

University of Louisville Student Health Insurance 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/ or call (855) 333-5735 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Select Providers: \$200 / (Person) In-Network Providers: \$700 / (Person) Out-of-Network Providers: \$1,000 / (Person)	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. Preventive Care , Pediatric Dental, Pediatric Vision and categories that specify deductible does not apply.	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?	Select Providers: \$10,000 / (Person) \$20,000 / (Family) In-Network Providers: \$10,000 / (Person) \$20,000 / (Family) Out-of-Network Providers: \$10,000 / (Person) \$20,000 / (Family)	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, 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. See www.anthem.com/find-care/?alphaprefix=AJW or call (833) 578-4443 for a list of network providers . Benefits and costs may vary by site of service and how the provider bills.	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 ?	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
		Select Providers	In-Network Providers	Out-of-Network Providers (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	\$30 copay per visit; 20% coinsurance; deductible does not apply	\$30 copay per visit; 30% coinsurance; deductible does not apply	\$30 copay per visit; 50% coinsurance; deductible does not apply	University of Louisville Campus Health Services (ULCHS) Benefits: The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Services. May not apply when related to surgery or Physiotherapy.
	Specialist visit	\$30 copay per visit; 20% coinsurance; deductible does not apply	\$30 copay per visit; 30% coinsurance; deductible does not apply	\$30 copay per visit; 50% coinsurance; deductible does not apply	
	Preventive care/screening/immunization	No charge	No charge	25% coinsurance after deductible is met	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.

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

If you have a test	Diagnostic Test (x-ray, blood work) in the office, clinic or home setting	Lab – No cost share X-ray - \$25 copay per visit; 20% coinsurance; deductible does not apply	Lab – No cost share X-ray - \$25 copay per visit; 30% coinsurance; deductible does not apply	Lab – \$20 copay per visit; 25% coinsurance; deductible does not apply X-ray - \$25 copay per visit; 50% coinsurance; deductible does not apply	-----none-----
	Advanced Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	50% coinsurance	-----none-----

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Select Providers	In-Network Providers	Out-of-Network Providers (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/	Typically Generic (Tier 1)	\$15/prescription, <u>deductible</u> does not apply (retail) and \$30/prescription, <u>deductible</u> does not apply (home delivery)	\$15/prescription, <u>deductible</u> does not apply (retail) and \$30/prescription, <u>deductible</u> does not apply (home delivery)	25% coinsurance, deductible does not apply (retail) and Not covered (home delivery)	For more information, refer to “Traditional Open Drug List” at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section.
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	\$30/prescription, <u>deductible</u> does not apply (retail) and \$60/prescription, <u>deductible</u> does not apply (home delivery)	\$30/prescription, <u>deductible</u> does not apply (retail) and \$60/prescription, <u>deductible</u> does not apply (home delivery)	25% coinsurance, deductible does not apply (retail) and Not covered (home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	20% coinsurance, deductible does not apply (retail) and Not covered (home delivery)	20% coinsurance, deductible does not apply (retail) and Not covered (home delivery)	25% coinsurance, deductible does not apply (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Emergency room care	\$150 copay per visit 30% coinsurance; deductible does not apply	\$150 copay per visit 30% coinsurance; deductible does not apply	Covered as In-Network	Copay waived if admitted or placed in observation.

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

If you need immediate medical attention	Emergency medical transportation	Not covered	30% coinsurance	Covered as In-Network	Non-emergency transportation is not covered.
	Urgent care	\$50 copay per visit 20% coinsurance; deductible does not apply	\$50 copay per visit 30% coinsurance; deductible does not apply	\$50 copay per visit 30% coinsurance; deductible does not apply	-----none-----

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Select Providers	In-Network Providers	Out-of-Network Providers (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	50% coinsurance	
	Physician/surgeon fees	20% coinsurance	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	50% coinsurance	-----none-----
	Inpatient services	20% coinsurance	30% coinsurance	50% coinsurance	
If you are pregnant	Office visits	\$30 copay per visit; 20% coinsurance; deductible does not apply	\$30 copay per visit; 20% coinsurance; deductible does not apply	\$30 copay per visit; 20% coinsurance; deductible does not apply	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	50% coinsurance	120 visits/benefit period
	Rehabilitation services	\$20 copay per visit; deductible does not apply	30% coinsurance	50% coinsurance	Outpatient manipulative therapy: 20 visits/benefit period Outpatient cardiac rehabilitation therapy: 36 visits/benefit period Outpatient physical, occupational, and speech therapy separate 25 visits/benefit period
	Habilitation services	\$20 copay per visit; deductible does not apply	30% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	30% coinsurance	20% coinsurance	90 days/benefit period

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

	Durable medical equipment	20% coinsurance	30% coinsurance	50% coinsurance	*See Durable Medical Equipment Section
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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Select Providers	In-Network Providers	Out-of-Network Providers (You will pay the most)	
	Hospice services	Paid at least equal to the Medicare benefits for Hospice Care	Paid at least equal to the Medicare benefits for Hospice Care	Paid at least equal to the Medicare benefits for Hospice Care	-----none-----
If your child needs dental or eye care	Children's eye exam	No charge	No charge	\$0 <u>copayment</u> up to <u>plan's</u> Maximum <u>Allowed Amount</u>	-----none-----
	Children's glasses	No charge	No charge	\$0 <u>copayment</u> up to <u>plan's</u> Maximum <u>Allowed Amount</u>	-----none-----
	Children's dental check-up	No charge	No charge	\$0 <u>copayment</u> up to <u>plan's</u> Maximum <u>Allowed Amount</u>	-----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.)		
• Dental care (adult) • Cosmetic surgery	• Infertility treatment • Routine eye care (adult)	• Acupuncture • Long term care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Most coverage provided outside the United States. See www.bcbsglobalcore.com	• Private-duty nursing	• Hearing aid

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

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) at an ARH provider

■ The plan's overall deductible	\$700
■ Specialist coinsurance	\$30
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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:

Cost Sharing	
Deductibles	\$700
Copayments	\$40
Coinsurance	\$3,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,100

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition) at an ARH provider

■ The plan's overall deductible	\$700
■ Specialist coinsurance	\$30
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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:

Cost Sharing	
Deductibles	\$700
Copayments	\$800
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1820

Mia's Simple Fracture

(in-network emergency room visit and follow up care) at an ARH provider

The plan's overall deductible	\$700
■ Specialist coinsurance	\$30
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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:

Cost Sharing	
Deductibles	\$700
Copayments	\$400
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,600

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) 333-5735

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 333-5735 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) 333-5735.

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) 333-5735:

Bassa (Bàsɔ̀ wùdù): M̐ dyi dyi-diè-dɛ bɛ́ bédé b́á céè-dɛ nià kɛ́ dyí ní, ɔ̀ mò̀ nì dyí-bédɛ̀n-dɛ́ b́é̀ m̐ ḱé gbo-kpá-kpá kè b̐́ kp̐́ d́é̀ m̐ b́í d́í-wùdù̀n b́ó ṕí dyí. B́é̀ m̐ ḱé wuɖu-zìin-nyò d̀ò̀ gbo wùdù̀ kɛ́, d́á (855) 333-5735.

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) 333-5735 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (855) 333-5735 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) 333-5735。

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 tāäüë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin col (855) 333-5735.

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) 333-5735.

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 (855) 333-5735 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 (855) 333-5735.

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) 333-5735.

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 (855) 333-5735.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ કો આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો સમાવેશ થાય છે. સુભાષિયા સાથે વાત કરવા માટે કોલ કરો (855) 333-5735.

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) 333-5735.

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 (855) 333-5735 ।

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 (855) 333-5735.

Igbo (Igbo): O bụrụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike inweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 333-5735.

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 (855) 333-5735.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855) 333-5735.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 333-5735

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 333-5735 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
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Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
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