



**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](http://www.baptisthealthplan.com) or by calling 1-800-787-2680.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$3,000</b> person / <b>\$6,000</b> family Doesn't apply to preventive care	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For participating providers <b>\$4,500</b> person / <b>\$9,000</b> family	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. Call 1-800-787-2680 or see <a href="http://bhp.prismisp.com">http://bhp.prismisp.com</a> for a list of participating providers. <b>The BHCC Network is used for this plan.</b>	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> . <b>Baptist Health Community Care Network</b> is used for this plan.
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> 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 5. See your policy or plan document for additional information about <u>excluded services</u> .

**Questions:** Call 1-800-787-2680 or visit us at [www.baptisthealthplan.com](http://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](http://www.baptisthealthplan.com) or call 1-800-787-2680 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 **network** of **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** 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 <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	45% coinsurance	Coinsurance subject to deductible. Includes professional services; excludes diagnostic testing.
	Specialist visit	20% coinsurance	45% coinsurance	See Primary Care (L) & (E).
	Other practitioner office visit	20% coinsurance chiropractor visit	45% coinsurance	Coinsurance subject to deductible unless 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. BHP's Preventive Guidelines List is available at <a href="http://www.baptisthealthplan.com">www.baptisthealthplan.com</a> 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 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

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
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.baptisthealthplan.com">www.baptisthealthplan.com</a></p>	Tier 1	20% coinsurance (retail and mail order)	No Coverage	Retail drugs covered up to a 30 day supply, Mail Order drugs up to 90 day supply. Refer to the Small Business Preferred Drug List for a complete listing. Coinsurance subject to deductible.
	Tier 2	20% coinsurance (retail and mail order)	No Coverage	See Tier 1 (L) & (E) section
	Tier 3	20% coinsurance (retail and mail order)	No Coverage	See Tier 1 (L) & (E) section
	Tier 4	20% coinsurance (retail and mail order)	No Coverage	Coinsurance is subject to deductible. Specialty drugs and injectables may only be obtained through Accredo Specialty Pharmacy Services. PA is required for certain specialty drugs.
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	45% coinsurance	Coinsurance subject to deductible unless stated. Refer to PA List for services that require PA.
	Physician/surgeon fees	20% coinsurance	45% coinsurance	See Facility Fee (L) & (E) section.
<p><b>If you need immediate medical attention</b></p>	Emergency room services	20% coinsurance	20% coinsurance	Coinsurance subject to deductible unless stated.
	Emergency medical transportation	20% coinsurance	20% coinsurance	See ER room services (L) & (E)
	Urgent care	20% coinsurance	20% coinsurance	See ER room services (L) & (E)
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	20% coinsurance	45% coinsurance	Coinsurance subject to deductible unless stated. Refer to PA List for services that require PA.
	Physician/surgeon fee	20% coinsurance	45% coinsurance	See Facility Fee (L) & (E) section.

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
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	20% coinsurance	45% coinsurance	Coinsurance subject to deductible unless stated.
	Mental/Behavioral health inpatient services	20% coinsurance	45% coinsurance	See M/B Health Outpatient (L) &( E)
	Substance use disorder outpatient services	20% coinsurance	45% coinsurance	See M/B Health Outpatient (L) & (E)
	Substance use disorder inpatient services	20% coinsurance	45% coinsurance	See M/B Health Outpatient (L) & (E)
<b>If you are pregnant</b>	Prenatal and postnatal care	20% coinsurance	45% coinsurance	Coinsurance subject to deductible unless stated.
	Delivery and all inpatient services	20% coinsurance	45% coinsurance	Coinsurance subject to deductible unless stated. Refer to PA List for services that require PA.
<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance	45% coinsurance	Coinsurance subject to deductible unless stated. Up to 100 visits per plan year.
	Rehabilitation services	20% coinsurance per visit ST/Cardiac 20% coinsurance per visit PT/OT/PR	45% coinsurance per visit ST/Cardiac 45% coinsurance per visit PT/OT/PR	Coinsurance subject to deductible unless 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 per visit ST 20% coinsurance per visit PT/OT	45% coinsurance per visit ST 45% coinsurance per visit PT/OT	Coinsurance subject to deductible unless 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 stated. Limit of 90 days per plan year.
	Durable medical equipment	20% coinsurance	45% coinsurance	Coinsurance subject to deductible unless stated. DME purchases over \$500 and all DME rentals require PA.
	Hospice service	Covered in Full after deductible	Covered in Full after deductible	Subject to deductible

<b>If your child needs dental or eye care</b>	Eye exam	20% coinsurance per visit	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	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. Pediatric dental benefits must be purchased through a separate stand alone dental plan to comply with the ACA.

### Excluded Services & Other Covered Services:

<b>Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Dental care (adult)</li> <li>• Routine foot care</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Infertility</li> <li>• Weight Loss Programs</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Long-term care</li> <li>• Routine eye care (Adult)</li> </ul>

<b>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.)</b>		
<ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Non-emergency care when traveling outside the U.S. (at Out-of-Network benefits)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (1 hearing aid per hearing-impaired ear every 36 months)</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing (2,000 hours per plan year; 4,000 hours lifetime maximum)</li> </ul>

## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (800)-787-2680 or (859)-269-4475. You may also contact your state insurance department at 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>.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 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 \$3,580
- Patient pays \$3,960

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$3,000
Copays	\$0
Coinsurance	\$940
Limits or exclusions	\$20
<b>Total</b>	<b>\$3,960</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$3,450
- Patient pays \$1,950

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$3,000
Copays	\$0
Coinsurance	\$370
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,950</b>

## 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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.