disorder). Severe mental disorders are subject to the same copays and benefit maximums applicable to other medical conditions for covered services. In order to receive maximum benefits, services must be rendered by a Anthem Blue Cross behavioral health provider. Please see the EOC for complete information.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Anthem Blue Cross PPO—Prudent Buyer Plan Exclusions and Limitations

Not Authorized. Any services not authorized by the member's primary care physician or medical group, except for emergency services and urgent care as specified as covered in the Evidence of Coverage (EOC).

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from such release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.

Services Provided by Non-Participating Providers. Any services provided by a non-participating provider, except for authorized referrals, emergency services or urgent care as specified as covered in the EOC

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the member does not claim those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

Government Treatment. Any services provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law.

Voluntary Payment. Services for which the member has no legal obligation to pay or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research;
2. At least 10% of its yearly budget must be spent on research not directly related to patient care;
3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. It must accept patients who are unable to pay; and
5. Two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Any treatment of mental or nervous disorders or alcohol or drug dependence, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs.

Orthodontia. Braces and other orthodontic appliances or services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Optometric Services or Supplies. Optometric services, eye exercises and orthoptics, except for eye examinations to determine the need for vision correction. Eyeglasses or contact lenses, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Obesity. Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to treatment of morbid obesity as determined by Blue Cross HMO or the member's medical group if the medical group authorizes the treatment in advance as medically necessary and appropriate.

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

Sterilization Reversal.

Infertility Treatment. Artificial insemination or in vitro fertilization procedures, and any related laboratory procedures. Infertility treatment, family planning or birth control services, except as specified as covered in the EOC.

Surrogacy. Any services or supplies provided in connection with a surrogate pregnancy, i.e., the bearing of a child by another woman for an infertile couple, unless the surrogate mother is an enrolled Blue Cross HMO member.

Sexual Dysfunction. Treatment of any sexual dysfunction, except when due to a physical abnormality, defect or disease. Treatment for a dysfunction which is the result of psychological causes is not covered.

Orthopedic Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related feet complications as specified as covered in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Chronic Pain. Treatment of chronic pain, except as specified as covered in the EOC.

Exercise Equipment. Exercise equipment or any charges for activities, instrumentalities or facilities normally intended or used for developing or maintaining physical fitness, including, but not limited to, charges from a physical fitness instructor, health club or gym, even if ordered by a physician.

Personal Items. Any supplies for comfort, hygiene or beautification.

Nutrition. Food or nutritional supplements.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Examinations. Routine physical or psychological examinations or tests required by employment or government authority, or at the request of a third party such as a school, camp or sport affiliated organization. Any other routine physical or psychological examination or test which does not directly treat an actual illness, injury or condition, except as specified as covered in the EOC.

Immunizations. Immunizations for foreign travel. Immunizations, except as specified as covered in the EOC.

Acupuncture. Acupuncture treatment except as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Rehabilitative Care. Rehabilitative care such as physical therapy, occupational therapy or speech therapy following illness or injury, unless provided by a home health agency, a visiting nurse association or hospice, or except as specified as covered in the EOC.

Outpatient Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, dietary supplements, health or beauty aids.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by the member's medical group.

Third Party Liability – Blue Cross of California is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination of Benefits – The benefits of this plan may be reduced if the member has any other group health, dental, prescription drug or vision coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

Prescription Drug Exclusions and Limitations

Immunizing agents, biological sera, blood, blood products or blood plasma.

Hypodermic syringes & or needles, except when dispensed for use with insulin & other self-injectable drugs or medications.

Drugs & medications used to induce non-spontaneous abortions.

Drugs & medications dispensed or administered in an outpatient setting, including outpatient hospital facilities and physicians' offices.

Professional charges in connection with administering, injecting or dispensing drugs.

Drugs & medications that may be obtained without a physician's written prescription, except insulin or niacin for cholesterol lowering.

Drugs & medications dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility.

Durable medical equipment, devices, appliances & supplies, even if prescribed by a physician, except contraceptive diaphragms, as specified as covered in the Plan.

Services or supplies for which the member is not charged.

Oxygen.

Cosmetics & health or beauty aids.

Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or experimental drugs.

Drugs or medications prescribed for experimental indications.

Any expense for a drug or medication incurred in excess of (a) the Drug Limited Fee Schedule for drugs dispensed by non-participating pharmacies; or (b) the prescription drug negotiated rate for drugs dispensed by participating pharmacies or through the mail service program

Drugs which have not been approved for general use by the State of California Department of Health or the Food and Drug Administration.

Smoking cessation drugs.

Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles).

Drugs used primarily to treat infertility (including, but not limited to, Clomid, Pergonal and Metrodin).

Anorexiants and drugs used for weight loss, except when used to treat morbid obesity (e.g., diet pills & appetite suppressants).

Drugs obtained outside the U.S.

Allergy desensitization products or allergy serum.

Infusion drugs, except drugs that are self-administered subcutaneously.

Select classes of drugs where non-preferred medications, which have therapeutic alternatives, have shown no benefit regarding efficacy or side effect over preferred drugs; however, this will not apply if the prescriber denotes "dispense as written" or "do not substitute".

Herbal, nutritional and dietary supplements except for formulas for the treatment of phenylketonuria.

Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin.

The Power of Blue. SM

This plan is insured by BC Life & Health Insurance Company. Blue Cross of California administers claims on behalf of BC Life & Health Insurance Company but is not financially liable for benefits payable.

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