LivingWell PPO Benefits Grid

LivingWell PPO — Plan Option

Lifetime Maximum	**In-Network**	Unlimited		**Out-of-Network**	Unlimited	
Health Reimbursement Arrangement (HRA)	None					
Annual Deductible*	**In-Network**	Single $1,000	Family $1,750	**Out-of-Network**	Single $1,750	Family $3,250
Annual Medical Out-of-Pocket Maximum** *(Applies to medical only — separate from the prescription out-of-pocket maximum.)*	**In-Network**	Single $3,000	Family $5,750	**Out-of-Network**	Single $5,750	Family $11,250
Co-insurance	**In-Network**	Plan: 80%	Member: 20%	**Out-of-Network**	Plan: 60%	Member: 40%
Doctor's Office Visits	**In-Network**	Co-pay:* $25 PCP; $50 Specialist		**Out-of-Network**	Deductible then 40%	
Annual Prescription Drug Out-of-Pocket Maximum** *(Applies to prescriptions and separate from medical.)*	**In-Network**	**Single $2,500**	**Family $5,000**	**Out-of-Network**	**Single $5,000**	**Family $10,000**
30-Day Supply of Prescriptions***						
Tier 1 — Generic	**In-Network**	$15		**Out-of-Network**	$30	
Tier 2 — Formulary	**In-Network**	$40		**Out-of-Network**	$80	
90-Day Supply of Prescriptions *(Retail or Mail Order)****						
Tier 1 — Generic	**In-Network**	$30		**Out-of-Network**	Not Covered	
Tier 2 — Formulary	**In-Network**	$80		**Out-of-Network**	Not Covered	
Physician Care *(Inpatient/Outpatient/Other)*	**In-Network**	Deductible then 20%		**Out-of-Network**	Deductible then 40%	
Diagnostic Tests**** in Doctor's Office	**In-Network**	Office Visit Co-pay*		**Out-of-Network**	Deductible then 40%	
Other Laboratory	**In-Network**	Deductible then 20%		**Out-of-Network**	Deductible then 40%	
Inpatient Hospital *(Semi-Private Room)*	**In-Network**	Deductible then 20%		**Out-of-Network**	Deductible then 40%	
Outpatient Hospital/Surgery	**In-Network**	Deductible then 20%		**Out-of-Network**	Deductible then 40%	
Outpatient/Ambulatory Surgery Center	**In-Network**	Deductible then 20%		**Out-of-Network**	Deductible then 40%	

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Emergency Room *(Benefit for emergency medical treatment only.)*	**In-Network** **Out-of-Network**	$150 Co-pay* then Deductible then 20%. Co-pay* waived if admitted $150 Co-pay* then Deductible then 20%. Co-pay* waived if admitted		
ER Physician Care	**In-Network**	Deductible then 20%	**Out-of-Network**	Deductible then 20%
Ambulance	**In-Network**	Deductible then 20%	**Out-of-Network**	Deductible then 20%
Urgent Care Center	**In-Network**	$50 Co-pay*	**Out-of-Network**	$50 Co-pay*
Routine Well Child	**In-Network**	Covered at 100%	**Out-of-Network**	Deductible then 40%
Routine Well Adult	**In-Network**	Covered at 100%	**Out-of-Network**	Deductible then 40%
Autism Services and Mental Health *(Treated the same as any other health condition. See specifics related to PCP office visit, inpatient, and outpatient services.)*				
Allergy Injections	**In-Network**	$15 Co-pay*	**Out-of-Network**	Deductible then 40%
Allergy Serum	**In-Network**	$15 Co-pay*	**Out-of-Network**	Deductible then 40%
Maternity Care *(See Medical Benefit Booklet for specifics.)*	**In-Network**	$25 Co-pay* (office visit pregnancy diagnosed) Delivery Charge: Deductible then 20%		
			Out-of-Network	Deductible then 40%
Durable Medical Equipment	**In-Network**	Deductible then 20%	**Out-of-Network**	Deductible then 40%
Therapy Services *(Physical, Occupational, Speech — combined limit of 90 visits per calendar year.)*	**In-Network**	Deductible then 20%	**Out-of-Network**	Deductible then 40%
Chiropractic Care *(Manipulation Therapy.) Maximum of 26 visits per calendar year; no more than 1 visit per day.*	**In-Network**	$25 Co-pay*	**Out-of-Network**	Deductible then 40%

Notes: You can refer to the Summary of Benefits and Coverage (SBC) for more information. KEHP has made every attempt to ensure the accuracy of the benefits outlined in this Benefits Grid. If an error has occurred, the benefits outlined in the 2021 Summary Plan Descriptions (SPDs) and Medical Benefit Booklets will determine how benefits are paid. Benefits are subject to the terms, conditions, limitations, and exclusions set forth in the SPDs.

* Co-pays do **not** accumulate toward the deductible, but they do accumulate toward the applicable out-of-pocket maximum.

** All covered expenses apply to the out-of-pocket maximum, except routine well child and routine well adult. The out-of-pocket maximum accumulates separately and independently for medical and prescription drug benefits.

*** Certain drugs to treat diabetes, COPD, and asthma are subject to reduced co-pays with no deductibles.

**** Claims are processed based on provider billing type, which may include separate charges from a lab performing services outside of the doctor's office visit.