

## LivingWell HDHP: 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 <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>\$2,100</b> Single/ <b>\$4,200</b> Family for In-Network Providers<br><b>\$4,200</b> Single/ <b>\$8,450</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>\$8,300</b> Single/ <b>\$16,650</b> Family for In-Network Providers<br><b>\$16,650</b> Single/ <b>\$33,300</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</a> charge 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<br>(You will pay the least)                                                                                              | Out-of-Network Provider<br>(You will pay the most)              |                                                                                                                                                                                                                                                                            |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                       | Primary care visit to treat an injury or illness       | 30% 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                       | 30% 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)    | 30% after <a href="#">deductible</a>                                                                                                      | 50% after <a href="#">deductible</a>                            |                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                              | Imaging (CT/PET scans, MRIs)                           | 30% after <a href="#">deductible</a>                                                                                                      | 50% after <a href="#">deductible</a>                            |                                                                                                                                                                                                                                                                            |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.caremark.com</a> . | Generic drugs – Tier 1                                 | 30% after <a href="#">deductible</a> for a 30 or 90-day supply.                                                                           | 50% after <a href="#">deductible</a> for a 30 or 90-day supply. | 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> .<br>The maximum you will pay for a 30-day supply of insulin is \$30. |
|                                                                                                                                                                              | Formulary – Tier 2                                     | 30% after <a href="#">deductible</a> for a 30 or 90-day supply.                                                                           | 50% after <a href="#">deductible</a> for a 30-day supply        | 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 – Tier 3                     | 30% after <a href="#">deductible</a> for GLP-1 weight loss drugs 30-day supply                                                            | 50% after <a href="#">deductible</a> for a 30-day supply        | GLP-1 Weight Loss Drugs are 30% after <a href="#">deductible</a> . Other non-preferred brand drugs are excluded.                                                                                                                                                           |
|                                                                                                                                                                              | <a href="#">Specialty drugs</a>                        | 30% after <a href="#">deductible</a> for 30-day supply.<br>30% 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> .                                                                     |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                    |
|---------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                           |
|                                                                           |                                                  |                                              |                                                    | No coverage for specialty drugs when at the Emergency Room for non-emergency services.                                                                                                                                                    |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 30% after <u>deductible</u>                  | 50% after <u>deductible</u>                        |                                                                                                                                                                                                                                           |
|                                                                           | Physician/surgeon fees                           | 30% after <u>deductible</u>                  | 50% after <u>deductible</u>                        |                                                                                                                                                                                                                                           |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 30% after <u>deductible</u>                  | 30% after <u>deductible</u>                        |                                                                                                                                                                                                                                           |
|                                                                           | <a href="#">Emergency medical transportation</a> | 30% after <u>deductible</u>                  | 30% after <u>deductible</u>                        |                                                                                                                                                                                                                                           |
|                                                                           | <a href="#">Urgent care</a>                      | 30% after <u>deductible</u>                  | 30% after <u>deductible</u>                        |                                                                                                                                                                                                                                           |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 30% after <u>deductible</u>                  | 50% after <u>deductible</u>                        |                                                                                                                                                                                                                                           |
|                                                                           | Physician/surgeon fees                           | 30% after <u>deductible</u>                  | 50% after <u>deductible</u>                        |                                                                                                                                                                                                                                           |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | 30% after <u>deductible</u>                  | 50% after <u>deductible</u>                        |                                                                                                                                                                                                                                           |
|                                                                           | Inpatient services                               | 30% after <u>deductible</u>                  | 50% after <u>deductible</u>                        |                                                                                                                                                                                                                                           |
| If you are pregnant                                                       | Office visits                                    | 30% after <u>deductible</u>                  | 50% after <u>deductible</u>                        |                                                                                                                                                                                                                                           |
|                                                                           | Childbirth/delivery professional services        | 30% after <u>deductible</u>                  | 50% after <u>deductible</u>                        |                                                                                                                                                                                                                                           |
|                                                                           | Childbirth/delivery facility services            | 30% 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>                 | 30% after <u>deductible</u>                  | 50% after <u>deductible</u>                        | Limited to 60 visits per year.                                                                                                                                                                                                            |
|                                                                           | <a href="#">Rehabilitation services</a>          | 30% 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>            | 30% 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                                                                 |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                     |
|----------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------|
|                                        |                                           | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                            |
|                                        |                                           |                                              |                                                    | 26 visits per calendar year and no more than one visit per day.                                            |
|                                        | <a href="#">Skilled nursing care</a>      | 30% after <u>deductible</u>                  | 50% after <u>deductible</u>                        | Limited to 100 visits per year. Only available in a Home Health setting and applies to Home Health limits. |
|                                        | <a href="#">Durable medical equipment</a> | 30% after <u>deductible</u>                  | 30% after <u>deductible</u>                        |                                                                                                            |
|                                        | <a href="#">Hospice services</a>          | 30% after <u>deductible</u>                  | 50% after <u>deductible</u>                        |                                                                                                            |
| If your child needs dental or eye care | 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<br>ATTN: Appeals<br>P.O. Box 105568<br>Atlanta, GA 30348-5568 | CVS/Caremark<br>Appeals Department<br>MC109<br>P.O. Box 52084 |
|-------------------------------------------------------------------------------------------|---------------------------------------------------------------|

**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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,100 |
| ■ <a href="#">Specialist</a>                                    | NA      |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,100        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$3,162        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$5,322</b> |

### Managing Joe's Type 2 Diabetes

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,100 |
| ■ <a href="#">Specialist</a>                                    | NA      |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,100        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$1,044        |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$3,164</b> |

### Mia's Simple Fracture

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,100 |
| ■ <a href="#">Specialist</a>                                    | NA      |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,100        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$210          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,310</b> |

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