BlueCross BlueShield of Tennessee

Group Name: LMU Student Plan

Option: PPO

Network: S

Effective Date: August 1, 2008

PPO Benefits

Benefit Features	Network Providers	Out-of-Network Providers [2]
Annual Deductible		
Individual	$500	$1,000
Family	$1,000	$2,000
Annual Out-of-Pocket Maximum Amount		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Dependent Age Limit	To age 24	
Lifetime Maximum Benefit	$1,000,000	
Pre-Existing Condition Waiting Period [1]	12 months	

Benefits for Covered Services	Network Benefits	Out-of-Network Benefits [2]
Practitioner Office Services		
Office Visits	$25 Copay	60% after Deductible
LMU-DCOM Outpatient Services	100% - No Copay	60% after Deductible
Routine Diagnostic Lab, X-Ray, & Injections	No Additional Copay	60% after Deductible
Non-routine Diagnostic Services [5]	80% after Deductible	60% after Deductible
Provider-Administered Specialty Pharmacy Products [9]	$50 Copay	60% after Deductible
Preventive Health Care Services		
Well Child Care (to age 6)	$25 Copay	60% after Deductible
Annual Well Woman Exam	$25 Copay	60% after Deductible
Annual Mammography Screening	No Additional Copay	60% after Deductible
Annual Cervical Cancer Screening	No Additional Copay	60% after Deductible
Prostate Cancer Screening	No Additional Copay	60% after Deductible
Immunizations (to age 6)	No Additional Copay	60% after Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [3]	80% after Deductible	60% after Deductible
Outpatient Surgery [4]	80% after Deductible	60% after Deductible
Routine Diagnostic Services-Outpatient	100% (no deductible)	60% after Deductible
Non-routine Diagnostic Services-Outpatient [5]	80% after Deductible	60% after Deductible
Provider-Administered Specialty Pharmacy Products [9]	80% after Deductible	60% after Deductible
Other Outpatient Services [6]	80% after Deductible	60% after Deductible
Emergency Care Services [10]	$120 Copay, then 80%	$120 Copay, then 80%
Emergency Care Non-Routine Diagnostics [5]	80% after Deductible	80% after Deductible
Medical Equipment		
Durable Medical Equipment, Prosthetic & Orthotic Appliances	80% after Deductible	60% after Deductible
Therapeutic Services [7]		
Therapy (Limited to 30-36 visits per year per therapy type)	80% after Deductible	60% after Deductible
Skilled Nursing Facility & Rehabilitation Facility Services [3]		
Limited to 60 days combined	80% after Deductible	60% after Deductible
Home Health Services [8]		
Limited to 60 visits per year	80% after Deductible	60% after Deductible
Hospice Services	100%	60% after Deductible
Ambulance Service	80% after Deductible	80% after Deductible

Notes:

1. HIPAA regulations apply. A Group enrollee's pre-existing condition waiting period can be reduced by the enrollee's applicable 'creditable coverage'.
2. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
3. Services require prior authorization. When using network providers outside Tennessee and all out-of-network providers, benefits will be reduced to 50% if prior authorization is not obtained and services are medically necessary. If services are not medically necessary no benefits will be provided.
4. Surgeries include invasive diagnostic procedures such as colonoscopy and sigmoidoscopy.
5. CAT scans, MRIs, nuclear medicine and other similar technologies.
6. Includes services such as chemotherapy, radiation therapy, and renal dialysis.
7. Physical, speech, manipulative, and occupational therapies are limited to 30 visits per therapy type per year. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per year.
8. Requires prior authorization.
9. Refer to www.bcbst.com for Specialty Pharmacy Drug List
10. Copay, if applicable, waived if admitted to hospital

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Exclusions From Coverage

• Services or supplies not listed as Covered Services in the Evidence of Coverage (EOC);
• Services or supplies that are not Medically Necessary and Appropriate or have not been authorized by the Plan;
• Services or supplies that are Investigational in nature;
• When more than one treatment alternative exists, each is Medically Appropriate and Medically Necessary, and each would meet Your needs, We reserve the right to provide payment for the least expensive Covered Service alternative.
• Illness or injury resulting from war, which occurred before Your Coverage began under this EOC and which is Covered by veteran's benefit or other coverage for which You are legally entitled;
• Self treatment or training;
• Staff consultations required by hospital or other facility rules;
• Services which are free;
• Treatment of illness or injury related to Your participation in a felony, attempted felony, riot or insurrection;
• Treatment of work related illness or injury, regardless of presence or absence of workers' compensation coverage. Exclusion does not apply to injuries or illnesses of an employee who is sole-proprietor of the Group, partner of the Group or corporate officer of the Group, provided the officer filed an election not to accept Workers' Compensation with the appropriate government department;
• Personal, physical fitness, recreational or convenience items and services such as barber and beauty services, television, air conditioners, humidifiers, air filters, heaters, physical fitness equipment, saunas, whirlpools, water purifiers, swimming pools, tanning beds, weight loss programs, physical fitness programs, self-help devices which are not primarily medical in nature, even if ordered by a Practitioner;
• Services or supplies received before Your effective date for Coverage with this Plan;
• Services or supplies received after Your Coverage under this Plan ceases for any reason, even though the expenses relate to a condition that began while You were Covered;
• Services or supplies received in a dental or medical department maintained by or on behalf of the employer, mutual benefit association, labor union or similar group;
• Telephone or email consultations, or charges for failure to keep a scheduled appointment or charges to complete a claim form or to provide medical records;
• Services for providing requested medical information or completing forms;
• Court ordered examinations and treatment, unless Medically Necessary;
• Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day;
• Benefits for Pre-existing Conditions until any Pre-existing Condition Waiting Periods have been met;
• Charges in excess of the Maximum Allowable Charge for Covered Services or any charges which exceed the Lifetime Maximum;
• Any service stated in the EOC as a non-Covered Service or limitation;
• Charges for services performed by a family member;
• Any charges for handling fees;
• Nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;
• Safety items, or items to affect performance primarily in sports-related activities;
• Services or supplies related to obesity, including surgical or other treatment of morbid obesity;
• Services or supplies related to treatment of complications (except complications of pregnancy) that are a direct or closely related result of a Member's refusal to accept treatment, medicines, or a course of treatment that a Provider has recommended or has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating physician;
• Services or supplies related to cosmetic services, including surgical or other services, drugs or devices;
• Blepharoplasty and browplasty, except for correction of injury to the orbital area resulting from physical trauma or non-cosmetic surgical procedures (e.g., removal of malignancies), treatment of edema and irritation resulting from Grave's disease, or correction of trichiasis, ectropion, or entropion of the eyelids;
• Services and charges related to the care of the biological mother of an adopted child, if the biological mother is not a Member. Services and charges relating to surrogate parenting;
• Sperm preservation;
• Orthognathic surgery;
• Maintenance Care;
• Private duty nursing;
• Pharmacogenetic testing;
• Treatment of sexual dysfunction, regardless of cause;
• Removal of impacted teeth, including wisdom teeth;
• Professional services for maternity delivery in a home setting or location other than a licensed hospital or birthing center;
• Methadone maintenance therapy and buprenorphine maintenance therapy;
• Cranial orthosis, including helmet or headband, for the treatment of plagiocephaly;
• Office visits and physical exams for school, camp, employment, travel, insurance, marriage or legal proceedings, and related immunizations and tests;
• Routine foot care for the treatment of flat feet, corns, bunions, calluses, toenails, fallen arches, weak feet or chronic foot strain;
• Foot orthotics, shoe inserts and custom made shoes, except as required by law for diabetic patients or as a part of a leg brace;
• Preventive services not listed as Covered;
• Services not provided in accordance with the Plan's Medical Policy guidelines.
Dental procedures, except as otherwise indicated in the EOC;
• Procedures which require precertification, Prior Authorization and/or special consent, in accordance with the Plan's Medical Policy for which Authorization was not provided;
• Inpatient stays primarily for therapy (such as physical or occupational therapy);
• Private room when not authorized by the Plan and room and board charges are in excess of semi-private room;
• Emergency treatment of a chronic, non-Emergency condition, where symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency;
• Ambulance transportation for Your convenience, that is not essential to reduce the probability of harm to You, when You are not transported to a facility, or transfers between facilities that did not receive Prior Authorization from the Plan;
• Behavioral Health Services except as specified in separate Rider;
• Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality, including but not limited to artificial insemination, in vitro fertilization, fallopian tube reconstruction, uterine reconstruction, assisted reproductive technology (ART) including but not limited to GIFT and ZIFT, fertility injections, fertility drugs, services for follow-up care related to infertility treatments;
• Reversal of sterilization;
• Induced abortion unless the health care Practitioner certifies in writing that the pregnancy would endanger the life of the mother, the pregnancy is a result of rape or incest, the fetus is not viable, or the fetus has been diagnosed with a lethal or otherwise significant abnormality;
• Services, supplies or prosthetics primarily to improve appearance;
• Surgeries to correct or repair the results of a prior surgical procedure, the primary purpose of which was to improve appearance;
• Surgeries and related services to change gender;
• Custodial, domiciliary or private duty nursing services;
• Cognitive rehabilitation;
• Therapy/Rehabilitative treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care;
• Enhancement therapy which is designed to improve Your physical status beyond Your pre-injury or pre-illness state;
• Complementary and alternative therapeutic services, including, but not limited to massage therapy, acupuncture, craniosacral therapy, neuromuscular reeducation, vision exercise therapy, and cognitive rehabilitation;
• Therapy modalities that do not require the attendance or supervision of a licensed therapist;
• Behavioral therapy, play therapy, communication therapy, and therapy for self correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs;
• Organ transplant and related services that were not Authorized through Transplant Case Management;
• Transplant related charges in excess of the Transplant Maximum Allowable Charge;
• Removal of an organ from a Member for purposes of transplantation into another person, except as Covered by the Donor Organ Procurement provision;
• Treatment for routine dental care and related services including, but not limited to crowns, caps, plates, bridges, dental x-rays, fillings, tooth extraction, periodontal surgery, prophylactic removal of teeth, root canals, preventive care (cleanings, x-rays), replacement of teeth (including implants, false teeth, bridges), bone grafts (alveolar surgery), treatment of injuries caused by biting and chewing, treatment of teeth roots and treatment of gums surrounding the teeth;
• Treatment for correction of underbite, overbite, and misalignment of the teeth including but not limited to, braces for dental indications, orthognathic surgery, and occlusal splints;
• Diagnostic Services which are not Medically Necessary and Appropriate;
• Diagnostic Services not ordered by a Practitioner;
• Pharmaceuticals purchased with a prescription except those dispensed at a participating facility, unless listed in a separate rider;
• Pharmaceuticals that may be purchased without a prescription;
• Self-administered Specialty Pharmacy Products as identified on the Plan's specialty pharmacy list, except as may be Covered by a separate Rider;
• Services, surgeries and supplies to detect or correct refractive errors of the eyes;
• Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses;
• Eye exercises and/or therapy;
• Visual training;
• Charges exceeding the total cost of the Maximum Allowable Charge to purchase Durable Medical Equipment;
• Unnecessary repair, adjustment or replacement or duplicates of any such equipment;
• Supplies and accessories that are not necessary for the effective functioning of the covered equipment;
• Items to replace those which were lost, damaged, stolen or prescribed as a result of new technology;
• Items which require or are dependent on alteration of home, workplace or transportation vehicle;
• Motorized scooters, exercise equipment, hot tubs, pool, saunas;
• "Deluxe" or "enhanced" equipment;
• Diabetic treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary;
• Diabetic Supplies not required by state statute;
• Hearing aids;
• Prosthetics primarily for cosmetic purposes, including but not limited to wigs, or other hair prosthesis or transplants;
• Replacement of contacts after the initial pair have been provided following cataract surgery;
• Items such as non-treatment services or routine transportation, homemaker or housekeeping services, behavioral counseling, supportive environmental equipment, Maintenance Care or Custodial Care, social casework, meal delivery, personal hygiene, and convenience items;
• Services such as homemaker or housekeeping services, meals, convenience or comfort items not related to the illness, supportive environmental equipment, private duty nursing, routine transportation and funeral or financial counseling;
• Supplies that can be obtained without a prescription (except for diabetic supplies).

Please refer to the Evidence of Coverage for a complete description of PPO benefits and exclusions.

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