
 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/fi>. 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 (844) 412-0752 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$300/person for UK Healthcare Providers . \$500/person for In- Network Providers . \$1,000/person for Out-of- Network Providers .	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 .
Are there services covered before you meet your deductible ?	Yes. Primary Care visit, Specialist visit, Preventive care , and Vision exam for UK Healthcare and In- Network Providers .	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 ?	\$6,350/individual or \$12,700/family for In- Network Providers and UK Healthcare Providers combined. \$12,700/individual or \$25,400/family for Out-of- 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 ?	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, Blue Access (PPO). See www.anthem.com or call (844) 412-0752 for a list of network providers .	You pay the least if you use a provider in UK. 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.
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
		UK HealthCare Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (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	\$25/visit deductible does not apply	\$30/visit deductible does not apply	50% coinsurance	-----none-----
	Specialist visit	\$45/visit deductible does not apply	\$50/visit deductible does not apply	50% coinsurance	-----none-----
	Preventive care / screening / immunization	No charge	No charge	50% coinsurance	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)	20% coinsurance	35% coinsurance	50% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	35% coinsurance	50% coinsurance	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/ National	Tier 1 - Typically Generic	\$10/prescription or 10% coinsurance , whichever is greater up to \$50 maximum /prescription deductible does not apply (retail) and \$60/prescription or 20% coinsurance , whichever is greater up to \$120 maximum	\$30/prescription or 20% coinsurance , whichever is greater up to \$60 maximum /prescription deductible does not apply (retail) and \$60/prescription or 20% coinsurance , whichever is greater up to \$120 maximum	Not covered	*See Prescription Drug section

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UK HealthCare Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
		/prescription deductible does not apply (home delivery)	/prescription deductible does not apply (home delivery)		
	Tier 2 - Typically Preferred / Brand	\$30/prescription or 20% coinsurance , whichever is greater up to \$60 maximum /prescription deductible does not apply (retail) and \$100/prescription or 30% coinsurance , whichever is greater up to \$150 maximum /prescription deductible does not apply (home delivery)	\$50/prescription or 30% coinsurance , whichever is greater up to \$75 maximum /prescription deductible does not apply (retail) and \$100/prescription or 30% coinsurance , whichever is greater up to \$150 maximum /prescription deductible does not apply (home delivery)	Not covered	
	Tier 3 - Typically Non- Preferred / Specialty Drugs	\$60/prescription or 50% coinsurance , whichever is greater deductible does not apply (retail) and \$225/prescription or 50% coinsurance , whichever is greater deductible	\$75/prescription or 50% coinsurance , whichever is greater deductible does not apply (retail) and \$225/prescription or 50% coinsurance , whichever is greater deductible	Not covered	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UK HealthCare Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
		does not apply (home delivery)	does not apply (home delivery)		
	Tier 4 - Typically Specialty (brand and generic)	10% coinsurance deductible does not apply (retail) and 20% coinsurance deductible does not apply (home delivery)	20% coinsurance deductible does not apply (retail) and 20% coinsurance deductible does not apply (home delivery)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	35% coinsurance	50% coinsurance	-----none-----
	Physician/surgeon fees	20% coinsurance	35% coinsurance	50% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	\$200/visit deductible does apply then 20% coinsurance	\$200/visit deductible does apply then 20% coinsurance	Covered as In- Network	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	Covered as In- Network	-----none-----
	Urgent care	\$75/visit deductible does not apply	\$75/visit deductible does not apply	50% coinsurance	No coverage for Urgent care
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	35% coinsurance	50% coinsurance	-----none-----
	Physician/surgeon fees	20% coinsurance	35% coinsurance	50% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25/visit deductible does not apply	\$30/visit deductible does not apply	Office Visit 50% coinsurance Other Outpatient 50% coinsurance	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	20% coinsurance	35% coinsurance	50% coinsurance	-----none-----
If you are pregnant	Office visits	No charge	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	35% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	35% coinsurance	50% coinsurance	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UK HealthCare Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	35% coinsurance	50% coinsurance	100 visits/benefit period for In-Network Providers and Out-of-Network Providers combined.
	Rehabilitation services	\$15/visit deductible does not apply	\$15/visit deductible does not apply	\$15/visit deductible does not apply	*See Therapy Services section
	Habilitation services	\$15/visit deductible does not apply	\$15/visit deductible does not apply	\$15/visit deductible does not apply	
	Skilled nursing care	20% coinsurance	35% coinsurance	50% coinsurance	60 days limit/benefit period for In-Network Providers and Out-of-Network Providers combined.
	Durable medical equipment	Not covered	35% coinsurance	50% coinsurance	*See Durable Medical Equipment Section
	Hospice services	Not covered	35% coinsurance	50% coinsurance	No coverage for Hospice Services
If your child needs dental or eye care	Children's eye exam	\$20/visit deductible does not apply	\$30/visit deductible does not apply	Not covered	*See Vision Services section
	Children's glasses	100%/Eyeglass frames with a retail cost up to \$130 \$15/Eyeglass frames with a retail cost up to \$130 - \$160 \$30/Eyeglass frames with a retail cost up to \$160 - \$200	Not covered	Not covered	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UK HealthCare Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
		\$50/Eyeglass frames with a retail cost up to \$200 - \$250 60% coinsurance /Eyeglass frames with a retail cost greater than \$250			
	Children’s dental check-up	50% coinsurance	Not Applicable	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](#).)

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Acupuncture • Dental care (adult) • Hospice Services • Private-duty nursing • Weight loss programs | <ul style="list-style-type: none"> • Bariatric surgery • Dental Check-up • Infertility treatment • Routine foot care unless you have been diagnosed with diabetes. | <ul style="list-style-type: none"> • Cosmetic surgery • Long- term care • Urgent care |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|

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

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|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Chiropractic care 12 visits/benefit period. • Routine eye care (adult) | <ul style="list-style-type: none"> • Hearing aids \$3,000 maximum/benefit period.1/left ear every 48 months. 1/right ear every 48 months for children 18 years of age or under. | <ul style="list-style-type: none"> • Most coverage provided outside the United States. See www.bcbsglobalcore.com |
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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 Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov. Other coverage

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

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

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

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](#).

—————*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/fi>.

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	\$300
■ Specialist copayment	\$45
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$50
Coinsurance	\$2,487
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,897

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

■ The plan's overall deductible	\$300
■ Specialist copayment	\$45
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$107
Copayments	\$290
Coinsurance	\$1,755
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,207

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

■ The plan's overall deductible	\$300
■ Specialist copayment	\$45
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$195
Coinsurance	\$132
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$627

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 (844) 412-0752

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (844) 412-0752 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 (844) 412-0752.

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՝ (844) 412-0752:

Bassa (Bàsɔ́ Wùdù): M̄ dyi dyi-diè-djé b̄é b̄édjé b̄á céè-djé n̄ià ke dyí ní, ɔ̀ m̀ò n̄i dyí-b̄é d̄jé-in-djé b̄é m̄ ké gbo-kpá-kpá kè b̄ĩ kp̄ō djé m̄ bí d̄í-wù d̄ù ùn b̄ó pí d̄yí. B̄é m̄ ké wu d̄u-zì in-nyò d̄ò gbo wù d̄ù ke, d̄á (844) 412-0752.

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 (844) 412-0752 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (844) 412-0752 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 (844) 412-0752。

Dinka (Dinka): Na n̄ɔŋ thiēc nē ke de yā thorē, ke yin n̄ɔŋ loŋ bē yi kuony ku w̄er alēu bē ḡɛɛr yic yin ne thoŋ du ke cin w̄eu tāāuē ke piny. Te k̄ɔr yin ba jam w̄enē ran ye thok geryic, ke yin c̄ɔl (844) 412-0752.

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 (844) 412-0752.

Farsi (فارسي): 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 (844) 412-0752 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 (844) 412-0752.

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 (844) 412-0752.

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 (844) 412-0752.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (844) 412-0752.

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 (844) 412-0752.

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 (844) 412-0752 ।

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 (844) 412-0752.

Igbo (Igbo): O bụrụ na ị nwere ajuju o bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ugwo o bụla. Ka gị na okwọa okwu kwuo okwu, kpọọ (844) 412-0752.

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 (844) 412-0752.

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 (844) 412-0752.

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 (844) 412-0752

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、(844) 412-0752 にお電話ください。

Language Access Services:

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ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ (844) 412-0752 ។

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Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojí' hodiilnih (844) 412-0752.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (844) 412-0752

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