

KEHP 2016 BENEFITS GRID

Plan Options	LivingWell CDHP		LivingWell PPO		Standard PPO		Standard CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Health Reimbursement Arrangement (HRA)	Single \$500; Family \$1,000		Not Applicable		Not Applicable		Single \$250; Family \$500	
Annual Deductible*	Single \$1,250 Family \$2,500	Single \$2,500 Family \$5,000	Single \$500 Family \$1,000	Single \$1,000 Family \$2,000	Single \$750 Family \$1,500	Single \$1,500 Family \$3,000	Single \$1,750 Family \$3,500	Single \$3,000 Family \$6,000
	Applies to Medical and Pharmacy		Applies to Medical		Applies to Medical		Applies to Medical and Pharmacy	
Annual Medical Out-of-Pocket Maximum**	Single \$2,500 Family \$5,000	Single \$5,000 Family \$10,000	Single \$2,500 Family \$5,000	Single \$5,000 Family \$10,000	Single \$3,500 Family \$7,000	Single \$7,000 Family \$10,000	Single \$3,500 Family \$7,000	Single \$7,000 Family \$10,000
Deductibles & Out-of-Pocket Maximums for In-Network and Out-of-Network providers accumulate separately and do not cross apply.								
Co-Insurance	Plan: 85% Member: 15%	Plan: 60% Member: 40%	Plan: 80% Member: 20%	Plan: 60% Member: 40%	Plan: 70% Member: 30%	Plan: 50% Member: 50%	Plan: 70% Member: 30%	Plan: 50% Member: 50%
Doctor's Office Visits	Deductible then 15%	Deductible then 40%	Co-Pay: \$25 PCP; \$45 Specialist	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Physician Care (Inpatient/Outpatient/Other)	Deductible then 15%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Diagnostic Tests**** In Doctor's Office	Deductible then 15%	Deductible then 40%	Office Visit Co-Pay	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Other Laboratory	Deductible then 15%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Inpatient Hospital (Semi-Private Room)	Deductible then 15%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Outpatient Hospital/Surgery	Deductible then 15%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Outpatient/Ambulatory Surgery Center	Deductible then 15%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Emergency Room (Benefit for emergency medical treatment only)	Deductible then 15%		\$150 Co-Pay then Deductible then 20% Co-Pay waived if admitted.		\$150 Co-Pay then Deductible then 30% Co-Pay waived if admitted.		Deductible then 30%	
ER Physician Care	Deductible then 15%		Deductible then 20%		Deductible then 30%		Deductible then 30%	
Ambulance	Deductible then 15%		Deductible then 20%		Deductible then 30%		Deductible then 30%	

Urgent Care Center	Deductible then 15%		\$50 Co-Pay		Deductible then 30%		Deductible then 30%	
Routine Well Child	Covered at 100%	Deductible then 40%	Covered at 100%	Deductible then 40%	Covered at 100%	Deductible then 50%	Covered at 100%	Deductible then 50%
Routine Well Adult	Covered at 100%	Deductible then 40%	Covered at 100%	Deductible then 40%	Covered at 100%	Deductible then 50%	Covered at 100%	Deductible then 50%
Mental Health	Treated the same as any other health condition. See specifics related to PCP office visit, inpatient and outpatient services.							
Autism Services	Treated the same as any other health condition. See specifics related to PCP office visit, inpatient and outpatient services.							
Allergy Injections	Deductible then 15%	Deductible then 40%	\$15 Co-Pay	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Allergy Serum	Deductible then 15%	Deductible then 40%	\$15 Co-Pay	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Maternity Care (See SPD for Specifics)	Deductible then 15%	Deductible then 40%	\$25 Co-Pay (office visit pregnancy diagnosed) Delivery Charge: Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Durable Medical Equipment	Deductible then 15%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Therapy Services (Per Visit: Physical, Occupational, Speech)	Deductible then 15%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
	Maximum of 30 visits per calendar year, per therapy service type		Maximum of 30 visits per calendar year, per therapy service type		Maximum of 30 visits per calendar year, per therapy service type		Maximum of 30 visits per calendar year, per therapy service type	
Chiropractic Care	Deductible then 15%	Deductible then 40%	\$25 Co-Pay	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
	Maximum of 26 visits per calendar year; no more than 1 visit per day		Maximum of 26 visits per calendar year; no more than 1 visit per day		Maximum of 26 visits per calendar year; no more than 1 visit per day		Maximum of 26 visits per calendar year; no more than 1 visit per day	
Prescription Drugs	Administered by CVS/Caremark							
Annual Rx Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Single \$2,500 Family \$5,000	Not Applicable	Single \$2,500 Family \$5,000	Not Applicable	Combined with Medical	Combined with Medical
30-Day Supply*** Tier 1 – Generic Tier 2 – Formulary Tier 3 – Non-Formulary	Deductible then 15%	Deductible then 40%	\$10 \$35 \$55	Not Applicable	30% Min \$10–Max \$25 Min \$20–Max \$50 Min \$60–Max \$100	Not Applicable	Deductible then 30%	Deductible then 50%
90-Day Supply (Retail or Mail Order)*** Tier 1 – Generic Tier 2 – Formulary Tier 3 – Non-Formulary	Deductible then 15%	Not Applicable	\$20 \$70 \$110	Not Applicable	30% Min \$20–Max \$50 Min \$40–Max \$100 Min \$120–Max \$200	Not Applicable	Deductible then 30%	Not Applicable

Notes: The boxed areas of the grid are components of each plan most often used by members when choosing a plan option, but are not all inclusive. **Please refer to the Summary Plan Descriptions (SPDs) and Medical Benefit Booklets, available January 30, 2016, for a complete list of benefits.** KEHP has made every attempt to ensure the accuracy of the benefits outlined in this Benefits Grid. However, if an error has occurred, the benefits outlined in the 2016 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.

For the **LivingWell CDHP and the **Standard CDHP** plans, all covered expenses apply to the out-of-pocket maximum. For the **LivingWell PPO** and the **Standard PPO** plans, the out-of-pocket maximum accumulates separately and independently for medical and prescription drug benefits.

*** Certain maintenance drugs are subject to lower co-pays and coinsurances. Please see the Diabetes Value Benefit.

**** Provider billing type which may include separate charges from a lab performing services outside of the doctor's office visit.