

Your Summary of Benefits



The KY Conference of the United Methodist Church Blue Access® (PPO) Summary of Benefits, Effective September 1, 2010

Please note: As we receive additional guidance and clarification from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits. At this time, we do not expect rates to be impacted by these changes.

Covered Benefits	Network	Non-network
Deductible (Single/Family)	\$500/\$1,000	\$1,000/\$2,000
Out-of-Pocket Maximum (Single/Family)	\$2,200/\$4,400	\$5,000/\$10,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: <ul style="list-style-type: none"> • allergy injections (PCP and SCP) • allergy testing • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and Pharmaceuticals 	\$15/\$15 \$5 15% 15%	40% 40% 40% 40%
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations ¹ , Annual diabetic eye exam, Vision and Hearing screenings <ul style="list-style-type: none"> • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility 	No copayment/coinsurance No copayment/coinsurance	40% 40%
Emergency and Urgent Care <ul style="list-style-type: none"> • Emergency Room Services @ Hospital (facility/other covered services) (copayment waived if admitted) • Urgent Care Center Services • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and Pharmaceuticals • Allergy injections • Allergy testing 	15% 15% 15% \$5 15%	15% 40% 40% 40% 40%
Inpatient and Outpatient Professional Services Include but are not limited to: <ul style="list-style-type: none"> • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams 	15%	40%

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Inpatient Facility Services Unlimited days except for: <ul style="list-style-type: none"> 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) 120 days Network/Non-Network combined for skilled nursing facility 	15%	40%
Outpatient Surgery Hospital/Alternative Care Facility <ul style="list-style-type: none"> Surgery and administration of general anesthesia 	15%	40%
Other Outpatient Services (including but not limited to): <ul style="list-style-type: none"> Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. Home Care Services (Network/Non-network combined) 90 visits (limit does not apply to IV Therapy) Durable Medical Equipment and Orthotics (Network/Non-network combined) \$10,000 benefit maximum (excluding Prosthetic Devices and Limbs and Medical Supplies) Prosthetic Devices \$10,000 benefit maximum Prosthetic Limbs: \$10,000 benefit maximum Physical Medicine Therapy Day Rehabilitation programs Hospice Care Ambulance Services 	15%	40%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: <ul style="list-style-type: none"> Physical therapy: 30 visits Occupational therapy: 30 visits Manipulation therapy: 20 visits Speech therapy: 30 visits Cardiac Rehabilitation: 36 visits Pulmonary Rehabilitation: 30 visits 	No copayment/coinsurance 15%	No copayment/coinsurance 15%
Accidental Dental: \$3,000 limit (Network/Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	Copayments/Coinsurance based on setting where covered services are received

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Behavioral Health Services²: <ul style="list-style-type: none"> • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional 	Copayments/Coinsurance based on setting where covered services are received.	Copayments/Coinsurance based on setting where covered services are received
Human Organ and Tissue Transplants³ <ul style="list-style-type: none"> • Acquisition and transplant procedures, harvest and storage 	No copayment/coinsurance	50%
Prescription Drug Options:⁴ Network Tier structure equals 1/2/3 <ul style="list-style-type: none"> • Network Retail Pharmacies: (30-day supply) Includes diabetic test strip • Anthem Rx Direct Mail Service: (90-day supply) Includes diabetic test strip Medicare Rx - Wrap Member may be responsible for additional cost when not selecting the available generic drug. Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits.	Deductible \$50 Single/\$150 Family \$10/\$25/\$40 \$30/\$75/\$120	Deductible \$50 Single/\$150 Family 50%, min \$40 ⁵ Not covered
Lifetime Maximum (Combined Network and Non-Network)⁶	\$5 million	\$5 million

Notes:

- Flat dollar copayments are excluded from the out-of-pocket limits. Also Prescription Drug deductible/copayments/coinsurance and Non-network Human Organ and Tissue Transplants are excluded from the out-of-pocket limits.
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance, However, the deductible does not apply to Emergency Room Services where a copayment and coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to the end of the month which the child attains age 26.
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan.

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- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies.
- No copayment/coinsurance 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.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.
- Autism: \$500 monthly maximum for children age 2-21
- Benefit period = calendar year
- Mammograms (routine and diagnostic) are subject to the PCP/OV cost share in office and outpatient facility settings

1 These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.

2 We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations. Behavioral Health Services (Mental Health and Substance Abuse) benefits provided in accordance with Federal Mental Health parity.

3 Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

4 If applicable, all prescription drug expenses except tier 1, (Network/Non-network, Retail/Mail-service combined) apply to the per individual deductible. Once the deductible is met, the appropriate copayment applies. Also if applicable, the Prescription Drug out of pocket maximum applies to Network Retail and Mail-Service combined.

5 Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips

6 Prescription Drugs do not accumulate toward the Medical Lifetime Maximum. However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims will be paid.

Precertification:

Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-existing Exclusion Period:

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements)

12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

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.