BAPTIST HEALTH PLAN **Silver HSA 2800 20%**

Coverage Period: Beginning on or after 01/01/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual and Individual + Family | **Plan Type:** HSA

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.baptisthealthplan.com or by calling 1-800-787-2680.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2800** individual / **$5600** family. Copayments do not apply to the **deductible**. Not applicable to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For In-Network providers **$6500** individual / **$13000** family. For Out-of-Network providers **$19500** individual / **$39000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. Call **1-800-787-2680** or see **http://bgfh.prismisp.com** for a list of all participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-787-2680 or visit us at www.baptisthealthplan.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.baptisthealthplan.com or call 1-800-787-2680 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	45% Coinsurance	Includes professional services; excludes diagnostic testing. Coinsurance subject to deductible unless otherwise stated.
	Specialist visit	20% Coinsurance	45% Coinsurance	Includes professional services; excludes diagnostic testing. Coinsurance subject to deductible unless otherwise stated.
	Other practitioner office visit	20% Coinsurance per chiropractic visit.	45% Coinsurance per chiropractic visit.	Coinsurance subject to deductible unless otherwise stated. BHP utilizes Optum Health for chiropractic services, and Prior Authorization (PA) may be required call (800) 873-4575. Limit of 12 visits per plan year.
	Preventive care/screening/immunization	Covered In Full (not subject to deductible)	45% Coinsurance	Coinsurance subject to deductible unless otherwise stated. Specialist copay may apply. BHP's Preventive Guidelines List is available at www.baptisthealthplan.com or by calling Customer Service.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	45% Coinsurance	Coinsurance subject to deductible unless otherwise stated. Refer to (PA) List for services that require (PA).
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	45% Coinsurance	See Limitations (L) & Exceptions (E) for Diagnostic Test.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.baptisthealthplan.com.	Tier 1	20% Coinsurance	No Coverage	Coinsurance subject to deductibe unless otherwise stated. Retail drugs covered up to a 30 day supply, Mail drugs up to a 90 day supply. Refer to the Small Business Preferred Drug List for a complete listing. Specialty drugs and injectables may only be obtained through Accredo Specialty Pharmacy Services. (PA) is required for certain specialty drugs.
	Tier 2	20% Coinsurance	No Coverage	See Tier 1 Limitations & Exclusions.
	Tier 3	20% Coinsurance	No Coverage	See Tier 1 Limitations & Exclusions.
	Tier 4	20% Coinsurance	No Coverage	See Tier 1 Limitations & Exclusions.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	45% Coinsurance	Coinsurance subject to deductible unless otherwise stated. (PA) is required for specific services to be covered. Refer to the (PA) List.
	Physician/surgeon fees	20% Coinsurance	45% Coinsurance	See Limitations (L) & Exceptions (E) for Facility Fee.
If you need immediate medical attention	Emergency room services	20% Coinsurance	20% Coinsurance	Coinsurance subject to deductible unless otherwise stated.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	Coinsurance subject to deductible unless otherwise stated.
	Urgent care	20% Coinsurance	20% Coinsurance	Coinsurance subject to deductible unless otherwise stated.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	45% Coinsurance	Coinsurance subject to deductible unless otherwise stated. (PA) is required for specific services to be covered. Refer to the (PA) List.
	Physician/surgeon fee	20% Coinsurance	45% Coinsurance	See Limitations (L) & Exceptions (E) for Facility fee.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% Coinsurance	45% Coinsurance	Coinsurance subject to deductible unless otherwise stated.
	Mental/Behavioral health inpatient services	20% Coinsurance	45% Coinsurance	Coinsurance subject to deductible unless otherwise stated.
	Substance use disorder outpatient services	20% Coinsurance	45% Coinsurance	Coinsurance subject to deductible unless otherwise stated.
	Substance use disorder inpatient services	20% Coinsurance	45% Coinsurance	Coinsurance subject to deductible unless otherwise stated.
If you are pregnant	Prenatal and postnatal care	20% Coinsurance	45% Coinsurance	Coinsurance subject to deductible unless otherwise stated.
	Delivery and all inpatient services	20% Coinsurance	45% Coinsurance	Coinsurance subject to deductible unless otherwise stated. Refer to the (PA) List for services that require (PA).

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	45% Coinsurance	Coinsurance subject to deductible unless otherwise stated. Up to 100 visits per plan year.
	Rehabilitation services	20% Coinsurance PT/OT/ST/PR/ Cardiac	45% Coinsurance PT/OT/ST/PR/ Cardiac	Coinsurance subject to deductible unless otherwise stated. Visit limits are combined for Rehabilitation & Habilitation Services. Up to 20 visits each plan year for Physical therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), Pulmonary Rehab (PR) & 36 visits each plan year for Cardiac Rehabilitation.
	Habilitation services	20% Coinsurance PT/OT/ST	45% Coinsurance PT/OT/ST	Coinsurance subject to deductible unless otherwise stated. Visit limits are combined for Rehabilitation & Habilitation Services. See above for limits.
	Skilled nursing care	20% Coinsurance	45% Coinsurance	Coinsurance subject to deductible unless otherwise stated. Limit of 90 days per plan year.
	Durable medical equipment	20% Coinsurance	45% Coinsurance	Coinsurance subject to deductible unless otherwise stated. DME purchases over $500 and all DME rentals require (PA).
	Hospice service	Covered in Full after deductible	Covered in Full after deductible	----------None----------
If your child needs dental or eye care	Eye exam	20% Coinsurance	No Coverage for Exam	Pediatric Vision: 1 exam every 12 months until end of the month member turns 21 years. Coinsurance subject to deductible unless otherwise stated.
	Glasses	50% Coinsurance (not subject to deductible)	50% Coinsurance (not subject to deductible)	Limited to one (1) pair of eyeglasses per year plus one (1) replacement pair if Medically Necessary per year.
	Dental check up	Not Covered	Not Covered	Excluded Service. The required pediatric dental benefits must be purchased through a separate stand alone dental plan to comply with the ACA.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long-Term Care
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Excluded Services & Other Covered Services:

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic Care	• Non-Emergency Care When Traveling Outside the U.S. (at Out-of-Network benefits)	• Private-Duty Nursing (2,000 hours per plan year; 4,000 hours lifetime maximum)
• Hearing Aids (1 hearing aid per hearing-impaired ear every 36 months)		

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at: (859) 269-4475 or (800) 787-2680. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for your plan's claims, you may be able to appeal or file a grievance. Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefit Security Administration at 1-866-444-EBSA (3272). For health plans written within the state of Kentucky, additional assistance may be available by contacting the Kentucky Department of Insurance, Consumer Protection Division at: P.O. Box 517, Frankfort, KY 40602 (502)-564-6034 or toll free for Kentucky residents only at (800)-595-6053 or http://insurance.ky.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $3740**
- **Patient pays $3800**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2800
Co-pays	$0
Co-insurance	$980
Limits or exclusions	$20
Total	**$3800**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $2110**
- **Patient pays $3290**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2800
Co-pays	$0
Co-insurance	$410
Limits or exclusions	$80
Total	**$3290**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.