### Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

University of Kentucky: RHP Regional Health Plan (Non-Gatekeeper)

**Coverage Period:** 07/01/2017–06/30/2018  
**Coverage for:** Individual + Family | **Plan Type:** HMO

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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](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:**  
--- | --- | ---  
What is the overall **deductible**? | $0. | See the Common Medical Events chart below for your costs for services this plan covers.  
Are there services covered before you meet your **deductible**? | No. | You will have to meet the deductible before the plan pays for any services.  
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? | $3,000/individual or $6,000/family for In-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**? | Penalties for non-compliance, Services deemed not medically necessary by Medical Management and/or Anthem, Prescription Drugs, Premiums, Balance-Billing charges, and Health Care this plan doesn't cover. | 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, HMO. See [www.anthem.com](http://www.anthem.com) or call (855) 634-3383 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan’s 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-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? | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if...
For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Participating Provider (You will pay the least)</th>
<th>Non-Participating Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$10/visit</td>
<td>Not covered</td>
<td>----none------</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$30/visit</td>
<td>Not covered</td>
<td>----none------</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>Vision Exam (Routine): Not Covered for In-Network Providers. 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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>Not covered</td>
<td>----none------</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$75/visit</td>
<td>Not covered</td>
<td>----none------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Typically Generic</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
<td>Tier 1 - $8 minimum, $50 maximum per 30 days</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.%5Binsert">www.[insert</a>]</td>
<td>Tier 2 - Typically Preferred/Brand</td>
<td>40% Coinsurance</td>
<td>40% Coinsurance</td>
<td>Tier 2 - $20 minimum, $60 maximum per 30 days</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Typically Non-Preferred/Specialty Drugs</td>
<td>50% Coinsurance</td>
<td>50% Coinsurance</td>
<td>Tier 3 - $40 minimum per 30 days</td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Typically Specialty (brand and generic)</td>
<td>$100 copay</td>
<td>$100 copay</td>
<td>Tier 4 – Limit to 30 day supply</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$75/visit</td>
<td>Not covered</td>
<td>----none------</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
<td>----none------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$100/visit</td>
<td>Covered as In-Network</td>
<td>If admitted as an Inpatient or Observation stay, ER copay is waived.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$75/visit</td>
<td>Covered as In-Network</td>
<td>----none------</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25/visit</td>
<td>Covered as In-Network</td>
<td>Pediatric Twilight Clinic: $10/visit for PCP with an additional $5/visit. UK participating urgent facilities: $25/visit.</td>
</tr>
</tbody>
</table>

* All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.
<table>
<thead>
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<th>Non-Participating Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$200/admission</td>
<td>Not covered</td>
<td>[none]</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
<td>[none]</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit $30/visit</td>
<td>Office Visit Not covered</td>
<td>Office Visit [none]</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$200/admission</td>
<td>Not covered</td>
<td>[none]</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
<td>[Cost sharing] does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$200/admission</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>60 visits/benefit period.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$15/visit</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$15/visit</td>
<td>Not covered</td>
<td>[See Therapy Services section]</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not covered</td>
<td>30 days limit/benefit period combined with physical medical rehab.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>$500 Out-of-Pocket maximum combined with Prosthetics and Orthotics.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
<td>[none]</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>$10/visit</td>
<td>Not covered</td>
<td>[See Vision Services section]</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>*See Dental Services section</td>
</tr>
</tbody>
</table>

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.):

- Bariatric surgery
- Infertility treatment
- Private-duty nursing Routine foot care unless you have been diagnosed with diabetes.
- Cosmetic surgery
- Long-term care
- Abortion covered only when it is medically necessary to preserve the life of the mother
- Dental care (adult)
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Chiropractic care 45 visits/benefit period combined with Physical, Occupational, Speech, Pool /Exercise hydro, Acupuncture, Pulmonary Rehab, Cardiac Rehab and Osteopathic Manipulations. Following procedure codes 98940/98941/98942/99201 and diagnostic are the only services covered. Diagnostic services are covered in the chiropractor’s offices for those chiropractor’s located in the RHP service area only. If using a chiropractor within the HMO network, diagnostic services are not covered in the chiropractor’s office, must use UK Chandler or UK Samaritan.

- Acupuncture 45 visits/benefit period.
- Routine eye care (adult)
- Hearing aids one/ear every 36 months for under age 18 includes coverage for the bone anchors on Hearing aids for children under the age of 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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage 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 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 105449, Atlanta, GA 30548-5449

Does this plan provide Minimum Essential Coverage? Yes
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

* 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
</tr>
<tr>
<td>$30</td>
<td>$30</td>
<td>$30</td>
</tr>
<tr>
<td><strong>Hospital (facility) copayment</strong></td>
<td><strong>Hospital (facility) copayment</strong></td>
<td><strong>Hospital (facility) copayment</strong></td>
</tr>
<tr>
<td>$200</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
</tr>
<tr>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- **Specialist** office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- **Diagnostic tests** (*ultrasounds and blood work*)
- **Specialist** visit (*anesthesia*)

**Total Example Cost** $12,840

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
<th>What isn’t covered Limits or exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>$420</td>
<td>$0</td>
<td>$96</td>
</tr>
</tbody>
</table>

The total Peg would pay is **$516**

**Total Example Cost** $7,460

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
<th>What isn’t covered Limits or exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>$140</td>
<td>$0</td>
<td>$6,041</td>
</tr>
</tbody>
</table>

The total Joe would pay is **$6,181**

**Total Example Cost** $2,010

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
<th>What isn’t covered Limits or exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>$600</td>
<td>$47</td>
<td>$0</td>
</tr>
</tbody>
</table>

The total Mia would pay is **$647**

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): የእስከ ምስጎት ይቆጥልም ከተርጠ ይህም ከጥቅ ለማል ከረርም ከሚ እና ይጋ ከማስ ይላ ይበ ከማ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከሚ ከ реакци: (855) 634-3383

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խաղաղության համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 634-3383:

Bassa (Bàssò Wòdù): Mi dyi dyi-die-dè bë bëbëba céè-dè nià ke dyì ni, c mònì dyi-bëbëbën-dë bë m ke gbo-kpá- kpá kë bô kpô dé m bïdzi- wùqùn bó pîdyi. Bë m ke wùdu-ziî-nyô dò gbo wùdù kë, dà (855) 634-3383.

Bengali (বাংলা): যদি এই নথিগুলির বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সহায়তা পাওয়ার ও ভাষার অধিকার আছে। একজন দোভাষী সাথে কথা বলার জন্য (855) 634-3383 (ফ্যাক্স) কল করুন।

Burmese (ဗမာ): မည်သူကိုအနည်းငယ်မှာ ဗိုလ်ချွတ်ပြီးဖော်ပြထားသောစာမျက်နှာကို ဖတ်ရန် သင်ကြားမည်။ (855) 634-3383

Chinese (中文): 如果您对本文件有任何疑问，您有权使用您的语言免费获得协助和资讯。如需与译员通话，请致电 (855) 634-3383。

Dinka (Dinka): Na náa théeè nè ke de yá thóre, ke yin ná̊g lo̱g bë yi kuony ku wek akë bë geér yiè yin ne thóò du ke cín wë̀ tääe ke piny. Te kor yìn ba jum wë̀në ran ye thok getyèè, ke yin col (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.

Farsi (فارسی): در صورتی که سوالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادریتان دریافت کنید. برای کنار گذاشتن یک مترجم شفاهی، با شماره (855) 634-3383 تماس بگیرید.

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 (855) 634-3383.
Language Access Services:

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 (855) 634-3383.

Greek (Ελληνικά): Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, όλες οι διαδικασίες να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνεία, τηλεφωνήστε στο (855) 634-3383.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપની પ્રશ્નો હોય તો, પ્રશ્નો બાદ આપની ભાષામાં મેંટ અને માહમતી મળવાનો તમને અહીંકાર છે. દુભાષયા સાથે વાત કરવા માટે, કોલ કરો (855) 634-3383.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn ed ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 634-3383.

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Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiard lus qhia hai ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 634-3383.

Igbo (Igbo): Ò bùr ù na į nwere ajụjụ ọ bùla gbasara akwụkwọ a, į nwere ikike įnweta enyemaka na ozi n'asịsị ị na akwụghị ugwọ ọ bùla. Ka ị na ọkwọ okwu kwọ kwọ, kpọọ (855) 634-3383.

Ilokano (Ilokano): Nu addaan ka iti aniamaan 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 (855) 634-3383.

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Language Access Services:

**Khmer** (ភាសាខ្មែរ): ប្រើការបញ្ជាក់ផ្ដល់ព័ត៌មានប្រឈមជាច្រើន: ស្លាប់ប្រើប្រាស់នូវប្រភេទទូរស័ព្ទប្រឈមជាច្រើនដោយសារប្រឈមជាច្រើននិងប្រើប្រាស់ឱ្យការប្រើប្រាស់ប្រភេទទូរស័ព្ទប្រឈមជាច្រើន។ អ៊ីន៊ុប៉ូ (855) 634-3383

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**Navajo (Dine)**: Díí náaltsoos biká’ígíí ła’ahgo bina’idíldkííyéhi bóhóneéézhí dóó bee ahóó’t’i’ t’áá ni nízdáa k’ééjí bee níl hodoonih t’áadoo bááh ilínígóó. Ata’ halné’ígíí ła’ bich’íí hadedzihí ninízíingo kojí hodiílínih (855) 634-3383.

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