**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/kehp or CVS/Caremark at 1-866-601-6934 or 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 kehp.ky.gov or call 1-844-402-5347 or 1-866-601-6034 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,000** Single/**$1,750** Family for In-Network Providers<br>**$1,750** Single/**$3,250** Family 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. Preventive Care. | 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?** | **$3,000** Single/**$5,750** Family for In-Network Providers<br>**$5,750** Single/**$11,250** 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. There is a separate annual prescription out-of-pocket maximum of $2,500 single and $5,000 family for in-network. This accumulates separately from the medical out-of-pocket maximum. |
| **Will you pay less if you use a network provider?** | Yes. See www.anthem.com/kehp or call 1-844-402-5347. See www.caremark.com or call 1-866-601-6934 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's 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 |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | 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 copayment | 40% after deductible | |
| | Specialist visit | $50 copayment | 40% after deductible | |
| | Preventive care/screening/ immunization | No charge | 40% after deductible | 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) | $25 copayment or $50 copayment / 20% after deductible | 40% after deductible | Copayment if test completed in doctor's office. |
| | Imaging (CT/PET scans, MRIs) | $25 copayment or $50 copayment / 20% after deductible | 40% after deductible | Copayment if test completed in doctor's office. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.caremark.com. | Generic drugs | $15 copayment 30-day supply $30 copayment 90-day supply | $30 copayment 30-day supply $80 copayment 90-day supply | 90 day supply for maintenance drugs at participating retail pharmacies and mail order. |
| | Preferred brand drugs | $40 copayment 30-day supply $80 copayment 90-day supply | Not Covered | 90 day supply for maintenance drugs at participating retail pharmacies and mail order. |
| | Non-preferred brand drugs | | | Non-preferred drugs are excluded. |
| | Specialty drugs | Same as non-specialty | Not Covered | 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) | 20% after deductible | 40% after deductible | |
| | Physician/surgeon fees | 20% after deductible | 40% after deductible | |
| **If you need immediate** | Emergency room care | $150 copayment then | $150 copayment then | Copayment waived if admitted. |

[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

| 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) | |
| **medical attention** | | 20% after deductible | 20% after deductible | |
| | Emergency medical transportation | 20% after deductible | 20% after deductible | |
| | Urgent care | $50 copayment | $50 copayment | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% after deductible | 40% after deductible | |
| | Physician/surgeon fees | 20% after deductible | 40% after deductible | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% after deductible | 40% after deductible | |
| | Inpatient services | 20% after deductible | 40% after deductible | |
| **If you are pregnant** | Office visits | 20% after deductible | 40% after deductible | |
| | Childbirth/delivery professional services | $25 copayment for office visit pregnancy diagnosed | 40% after deductible | |
| | Childbirth/delivery facility services | 20% after deductible | 40% after deductible | |
| **If you need help recovering or have other special health needs** | Home health care | 20% after deductible | 40% after deductible | Limited to 60 visits per year. |
| | Rehabilitation services | 20% after deductible | 40% after deductible | 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. |
| | Habilitation services | 20% after deductible | 40% after deductible | 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. |
| | Skilled nursing care | 20% after deductible | 40% after deductible | Limited to 30 visits per year. Only available in a Home Health setting and applies to Home Health limits. |

| 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) | |
| | Durable medical equipment | 20% after deductible | 40% after deductible | |
| | Hospice services | 20% after deductible | 40% after deductible | |
| **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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private Duty nursing
- Routine eye care (Adult)
- Routine foot care (unless you have been diagnosed with diabetes). Consult your Summary Plan Description.
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Bariatric surgery
- Chiropractic Care
- Hearing aids (Coverage is limited to 1 hearing aid per ear, every 36 months)

**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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 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,

[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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

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[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

## 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** | **$1,000** |
| **Specialist** | **$50** |
| **Hospital (facility)** | **20%** |
| **Other** | **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** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1000 |
| Copayments | $0 |
| Coinsurance | $2,000 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,060** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,000** |
| **Specialist** | **$50** |
| **Hospital (facility)** | **20%** |
| **Other** | **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** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1,000 |
| Copayments | $300 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,520** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,000** |
| **Specialist** | **$50** |
| **Hospital (facility)** | **20%** |
| **Other]** | **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** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1,000 |
| Copayments | $200 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,500** |

The plan would be responsible for the other costs of these EXAMPLE covered services.