


LivingWell CDHP: Kentucky Employees' Health Plan: Coverage for: Single, Parent-Plus, Couple and Family | Plan Type: PPO



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, contact Anthem at 1-844-402-5347 or [www.anthem.com/kehpc](http://www.anthem.com/kehpc) or CVS/Caremark at 1-866-601-6934 or [www.caremark.com](http://www.caremark.com). 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.kehpc.ky.gov](http://www.kehpc.ky.gov) or call 1-844-402-5347 or 1-866-601-6023 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$1,500</b> Single/ <b>\$2,750</b> Family for In-Network Providers <b>\$2,750</b> Single/ <b>\$5,250</b> Family for Out-of-Network Providers.	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. Preventive Care.	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 <a href="#">preventive services</a> 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>\$3,000</b> Single/ <b>\$5,750</b> Family for In-Network Providers <b>\$5,750</b> Single/ <b>\$11,250</b> Family for Out-of-Network Providers.	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 plan, 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> ?	<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 you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.anthem.com/kehpc">www.anthem.com/kehpc</a> or call 1-844-402-5347. See <a href="http://www.caremark.com">www.caremark.com</a> or call 1-866-601-6934 for a list of network providers.	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 network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's charge</a> and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-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
		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 office</a> or clinic	Primary care visit to treat an injury or illness	20% after <a href="#">deductible</a>	50% after <a href="#">deductible</a>	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.
	<a href="#">Specialist</a> visit	20% after <a href="#">deductible</a>	50% after <a href="#">deductible</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge		
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% after <a href="#">deductible</a>	50% after <a href="#">deductible</a>	
	Imaging (CT/PET scans, MRIs)	20% after <a href="#">deductible</a>	50% after <a href="#">deductible</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.caremark.com</a> .	Generic drugs – Tier 1	20% after <a href="#">deductible</a> for 30-day supply. 20% after <a href="#">deductible</a> for a 90-day supply of mail order or retail.	50% after <a href="#">deductible</a> for a 30-day supply.	The maximum you will pay for a 30-day supply of insulin is \$30.
	Formulary – Tier 2	20% after <a href="#">deductible</a> for 30-day supply	Not Covered	Prescription coinsurance and medical coinsurance both apply to the out-of-pocket maximum limit for this plan. The drug formulary (preferred drug list) is located at <a href="#">www.kehp.ky.gov</a> .
	Non-preferred brand drugs			Non-preferred brand drugs are excluded
	<a href="#">Specialty drugs</a>	20% after <a href="#">deductible</a> for 30-day supply. 20% after <a href="#">deductible</a> for a 90-day supply mail order or retail.	50% after <a href="#">deductible</a> 30-day supply only.	Prescription coinsurance and medical coinsurance both apply to the out-of-pocket maximum limit for this plan. The drug formulary (preferred drug list) is located at <a href="#">www.kehp.ky.gov</a> . No coverage for specialty drugs when at the Emergency Room for non-emergency services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after <u>deductible</u>	50% after <u>deductible</u>	
	Physician/surgeon fees	20% after <u>deductible</u>	50% after <u>deductible</u>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% after <u>deductible</u>	20% after <u>deductible</u>	
	<a href="#">Emergency medical transportation</a>	20% after <u>deductible</u>	20% after <u>deductible</u>	
	<a href="#">Urgent care</a>	20% after <u>deductible</u>	20% after <u>deductible</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after <u>deductible</u>	50% after <u>deductible</u>	
	Physician/surgeon fees	20% after <u>deductible</u>	50% after <u>deductible</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% after <u>deductible</u>	50% after <u>deductible</u>	
	Inpatient services	20% after <u>deductible</u>	50% after <u>deductible</u>	
If you are pregnant	Office visits	20% after <u>deductible</u>	50% after <u>deductible</u>	
	Childbirth/delivery professional services	20% after <u>deductible</u>	50% after <u>deductible</u>	
	Childbirth/delivery facility services	20% after <u>deductible</u>	50% after <u>deductible</u>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% after <u>deductible</u>	50% after <u>deductible</u>	Limited to 60 visits per year.
	<a href="#">Rehabilitation services</a>	20% after <u>deductible</u>	50% after <u>deductible</u>	Physical Therapy, Occupational Therapy, and Speech Therapy have a combined limit of 90 visits per calendar year. Chiropractic care and manipulation therapy is limited to 26 visits per calendar year and no more than one visit per day.
	<a href="#">Habilitation services</a>	20% after <u>deductible</u>	50% after <u>deductible</u>	Physical Therapy, Occupational Therapy, and Speech Therapy have a combined limit of 90 visits per calendar year. Chiropractic care and manipulation therapy is limited to 26 visits per calendar year and no more than one visit per day.
	<a href="#">Skilled nursing care</a>	20% after <u>deductible</u>	50% after <u>deductible</u>	Limited to 100 visits per year. Only

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				available in a Home Health setting and applies to Home Health limits.
	<a href="#">Durable medical equipment</a>	20% after <u>deductible</u>	20% after <u>deductible</u>	
	<a href="#">Hospice services</a>	20% after <u>deductible</u>	50% after <u>deductible</u>	
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	Children's vision screenings are covered under preventive care.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private Duty nursing</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care (unless you have been diagnosed with diabetes). Consult your Summary Plan Description.</li> <li>• Weight loss programs</li> </ul>	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)	
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic Care</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (Coverage is limited to 1 hearing aid per ear, every 36 months)</li> </ul>

**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: HealthEquity 888-678-4881. 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.

**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 on how 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:

Anthem BlueCross BlueShield  
 ATTN: Appeals  
 P.O. Box 105568  
 Atlanta, GA 30348-5568

CVS/Caremark  
 Appeals Department  
 MC109  
 P.O. Box 52084  
 Phoenix, AZ 85072-2084

**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](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 844-402-5347.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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](#) \$1500
- [Specialist](#) 20%
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,060</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1500
- [Specialist](#) 20%
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$816
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,336</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1500
- [Specialist](#) 20%
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$260
<i>What isn't covered</i>	
Limits or exclusions	
<b>The total Mia would pay is</b>	<b>\$1,760</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.