



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, [insert contact information]. 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 <https://www.healthcare.gov/sbc-glossary> 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 deductible ?	\$1,000 Single / \$1,750 Family for in-network providers . \$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 .	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 care without cost sharing and before you meet your deductible . See a list of covered preventive care at 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 . \$5,750 Single / \$11,250 Family for out-of-network providers . Prescription Drugs : \$2,500 Single / \$5,000 Family for in-network providers . \$5,000 Single / \$10,000 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 , the overall family out-of-pocket limit must be 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 .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.anthem.com/mcr/kehpf/find-care or call 1-844-402-5347. See info.caremark.com/oe/kehpf 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 in-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
		In-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	50% coinsurance after deductible	
	Specialist visit	\$50 copayment	50% coinsurance after deductible	
	Preventive care/screening /immunization	No charge	50% coinsurance 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 / 25% coinsurance after deductible	50% coinsurance after deductible	Copayment if test completed in doctor's office.
	Imaging (CT/PET scans, MRIs)	\$25 copayment or \$50 copayment / 25% coinsurance after deductible	50% coinsurance 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	Generic drugs	\$20 copayment for a 30-day supply \$40 copayment for a 90-day supply	\$40 copayment for a 30-day supply 90-day supply not covered	90-day supply for maintenance drugs at participating in-network retail pharmacies and mail order. The maximum you will pay for a 30-day supply of insulin is \$30.

* For more information about limitations and exceptions, see the [plan](#) or policy document at kehpf.ky.gov.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
coverage is available at www.caremark.com .	Preferred brand drugs	\$40 copayment for a 30-day supply \$80 copayment for a 90-day supply	\$80 copayment for a 30-day supply 90-day supply not covered	90-day supply for maintenance drugs at participating retail pharmacies and mail order.
	Non-preferred brand drugs	Not covered	Not covered	Non-preferred brand 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)	25% coinsurance after deductible	50% coinsurance after deductible	
	Physician/surgeon fees	25% coinsurance after deductible	50% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	\$150 copayment then 25% coinsurance after deductible	\$150 copayment then 25% coinsurance after deductible	Copayment waived if admitted.
	Emergency medical transportation	25% coinsurance after deductible	25% coinsurance after deductible	
	Urgent care	\$50 copayment	\$50 copayment	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance after deductible	50% coinsurance after deductible	
	Physician/surgeon fees	25% coinsurance after deductible	50% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance after deductible	50% coinsurance after deductible	
	Inpatient services	25% coinsurance after deductible	50% coinsurance after deductible	
If you are pregnant	Office visits	25% coinsurance after deductible	50% coinsurance after deductible	
	Childbirth/delivery professional services	\$25 copayment for office visit pregnancy diagnosed	50% coinsurance after deductible	
	Childbirth/delivery facility services	25% coinsurance after deductible	50% coinsurance after deductible	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	25% coinsurance after deductible	50% coinsurance after deductible	Limited to 60 visits per year.
	Rehabilitation services	25% coinsurance after deductible	50% coinsurance 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	25% coinsurance after deductible	50% coinsurance 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	25% coinsurance after deductible	50% coinsurance after deductible	Limited to 100 visits per year. Only available in a Home Health setting and applies to Home Health limits.
	Durable medical equipment	25% coinsurance after deductible	25% coinsurance after deductible	
	Hospice services	25% coinsurance after deductible	50% coinsurance after deductible	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Children's vision screens 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 (26 visit limit annually, 1 visit limit daily)
- Hearing aids (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: 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 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 [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, kwijigo 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 kehp.ky.gov.

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 copayment	\$50
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$40
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 copayment	\$50
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$900
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$920

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$350
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,650

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