BAPTIST HEALTH PLAN

KENTUCKY INDIVIDUAL
Baptist Gold HMO 1500 $10 Emb
Baptist Health Community Care Network Individual Gold
HMO KI160188

This plan is designed with Embedded Accumulators.

			Member pays for services provided by an In-Network Practitioner or Provider
Medical Calendar Year Deductible *(Copayments do not apply)*	•	Individual	$1,500
	•	Family	$3,000
Pharmacy Calendar Year Deductible *(Copayments do not apply)*	•	Individual	$500
	•	Family	$1,000
Calendar Year Out of Pocket Limit *(includes Deductible, Coinsurance, and Copayments)*	•	Individual	$5,500
	•	Family	$11,000
Physician Services *(includes Retail Clinics)*	•	Office Visit[4] *(includes professional services; excludes diagnostic testing and major diagnostic services)*	$10 Copay per PCP visit $40 Copay per Specialist visit
	•	Allergy Serum and Injections	$5 per injection
Preventive Health Services	•	Well Child Exams Well Adult Exams (refer to the BHP Preventive Health Guidelines for other preventive services)	Covered in Full (not subject to deductible)
Diagnostic Services	•	Labs and X-rays	$0 Copay per visit
	•	Allergy Testing	$0 Copay per visit
Major Diagnostic Services	•	Advanced Imaging and Nuclear Medicine *(including but not limited to PET, MRI, MRA, CT, SPECT)*	20% Coinsurance[1]
Inpatient Services	•	Medical/Surgical, Mental Health/Substance Abuse[4] and Professional Services	20% Coinsurance[1]
Outpatient Services	•	Ambulatory Surgery Hospital Outpatient Surgery Other Outpatient Procedures	20% Coinsurance[1]
Maternity Services	•	Prenatal Visit, Office Visits and Postpartum Care	$10 Copay per visit
	•	Inpatient Services	20% Coinsurance[1]
Urgent Care and Emergency Services	•	Urgent Care Facility	$50 Copay per visit
	•	Emergency Room Services and Physician Emergency Services	$250 Copay per visit (waived if admitted)
	•	Ambulance Services	$250 Copay per use
Therapy Services	•	Physical Therapy *(20 visits per plan year)*	$10 Copay per visit
	•	Occupational Therapy *(20 visits per plan year)*	$10 Copay per visit
	•	Speech Therapy *(20 visits per plan year)*	$40 Copay per visit
	•	Cardiac Rehabilitation Services *(36 visits per plan year)*	$40 Copay per visit
	•	Pulmonary Rehabilitation Services *(20 visits per plan year; When rendered as part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.)*	$10 Copay per visit

Therapy Services	•	Chiropractic Services *(12 visits per plan year)*	$10 Copay per visit
	•	Autism Spectrum Disorders/Applied Behavior Analysis Based Therapies *(age 1 year until end of the month member turns 21 years: 20 hours per month maximum)*	20% Coinsurance[1]
Other Services	•	Vision - Pediatric *(1 exam every 12 months until end of month member turns 21 years)*	$10 Copay per visit
	•	Vision - Pediatric Hardware Reimbursement	50% Coinsurance (not subject to deductible)
	•	Therapeutic Services *(including but not limited to Chemotherapy, Radiation Therapy, IV Therapy and Dialysis)*	20% Coinsurance[1]
	•	Skilled Nursing Facility/Rehabilitation Facility *(90 days per plan year)*	20% Coinsurance[1]
	•	Home Health *(100 visits per plan year)*	20% Coinsurance[1]
	•	Home Health - Private Duty Nursing *(2000 hours per plan year; 4000 hours lifetime maximum)*	20% Coinsurance[1]
	•	Hospice *Out of Network is Covered in Full (not subject to deductible)*	Covered in Full (not subject to deductible)
	•	Durable Medical Equipment Prosthetic Appliances Orthotic Devices Medical Supplies	20% Coinsurance[1]
Prescription Drugs	•	30 day supply - Retail	$12 Copay 1st tier $30 Copay[2] 2nd tier 30% Coinsurance[2] 3rd tier 60% Coinsurance[2]; $300 maximum per prescription 4th tier
	•	90 day supply - Mail Order	$30 Copay 1st tier $75 Copay[2] 2nd tier 30% Coinsurance[2] 3rd tier 60% Coinsurance[2]; $300 maximum per prescription 4th tier
Lifetime Maximum Benefit	•	The Lifetime Maximum Benefit available under this plan is Unlimited.	

1. **Medical Calendar Year** Deductible applies. After Medical Deductible, service is subject to Coinsurance and/or Copay.
2. **Pharmacy Calendar Year** Deductible applies. After Pharmacy Deductible, service is subject to Coinsurance and/or Copay.
3. Not applicable to this Schedule of Benefits.
4. Behavioral health services are administered by OptumHealth Behavioral Solutions – 877-369-2201.

This plan includes an Embedded Deductible. After the individual deductible has been met by one family member, benefits are payable for that individual. For family coverage, benefits are payable after any one family member meets the individual deductible, or any combination of family members meets the family deductible.

Prior Authorization - Services may require prior authorization from the Plan. Practitioners or Providers must obtain prior authorization prior to the services being rendered. Failure to obtain prior authorization results in a denial of benefits. It is ultimately your responsibility to ensure that prior authorization from the Plan has been obtained by your Practitioner or Provider. Please refer to your Policy.

Dependent and Young Adult Coverage – To be eligible for coverage as a Dependent of a Subscriber, an individual must be the lawful spouse of a Subscriber, a Dependent child of a Subscriber, or a young adult child under the age of twenty-six (26). Eligibility for coverage for a Dependent child of a Subscriber or a young adult child of a Subscriber under the age of twenty-six (26) is not based on financial dependency, residency, student status, marital status, or employment. A "child" means a newborn child, a stepchild, a child legally placed for adoption, a legally adopted child, a child for whom legal guardianship has been awarded, or a child for whom the Subscriber has a legal obligation under a divorce decree or other court order, including a qualified medical child support order, to provide health care coverage for a child.

Policy Year - Plan benefits are based on each successive 12-month period starting on the Effective Date of the Policy.

Prescription Drug Overrides - Baptist Health Plan (BHP) provides prescription drug overrides as required by applicable state law. Prescription drug overrides do not apply to any controlled medication.

Preferred Drug List - A copy of the Preferred Drug List is available online at www.BaptistHealthPlan.com, or by contacting Customer Service at 859-269-4475 or toll free at 800-787-2680.

Retail Clinics are health care clinics located in retail stores, supermarkets and pharmacies that treat uncomplicated minor illnesses and provide preventive health care services. They are sometimes referred to as “convenient care clinics” or “retail-based clinics.” These clinics are usually staffed by nurse practitioners (NPs) or physician assistants (PAs), but some are staffed by physicians. Retail clinics are covered at the primary care physician (PCP) benefit level.

Usual, Customary and Reasonable (UCR) Amount - UCR Amount is the amount that the Plan determines to be the Eligible Expense for a service. The Eligible Expense is determined by the healthcare service or procedure being performed and the usual amount paid for this procedure. If You go to a Participating Practitioner or Provider, You will be responsible for any Copayment, Coinsurance and/or Deductible amount. You will not be responsible for any amount billed over the Eligible Expense(s) for Covered Services, except when You fail to follow the Plan Delivery System Rules.

This plan does not provide out-of-network benefits. Services provided by an out-of-network Practitioner or Provider will be denied, unless determined by BHP to be of an Urgent and/or Emergent nature.

This Schedule of Benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Policy and Schedule of Benefits. In the event of a conflict between the Policy and this description, the terms of the Policy will prevail.