


University of Kentucky, SHIP: PPO \$300



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/aso>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (833) 578-4443 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$300/person for Preferred Network Providers . \$500/person for In- Network Providers . \$1000/person for Non- Network Providers .	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Primary Care. Specialist Visit . Preventive Care . Certain Prescription drugs . Vision. For more information see below.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$6,350/person or \$12,700/family for Preferred Network Providers and In- Network Providers combined. \$12,700/person or \$25,400/family for Non- Network Providers .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, health care this plan doesn't cover, and Non- Network Transplants.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes, Blue Access. See www.anthem.com or call (833) 578-4443 for a list of network providers . Costs may vary by	You pay the least if you use a provider in Preferred Network . You pay more if you use a provider in In- Network . You will pay the most if you use an Out-of-Network Provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an Out-of-

	site of service and how the provider bills.	Network Provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25/visit deductible does not apply	\$30/visit deductible does not apply	50% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	\$45/visit deductible does not apply	\$50/visit deductible does not apply	50% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care / screening /immunization	No charge	No charge	50% coinsurance	Non- Network preventive care services for children prior to their 6th birthday have no deductible . You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	35% coinsurance	50% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	35% coinsurance	50% coinsurance	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at	Typically Generic (Tier 1)	Greater of \$10 or 10% coinsurance up to \$50/prescription, deductible does not apply (retail) and Greater of \$30 or 20% coinsurance up to	Greater of \$30 or 20% coinsurance up to \$60/prescription, deductible does not apply (retail) and Greater of \$30 or 20% coinsurance up to	Not covered (retail and home delivery)	*See Prescription Drug section

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
www.express-script.com		\$60/prescription, deductible does not apply (30 day home delivery) and Greater of \$60 or 20% coinsurance up to \$120/prescription, deductible does not apply (90 day home delivery)	\$60/prescription, deductible does not apply (30 day home delivery) and Greater of \$60 or 20% coinsurance up to \$120/prescription, deductible does not apply (90 day home delivery)		
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	Greater of \$30 or 20% coinsurance up to \$60/prescription, deductible does not apply (retail) and Greater of \$50 or 30% coinsurance up to \$75/prescription, deductible does not apply (30 day home delivery) and Greater of \$100 or 30% coinsurance up to \$150/prescription, deductible does not apply (90 day home delivery)	Greater of \$50 or 30% coinsurance up to \$75/prescription, deductible does not apply (retail) and Greater of \$50 or 30% coinsurance up to \$75/prescription, deductible does not apply (30 day home delivery) and Greater of \$100 or 30% coinsurance up to \$150/prescription, deductible does not apply (90 day home delivery)	Not covered (retail and home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	Greater of \$60 or 50% coinsurance /prescription,	Greater of \$75 or 50% coinsurance /prescription,	Not covered (retail and home delivery)	

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
		<u>deductible</u> does not apply (retail) and Greater of \$75 or 50% <u>coinsurance</u> / prescription, <u>deductible</u> does not apply (30 day home delivery) and Greater of \$225 or 50% <u>coinsurance</u> / prescription, <u>deductible</u> does not apply (90 day home delivery)	<u>deductible</u> does not apply (retail) and Greater of \$75 or 50% <u>coinsurance</u> / prescription, <u>deductible</u> does not apply (30 day home delivery) and Greater of \$225 or 50% <u>coinsurance</u> / prescription, <u>deductible</u> does not apply (90 day home delivery)		
	Typically Preferred <u>Specialty</u> (brand and generic) (Tier 4)	Greater of \$10 or 10% <u>coinsurance</u> up to \$50/ prescription, <u>deductible</u> does not apply (retail) and Greater of \$75 or 20% <u>coinsurance</u> / prescription, <u>deductible</u> does not apply (30 day home delivery) and 20% <u>coinsurance</u> / prescription, <u>deductible</u> does not apply (90 day home delivery)	Greater of \$30 or 20% <u>coinsurance</u> up to \$60/ prescription, <u>deductible</u> does not apply (retail) and Greater of \$75 or 20% <u>coinsurance</u> / prescription, <u>deductible</u> does not apply (30 day home delivery) and 20% <u>coinsurance</u> / prescription, <u>deductible</u> does not apply (90 day home delivery)	Not covered (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	35% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Physician/surgeon fees	20% <u>coinsurance</u>	35% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$200/visit then 20% coinsurance	\$200/visit then 20% coinsurance	Covered as In- Network	Copay waived if admitted.
	Emergency medical transportation	Not covered	35% coinsurance	50% coinsurance	-----none-----
	Urgent care	\$75/visit deductible does not apply	\$75/visit deductible does not apply	50% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	35% coinsurance	50% coinsurance	60 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined.
	Physician/surgeon fees	20% coinsurance	35% coinsurance	50% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$25/visit deductible does not apply Other Outpatient 20% coinsurance	Office Visit \$30/visit deductible does not apply Other Outpatient 35% coinsurance	Office Visit 50% coinsurance Other Outpatient 50% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	20% coinsurance	35% coinsurance	50% coinsurance	-----none-----
If you are pregnant	Office visits	20% coinsurance	35% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	35% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	35% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	35% coinsurance	50% coinsurance	100 visits/benefit period.
	Rehabilitation services	\$15/visit deductible does not apply	\$15/visit deductible does not apply	\$15/visit deductible does not apply	*See Therapy Services section.
	Habilitation services	\$15/visit deductible does not apply	\$15/visit deductible does not apply	\$15/visit deductible does not apply	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	35% coinsurance	50% coinsurance	60 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined.
	Durable medical equipment	Not Applicable	35% coinsurance	50% coinsurance	*See Durable Medical Equipment Section
	Hospice services	20% coinsurance	35% coinsurance	50% coinsurance	-----none-----
If your child needs dental or eye care	Children's eye exam	Not Applicable	\$20/visit deductible does not apply	Not covered	*See Vision Services section
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	-----none-----

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> • Acupuncture • Dental care (Adult) • Glasses for a child • Routine foot care 	<ul style="list-style-type: none"> • Bariatric surgery • Dental care (Pediatric) • Infertility treatment • Weight loss programs 	<ul style="list-style-type: none"> • Cosmetic surgery • Dental Check-up • Long-term care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Most coverage provided outside the United States. See www.bcbsglobalcore.com • Spinal Manipulation 24 visits/benefit period 	<ul style="list-style-type: none"> • Hearing aids left ear 1 unit every 36 months • Private-duty nursing in a Home Setting only 	<ul style="list-style-type: none"> • Routine eye care (Adult) 1 exam/benefit period

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Insurance, 215 West Main Street, Frankfort, Kentucky 40601, (502) 564-3630, (800) 595-6053, TTY: (800) 648-6056, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov. Other coverage

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options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$300	■ The plan's overall deductible	\$300	■ The plan's overall deductible	\$300
■ Specialist copayment	\$45	■ Specialist copayment	\$45	■ Specialist copayment	\$45
■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%	■ Other coinsurance	20%	■ Other coinsurance	20%
<p>This EXAMPLE event includes services like:</p> <p>Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p>Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p>Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$300	Deductibles	\$100	Deductibles	\$300
Copayments	\$0	Copayments	\$300	Copayments	\$200
Coinsurance	\$2,500	Coinsurance	\$800	Coinsurance	\$40
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$1,200
The total Peg would pay is	\$2,860	The total Joe would pay is	\$1,220	The total Mia would pay is	\$1,740

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (833) 578-4443

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በገና የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (833) 578-4443 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 578-4443.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 578-4443:

Bassa (Bàsɔ̀ Wùdù): M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̀ò nì dyí-b̄édjèin-djè b̄é m̀ ké gbo-kpá-kpá kè b̄ǒ kpǒ djé m̀ bídjí-wùdùùn b̄ó pídyi. B̄é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̀á (833) 578-4443.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (833) 578-4443 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (833) 578-4443 သို့ ခေါ်ဆိုပါ။

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 578-4443。

Dinka (Dinka): Na nɔŋ thiëc në ke de yä thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl (833) 578-4443.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (833) 578-4443.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 578-4443 تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 578-4443.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (833) 578-4443.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (833) 578-4443.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (833) 578-4443.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 578-4443.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (833) 578-4443 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (833) 578-4443.

Igbo (Igbo): O bur u na i nwere ajuju o buła gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o buła. Ka gi na okowa okwu kwuo okwu, kpoo (833) 578-4443.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (833) 578-4443.

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Language Access Services:

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Language Access Services:

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Language Access Services:

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