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/asos. 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 (855) 634-3383 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$100/person or $200/family for UK HealthCare Providers, $500/person or $1,000/family for In-Network Providers, $1,500/person or $3,000/family for Non-Network Providers.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Primary Care Specialist Visit Preventive Care and Vision for UK HealthCare and In-Network Providers.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$3,000/person or $6,000/family for UK HealthCare Providers, $3,000/person or $6,000/family for In-Network Providers, $0/person or $0/family for Non-Network Providers. This plan has a separate Out of Pocket Maximum of $4,900/single or $9,800/family for Prescription Drugs.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Services deemed not medically necessary by Medical Management and/or Anthem,</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Premiums, balance-billing charges, and health care this plan doesn't cover.</td>
<td>You pay the least if you use a provider in UK HealthCare. 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-Network Provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>Yes, Blue Card PPO. See <a href="http://www.anthem.com">www.anthem.com</a> or call (855) 634-3383 for a list of network providers.</td>
<td>You can see the specialist you choose without a referral.</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>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>UK HealthCare Provider (You will pay the least)</th>
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<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15/visit deductible does not apply</td>
<td>$25/visit deductible does not apply</td>
<td>50% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$40/visit deductible does not apply</td>
<td>$50/visit deductible does not apply</td>
<td>50% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>none</td>
</tr>
</tbody>
</table>

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) | 10% coinsurance | 20% coinsurance | 50% coinsurance | Diagnostic X-rays and Laboratory are covered 100% up to $250 then appropriate deductible/coinsurance amount applies. |
| | Imaging (CT/PET scans, MRIs) | $75/visit | 20% coinsurance | 50% coinsurance | none |

| **If you need drugs to treat your** | Tier 1 - Generic | 10% coinsurance (90-day Rxs at UK) | 20% coinsurance | Not covered | $8 minimum/$50 maximum (30-day Rx, any pharmacy) |

* 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>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>illness or condition</td>
<td>More information about prescription drug coverage is available at <a href="http://www.expres-scripts.com">http://www.expres-scripts.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 2 - Preferred Brand</td>
<td>Pharmacies and Express Scripts Home Delivery</td>
<td>(30-day Rx retail pharmacy)</td>
<td>$24 minimum/$100 maximum (90-day Rx UK Phcy/Mail Order)</td>
</tr>
<tr>
<td>Tier 3 - Non-Preferred Brand</td>
<td>30% <strong>coinsurance</strong> (90-day Rx at UK Pharmacies and Express Scripts Home Delivery)</td>
<td>40% <strong>coinsurance</strong> (30-day Rx retail pharmacy)</td>
<td>$20 minimum/$60 maximum (30-day Rx any pharmacy) $60 minimum/$120 maximum (90-day Rx UK Phcy/Mail Order)</td>
</tr>
<tr>
<td>Specialty Generic</td>
<td>40% <strong>coinsurance</strong> (90-day Rx at UK Pharmacies and Express Scripts Home Delivery)</td>
<td>50% <strong>coinsurance</strong> (30-day Rx retail pharmacy)</td>
<td>Not covered</td>
</tr>
<tr>
<td>Specialty Brand</td>
<td>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>$8 minimum/$50 maximum (per 30-day Rx)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$100/visit</td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$100/visit then 20% <strong>coinsurance</strong> deductible does not apply</td>
<td>$100/visit then 20% <strong>coinsurance</strong> deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50/visit deductible does not apply</td>
<td>$50/visit deductible does not apply</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$300/admission</td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>50% <strong>coinsurance</strong></td>
</tr>
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</table>

*For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.*
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</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Office Visit $15/visit <strong>deductible</strong> does not apply&lt;br&gt;Other Outpatient 10% <strong>coinsurance</strong></td>
<td>Office Visit $25/visit <strong>deductible</strong> does not apply&lt;br&gt;Other Outpatient 20% <strong>coinsurance</strong></td>
<td>Office Visit 50% <strong>coinsurance</strong>&lt;br&gt;Other Outpatient 50% <strong>coinsurance</strong></td>
<td>Office Visit&lt;br&gt;----------none----------&lt;br&gt;Other Outpatient&lt;br&gt;----------none----------</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>$300/admission</td>
<td>20% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong>&lt;br&gt;50% <strong>coinsurance</strong>&lt;br&gt;50% <strong>coinsurance</strong>&lt;br&gt;----------none----------</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>$15/visit for the first 1 visit <strong>deductible</strong> does not apply, then 10% <strong>coinsurance</strong></td>
<td>$25/visit for the first 1 visit <strong>deductible</strong> does not apply, then 20% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
<td>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>10% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>$300/admission</td>
<td>20% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td><strong>Home health care</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
<td>100 visits/benefit period for In-Network Providers and Non-Network Providers combined.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td><strong>Rehabilitation services</strong></td>
<td>$20/visit <strong>deductible</strong> does not apply</td>
<td>$30/visit <strong>deductible</strong> does not apply</td>
<td>50% <strong>coinsurance</strong></td>
<td>*See Therapy Services section.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td><strong>Habilitation services</strong></td>
<td>$20/visit <strong>deductible</strong> does not apply</td>
<td>$30/visit <strong>deductible</strong> does not apply</td>
<td>50% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td><strong>Skilled nursing care</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
<td>100 days limit/person/benefit period for In-Network Providers and Non-Network Providers combined.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td><strong>Durable medical equipment</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
<td>*See Durable Medical Equipment Section</td>
</tr>
<tr>
<td>Hospice services</td>
<td><strong>Hospice services</strong></td>
<td>10% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong>&lt;br&gt;50% <strong>coinsurance</strong>&lt;br&gt;50% <strong>coinsurance</strong>&lt;br&gt;----------none----------</td>
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</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>$15/visit deductible does not apply</td>
<td>$25/visit deductible does not apply</td>
<td>50% coinsurance</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>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>Not covered</td>
<td></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.**

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered).
- Dental care (Pediatric)
- Infertility treatment
- Routine eye care (Adult)
- Tier 2 - Typically Preferred / Brand Specialty Brand
- Cosmetic surgery
- Dental Check-up
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes.
- Tier 3 - Typically Non-Preferred / Specialty Drugs
- Weight loss programs
- Dental care (Adult)
- Glasses for a child
- Private-duty nursing
- Tier 1 - Typically Generic
- Specialty Generic

**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
- 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.

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
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), or contact Anthem at the number on the back of your ID card. 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](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 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](https://eoc.anthem.com/eocdps/aso).
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)*

- **The plan’s overall deductible**: $100
- **Specialist copayment**: $40
- **Hospital (facility) copayment**: $300
- **Other coinsurance**: 10%

**What isn’t covered**

- Limits or exclusions: $60
- The total Peg would pay is: **$960**

**Total Example Cost**: $12,700

**In this example, Peg would pay:**

- **Deductibles**: $100
- **Copayments**: $300
- **Coinsurance**: $500

**Cost Sharing**

**In this example, Joe would pay:**

- **Deductibles**: $100
- **Copayments**: $200
- **Coinsurance**: $1,600

**What isn’t covered**

- Limits or exclusions: $20
- The total Joe would pay is: **$1,920**

**Total Example Cost**: $5,600

### Managing Joe’s Type 2 Diabetes
*(a year of routine in-network care of a well-controlled condition)*

- **The plan’s overall deductible**: $100
- **Specialist copayment**: $40
- **Hospital (facility) copayment**: $300
- **Other coinsurance**: 10%

**What isn’t covered**

- Limits or exclusions: $20
- The total Joe would pay is: **$1,920**

**Total Example Cost**: $5,600

### Mia’s Simple Fracture
*(in-network emergency room visit and follow up care)*

- **The plan’s overall deductible**: $100
- **Specialist copayment**: $40
- **Hospital (facility) copayment**: $300
- **Other coinsurance**: 10%

**What isn’t covered**

- Limits or exclusions: $0
- The total Mia would pay is: **$600**

**Total Example Cost**: $2,800

**In this example, Mia would pay:**

- **Deductibles**: $100
- **Copayments**: $300
- **Coinsurance**: $200

**Cost Sharing**

**About these Coverage Examples:**

- 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): ከአማርኛ ይፋፋን ያቋው ከነጻ ከማግኝት ይጋቢ ከጆች በማካኝነት በአማርኛ ይክፋል ከማግኝት ከማንኛውም ከነጻ ያላክት. የማጫር/አማርኛ (855) 634-3383.

 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։ Թարգմանվեց, դուք կարողանուք հեռահարել հետևյալ հեռախոսահամարով՝ (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。

 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.
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 (855) 634-3383.

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, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνεύ, τηλεφωνήστε στο (855) 634-3383.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ અંગે આપની ભાષામાં મિલે અને નડીને સમાધાન મળવા માટે, માફ કરો (855) 634-3383.

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 (855) 634-3383.

Hindi (हिंदी): अंग्रेजी अपके पास इस दस्तावेज के बारे में कोई प्रश्न हैं, तो आपको निष्ठुल अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषियों से बात करने के लिए, कॉल करें (855) 634-3383.


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Lao (ລາວ): ບໍ່FETCH ошибocument swing ໃນລາວ, ຂໍາມືດຮູບລາວຮ່ວມຂາໂບຍຮາກ ໃນໜ່ວຍ ຜ່າຖິ່ubo ເຊິ່ຫານພູພິພາສາ ແລະ ປັບນ່ວຍ ໃນໜ່ວຍ ຜ່າຖິ່ubໜື່ ເຊິ່ຫານພູພາສາ. ຈະ FETCH (855) 634-3383.

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