

**Bethel College**  
**Blue Access<sup>SM</sup> (PPO)**  
**Summary of Benefits, Effective January 1, 2010**

Covered Benefits	Network	Non-Network
<b>Deductible (Single/Family)</b>	\$500/\$1,500	\$1,000/\$3,000
<b>Out-of-Pocket Maximum (Single/Family)</b>	\$3,000/\$6,000	\$6,000/\$12,000
<b>Physician Home and Office Services (PCP/SCP)</b> Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including office surgeries and allergy serum: <ul style="list-style-type: none"> <li>allergy injections (PCP and SCP)</li> <li>allergy testing</li> <li>non-routine mammograms (regardless of outpatient setting)</li> <li>MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and non-maternity related Ultrasounds</li> </ul>	\$25/\$40  \$5 10% No copayment/coinsurance 10%	30%  30% 30% 30%
<b>Preventive Care Services</b> Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, immunizations <sup>1</sup> , Annual diabetic eye exam, Routine Vision and Hearing exams. <ul style="list-style-type: none"> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> <li>Routine mammograms</li> <li>Diabetic education</li> <li>Medical nutritional therapy</li> </ul>	No copayment/coinsurance No copayment/coinsurance No copayment/coinsurance No copayment/coinsurance No copayment/coinsurance	30% 30% 30% 30% Not covered
<b>Emergency and Urgent Care</b> <ul style="list-style-type: none"> <li><b>Emergency Room Services @ Hospital (facility/other covered services)</b> (copayment waived if admitted)</li> <li><b>Urgent Care Center Services</b></li> </ul>	\$100/10%  \$35	\$100/10%  \$35
<b>Inpatient and Outpatient Professional Services</b> Include, but are not limited to: <ul style="list-style-type: none"> <li>Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</li> </ul>	10%	30%
<b>Inpatient Facility Services</b> Unlimited days except for: <ul style="list-style-type: none"> <li>60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> <li>90 days Network/Non-Network combined for skilled nursing facility</li> </ul>	10%	30%
<b>Outpatient Surgery Hospital/Alternative Care Facility</b> <ul style="list-style-type: none"> <li>Surgery and administration of general anesthesia</li> </ul>	10%	30%
<b>Other Outpatient Services (including but not limited to):</b> <ul style="list-style-type: none"> <li>Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.</li> <li>Home Care Services (Network/Non-Network combined) 90 visits (excludes IV Therapy)</li> <li>Durable Medical Equipment and Orthotics (Network/Non-network combined) \$4,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies)</li> <li>Prosthetic Devices \$4,000 benefit maximum</li> <li>Prosthetic limbs are unlimited</li> <li>Physical Medicine Therapy Day Rehabilitation programs</li> <li>Hospice Care</li> <li>Ambulance Services</li> </ul>	10%          10% 10%	30%          10% 10%

Covered Benefits	Network	Non-Network
<b>Outpatient Therapy Services</b> (Combined Network and Non-Network limits apply) <ul style="list-style-type: none"> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul> Limits apply to: <ul style="list-style-type: none"> <li>Physical therapy: 30 visits</li> <li>Occupational therapy: 30 visits</li> <li>Manipulation therapy: 12 visits</li> <li>Speech therapy: 20 visits</li> </ul>	\$25/\$40 10%	30% 30%
<b>Behavioral Health Services:</b> <b>Mental Health and Substance Abuse</b> <ul style="list-style-type: none"> <li>Inpatient Facility Services</li> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul>	10% \$25/\$40 10%	30% 30% 30%
<b>Human Organ and Tissue Transplants<sup>2</sup></b> <ul style="list-style-type: none"> <li>Acquisition and transplant procedures, harvest and storage</li> </ul>	No copayment/coinsurance	50%
<b>Prescription Drug Options:<sup>3</sup></b> Network Tier structure equals 1/2/3 (and 4, if applicable) <ul style="list-style-type: none"> <li><b>Network Retail Pharmacies:</b> (30-day supply) Includes diabetic test strip</li> <li><b>Anthem Rx Direct Mail Service:</b> (90-day supply) Includes diabetic test strip</li> </ul> <b>Medicare Rx - Wrap</b> <b>Specialty Medications</b> must be obtained via our Specialty Pharmacy network in order to receive network level benefits	\$10/\$40/\$60/25% Tier 4 subject to \$2,500 out-of-pocket  \$20/\$80/\$120/25% Tier 4 subject to \$2,500 out-of-pocket	50%, min \$30 <sup>4</sup>  Not covered
<b>Lifetime Maximum (Combined Network and Non-Network)<sup>5</sup></b> <ul style="list-style-type: none"> <li>Medical</li> <li>Surgical Treatment of Morbid Obesity (contributes toward the medical lifetime maximum)</li> </ul>	\$1 million \$10,000	\$1 million \$10,000

**Notes:**

- Prescription Drug deductibles/copayments/coinsurance and Non-network Human Organ and Tissue Transplants are excluded from the Out-of-pocket limits.
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services @ Hospital where a percentage (%) coinsurance applies to other covered services.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to the end of the calendar year which the child attains age 19; or to the end of the calendar year which the child attains age 23 if the child qualifies as a full-time student.
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYN's and Geriatrics or any other Network Provider as allowed by the plan.
- Physicians Home and office visit copayment also applies if the office visit is billed with allergy injections.
- No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.
- Benefit period = calendar year
- Exclude coverage for all abortions.
- Prosthetic limbs are unlimited and do not apply to the plan lifetime maximum

<sup>1</sup>These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.

<sup>2</sup>Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

<sup>3</sup>If applicable, all prescription drug expenses except tier 1, (Network/Non-network, Retail/Mail-service combined) apply to the per individual deductible. Once the deductible is met, the appropriate copayment applies. -Also if applicable, the Prescription Drug out of pocket maximum applies to Network Retail and Mail-Service combined.

<sup>4</sup>Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

<sup>5</sup>All prescription Drugs do not accumulate toward the Medical Lifetime Maximum. However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims will be paid.

**Precertification:**

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

**Pre-existing Exclusion Period:**

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements):  
12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date