

WAKE FOREST UNIVERSITY

2007 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
Mammograms	\$20 co-pay	70% after deductible	\$20 co-pay	60% after deductible
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
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
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
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

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PLAN FEATURES	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
PRESCRIPTION DRUG (Catalyst Rx)				
Retail				
Generic	\$15 co-pay	Not covered	\$15 co-pay	Not covered
Brand (Formulary/Preferred)	\$25 co-pay	Not covered	\$25 co-pay	Not covered
Brand (Non-Formulary/Non-preferred)	\$40 co-pay	Not covered	\$40 co-pay	Not covered
Number of Days Supply	30 days		30 days	
Extended Supply - at participating pharmacies				
Generic	\$45 co-pay	Not covered	\$45 co-pay	Not covered
Brand (Formulary/Preferred)	\$75 co-pay	Not covered	\$75 co-pay	Not covered
Brand (Non-Formulary/Non-preferred)	\$120 co-pay	Not covered	\$120 co-pay	Not covered
Number of Days Supply	90 days		90 days	
Mail Order				
Mail Order Mandatory	See Plan Document	See Plan Document	See Plan Document	See Plan Document
Generic	\$37.50 co-pay	Not covered	\$37.50 co-pay	Not covered
Brand (Formulary/Preferred)	\$62.50 co-pay	Not covered	\$62.50 co-pay	Not covered
Brand (Non-Formulary/Non-preferred)	\$100.00 co-pay	Not covered	\$100.00 co-pay	Not covered
Number of Days Supply for Mail Order	90 days		90 days	
MENTAL HEALTH (Carolina Behavioral Health Alliance)				
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 maximum)	\$16,000 per year, \$32,000 lifetime (combined maximum)	\$16,000 per year, \$32,000 lifetime (combined maximum)	\$16,000 per year, \$32,000 lifetime (combined maximum)

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.

Mental Health provider is [Carolina Behavioral Health Alliance](#). Member Service # is (800) 475-7900.

Pharmacy provider is [Catalyst](#). Member Service # is (888) 869-4600.

Medical provider is [BlueCross BlueShield of NC](#). Member Service # is (877) 258-3334.

Wake Forest University Benefits Office:

Gail Brewer (336) 758-5996
Benefits Counselor



**BlueCrossBlueShield
of North Carolina**

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