

# Your Anthem Benefits



## Bethel College Blue Access<sup>SM</sup> for High Deductible Health Plan Option E1 Summary of Benefits, Effective January 1, 2009

Covered Benefits	Network	Non-Network
<b>Deductible</b> Family coverage requires the family deductible to be met before coinsurance applies. The single deductible <b>does not</b> apply to family coverage. (This only applies to non-embedded deductible designs.)	Single: \$2,650 Family: \$5,250	Single: \$5,300 Family: \$10,600
<b>Out-of-Pocket Limit</b>	Single: \$2,650 Family: \$5,250	Single: \$10,600 Family: \$21,200
<b>Physician Home and Office Services (PCP/SCP)</b> Primary Care Physician (PCP)/Specialty Care Physician (SCP) <ul style="list-style-type: none"> <li>Including Office Surgeries, allergy serum, allergy injections and allergy testing</li> </ul>	0%	30%
<b>Preventive Care Services</b> Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams, Routine Mammograms, Diabetic Education and Certain Medical Nutritional Therapy (Network only) <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>	No copayment/coinsurance No copayment/coinsurance	30% 30%
<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>	0% 0%	0% 0%
<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>	0%	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>	0%	30%
<b>Outpatient Surgery Hospital/Alternative Care Facility</b> <ul style="list-style-type: none"> <li>Surgery and administration of general anesthesia</li> </ul>	0%	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>Physical Medicine Therapy Day Rehabilitation programs</li> <li>Hospice Care</li> <li>Ambulance Services</li> </ul>	0% 0%	30% 0%