

Waiver HRA: Kentucky Employees' Health Plan

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

Coverage Period: 01/01/2017– 12/31/2017

Coverage for: Single/Family | Plan Type: HRA



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 www.kehp.ky.gov or by calling WageWorks at 877-430-5519.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?		
Are there other <u>deductibles</u> for specific services?		
What is not included in the <u>out-of-pocket limit</u> ?		
Is there an overall annual limit on what the plan pays?	Yes	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits. This HRA is for employees who waive health insurance with KEHP and who are eligible to receive HRA funds of \$175 per month, up to a maximum of \$2100 per year, deposited in two installments. The first installment of \$1,050 will be deposited to the HRA on January 1, and the second installment of \$1,050 will be deposited on July 1. Covered expenses will be reimbursed up to the maximum amount, either through a paper claims submission or via the WageWorks Healthcare Card. Claims incurred during the calendar year must be submitted to WageWorks no later than 90 days into the following calendar year – this is referred to as the Run-out period.
Does this plan use a <u>network of providers</u> ?		
Do I need a referral to see a <u>specialist</u> ?		
Are there services this plan doesn't cover?		

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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	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Specialist visit	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Other practitioner office visit	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Preventive care/screening/immunization	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Imaging (CT/PET scans, MRIs)	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
If you need drugs to treat your illness or condition	Generic drugs	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Preferred brand drugs	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	More information about prescription	Non-preferred brand drugs	100%	100%

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<u>drug coverage</u> is available at 877-597-7474.	Specialty drugs	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Physician/surgeon fees	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
If you need immediate medical attention	Emergency room services	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Emergency medical transportation	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Urgent care	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
If you have a hospital stay	Facility fee (e.g., hospital room)	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Physician/surgeon fee	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Mental/Behavioral health inpatient services	100%	100%	
	Substance use disorder outpatient services	100%	100%	
	Substance use disorder inpatient services	100%	100%	
If you are pregnant	Prenatal and postnatal care	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Delivery and all inpatient services	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.

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If you need help recovering or have other special health needs	Home health care	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Rehabilitation services	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Habilitation services	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Skilled nursing care	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Durable medical equipment	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Hospice service	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
If your child needs dental or eye care	Eye exam	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Glasses	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.
	Dental check-up	100%	100%	Maximum reimbursement is \$2,100 for all services for calendar year.

Excluded Services & Other Covered Services:

<p>Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u>.)</p> <ul style="list-style-type: none"> Premiums, including health insurance, COBRA, LTC, or Medicare premiums.
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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.)

- Dental care (Adult and child)
- Bariatric surgery
- Chiropractic care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Hearing aids
- Acupuncture
- Infertility services
- Routine eye care (Adult and child)
- Weight loss programs
- Cosmetic surgery (Requires prior auth. Services will only be considered if due to a bodily injury or illness and functional impairment is present.)

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 the 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 877-597-7474. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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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 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

Fax Number: 1-866-443-1172

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 NOT 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 NOT meet the minimum value standard for the benefits it provides.**

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

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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 \$2,100
- Patient pays \$5,440

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	
Copays	
Coinsurance	
Limits or exclusions	
Total	\$5,440

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,100
- Patient pays \$3,300

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	
Copays	
Coinsurance	
Limits or exclusions	
Total	\$3,300

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.
- 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.

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