

MEDICAL



Pepperdine University 2011/2012 Multi-Choice Medical Program • September, 2011

	Blue Cross HMO	Blue Cross EPO	Blue Cross POS \$350/\$20/80%/70% Point-of-Service Plan (POS)			Kaiser HMO
	HMO/IPA/PMG MODEL	PPO	HMO	PPO	OUT-OF-NETWORK	HMO/STAFF MODEL
Plan Concept	A Health Maintenance Organization requires that you use their facilities and reside within the service area. No claim forms are required.	Blue Cross EPO members must receive health care services from Blue Cross PPO (Prudent Buyer) network providers, unless you receive authorized referrals or need emergency and/or out-of-area urgent care.	The POS (Point-of-Service) plan requires you to choose a Blue Cross primary care physician and reside within the service area. You receive a higher benefit when services are authorized by the Blue Cross primary care physician. However, you may elect to go "outside" of the network and receive a lesser benefit.			A Health Maintenance Organization requires that you use their facilities and reside within their service area. No claim forms are required.
Deductible (calendar year) Individual/Family	No Deductible	\$100/member/max 3 separate family deductibles	No Deductible	\$350 Individual / \$700 Family	\$750 Individual / \$1,500 Family	No Deductible
Inpatient Deductible (applies to Ambulatory Surgical Center)	N/A	N/A	N/A	N/A	\$500 (waived for emergency admissions)	N/A
Non-certification Deductible	N/A	N/A	N/A	N/A	\$250 for each admission to a hospital or Ambulatory Surgical Center if review is not obtained (waived for emergency admissions)	N/A
Lifetime Maximum • Medical • Psychological & Nervous • Alcoholism/Chemical Dependency	Unlimited Unlimited Unlimited	Unlimited Included in Medical Maximum Included in Medical Maximum	Unlimited	Unlimited Included in Medical Maximum Included in Medical Maximum		Unlimited

I. Hospital Charges (Including Mental Health and Substance Abuse Care*)

Hospital Room (Semi-Private)	Full Coverage	90%	100%	80%	70% Additional reductions may apply. See brochure for details.	Full Coverage
Intensive Care	Full Coverage	90%	100%	80%	70% Additional reductions may apply. See brochure for details.	Full Coverage
Skilled Nursing	Full coverage up to 100 days each calendar year.	90% (100 days each calendar year)	100% (100 days each calendar year)	80% (100 days each calendar year)	70% Additional reductions may apply. See brochure for details. (100 days each calendar year)	Up to 100 days at authorized facility (skilled nursing facility)
MATERNITY Normal Delivery	Full Coverage	90%	100%	80%	70%	Full Coverage
Miscarriage & Caesarean Section	Full Coverage	90%	100%	80%	70%	Full Coverage
Ectopic and Complications	Full Coverage	90%	100%	80%	70%	Full Coverage

II. Doctor's Charges (Including Mental Health and Substance Abuse Care*)

Primary and Assistant Surgeon	Full Coverage	90%	100%	80%	70%	Full Coverage
Anesthesiologist	Full Coverage	90%	100%	80%	70%	Full Coverage
Hospital Visits	Full Coverage	90%	100%	80%	70%	Full Coverage
Office Visits	\$20 Charge/visit	\$20 Charge/visit (deductible waived)	\$20 Charge/visit	80%	70%	\$20 Charge/visit
Out-Patient Surgery	Full Coverage with \$20 office visit	90%	100%	80%	70%	Full Coverage with \$20 office visit
Chiropractic	See Footnote ⁽¹⁾ \$15 copay, 30 visits max. per cal. year	90% (limited to 48 visits/ calendar year)	Refer to physiotherapy benefits below	See Footnote ⁽¹⁾ \$15 copay, 30 visits max. per cal. year	70% (Benefit limited to \$25/Visit)	See Footnote ⁽¹⁾ \$15 copay, 30 visits max. per cal. year
OBSTETRICS Normal Delivery	\$20 Charge each visit	\$20/visit ⁽²⁾ Physician office visits (deductible waived) 90% Inpatient physician svcs. 90% Hospital & ancillary svcs.	\$20 Charge each visit	80%	70%	\$20 Charge first visit Full Coverage thereafter
Miscarriage & Caesarean Section	Same as any other illness; copays may apply	90%	Same as any other illness; copays may apply	80%	70%	Full Coverage
Ectopic and Complications	Same as any other illness; copays may apply	90%	Same as any other illness; copays may apply	80%	70%	Full Coverage
Well Child Exams & Immunizations (less than age 19); refer to booklet for details	Full coverage	Full coverage	Full coverage	No Coverage	No Coverage	Full Coverage
Routine Adult Physical Exams	Full coverage	Full coverage	Full coverage	No Coverage	No Coverage	Full coverage
Immunizations (Specific) (over age 18)	Full coverage	No copay (deductible waived)	Full coverage	No Coverage	No Coverage	Full coverage for certain immunizations
Well Woman Exams	Full Coverage	Full Coverage	Full Coverage	80% Limited to one exam/ calendar year	70% Limited to one exam/ calendar year	Full Coverage
X-Ray and Lab (Out-of-Hospital)	Full Coverage	90% (full coverage for preventative Services)	100% (\$100 for some tests)	80%	70%	Full Coverage
Renal Dialysis	Full Coverage	90%	100%	80%	70%	\$20 Charge/visit
Organ Transplants	Same as any other illness; Copays may apply	See brochure for details	Same as any other illness; Copays may apply.	See brochure for details	See brochure for details	See brochure for details
Physiotherapy	\$20 Charge/visit (60 consecutive calendar days for each illness or injury)	90% Limited to 48 visits per calendar year combined with physical therapy, occupational therapy and chiropractic	\$20 Charge/visit (60 consecutive calendar days for each illness or injury)	\$20 Charge/visit (30 consecutive calendar days for each illness or injury)	70% (60 consecutive calendar days for each illness or injury; benefit limited to \$25/Visit)	\$20 Charge/visit
FAMILY PLANNING Birth Control	See Blue Cross Rx benefit on reverse					\$10 generic/\$20 brand (up to 100 day supply)
IUDs	\$20 Charge/visit	\$20 Charge/visit	\$20 Charge/visit	80%	70%	\$20 Charge/visit
Tubal Ligation	\$150 charge	90%	\$150 charge		50%	Full Coverage, \$20 if physicians office
Vasectomy	\$50 charge	90%	\$75 charge		50%	Full Coverage, \$20 if physicians office
Eye Refractions	\$20 Charge/visit(authorized)	No Coverage	\$20 Charge/visit(authorized)	No Coverage	No Coverage	\$20 Charge/visit
Lenses and Frames	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage

III. Other Charges

Prescription Drugs (May include dental Rx's through participating pharmacies only)	See Blue Cross Rx benefit on reverse					\$10/Rx charge generic; \$20/Rx charge brand name (up to 100 day supply)
Ambulance	Full Coverage	90%	Full Coverage	80%	80%	Full Coverage (authorized)
Durable Equipment (Including Hearing Aids limit 1 per every 3 years)	Full Coverage	90%	Full Coverage	80%	70%	Full Coverage (3) plus co-payment 20% of cost exceeding \$2,500
Home Health Service**	Full coverage	90%***	100%***	80%***	70%***	Full Coverage (authorized)
Blood and Plasma	Full Coverage	90%	100%	80%	70%	No Charge if replaced
Hospice	Full Coverage	90%	Full Coverage	80%	80%	Covered, refer to brochure for details

IV. Emergency Benefits

Emergency/Accident In-Area or Out-of-Area	\$100 Charge for Emergency Room (waived if admitted)	90% \$100 deductible (waived if admitted)	\$100 ER Charge (waived if admitted)	\$100 ER Charge (waived if admitted)	\$100 ER Charge (waived if admitted)	\$100 ER Charge (waived if admitted)
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V. Special Restrictions

Pre-Existing Condition Limitation	Full Coverage	Full Coverage****	Full Coverage	Full Coverage	Full Coverage	Full Coverage
Third Party Liability	Benefits Assigned	Benefits Assigned	Benefits Assigned	Benefits Assigned	Benefits Assigned	Benefits Assigned
OUT-OF-POCKET MAXIMUM The Coinsurance out-of-pocket maximum refers to expenses you have paid toward eligible expenses.	N/A	\$1,000/Individual	N/A	\$2,000/Individual	\$3,000/Individual	N/A
The Copayment Maximum (refers to calendar year limit of copayments for office visits, emergency room, etc.)	\$1,500 / Individual; \$3,000 / Two-Party \$4,500 / Family	N/A	\$1,500 / Individual; \$3,000 / Family	N/A	N/A	\$1,500 / Individual; \$3,000 / Family (Calendar Year 2011)

(1) Chiropractic Services are provided through a separate network of participating chiropractors.

(2) The out-of-pocket maximum does not apply to some certain Family Planning benefits.

(3) Kaiser hearing aid benefit limited to \$2,500 per device, 2 devices per 36 months period.

*Mental Health and Substance Abuse Benefits will be provided at the same level as other covered medical benefits under the Mental Health Parity and Addiction Equity Act.

**All benefits and services received (whether in-network or out-of-network) count toward these limits.

***Limit of 100 visits per calendar year

****6 months treatment free, or 6 months covered under the Plan (HIPAA applies)

Note: Plan coverage is actually governed by more formal legal plan documents. Applicable laws and insurance contracts may also affect coverage. While every effort has been made to provide clear and accurate information, in the event of any discrepancy between these materials and the official plan documents, the plan documents or contracts will govern.



2011-2012

PEPPERDINE OVERVIEW

DENTAL



Pepperdine University Benefit Comparison and Dual Choice Option • September, 2011

	DELTA DENTAL		DELTACARE USA
	DELTA PREFERRED OPTION	DELTA PREMIER OPTION	
Plan Concept	Delta Dental offers you the choice of using their Preferred Providers or any dentist you choose. By using the Preferred Dentists, as listed in the brochure, you will automatically receive a higher benefit as illustrated below. The brochure is available in Human Resources. The following is a brief benefit comparison highlighting the Delta Preferred Option benefits and the Delta Premier benefits. All Delta dentists provide and complete claim forms at no charge.		This is a Pre-Paid Dental Plan and care is provided by specific dentists. If you select the plan, you must use these providers to receive benefits. Refer to the brochure for locations and benefits information available in Human Resources.
Annual Deductible	None	\$50 Basic & Major Services combined (No deductible for Diagnostic & Preventive & Orthodontia); \$150 Maximum Family Deductible.	No Annual Deductible—Certain procedures require a co-payment.
Annual Benefit Maximum	\$2,000	\$2,000	None
Orthodontia Maximum (Lifetime)	\$2,000	\$2,000	None (See IV. Orthodontics)

BENEFIT PERCENTAGES FOR COVERED DENTAL SERVICES

I. Diagnostic & Preventive			
Visits & Exams (Visit for oral examination, prophylaxis, including scaling, polishing, fluoride. Certain limitations apply. Please read the dental brochures for details.	100%	100%	100%
X-Rays—Full Mouth Series, Bite Wing X-Rays—Certain limitations apply. Please read the dental brochures for details.	100%	100%	100%
II. Basic/Restorative			
Endodontics—Pulp Capping (Root Canal Therapy)	95%	80%	Charges range from \$0 to \$300.
Repairs/Restorations (Amalgam (silver) fillings, Composite fillings)	95%	80%	Charges range from \$0 to \$85.
Sealants	95%*	80%*	\$10 per tooth.
Periodontics	95%	80%	Charges range from \$15 to \$300.
Oral Surgery	95%	80%	Charges range from \$0 to \$110.
III. Major			
Restorative—Inlay/Onlay, Crowns, Cast Restorations	50% Benefit per tooth limited to once every five years.	50% Benefit per tooth limited to once every five years.	Refer to brochure for details.
Prosthetics—Construction or repair of fixed bridges, partial dentures, complete dentures	50%*	50%**	Co-payment varies according to procedure (\$10 to \$210, refer to brochure for details).
Implants (Pre-authorization required)	50%**	50%**	No coverage
IV. Orthodontics			
	50%**	50%**	Co-payment varies with phase of treatment. See brochure for details.

* Limited to first molars under age 9, second molars under age 14, once every three years, permanent molars only with no decay or restoration.

** Newly covered employees and dependents will be subject to a 12 month waiting period for prosthetics, orthodontics and implants.

VISION



Highlights of VSP Signature Vision Plan • September, 2011

VSP SIGNATURE VISION PLAN		
Plan Concept	VSP offers you the choice of using their Preferred Providers or any optometrist you choose. By using an optometrist from the network listing you receive a vision exam and frames/lenses with a \$20 co-payment. No claim form is required within the network. However, preauthorization and claim form are required out-of-network.	
Benefits Every 12 Months For:	In-Network	Out-of-Network
Examination	You pay \$20 co-payment	Plan Reimburses up to \$45
Lenses (single to trifocal)	Included	Plan Reimburses from \$45 to \$85
Frame (benefit every 24 months)	\$130 allowance	Plan Reimburses up to \$47
Contact Lens (in lieu of lens and frame benefit)	\$130 allowance	Plan Reimburses up to \$105

BLUE CROSS RX

Participating Pharmacies/Mail Service	Specialty Pharmacy Drugs	Non-participating Pharmacies
Generic drugs \$10	Generic drugs \$10	Member pays the retail participating pharmacies co-pay plus: 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. (30-day supply)
Brand name formulary drugs ¹ \$25	Brand name formulary drugs ¹ \$25	
Brand name non-formulary drugs ¹ \$45	Brand name non-formulary drugs ¹ \$45	
Compound drugs ¹ \$45	Compound drugs ¹ \$45	
Self administered injectable drugs, except insulin 20% co-pay of prescription drug maximum allowed amount (maximum \$100 co-pay)	Self administered injectable drugs, except insulin 20% co-pay of prescription drug maximum allowed amount (maximum \$100 co-pay)	
30-day supply retail, 90-day supply Mail Service ² . Specialty pharmacy drugs not covered at retail participating pharmacies.	May only be obtained through the specialty pharmacy program. (30-day supply)	

¹Preferred Generic Program. If a member requests a formulary or non-formulary brand name drug when a generic drug version exists, the member pays the generic drug co-pay plus the difference in cost between the prescription drug maximum allowed charge for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost for that type of prescription drug. The Preferred Generic Program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug (formulary or non-formulary) is medically necessary for the member. In such case, the applicable co-pay for the dispensed drug will apply.

²Supply limits for certain drugs may be different. Please refer to the EOC/Certificate for complete information. 60-day supply for federally classified; Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double co-pay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs.



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