Western Kentucky University
Anthem BlueCross BlueShield
Basic PPO Plan

Coverage Period: 01/01/2019 – 12/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | **Plan Type:** CDHP

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 https://eoc.anthem.com/eocdps/aso or by calling 1- 888-650-4047.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,700** single / **$4,800** family for In-Network Provider. **$4,200** single/ **$8,400** family for Non-Network Provider. Does not apply to In-Network Preventive Care. In-Network Provider and Non-Network Provider deductibles are separate and do not count towards each other.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes; In-Network Provider Single: **$4,700,** Family: **$8,800** Non-Network Provider Single: **$8,200** family / **$16,400**. In-Network Provider and Non-Network Provider out-of-pocket are separate and do not count towards each other.	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.

Questions: Call 1-888-650-4047 or visit us at www.anthem.com
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-888-650-4047to request a copy.

Important Questions	Answers	Why this Matters:
What is not included in the out–of–pocket limit?	Balance-Billed Charges, Health Care This Plan Doesn't Cover, Premiums, and Non-Network Human Organ and Tissue Transplant (HOTT) Services.	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. This policy has no overall annual limit on the amount it will pay each year.	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 **network providers**, see www.anthem.com or call 1-888-650-4047	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the term in-network, preferred, or participating to refer to providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	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 8. See your policy or plan document for additional information about excluded services.

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- **Copayments** are fixed dollar amounts (for example, $15) 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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance	30% coinsurance	——————none——————
	Specialist visit	15% coinsurance	30% coinsurance	——————none——————
	Other practitioner office visit	Manipulative Therapy 15% coinsurance Acupuncturist Not Covered	Manipulative Therapy 30% coinsurance Acupuncturist Not Covered	Manipulative Therapy Coverage is limited to 20 visits per year. Services from In-Network Providers and Non-Network Providers count towards your limit.
	Preventive care/screening/ immunization	No cost share	30% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	Lab-Office 15% coinsurance X-Ray – Office 15% coinsurance	30% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	15% coinsurance	30% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Tier 1 – Typically Generic	$10 copay / prescription (30 day retail) $25 copay / prescription (90 day retail or mail order)	100% (in-network benefits only)	Prescriptions are subject to the medical plan deductibles Note: Some preventive medications are covered in full or may not be subject to the deductible
More information about **prescription drug coverage** is available at www.express-scripts.com	Tier 2 – Preferred/Formulary Brand	$30 copay / prescription (30 day retail) $75 copay / prescription (90 day retail or mail order)	100% (in-network benefits only)	Prescriptions are subject to the medical plan deductibles Note: Some preventive medications are covered in full or may not be subject to the deductible
	Tier 3 – Typically Non-preferred/Non-Formulary and Specialty Drugs	50% coinsurance (min $40; max $140) / prescription (30 day retail) $45% coinsurance (min $100; max $350)/ prescription (90 day retail or mail order)	100% (in-network benefits only)	Prescriptions are subject to the medical plan deductibles Note: Some preventive medications are covered in full or may not be subject to the deductible
If you have outpatient surgery	Facility Fee (e.g., ambulatory surgery center)	15% coinsurance	30% coinsurance	——————none——————
If you need	Emergency room services	15% coinsurance	15% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
immediate medical attention	Emergency medical transportation	15% coinsurance	15% coinsurance	——————none——————
	Urgent care	15% coinsurance	30% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	30% coinsurance	Physical Medicine and Rehabilitation (Network and Non-network combined) limited to 60 days, includes Day Rehabilitation programs.
	Physician/surgeon fee	15% coinsurance	30% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit 15% coinsurance Mental/Behavioral Health Facility Visit – Facility Charges 15% coinsurance	Mental/Behavioral Health Office Visit 30% coinsurance Mental/Behavioral Health Facility Visit – Facility Charges 30% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	15% coinsurance	30% coinsurance	——————none——————
	Substance use disorder outpatient services	Substance Abuse Office Visit 15% coinsurance Substance Abuse Facility Visit – Facility Charges 15% coinsurance	Substance Abuse Office Visit 30% coinsurance Substance Abuse Facility Visit – Facility Charges 30% coinsurance	——————none——————
	Substance use disorder inpatient services	15% coinsurance	30% coinsurance	——————none——————
If you are pregnant	Prenatal and postnatal care	15% coinsurance	30% coinsurance	Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	15% coinsurance	30% coinsurance	Applies to inpatient facility. Other cost shares may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	15% coinsurance	30% coinsurance	Coverage is limited to 100 visits per year. Does not include I.V. Therapy. Services from In-Network Providers and Non-Network Providers count towards your limit.
	Rehabilitation services	15% coinsurance	30% coinsurance	Coverage for physical therapy is limited to 30 visits per year, occupational therapy is limited to 30 visits per year, speech therapy is limited to 20 visits per year, cardiac rehabilitation is unlimited, and pulmonary rehabilitation is unlimited. Outpatient and office services count toward the limit. The amount you pay may be different depending on how or where your care was provided. See your formal contract of coverage for complete details. Services from In-Network Providers and Non-Network Providers count towards your limit
	Habilitation services	15% coinsurance	30% coinsurance	Habilitation visits count towards your Rehabilitation limit.
	Skilled nursing care	15% coinsurance	30% coinsurance	Coverage is limited to 90 days per year. Services from In-Network Providers and Non-Network Providers count towards your limit.
	Durable medical equipment	15% coinsurance	30% coinsurance	————————none————————
	Hospice service	15% coinsurance	15% coinsurance	————————none————————
If you need dental or eye care	Eye exam	15% coinsurance	30% coinsurance	Coverage is for vision exam only. Consult your formal contract of coverage. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Glasses	Not Covered	Not Covered	————————none————————

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	Dental check-up	Not Covered	Not Covered	——————none——————

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
- Cosmetic surgery
- Dental care
- Hearing aids except every three years for members under 18 years of age
- Infertility treatment
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes. Consult your formal contract of coverage.
- 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.)**

- Chiropractic care
- Most coverage provided outside the United
- Private-duty nursing Services limited to 82 visits/year and 164 visits/lifetime

States. See www.bcbs.com/bluecardworldwide.	• Routine eye care for vision exam only. Consult your formal contract of coverage.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon 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 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 1-888-650-4047. You may also contact your state insurance department, the Department of Labor's Employee Benefits Security Administration
1-866-444-EBSA (3272)
www.dol.gov/ebsa/healthreform.

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:

Anthem Blue Cross Blue Shield
ATTN: Appeals
P.O. Box 105568
Atlanta GA 30348-5568

Or Contact:

Department of Labor's Employee Benefits Security Administration at
1-866-444-EBSA (3272) or
www.dol.gov/ebsa/healthreform

Department of Insurance
215 West Main Street
Frankfort Kentucky 40601
Main: 502-564-3630
Toll Free (Kentucky only): 800-595-6053
TTY: 800-648-6056

A consumer assistance program can help you file your appeal.
Contact:
Kentucky Department of Insurance
Consumer Protection Division
P.O. 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:

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** $4,114
- **Patient pays** $3,426

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	$2,700
Copays	$0
Coinsurance	$726
Total	**$3,426**

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.