

## Bethel College Blue Access<sup>SM</sup> for High Deductible Health Plan Option E1 Summary of Benefits, Effective January 1, 2010

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>Emergency Room Services @ Hospital (facility/other covered services) (copayment waived if admitted)</li> <li>Urgent Care Center Services</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>Prosthetic limbs are unlimited</li> <li>Physical Medicine Therapy Day Rehabilitation programs</li> <li>Hospice Care</li> <li>Ambulance Services</li> </ul>	0% 0%	30% 0% 0%

Covered Benefits	Network	Non-Network
<b>Outpatient Therapy Services</b> (Combined Network & 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: 20 visits</li> <li>Occupational therapy: 20 visits</li> <li>Manipulation therapy: 12 visits</li> <li>Speech therapy: 20 visits</li> </ul>	0% 0%	30% 30%
<b>Behavioral Health Services:</b> <b>Mental Health and Substance Abuse</b> (limits and maximums apply) <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>	0% 0% 0%	30% 30% 30%
<b>Human Organ and Tissue Transplants</b> <ul style="list-style-type: none"> <li>Acquisition and transplant procedures, harvest and storage.</li> </ul>	0%	30%
<b>Prescription Drugs</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.	20%/20%/20%/80% Tier 4 – subject to \$2,500 out-of-pocket  20%/20%/20%/80% Tier 4 – subject to \$2,500 out-of-pocket	30% <sup>2</sup>  Not covered
<b>Lifetime Maximum (Combined Network and Non-network)<sup>3</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>	\$5 million \$10,000	\$5 million \$10,000

**Notes:**

- All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).
  - Deductible(s) apply to covered services listed with a percentage (%) coinsurance including prescription drugs.
  - 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.
  - 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>2</sup>Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.  
<sup>3</sup>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