University of Kentucky: Self-funded Student Health Plan Coverage Period: 08/15/2019 – 08/15/2020

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Single & Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **uky.myahpcare.com** or by calling **1-855-856-2385**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Per individual: **$0** at UHS, **$300** at UK HealthCare, **$500** at other In-network Providers, and **$1,000** at Out-of-network Providers	You must pay all costs up to the **deductible** amount before this **plan** begins to pay for covered services you use. Check your plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes	Certain Per-service Deductibles and Copays apply to some services. Refer to the plan document referenced above for details.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,350** per individual/$**12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Excluded services, penalties for not complying with plan provisions.	Even though you pay these expenses, they don't count toward the **out-of- pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of PPO Providers please call **1-855-856-2385** or see **uky.myahpcare.com**.	If you use a **PPO** doctor or other health care provider, this **plan** will pay some or all of the costs of covered services. Be aware, your **PPO** doctor or hospital may use a **Non-PPO** provider for some services. Plans use the term **in-network, preferred**, or **participating providers** in their network. See the chart starting on page 2 for how this **plan** pays different providers.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 7. See your **plan** document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay	Deductible and 50% coinsurance	0% coinsurance at UHS.
	Specialist visit	$45 copay	Deductible and 50% coinsurance	0% coinsurance at UHS.
	Other practitioner office visit	20/35% coinsurance	50% coinsurance	0% coinsurance at UHS.
	Preventive care/screening/immunization	0% Coinsurance	50% coinsurance	No deductibles/copays In-network
If you have a test	Diagnostic test (x-ray, blood work)	20/35% coinsurance	50% coinsurance	Excluding Preventive Care Services.
	Imaging (CT/PET scans, MRIs)	20/35% coinsurance	50% coinsurance	Excluding Preventive Care Services.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **uky.myahpcare.com**.	Generic drugs	10% coinsurance Min $10, Max $50	No Benefit	Retail – 30 day supply Mail Order – 90 day supply Out-of-network mail order drugs are not covered. UK Pharmacy copays shown. Other copays apply for other In-network pharmacies, deductibles apply Out-of-network. Mail order copays not shown.
	Preferred brand drugs	20% coinsurance Min $30, Max $60	No Benefit	
	Non-preferred brand drugs	50% coinsurance Min $60	No Benefit	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Specialty drugs	50% coinsurance Min $60	No Benefit	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20/35% coinsurance	50% coinsurance	Excludes non-scheduled surgery and surgery performed in a hospital ER.
	Physician/surgeon fees	20/35% coinsurance	50% coinsurance	Secondary surgical procedures paid at 50% of first. 0% coinsurance at UHS.
If you need immediate medical attention	Emergency room services	$200 copay 80% Coinsurance	$200 copay 80% Coinsurance	No benefits at UHS
	Emergency medical transportation	35% Coinsurance	50% coinsurance	No benefits at UHS or UK HealthCare
	Urgent care	$75 copay	Deductible and 50% coinsurance	No benefits at UHS or UK HealthCare
If you have a hospital stay	Facility fee (e.g., hospital room)	20/35% coinsurance	50% coinsurance	Daily semi-private room rate.
	Physician/surgeon fee	20/35% coinsurance	50% coinsurance	Secondary procedures 50% of first.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20/35% coinsurance	50% coinsurance	See plan document.
	Mental/Behavioral health inpatient services	20/35% coinsurance	50% coinsurance	See plan document.
	Substance use disorder outpatient services	20/35% coinsurance	50% coinsurance	See plan document.
	Substance use disorder inpatient services	20/35% coinsurance	50% coinsurance	See plan document.
If you are pregnant	Prenatal and postnatal care	20/35% coinsurance	50% coinsurance	Prenatal office visits are covered at 100% after the initial visit In-network.
	Delivery and all inpatient services	20/35% coinsurance	50% coinsurance	48 hour stay following vaginal delivery, and 96 hours following C-section.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	35% Coinsurance	50% coinsurance	Limited to 100 days per plan year
	Rehabilitation services	$15 copay	50% coinsurance, $15 copay per visit	Copays waived if treatment follows surgery or hospital confinement. Medical necessity review after 12 visits.
	Habilitation services	$15 copay	50% coinsurance, $15 copay per visit	
	Skilled nursing care	20/35% coinsurance	50% coinsurance	In lieu of hospital confinement or within 24 hours after hospital stay.
	Durable medical equipment	20/35% coinsurance	50% coinsurance	See the pan document for details.
	Hospice service	35% Coinsurance	50% coinsurance	If expected life span 6 months or less.
If your child needs dental or eye care	Eye exam	$20 Copay	No Benefit	See the plan document for details.
	Glasses	Varies, see page 39 of the plan document.	No Benefit	See the plan document for details.
	Dental check-up	50% coinsurance	No Benefit	See the plan document for details.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Infertility treatment
- Routine foot care
- Weight Loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Autism
- Chiropractic care

Your Rights to Continue Coverage:

If you lose coverage under the plan, depending on the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the **plan**. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the **plan** at 1-855-856-2385. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 orwww.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your **plan**, you may be able to **appeal** or file a **grievance**.
For questions about your rights, this notice, or assistance, you can contact:

ARC Administrators ATTN: Appeals
PO Box 12290
Lexington, KY 40582

Department of Labor, Employee Benefit Security Administration
1-866-444-EBSA (3272)
www.dol.ebsa/healthreform

Additionally, a consumer assistance program can help you file your appeal. Contact:
Kentucky Department of Insurance, Consumer Protection Division
PO Box 517
Frankfort, KY 40602
877-587-7222
http://healthinsurancehelp.ky.gov

DOI.CAPOmbudsman@ky.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage."

This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).

This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services: 1-855-856-2385

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,695
- **Patient pays** $1,845

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$45
Coinsurance	$1,300
Limits or exclusions	$200
Total	**$1,845**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,700
- **Patient pays** $1,700

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$300
Coinsurance	$1,000
Limits or exclusions	$100
Total	**$1,700**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.