


University of Kentucky: UK-PPO Plan



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/](http://www.healthcare.gov/sbc-glossary/) or call (855) 634-3383 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$100/person or \$200/family for UK HealthCare <a href="#">Providers</a> . \$500/person or \$1,000/family for In- <a href="#">Network Providers</a> . \$1,500/person or \$3,000/family for Non- <a href="#">Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Primary Care <a href="#">Specialist</a> Visit <a href="#">Preventive Care</a> and Vision for UK HealthCare and In- <a href="#">Network Providers</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$3,000/person or \$6,000/family for UK HealthCare <a href="#">Providers</a> . \$4,000/person or \$8,000/family for In- <a href="#">Network Providers</a> . \$0/person or \$0/family for Non- <a href="#">Network Providers</a> . This <a href="#">plan</a> has a separate <a href="#">Out of Pocket</a> Maximum of \$5,000/single or \$10,000/family for <a href="#">Prescription Drugs</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Services deemed not medically necessary by Medical Management and/or Anthem, <a href="#">Premiums</a> , <a href="#">balance-billing</a>	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

	charges, health care this <a href="#">plan</a> doesn't cover.	
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes, Blue Card PPO. See <a href="http://www.anthem.com">www.anthem.com</a> or call (855) 634-3383 for a list of <a href="#">network providers</a> .	You pay the least if you use a <a href="#">provider</a> in <a href="#">Preferred Network</a> . You pay more if you use a <a href="#">provider</a> in <a href="#">In-Network</a> . You will pay the most if you use an <a href="#">Out-of-Network Provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">Out-of-Network Provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15/visit <a href="#">deductible</a> does not apply	\$25/visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Specialist</a> visit	\$40/visit <a href="#">deductible</a> does not apply	\$50/visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Preventive care</a> / <a href="#">screening</a> /immunization	No charge	No charge	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Diagnostic X-rays and Laboratory are covered 100% up to \$250 then appropriate <a href="#">deductible</a> / <a href="#">coinsurance</a> amount applies.
	Imaging (CT/PET scans, MRIs)	\$75/visit	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you need drugs to treat your	Tier 1 - Typically Generic	10% <a href="#">coinsurance</a> (90-day Rxs at UK Pharmacies and	20% <a href="#">coinsurance</a> (30-day Rx retail Pharmacy)	Not covered	\$8 minimum/\$50 maximum (30-day Rx, any pharmacy) \$24 minimum/\$100 maximum

\* 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)	
<b>illness or condition</b> More information about <a href="http://www.express-scripts.com">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">http://www.express-scripts.com</a>		Express Scripts Home Delivery)			(90-day Rx UK Phcy/Mail Order)
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	30% <a href="#">coinsurance</a> (90-day Rxs at UK Pharmacies and Express Scripts Home Delivery	40% <a href="#">coinsurance</a> (30-day Rx retail pharmacy)	Not covered	\$20 minimum/\$60 maximum (30-day Rx any pharmacy) \$60 minimum/\$120 maximum (90-day Rx UK Phcy/Mail Order)
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	40% <a href="#">coinsurance</a> (90-day Rxs at UK Pharmacies and Express Scripts Home Delivery)	50% <a href="#">coinsurance</a> (30-day Rx retail pharmacy)	Not covered	\$60 minimum (30-day Rx any pharmacy) \$120 minimum (90-day Rx UK Phcy/Mail Order)
	Tier 4 - Specialty Generic	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	\$8 minimum/\$50 maximum (per 30-day Rx)
	Tier 4 - Specialty Brand	\$200 per 30-day Rx	\$200 per 30-day Rx	Not covered	-----none-----
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100/visit	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100/visit then 20% <a href="#">coinsurance deductible</a> does not apply	\$100/visit then 20% <a href="#">coinsurance deductible</a> does not apply	Covered as In- <a href="#">Network</a>	Copay waived if admitted.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	\$50/visit <a href="#">deductible</a> does not apply	\$50/visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$300/admission	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	60 days/benefit period for Inpatient Rehabilitation and Non-Network Providers combined.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----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 mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$15/visit <a href="#">deductible</a> does not apply Other Outpatient 10% <a href="#">coinsurance</a>	Office Visit \$25/visit <a href="#">deductible</a> does not apply Other Outpatient 20% <a href="#">coinsurance</a>	Office Visit 50% <a href="#">coinsurance</a> Other Outpatient 50% <a href="#">coinsurance</a>	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	\$300/admission	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you are pregnant	Office visits	\$15/visit for the first 1 visit <a href="#">deductible</a> does not apply, then 10% <a href="#">coinsurance</a>	\$25/visit for the first 1 visit <a href="#">deductible</a> does not apply, then 10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	\$300/admission	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	100 visits/benefit period for In- <a href="#">Network Providers</a> and Non- <a href="#">Network Providers</a> combined.
	<a href="#">Rehabilitation services</a>	\$20/visit <a href="#">deductible</a> does not apply	\$30/visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	*See Therapy Services section.
	<a href="#">Habilitation services</a>	\$20/visit <a href="#">deductible</a> does not apply	\$30/visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	100 days limit/person/benefit period for In- <a href="#">Network Providers</a> and Non- <a href="#">Network Providers</a> combined.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	*See <a href="#">Durable Medical Equipment</a> Section
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----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 your child needs dental or eye care	Children's eye exam	\$15/visit <a href="#">deductible</a> does not apply	\$25/visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	*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](#).)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Dental care (Pediatric)
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes.
- Cosmetic surgery
- Dental Check-up
- Private-duty nursing
- Weight loss programs
- Dental care (Adult)
- Glasses for a child
- Routine eye care (Adult)

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Acupuncture 45 visits/benefit period for physical therapy, occupational therapy, speech therapy, Cardiac therapy, and manipulative treatment for In-Network Providers and Non-Network Providers combined.
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Bariatric surgery
- Spinal Manipulation 45 visits/benefit period for physical therapy, occupational therapy, speech therapy, Cardiac therapy, and Acupuncture for In-Network Providers and Non-Network Providers combined
- Hearing aids one/ear every 36 months under age 18.

**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](http://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](http://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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Specialist copayment</a>	\$40	■ <a href="#">Specialist copayment</a>	\$40	■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">copayment</a>	\$300	■ Hospital (facility) <a href="#">copayment</a>	\$300	■ Hospital (facility) <a href="#">copayment</a>	\$300
■ Other <a href="#">coinsurance</a>	10%	■ Other <a href="#">coinsurance</a>	10%	■ Other <a href="#">coinsurance</a>	10%
<p>This EXAMPLE event includes services like:</p> <p><a href="#">Specialist</a> office visits (<i>prenatal care</i>)            Childbirth/Delivery Professional Services            Childbirth/Delivery Facility Services  <a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)  <a href="#">Specialist</a> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Primary care physician</a> office visits (<i>including disease education</i>)  <a href="#">Diagnostic tests</a> (<i>blood work</i>)  <a href="#">Prescription drugs</a>  <a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Emergency room care</a> (<i>including medical supplies</i>)  <a href="#">Diagnostic test</a> (<i>x-ray</i>)  <a href="#">Durable medical equipment</a> (<i>crutches</i>)  <a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<a href="#">Cost Sharing</a>		<a href="#">Cost Sharing</a>		<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$100	<a href="#">Deductibles</a>	\$100	<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$300	<a href="#">Copayments</a>	\$200	<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$500	<a href="#">Coinsurance</a>	\$1,600	<a href="#">Coinsurance</a>	\$200
<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	\$0
<b>The total Peg would pay is</b>	<b>\$960</b>	<b>The total Joe would pay is</b>	<b>\$1,920</b>	<b>The total Mia would pay is</b>	<b>\$600</b>

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 (855) 634-3383

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በገና የማግኘት ሙብት አለዎት። አስተርጓሚ ለማናገር (855) 634-3383 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 (855) 634-3383.

**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՝ (855) 634-3383:

**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 b̄ǎ kpǎ djé m̀ bídjí-wùdùùn b̄ó pídyi. B̄é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̀á (855) 634-3383.

**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 (855) 634-3383 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (855) 634-3383 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(855) 634-3383。

**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 (855) 634-3383.

**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 (855) 634-3383.

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