Your Summary of Benefits

Anthem BlueCross BlueShield

Bd of Pensions of the KY Annual Conference of the United Methodist Church
Gold Plan Lumenos Health Savings Accounts
Effective January 1, 2018

Covered Benefits	Network	Non-network
Deductible Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage.	Single: $1,500 Family: $3,000	Single: $3,000 Family: $6,000
Out-of-Pocket Limit	Single: $3,000 Family: $6,000	Single: $6,000 Family: $12,000
Physician Home and Office Services • Including Office Surgeries, allergy serum, allergy injections and allergy testing	20%	40%
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	40%
Emergency and Urgent Care • Emergency Room Services (facility/other covered services) (copayment waived if admitted) • Urgent Care Center Services	20% 20%	20% 40%
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	20%	40%
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) • 100 days for skilled nursing facility	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	40%
Blue 8.0		

Your Summary of Benefits

Covered Benefits	Network	Non-network
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	20% 0% 20%	40% 0% 20%
Accidental Dental Services Unlimited per accident	20%	40%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Cardiac Rehabilitation 36 visits • Pulmonary Rehabilitation 30 visits • Physical therapy: 30 visits • Occupational therapy: 30 visits • Manipulation therapy: 20 visits • Speech therapy: 30 visits	 20% 20%	 40% 40%
Behavioral Health Services: Mental Illness and Substance Abuse[1] • Inpatient Facility Services • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility	Benefits provided in accordance with Federal Mental Health Parity	40%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	20%	40%

Your Summary of Benefits

Covered Benefits	Network	Non-network
Prescription Drugs Deductible Network Tier structure equals 1/2/3	Medical deductible applies before copayment/coinsurance	
• Network Retail Pharmacies: (30-day supply) Includes diabetic test strip	20%	40%[2]
• Anthem Rx Home Delivery Service: (90-day supply) Includes diabetic test strip	10%	Not covered
- Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail service - Member may be responsible for additional cost when not selecting the available generic drug.		
Medicare RX - Wrap	Accumulates to the overall out of pocket limit 100% coverage	

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 services listed with a percentage (%) coinsurance, including 0%.
- Deductible applies to all prescription drug expenses for Rx plans. Once the deductible is met the appropriate copayment/ coinsurance applies. Copayments/coinsurance accumulate to the Medical OOP max. Once the Medical OOP max is met, no additional costshare applies.
- Once the family deductible is satisfied by either one member or all members collectively, then the additional percentage coinsurance will be required before the family out-of-pocket is satisfied. Does not apply to embedded deductible plans.
- Network and Non-network Deductible, 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
- Autism Spectrum Disorder is covered based on the state law for members age 1 through 21
- 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.
- 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.
- No Cost Share (NCS): No deductible/copayment/coinsurance up to the maximum allowable amount
- 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.

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.

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.