
 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-KEHP (5347) or [www.anthem.com/kehpc](http://www.anthem.com/kehpc), or by contacting 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 [kehpc.ky.gov](http://kehpc.ky.gov) or call 1-844-402-KEHP (5347) or 1-866-601-6934 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p><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.</p>	<p>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>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. Preventive Care.</p>	<p>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>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><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.</p>	<p>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.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><a href="#">Premiums</a>, <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>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.</p>	<p>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.</p>
<p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>	<p>No</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	15% after <a href="#">deductible</a>	40% 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	15% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge	40% after <a href="#">deductible</a>	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	15% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	
	Imaging (CT/PET scans, MRIs)	15% after <a href="#">deductible</a>	40% after <a href="#">deductible</a>	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.caremark.com</a> .	Generic drugs – Tier 1	15% after <a href="#">deductible</a> for 30-day supply. 15% after <a href="#">deductible</a> for a 90-day supply mail order or retail.	40% 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> .
	Formulary brand drugs – Tier 2	15% after <a href="#">deductible</a> for 30-day supply. 15% after <a href="#">deductible</a> for a 90-day supply mail order or retail.	40% 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> .
	Non-formulary brand drugs – Tier 3	15% after <a href="#">deductible</a> for 30-day supply. 15% after <a href="#">deductible</a> for a 90-day supply mail order or retail.	40% 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> .
	<a href="#">Specialty drugs</a>	15% after <a href="#">deductible</a> for 30-day supply. 15% after <a href="#">deductible</a> for a 90-day supply mail order or retail.	40% 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
<b>If you have outpatient surgery</b>	Facility fee (e.g. ambulatory surgery center)	15% after <u>deductible</u>	40% after <u>deductible</u>	
	Physician/surgeon fees	15% after <u>deductible</u>	40% after <u>deductible</u>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	15% after <u>deductible</u>	40% after <u>deductible</u>	
	<a href="#">Emergency medical transportation</a>	15% after <u>deductible</u>	40% after <u>deductible</u>	
	<a href="#">Urgent care</a>	15% after <u>deductible</u>	40% after <u>deductible</u>	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	15% after <u>deductible</u>	40% after <u>deductible</u>	
	Physician/surgeon fees	15% after <u>deductible</u>	40% after <u>deductible</u>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	15% after <u>deductible</u>	40% after <u>deductible</u>	
	Inpatient services	15% after <u>deductible</u>	40% after <u>deductible</u>	
<b>If you are pregnant</b>	Office visits	15% after <u>deductible</u>	40% after <u>deductible</u>	
	Childbirth/delivery professional services	15% after <u>deductible</u>	40% after <u>deductible</u>	
	Childbirth/delivery facility services	15% after <u>deductible</u>	40% after <u>deductible</u>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	15% after <u>deductible</u>	40% after <u>deductible</u>	Limited to 60 visits per year.
	<a href="#">Rehabilitation services</a>	15% after <u>deductible</u>	40% 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>	15% after <u>deductible</u>	40% 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>	15% after <u>deductible</u>	40% after <u>deductible</u>	Limited to 30 visits per year. Only available in a Home Health setting and applies to Home

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
				Health limits.
	<a href="#">Durable medical equipment</a>	15% after <u>deductible</u>	40% after <u>deductible</u>	
	<a href="#">Hospice services</a>	15% after <u>deductible</u>	40% 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 [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: Personnel Cabinet, Department of Employee Insurance at 888-581-8834, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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 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

Additionally, a consumer assistance program can help you file your appeal. Contact Kentucky Health Insurance Advocate, Department of Insurance, 215 West Main Frankfort, Kentucky 40601, or call 800-595-6053.

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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-KEHP 5347.

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*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>	\$1500
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	NA
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	15%

#### 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>\$12,080</b>
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In this example, Peg would pay: **\$3,060**

Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,500

#### *What isn't covered*

Limits or exclusions	\$60
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<b>The total Peg would pay is</b>	<b>\$3,060</b>
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### 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>	\$1500
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	NA
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	15%

#### 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>\$7,400</b>
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In this example, Joe would pay: **\$2,633**

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$
Coinsurance	\$1,078

#### *What isn't covered*

Limits or exclusions	\$55
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<b>The total Joe would pay is</b>	<b>\$2,633</b>
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### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1500
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	NA
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	15%

#### 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>\$1,900</b>
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In this example, Mia would pay: **\$1,789**

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$
Coinsurance	\$289

#### *What isn't covered*

Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$1,789</b>
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