
 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 (888) 224-4902 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$250</b> /individual or <b>\$750</b> /family for In- <a href="#">Network Providers</a> . <b>\$500</b> /individual or <b>\$1,500</b> /family for Out-of- <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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Specialist</a> visit, Vision exam, <a href="#">Preventive care</a> , and Primary Care visit for 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 preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . 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> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>Medical</b> <b>\$2,250</b> /individual or <b>\$4,750</b> /family for In- <a href="#">Network Providers</a> . <b>\$4,500</b> /individual or <b>\$13,500</b> /family for Out-of- <a href="#">Network Providers</a> . <b>Prescription Drug</b> <b>\$4,600</b> /individual or <b>\$9,200</b> /family for In- <a href="#">Network Providers</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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Services deemed not medically necessary by Medical Management and/or Anthem, <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if	Yes, Blue Access (PPO). See	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's</a>

you use a <a href="#">network provider</a> ?	<a href="http://www.anthem.com">www.anthem.com</a> or call (888) 224-4902 for a list of <a href="#">network providers</a> .	<a href="#">network</a> . You will pay the most if you use an out-of- <a href="#">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 out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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
		In-Network Provider (You will pay the least)	Out-of-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	<b>UofL (ULP) PCP Provider:</b> No charge  <b>Anthem Network:</b> \$20/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Specialist</a> visit	\$35/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Preventive care</a> / <a href="#">screening</a> / <a href="#">immunization</a>	No charge	40% <a href="#">coinsurance</a>	Hearing exam (routine): Not covered. Vision exam includes refraction (routine): \$15/visit deductible does not apply for In-Network Providers and one/benefit period. 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)	Lab – Office No charge X-Ray – Office 10% <a href="#">coinsurance</a>	Lab – Office 40% <a href="#">coinsurance</a> X-Ray – Office 40% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----

\* 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>* <b>Express Scripts</b> (“PBM”) has been designated by your employer to provide <b>pharmacy services</b> by the Plan. For <b>prescription drug coverage</b>, we recommend downloading the <b>Express Scripts</b> mobile app. Details on how to download the app can be found on the website, <a href="https://www.express-scripts.com">https://www.express-scripts.com</a>.</p>				
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="https://www.express-scripts.com">prescription drug coverage</a> is available at <a href="https://www.express-scripts.com">www.express-scripts.com</a>.</p>	Tier 1 - Typically Generic	Retail: \$10 <a href="#">copay</a>  Retail 90 day supply: \$30 <a href="#">copay</a>  Mail (maintenance drugs only): \$0 <a href="#">copay</a>	Not covered	<p><a href="#">Cost share</a> shown is per prescription;</p> <p>Certain preventive <a href="#">prescription drugs</a> may be covered at a reduced <a href="#">cost share</a> or no <a href="#">cost share</a>.</p> <p>Infertility drugs are subject to a \$5,000 lifetime limit.</p> <p>Penalties may apply to brands that have generic equivalents.</p> <p>Penalties do not apply to the <a href="#">deductible</a> or <a href="#">out-of-pocket limit</a>.</p> <p><a href="#">Prior authorization or step therapy</a> may be required. Select drugs have quantity limits.</p> <p><a href="#">Formulary</a> exclusions may apply.</p> <p><a href="#">Specialty drugs</a> are required to be filled at specialty pharmacy.</p> <p><a href="#">Specialty drugs</a> are limited to a 30 day supply.</p>
	Tier 2 - Typically <a href="#">Preferred</a> / Brand	Retail: 25% <a href="#">coinsurance</a> , \$60 max  Retail 90 day supply: 25% <a href="#">coinsurance</a> , \$180 max  Mail: 15% <a href="#">coinsurance</a> , up to \$120 max	Not covered	
	Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a>	Retail: 40% <a href="#">coinsurance</a> , \$100 max  Retail 90 day supply: 40% <a href="#">coinsurance</a> , \$300 max  Mail: 35% <a href="#">coinsurance</a> , up to \$200 max	Not covered	
	Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)	Tier 1: 25% <a href="#">coinsurance</a> , \$100 max  Tier 2: 25% <a href="#">coinsurance</a> , \$150 max  Tier 3: 40% <a href="#">coinsurance</a> , up to \$250 max	Not covered	

\* 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150/visit <a href="#">deductible</a> does not apply	Covered as In- <a href="#">Network</a>	Copay waived if admitted.
	<a href="#">Emergency medical transportation</a>	\$100/visit <a href="#">deductible</a> does not apply	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	\$30/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office Visit University of Louisville Physician: No charge All other PCP: \$20/visit <a href="#">deductible</a> does not apply Other Outpatient 10% <a href="#">coinsurance</a>	Office Visit 40% <a href="#">coinsurance</a> Other Outpatient 40% <a href="#">coinsurance</a>	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
<b>If you are pregnant</b>	Office visits	University of Louisville Physician: No charge All other PCP: \$20/pregnancy first 1 visit <a href="#">deductible</a> does not apply then 10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	One <a href="#">copayment</a> per pregnancy for both office visits and childbirth/delivery professional services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	100 visits/benefit period.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	*See Therapy Services section
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	120 days limit/benefit period.

\* 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	*See <a href="#">Durable Medical Equipment Section</a>
	<a href="#">Hospice services</a>	No charge	40% <a href="#">coinsurance deductible</a> does not apply	-----none-----
If your child needs dental or eye care	Children’s eye exam	<b>UofL (ULP) PCP Provider:</b> No charge <b>Anthem Network:</b> \$20/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	*See Vision Services section
	Children’s glasses	Not covered	Not covered	
	Children’s dental check-up	Not covered	Not covered	*See Dental Services section

**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](#).)

- Acupuncture
- Dental Check-up
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Cosmetic surgery
- Glasses for a child
- Private-duty nursing
- Dental care (adult)
- Long- term care
- Routine foot care unless you have been diagnosed with diabetes.

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

- Routine eye care (adult)
- Infertility treatment (\$5,000 medical lifetime limit and \$5,000 prescription drug lifetime limit)
- Chiropractic care 30 visits/benefit period.
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Hearing aids one/ear every 36 months; \$3,000 limit.
- Bariatric surgery

**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, (800) 648-6056. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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.

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

**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 Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Department of Insurance, 215 West Main Street, Frankfort, Kentucky 40601, (502) 564-3630, (800) 595-6053, (800) 648-6056

**Does this plan provide Minimum Essential Coverage? Yes/No**

[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/No**

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)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 0%

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	\$12,700
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$1,320</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$4,500</b>

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$710</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 (888) 224-4902

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (888) 224-4902 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 (888) 224-4902.

**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՝ (888) 224-4902:

**Bassa (Bàsɔ̀ wùdù):** M̄ dyi dyi-diè-djè b̄ě b̄édjé b̄á céè-djè nià k̄e dyí ní, ɔ̀ m̄ò nì dyí-b̄èdjèin-djè b̄é m̄ k̄é gbo-kpá-kpá k̄è b̄ǎ kp̄ǎ djé m̄ bídjí-wùdùùn b̄ó pídyi. B̄é m̄ k̄é wuɖu-zìin-nyò djò gbo wùdù k̄e, djá (888) 224-4902.

**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 (888) 224-4902 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (888) 224-4902 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 (888) 224-4902。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yā 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 col (888) 224-4902.

**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 (888) 224-4902.

**Farsi (فارسی):** 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 (888) 224-4902 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 (888) 224-4902.

**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 (888) 224-4902.

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