MEDICAL PLANS SUMMARY OF COVERAGE

2008 Medical Plan Highlights	Core Plan		Value Plan	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
PLAN FEATURES				
ANNUAL DEDUCTIBLE				
Individual	$200	$500	$750	$1,500
Family	$500	$1,250	$1,875	$3,750
COINSURANCE	90%	70%	80%	60%
OUT-OF-POCKET (OOP) MAXIMUM - includes deductible				
Annual OOP Limit/Individual	$1,000	$2,500	$2,500	$10,000
Annual OOP Limit/Family	$2,500	$6,250	$6,250	$25,000
LIFETIME BENEFIT MAXIMUM	$2,000,000	$2,000,000	$2,000,000	$2,000,000
OUTPATIENT SERVICES				
Office Visit/Exam	$20 co-pay	70% after deductible	$20 co-pay	60% after deductible
Well-Child Care	Well baby care up to age 3 $0 co-pay	70% after deductible	Well baby care up to age 3 $0 co-pay	60% after deductible
Immunizations	Included	Included	Included	Included
Periodic Exams with Preventive Tests	$20 co-pay	70% after deductible	$20 co-pay	60% after deductible
Outpatient Specialist Visit	$20 co-pay	70% after deductible	$20 co-pay	60% after deductible
Eye Exam (limit 1 per benefit year)	$20 co-pay	70% after deductible	$20 co-pay	60% after deductible
Non-Routine Diagnostic X-Ray and Lab Tests	90% after deductible	70% after deductible	80% after deductible	60% after deductible
MATERNITY CARE				
Initial Office Visit	$20 co-pay	70% after deductible	$20 co-pay	60% after deductible
Pregnancy and Maternity Care (Pre-Natal Care)	90% after deductible	70% after deductible	80% after deductible	60% after deductible

2008 Medical Plan Highlights	Core Plan		Value Plan	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
PLAN FEATURES				
INPATIENT HOSPITAL SERVICES				
Inpatient Hospitalization	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Semi-Private Room & Board; Including Services and Supplies	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Pre-Authorization of Services Required	$500 penalty applies if non-emergency admission is not certified	$500 penalty applies if non-emergency admission is not certified	$500 penalty applies if non-emergency admission is not certified	$500 penalty applies if non-emergency admission is not certified
SURGICAL SERVICES				
Outpatient Facility Charge	90% after deductible	70% after deductible	80% after deductible	60% after deductible
EMERGENCY ROOM				

Emergency Room Visit	$75 co-pay if not admitted; if admitted, 90% after deductible	$75 co-pay if not admitted; if admitted, 70% after deductible	$75 co-pay if not admitted; if admitted, 80% after deductible	$75 co-pay if not admitted; if admitted, 60% after deductible
URGENT CARE				
Urgent Care Facility	$50 co-pay per visit	70% after deductible	$50 co-pay per visit	60% after deductible
OTHER SERVICES & SUPPLIES				
Durable Medical Equipment & Prosthetic Devices	90% after deductible, $2,500 limit per year	70% after deductible, $2,500 limit per year	80% after deductible, $2,500 limit per year	60% after deductible, $2,500 limit per year
Home Health Care	90% after deductible, 40 visits per calendar year	70% after deductible, 40 visits per calendar year	80% after deductible, 40 visits per calendar year	60% after deductible, 40 visits per calendar year
Skilled Nursing or Extended Care Facility	90% after deductible, 90 days per year combined	70% after deductible, 90 days per year combined	80% after deductible, 90 days per year combined	60% after deductible, 90 days per year combined
Chiropractic Care	90% after deductible, $1,000 limit per year	70% after deductible, $1,000 limit per year	80% after deductible, $1,000 limit per year	60% after deductible, $1,000 limit per year
Hospice Care	90% after deductible	70% after deductible	80% after deductible	60% after deductible
INFERTILITY				
Diagnosis & Treatment - Lifetime benefit maximum of $10,000; separate Lifetime benefit maximum of $5,000 for Prescriptions (Rx) connected to infertility treatment	90% after deductible; Must be at WFU Baptist Med Ctr	Not covered	80% after deductible; Must be at WFU Baptist Med Ctr	Not covered

2008 Medical Plan Highlights	**Core Plan**		**Value Plan**	
PLAN FEATURES	**In-Network Benefits**	**Out-of-Network Benefits**	**In-Network Benefits**	**Out-of-Network Benefits**
OUTPATIENT THERAPY SERVICES				
Physical	90% after deductible, 20 visits max	70% after deductible, 20 visits max	80% after deductible, 20 visits max	60% after deductible, 20 visits max
Occupational	90% after deductible, 20 visits max	70% after deductible, 20 visits max	80% after deductible, 20 visits max	60% after deductible, 20 visits max
Speech	90% after deductible, 20 visits max	70% after deductible, 20 visits max	80% after deductible, 20 visits max	60% after deductible, 20 visits max
PRESCRIPTION DRUG (Catalyst Rx)				
Retail				
Generic	$10 co-pay	Not covered	$10 co-pay	Not covered

Brand (Formulary/Preferred) Brand (Non-Formulary/Non-preferred) Number of Days Supply	$25 co-pay $50 co-pay 30 days	Not covered Not covered	$25 co-pay $50 co-pay 30 days	Not covered Not covered
Extended Supply - at participating pharmacies Generic Brand (Formulary/Preferred) Brand (Non-Formulary/Non-preferred) Number of Days Supply	$30 co-pay $75 co-pay $150 co-pay 90 days	Not covered Not covered Not covered	$30 co-pay $75 co-pay $150 co-pay 90 days	Not covered Not covered Not covered
Mail Order (3 month supply for cost of 2.5 months) Mail Order Mandatory Generic Brand (Formulary/Preferred) Brand (Non-Formulary/Non-preferred) Number of Days Supply for Mail Order	See Plan Document $25.00 co-pay $62.50 co-pay $125 co-pay 90 days	See Plan Document Not covered Not covered Not covered	See Plan Document $25.00 co-pay $62.50 co-pay $125 co-pay 90 days	See Plan Document Not covered Not covered Not covered
Specialty Medications – used to treat chronic (long-term), lifetime conditions, or rare diseases. Must be obtained through Walgreens Specialty Pharmacy to be covered. Contact Walgreens at least 14 days before you need Rx at 866-823-2712	10% of the cost with a minimum co-pay of $50 and a maximum co-pay of $100 for a 30 day supply	Not covered	10% of the cost with a minimum co-pay of $50 and a maximum co-pay of $100 for a 30 day supply	Not covered
Inpatient Care	90% after deductible, 45 days max	70% after deductible, 30 days max	80% after deductible, 45 days max	60% after deductible, 30 days max
Outpatient Care	$20 co-pay, 40 visits max	70% after deductible, 40 visits max	$20 co-pay, 40 visits max	60% after deductible, 40 visits max
CHEMICAL DEPENDENCY (Carolina Behavioral Health Alliance)				
Inpatient Care	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Outpatient Care	$20 co-pay	70% after deductible	$20 co-pay	60% after deductible
Combined Maximum Benefit	$16,000 per year, $32,000 lifetime (combined max)	$16,000 per year, $32,000 lifetime (combined max)	$16,000 per year, $32,000 lifetime (combined max)	$16,000 per year, $32,000 lifetime (combined max

The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the contract, the contract will prevail.