Your Summary of Benefits

Anthem BlueCross BlueShield

Rockcastle Regional Hospital & Respiratory Care
Blue Access® for Health Savings Accounts – Low Plan
Effective January 1, 2018

Covered Benefits	Network	Non-Network
Deductible The single deductible applies to the family deductible. Once the single deductible has been satisfied, benefits for that member are payable subject to coinsurance. Once the family deductible has been satisfied, benefits for the family are payable subject to coinsurance	Single: $5,000 Family: $10,000	Single: $10,000 Family: $20,000
Out-of-Pocket Limit	Single: $5,000 Family: $10,000	Single: $10,000 Family: $20,000
Physician Home and Office Services • Including Office Surgeries, allergy serum, allergy injections and allergy testing	0%	0%
Preventive Care Services Services included but not limited to: Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening	No cost share	0%
Emergency and Urgent Care • Emergency Room Services (facility/other covered services) (copayment waived if admitted) • Urgent Care Center Services	0% 0%	0% 0%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0%	0%
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: • 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days for skilled nursing facility	0%	0%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	0%	0%
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Other Outpatient Services including but not limited to: • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services 100 visits (excludes IV Therapy) (Network/Non-network combined) • Durable Medical Equipment, Orthotics and Prosthetics • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	0% 0% 0%	0% 0% 0%
Accidental Dental Services (Combined Network and Non-network)	Copayments/Coinsurance based on setting where covered services are received.	0%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical therapy: 20 visits • Occupational therapy: 20 visits • Manipulation therapy: 12 visits • Speech therapy: 20 visits • Cardiac Rehabilitation: 36 visits • Pulmonary Rehabilitation: 20 visits	 0% 0%	 0% 0%
Behavioral Health Service Mental Illness and Substance Abuse[1]: • Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional.	Not Covered	Not Covered
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	0%	50%

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Deductible Prescription Drugs	Medical deductible applies before coinsurance	
• Network Retail Pharmacies: (30-day supply) Includes diabetic test strip	0%	0%[2]
• Home Delivery Service: (90-day supply) Includes diabetic test strip	0%	Not covered
Members have additional cost with retail supply greater than 30 days. Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail service. Out-of-Pocket Medicare Rx - Wrap		

Notes:

- All medical and drug cost shares, deductibles and percentage (%) coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- Deductible(s) apply to covered medical services listed with a percentage (%) coinsurance, including 0%.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to end of the month which the child attains age 26
- No cost share (NCS) 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.
- Live Health Online (LHO) is covered at the PCP costshare.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.
- Autism Spectrum Disorder is covered based on the state law for members age 1 through 21
- Benefit period = calendar year
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime
- Wigs limited to 1 per benefit period
- Vision limited services – additional vision services are covered when specifically coded as determination of refraction, routine ophthalmological examination including refraction for new and established patients, and a visual functional screening for visual acuity. No additional ophthalmological services are covered as part of the medical coverage.

1 We encourage you to refer to the Schedule of Benefits for limitations.
2 Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
**4th Tier per script 30 day supply.

Precertification:
Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.

Pre-existing Exclusion Period: None

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

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This benefit overview is for illustrative purposes and some content may be pending Kentucky Department of Insurance approval

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.
By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.