Blaze your own path to wellness

Your 2023 Benefits Selection Guide from the Personnel Cabinet

Open enrollment is **October 10 – October 28, 2022.**

LivingWell Promise for 2023:

All planholders must take the online WebMD health assessment or complete a biometric screening.

This Benefits Selection Guide is published annually, before Open Enrollment, to help you make benefit choices. This guide can be used throughout 2023 for new employees and when there is a qualifying event that permits a benefit change.

TEAM KENTUCKY PERSONNEL CABINET | Kentucky Employees' Health Plan

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Welcome

This Benefits Selection Guide (BSG) is available to review when making benefit selections for you and your family. It is published annually, to help you make benefit choices during Open Enrollment. You can also use this guide to select benefits as a new employee or if you experience a qualifying event during the year. It is very important that you thoroughly read this guide, so you are aware of the many benefits that are available to you.

Pay close attention to the important information you will need to review while making your benefit elections:

- Health, dental, and vision plan options
- Premiums
- Benefit grids
- Flexible Spending Accounts (FSA)
- Waiving health insurance

Although not part of Open Enrollment, you will also find your life insurance plan options, benefit grids, and premiums. You don't have to make new life insurance elections for 2023, but make sure your beneficiaries are up to date.

If you have questions, refer to the Contacts Information on page 28 to find who can best answer your question.

Open Enrollment Highlights

Health Insurance Premiums and Benefits

- There will be no employee increase in health insurance premium contributions for 2023.
- There will be no changes to co-pays, co-insurance, deductibles, or maximum out-of-pocket amounts.

Health Insurance Plan Option Change

The LivingWell Limited High Deductible Plan will not be available in 2023.

- If you are enrolled in the LivingWell Limited High Deductible Plan in 2022 by default, you will automatically be moved to the LivingWell Basic CDHP with NO HRA funding for 2023.
- If you are enrolled in the LivingWell Limited High Deductible Plan in 2022 by election, you will automatically be moved to the LivingWell Basic CDHP with HRA funding for 2023.
- If you do not wish to have the LivingWell Basic CDHP for 2023, you will need to log into KHRIS ESS at **khris.ky.gov** and select another plan option.

New Default Plan

- The LivingWell Basic CDHP plan with no HRA funding will be the new default plan for new employees who do not make an election.

Who Has to Enroll

- Although you are not required to re-enroll, we encourage you to review your plan options and ensure that the plan you currently have still meets your needs.
- Except as described above regarding the LivingWell Limited High Deductible Plan, if you want to keep the same health insurance plan, dental plan, or vision plan that you have in 2022, you do not have to do anything during the Open Enrollment period.
- You must take action, however, if you want the Waiver General Purpose HRA.
- You must take action if you want the Healthcare Flexible Spending Account or Child & Adult Daycare Flexible Spending Account.
- See complete list to the right for who needs to enroll and who does not need to enroll.

Do You Have to Enroll for Plan Year 2023?

Yes, if...

- You want to change your health insurance plan.
- You currently have the LivingWell Limited High Deductible Plan and you do not want to be automatically enrolled into the LivingWell Basic CDHP.
- You want to add or drop dependents.
- You want to keep or elect the Waiver General Purpose HRA.
- You want to keep or elect a Healthcare FSA.
- You want to keep or elect a Child and Adult Daycare FSA.
- You want to change or elect a dental or vision plan.

No, if...

- You want to keep your current health insurance plan.
- You currently have the LivingWell Limited High Deductible Plan by default and want the LivingWell Basic CDHP with no HRA funding in 2023.
- You currently have a Waiver Limited Purpose HRA and you want to keep it.
- You are a Kentucky Public Pension Authority (KPPA) or Teachers' Retirement System (TRS) retiree under the age of 65 who returned to work and want to keep your current health insurance plan with your active employer.
- You want to keep your current dental and vision insurance plan.

Dental Plans

There will be a small increase in dental premiums in 2023.

Life Insurance

Life insurance is not part of Open Enrollment this year, but you can make changes anytime. You can add or increase optional life insurance for yourself or your spouse as long as you provide satisfactory Evidence of Insurability (Statement of Health). You can add or increase optional life insurance on your dependents at any time without Evidence of Insurability.

You can also enroll in life insurance if you are a new employee or if you have a life-changing event, such as gaining a new child, getting married, or getting divorced.

Benefit Fairs

Benefit fairs will be virtual. It's easy to join, just pick a time that fits your schedule (all times Eastern). You can find links to the webinars at **kehp.ky.gov**.

Monday	Tuesday	Wednesday	Thursday	Friday
September 26	**September 27**	**September 28**	**September 29**	**September 30**
9:00 a.m. KEHP	9:00 a.m. Anthem	9:00 a.m. CVS	9:00 a.m. HealthEquity	9:00 a.m. WebMD
5:00 p.m. KEHP	5:00 p.m. Anthem	5:00 p.m. CVS	5:00 p.m. HealthEquity	5:00 p.m. WebMD
October 3	**October 4**	**October 5**	**October 6**	
9:00 a.m. SmartShopper	9:00 a.m. TRS	9:00 a.m. Hinge Health	9:00 a.m. RethinkCare	
5:00 p.m. SmartShopper	5:00 p.m. TRS	5:00 p.m. Hinge Health	5:00 p.m. RethinkCare	

Health Insurance

The Kentucky Employees' Health Plan (KEHP) offers three health insurance plan options. Review the details below to see which plan option is best for you and your family. There are more plan specifics in this guide and in the Medical Benefit Booklet for each plan.

LivingWell CDHP

Do you want to pay lower premiums and receive money in an HRA to help reduce your deductible? The LivingWell CDHP may be the plan for you.

- It's the best value of the plans offered by KEHP.
- It is recommended for those who have a little or a lot of healthcare expenses.
- All covered services, except for certain items like preventive care and a few specific prescriptions, are subject to the deductible.
- Once you meet the deductible, the plan will pay 80% of covered expenses and you will pay a 20% co-insurance.
- Both your medical and pharmacy expenses apply to the deductible and the maximum out-of-pocket .
- Once your maximum out-of-pocket is met, your covered medical and pharmacy claims will be paid at 100%.

You will receive HRA funds through a HealthEquity debit VISA Healthcare Card.

- The card is pre-funded with $500 if you have single coverage, or $1,000 if you have couple, parent-plus, or family coverage levels.
- Use the HRA funds to help pay for your co-insurance, which reduces your deductible.
- Use this card at your doctor's office, hospital, or pharmacy. Simply swipe the card to help pay for your eligible expenses, which will be deducted from your card balance.
- You can also use this card to pay for eligible vision and dental expenses. These expenses do not reduce your deductible.
- Your HRA funds may roll over to a subsequent year, up to a maximum of $7,500.

LivingWell PPO

Are you willing to pay more in premiums to limit your out-of-pocket costs to a co-payment for certain services? The LivingWell PPO may be the plan for you.

- Co-pays apply to doctor's office visits, allergy serum, allergy shots, urgent care centers, and non-specialty prescriptions.
- An emergency room co-pay, plus your deductible and then co-insurance, will apply when you use an emergency room.
- Your co-pays will not apply to your deductible.
- Your co-pays will apply to your maximum out-of-pocket. Once your out-of-pocket is met, no other co-pays apply.
- Most expenses are subject to the deductible and then covered at 75%.
- There is zero cost-share for specialty drugs for those enrolled in the PrudentRx specialty program. A 30% co-insurance for specialty drugs applies for those not enrolled.
- This plan has two maximum out-of-pocket amounts — one for medical expenses and the other for prescription expenses. They accumulate separately, which means you may pay more out of your pocket depending on your expenses.

LivingWell Basic CDHP

How about more basic health insurance coverage and lower premiums, and an HRA to help reduce your deductible? LivingWell Basic CDHP is just that.

- This is basic coverage for a lower premium.
- You will pay 30% for covered services after you meet your deductible.
- Both your medical and pharmacy expenses apply to the maximum out-of-pocket .
- Once your maximum out-of-pocket is met, your covered medical and pharmacy claims will be paid at 100%.

You will receive HRA funds through a HealthEquity debit VISA Healthcare Card.

- The card is pre-funded with $250 if you have single coverage, or $500 if you have couple, parent-plus, or family coverage levels.
- Use the HRA to help pay for your co-insurance, which reduces your deductible.
- Use this card at your doctor's office, hospital, or pharmacy. Simply swipe the card to help pay for your eligible expenses, which will be deducted from your card balance.
- You can also use this card to pay for eligible vision and dental expenses. These expenses do not reduce your deductible.
- Your HRA funds may roll over to a subsequent year, up to a maximum of $7,500.

Benefits Grid

	LivingWell CDHP		LivingWell PPO		LivingWell Basic CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum	Unlimited					
HRA	Single $500; Family $1,000		No HRA		Single $250; Family $500	
Annual Deductible	Single $1,500 Family $2,750	Single $2,750 Family $5,250	Single $1,000 Family $1,750	Single $1,750 Family $3,250	Single $2,000 Family $3,750	Single $3,250 Family $6,250
Annual Maximum Out-of-Pocket	Applies to Medical and Pharmacy Single $3,000 Family $5,750	 Single $5,750 Family $11,250	Applies to Medical Single $3,000 Family $5,750	 Single $5,750 Family $11,250	Applies to Medical and Pharmacy Single $4,000 Family $7,750	 Single $7,750 Family $11,250
Deductibles and Maximum Out-of-Pocket for In-Network and Out-of-Network providers accumulate separately and do not cross-apply						
Co-Insurance	Plan: 80% Member: 20%	Plan: 50% Member: 50%	Plan: 75% Member: 25%	Plan: 50% Member: 50%	Plan: 70% Member: 30%	Plan: 50% Member: 50%
Doctor's Office Visit	Deductible, then 20%	Deductible, then 50%	Co-pay: $25 PCP $50 Specialist	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Annual Prescription Drug Maximum Out-of-Pocket	Combined with Medical		Single $2,500 Family $5,000	Single $5,000 Family $10,000	Combined with Medical	
30-Day Supply						
Tier 1 – Generic Tier 2 – Formulary	Deductible, then 20%	Deductible, then 50%	$20 $40	$40 $80	Deductible, then 30%	Deductible, then 50%
			Zero cost-share for specialty drugs for those enrolled in the PrudentRx specialty program. A 30% co-insurance for specialty drugs applies for those not enrolled.			
90-Day Supply (Retail or Mail Order)	Deductible, then 20%	Not Covered	$40 $80	Not Covered	Deductible, then 30%	Not Covered
COVERED SERVICES						
Preventive Care Office Visits						
Well-baby, well-child visits, as recommended	100%	Deductible, then 50%	100%	Deductible, then 50%	100%	Deductible, then 50%
Adult annual physical exam	100%	Deductible, then 50%	100%	Deductible, then 50%	100%	Deductible, then 50%
Immunizations, as recommended	100%	Deductible, then 50%	100%	Deductible, then 50%	100%	Deductible, then 50%
Screenings including Pap smears, and labs, as part of the preventive office visit	100%	Deductible, then 50%	100%	Deductible, then 50%	100%	Deductible, then 50%
Outpatient Services						
Primary Care and Specialist Office Visits	Deductible, then 20%	Deductible, then 50%	Co-pay $25 PCP $50 Specialist	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
LiveHealth Online telehealth for Medical and Behavioral Health	100%	N/A	100%	N/A	100%	N/A
Telehealth with provider other than LiveHealth Online	Deductible, then 20%	Deductible, then 50%	Co-pay $25 PCP $50 Specialist	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Diagnostic tests in doctor's office	Deductible, then 20%	Deductible, then 50%	Office Visit Co-pay	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%

	LivingWell CDHP		LivingWell PPO		LivingWell Basic CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Surgery in Office Setting	Deductible, then 20%	Deductible, then 50%	Deductible, then 25%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Behavioral Health and Substance Abuse Use	Deductible, then 20%	Deductible, then 50%	Deductible, then 25%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Autism Services	Deductible, then 20%	Deductible, then 50%	Deductible, then 25%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Allergy Injection without Office Visit	Deductible, then 20%	Deductible, then 50%	$15 Co-pay	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Allergy Serum	Deductible, then 20%	Deductible, then 50%	$15 Co-pay	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Chiropractic Care (manipulation therapy) (maximum of 26 visits per year, no more than one visit a day)	Deductible, then 20%	Deductible, then 50%	$25 Co-pay	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Therapy Services (per visit: physical, occupational, speech – maximum combined limit of 90 visits per year)	Deductible, then 20%	Deductible, then 50%	Deductible, then 25%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Emergency Services						
Urgent Care Center	Deductible, then 20%		$50 Co-pay		Deductible, then 30%	
Emergency Room (emergency medical treatment only)	Deductible, then 20%		$150 Co-pay, then Deductible, then 25%. Co-pay waived if admitted.		Deductible, then 30%	
Emergency Room Physician	Deductible, then 20%		Deductible, then 25%		Deductible, then 30%	
Ambulance	Deductible, then 20%		Deductible, then 25%		Deductible, then 30%	
Other Services						
Inpatient Hospital (Semi-private room)	Deductible, then 20%	Deductible, then 50%	Deductible, then 25%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Outpatient Hospital/Surgery	Deductible, then 20%	Deductible, then 50%	Deductible, then 25%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Outpatient/Ambulatory Surgery Center	Deductible, then 20%	Deductible, then 50%	Deductible, then 25%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Maternity Care	Deductible, then 20%	Deductible, then 50%	$25 Co-pay (office visit pregnancy diagnosed) Delivery Charge: Deductible, then 25%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Durable Medical Equipment and Supplies	Deductible, then 20%	Deductible, then 50%	Deductible, then 25%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Home Health Care	Deductible, then 20%	Deductible, then 50%	Deductible, then 25%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
X-ray, Lab, and Diagnostics including MRI, CT, and PET scans	Deductible, then 20%	Deductible, then 50%	Deductible, then 25%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%

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. 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 2023 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 maximum out-of-pocket. Once your maximum out-of-pocket is met, you do not have to pay any more co-pays.
- Certain drugs to treat diabetes, COPD, and asthma are subject to reduced co-pays and co-insurance with no Deductibles. A 90-day supply of maintenance drugs may be subject to lower co-pays and co-insurance. Select preventive/maintenance drugs bypass the deductible on the CDHPs.
- 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.

2023 Monthly Premium Contributions for Non-Tobacco Users

Who completed the LivingWell Promise in 2022 for 2023			
LivingWell CDHP	**Total Premium**	**Employer Contribution**	**Employee Contribution**
Single	$813.02	$759.56	$53.46
Parent-Plus	$1,117.34	$980.28	$137.06
Couple	$1,608.24	$1,268.90	$339.34
Family	$1,794.34	$1,395.42	$398.92
Family Cross-Reference	$936.90	$850.00	$86.90
LivingWell PPO	**Total Premium**	**Employer Contribution**	**Employee Contribution**
Single	$833.64	$744.50	$89.14
Parent-Plus	$1,177.30	$923.20	$254.10
Couple	$1,792.42	$1,220.66	$571.76
Family	$1,988.62	$1,271.98	$716.64
Family Cross-Reference	$998.02	$827.54	$170.48
LivingWell Basic CDHP	**Total Premium**	**Employer Contribution**	**Employee Contribution**
Single	$783.92	$755.58	$28.34
Parent-Plus	$1,078.16	$1,010.64	$67.52
Couple	$1,650.78	$1,369.36	$281.42
Family	$1,837.42	$1,499.74	$337.68
Family Cross-Reference	$919.72	$888.22	$31.50

Who did NOT complete the LivingWell Promise in 2022 for 2023			
LivingWell CDHP	**Total Premium**	**Employer Contribution**	**Employee Contribution**
Single	$813.02	$719.56	$93.46
Parent-Plus	$1,117.34	$940.28	$177.06
Couple	$1,608.24	$1,228.90	$379.34
Family	$1,794.34	$1,355.42	$438.92
Family Cross-Reference	$936.90	$810.00	$126.90
LivingWell PPO	**Total Premium**	**Employer Contribution**	**Employee Contribution**
Single	$833.64	$704.50	$129.14
Parent-Plus	$1,177.30	$883.20	$294.10
Couple	$1,792.42	$1,180.66	$611.76
Family	$1,988.62	$1,231.98	$756.64
Family Cross-Reference	$998.02	$787.54	$210.48
LivingWell Basic CDHP	**Total Premium**	**Employer Contribution**	**Employee Contribution**
Single	$783.92	$715.58	$68.34
Parent-Plus	$1,078.16	$970.64	$107.52
Couple	$1,650.78	$1,329.36	$321.42
Family	$1,837.42	$1,459.74	$377.68
Family Cross-Reference	$919.72	$848.22	$71.50

All employee premium contributions are per employee, per month.

2023 Monthly Premium Contributions for Tobacco Users

Who completed the LivingWell Promise in 2022 for 2023			
LivingWell CDHP	**Total Premium**	**Employer Contribution**	**Employee Contribution**
Single	$813.02	$719.56	$93.46
Parent-Plus	$1,117.34	$900.28	$217.06
Couple	$1,608.24	$1,188.90	$419.34
Family	$1,794.34	$1,315.42	$478.92
Family Cross-Reference	$936.90	$810.00	$126.90
LivingWell PPO	**Total Premium**	**Employer Contribution**	**Employee Contribution**
Single	$833.64	$704.50	$129.14
Parent-Plus	$1,177.30	$843.20	$334.10
Couple	$1,792.42	$1,140.66	$651.76
Family	$1,988.62	$1,191.98	$796.64
Family Cross-Reference	$998.02	$787.54	$210.48
LivingWell Basic CDHP	**Total Premium**	**Employer Contribution**	**Employee Contribution**
Single	$783.92	$715.58	$68.34
Parent-Plus	$1,078.16	$930.64	$147.52
Couple	$1,650.78	$1,289.36	$361.42
Family	$1,837.42	$1,419.74	$417.68
Family Cross-Reference	$919.72	$848.22	$71.50

Who did NOT complete the LivingWell Promise in 2022 for 2023			
LivingWell CDHP	**Total Premium**	**Employer Contribution**	**Employee Contribution**
Single	$813.02	$679.56	$133.46
Parent-Plus	$1,117.34	$860.28	$257.06
Couple	$1,608.24	$1,148.90	$459.34
Family	$1,794.34	$1,275.42	$518.92
Family Cross-Reference	$936.90	$770.00	$166.90
LivingWell PPO	**Total Premium**	**Employer Contribution**	**Employee Contribution**
Single	$833.64	$664.50	$169.14
Parent-Plus	$1,177.30	$803.20	$374.10
Couple	$1,792.42	$1,100.66	$691.76
Family	$1,988.62	$1,151.98	$836.64
Family Cross-Reference	$998.02	$747.54	$250.48
LivingWell Basic CDHP	**Total Premium**	**Employer Contribution**	**Employee Contribution**
Single	$783.92	$675.58	$108.34
Parent-Plus	$1,078.16	$890.64	$187.52
Couple	$1,650.78	$1,249.36	$401.42
Family	$1,837.42	$1,379.74	$457.68
Family Cross-Reference	$919.72	$808.22	$111.50

All employee premium contributions are per employee, per month.

Prescription Drug Coverage

All health plan options have prescription drug coverage. CVS/Caremark manages the prescription benefits for KEHP, but you do not have to use a CVS pharmacy. Go to any in-network pharmacy that you choose and get a 30-day or 90-day supply of drugs! If you prefer to have your prescriptions delivered to your door, use the CVS/Caremark retail mail order program.

Sign up at caremark.com

Your drug coverage is limited to drugs on the Value Formulary. You can view both the condensed and detailed versions of the Value Formulary at **kehp.ky.gov** or **caremark.com**. Some drugs are subject to prior authorization. An appeals process is available for drugs not covered under the Value Formulary or for drugs prescribed by a physician where usage or dosage is contrary to FDA approval. For specific questions about your prescriptions, contact CVS/Caremark at **866-601-6934**.

You may want to share the formulary listing with your primary care physician or other providers.

Preventive Therapy Drug Benefit — Bypass Your Deductible (LivingWell CDHP or the LivingWell Basic CDHP Only)

If you have the LivingWell CDHP or the LivingWell Basic CDHP, you only have to pay for the co-insurance amount for medications on the Preventive Therapy Drug Benefit list without having to first meet your deductible.
This list includes medications you need on a regular basis to prevent conditions such as high blood pressure or high cholesterol. You can see the Preventive Therapy Drug Benefit list at **kehp.ky.gov**.

PrudentRx (Available for the LivingWell PPO)

If you have the LivingWell PPO plan, you may be able to save money on your specialty prescriptions. PrudentRx has collaborated with CVS Caremark® to offer a third-party (manufacturer) co-pay assistance program that may help save you money when you fill your prescription through CVS Specialty, CVS/Caremark and PrudentRx will work with you to obtain third-party co-pay assistance for your medication, if available.

Once you're enrolled in the PrudentRx program, you'll pay nothing out-of-pocket — that's right, $0 — for medications on your plan's specialty drug list dispensed by a pharmacy in the CVS Specialty network.

Your enrollment in the program will be started automatically, but some additional steps may be required, such as signing up for a manufacturer's co-pay assistance program. You can choose to opt out at any time, but if you do opt out, a 30% co-insurance will apply to your specialty medications.

CVS/Caremark has a **Check Drug and Cost Coverage** tool that is helpful in comparing the cost of drugs at nearby pharmacies. The lower the cost of the drug, the less you will pay in co-insurance (except for the LivingWell PPO plan, which offers a fixed co-pay for prescription drugs). Sign in at **caremark.com**, select **Plan & Benefits,** and choose **Check Drug and Cost Coverage**.

Prescription Drug Coverage

Value Benefits for Diabetes, COPD, and Asthma

As costs of prescription drugs continue to rise, KEHP wants to help you by reducing what you have to pay! For several years, KEHP has offered Value Benefits, and we now know that you are being more compliant in taking your medications – because they cost you less! This is effective in improving your health, saving you money, and reducing plan costs. It's a win-win for all!

The Value Benefit for diabetes, COPD, and asthma means your costs are reduced if you receive maintenance prescriptions or supplies. Some examples include:

- Inhalers
- Pressure machines
- Infusion pumps
- Blood pressure monitoring devices
- Cardiac monitors
- Supplies and durable medical equipment

You will pay a reduced co-pay and/or co-insurance, and you won't have a deductible.

See the chart below for the cost that you will pay. The maximum you will pay for a 30-day supply of insulin is $30.

Most supplies and durable medical equipment related to diabetes, COPD, and asthma are covered in full with **NO DEDUCTIBLE**.

Value Benefit Design	LivingWell CDHP	LivingWell PPO	LivingWell Basic CDHP
30-Day Supply	(No Deductible)		(No Deductible)
Tier 1 — Generic	0%	0%	0%
Tier 2 — Formulary	10%	$25	25%
90-Day Supply (Retail or Mail Order)	(No Deductible)		(No Deductible)
Tier 1 — Generic	0%	0%	0%
Tier 2 — Formulary	10%	$50	25%

Waiver General Purpose HRA

If you don't need health insurance, you may be eligible for the Waiver General Purpose Health Reimbursement Arrangement (HRA). **YOU MUST** elect the Waiver General Purpose HRA, or you will **NOT** receive $2,100. The HRA covers medical, dental, and vision services that your health insurance plan doesn't cover, such as the deductible and other out-of-pocket costs.

You will be eligible for a Waiver General Purpose HRA only if you have other employer-sponsored health insurance. You can use this HRA for you and your dependents as long as you can attest that all persons covered under the Waiver General Purpose HRA have other employer-sponsored group health insurance coverage.

Your employer will contribute $175 per month, up to $2,100 per year, to your HealthEquity debit VISA Healthcare Card. It will be funded in two equal installments: $1,050 on January 1 and $1,050 on July 1.

You have a 90-day run-out period until March 31, 2024, to request reimbursement for eligible expenses that occurred between January 1, 2023, and December 31, 2023.

The balance remaining in your Waiver General Purpose HRA (up to $2,100) at the end of 2023 will carry over to 2024 as long as you continue to waive your health insurance coverage and elect the Waiver General Purpose HRA.

Expenses that may be reimbursed under your Waiver General Purpose HRA include:

- Medical and prescription expenses, including over-the-counter (OTC) medications, feminine products, and certain protective equipment, such as face masks and hand sanitizer.
- Co-payments and co-insurance.
- Certain dental fees, such as fees for exams, cleanings, fillings, and crowns.
- Orthodontic treatment.
- Vision fees, including fees for exams, contacts, eyeglasses, and laser vision correction.
- Medical supplies, such as wheelchairs, crutches, and walkers.

Who Is Eligible to Waive Coverage and Receive the Waiver General Purpose HRA

- Any active employee of a state agency, school board, or certain quasi-governmental agencies, who is eligible for state-sponsored health insurance coverage.
- A retiree who has returned to work who has other group health insurance (not with KPPA or TRS).

Who Is Not Eligible

- An employee of an agency that does not participate in KEHP's FSA/HRA program with HealthEquity.
- A retiree under age 65 who has gone back to work and elected coverage under the retirement system.
- An employee who does not have employer-sponsored group health insurance coverage.
- An employee who has individual health insurance coverage through the Marketplace.
- An employee whose only other insurance is Medicare, Tricare, Medicaid, Veterans' Benefits, or other government-sponsored health insurance.
- An employee who is contributing or whose spouse is contributing to a Health Savings Account (HSA).

The HealthEquity debit VISA Healthcare Card can only be used for services rendered in 2023. You must file a Pay-Me-Back or Pay-My-Provider claim with HealthEquity for any services rendered in 2022.

Waiver Limited Purpose HRA

If you have a Waiver Limited Purpose HRA in 2022 and wish to keep it, you do not have to make an election during open enrollment. If you do not wish to keep the Waiver Limited Purpose HRA in 2023, you must make a different election during open enrollment. The Waiver Limited Purpose HRA is available to those who have individual or government-sponsored health insurance, such as Medicare, Medicaid, or Tricare, and don't need a health plan. This HRA only covers dental and vision expenses incurred by you and your dependents.

Your employer will contribute $175 per month, up to $2,100 per year, to your HealthEquity debit VISA Healthcare Card. It will be funded in two equal installments: $1,050 on January 1 and $1,050 on July 1.

You have a 90-day run-out period until March 31, 2024, to request reimbursement for eligible FSA expenses that occurred between January 1, 2023, and December 31, 2023.

The balance remaining in your Waiver Limited Purpose HRA (up to $2,100) at the end of 2023 will carry over to 2024, as long as you continue to waive your health insurance coverage and elect the Waiver Limited Purpose HRA.

Note: The Waiver Limited Purpose HRA is not dental or vision insurance, but it may be used to pay for or reimburse you for dental and vision expenses. Examples of expenses that may be reimbursed from your Waiver Limited Purpose HRA include:

- Certain dental fees, such as fees for exams, cleanings, fillings, and crowns.
- Orthodontic treatment.
- Vision fees, including fees for exams, contacts, eyeglasses, and laser vision correction.

Who Is Eligible for the Waiver Limited Purpose HRA

- Any active employee of a state agency, school board, or certain quasi-governmental agencies, who is eligible for state-sponsored health insurance coverage.
- A retiree who has returned to work who has other health insurance (not with KPPA or TRS).
- Members who are not eligible for the Waiver General Purpose HRA because they have an individual or government-sponsored health insurance plan.

Who Is Not Eligible

- An employee of an agency that does not participate in KEHP's FSA/HRA program with HealthEquity.
- A retiree under age 65 who has gone back to work and elected coverage under the retirement system.

The HealthEquity debit VISA Healthcare Card can only be used for services rendered in 2023. You must file a Pay-Me-Back or Pay-My-Provider claim with HealthEquity for any services rendered in 2022.

Healthcare Flexible Spending Account (FSA)

Consider enrolling in an FSA for 2023 and save on a variety of expenses by paying for them on a pre-tax basis. If you're not currently enrolled, you are paying more in taxes for out-of-pocket healthcare expenses.

If you already have a Healthcare FSA, and you want it again for 2023, you must re-enroll.

A Healthcare FSA lets you put pre-tax money into an account to use for out-of-pocket expenses, such as deductibles, co-payments, and co-insurance for medical claims, as well as prescriptions and some over-the-counter medications and supplies. You can also use a Healthcare FSA to cover dental and vision costs.

The money you elect to contribute for the entire year is available to you on a pre-funded Healthcare VISA card on January 1.

Reasons to Select a Healthcare FSA

- Contribute up to a maximum of **$2,850 per year before taxes**. The minimum you can contribute is $120 per year.
- Carry over a minimum of $50 and a maximum of $570 from one calendar year to the next — there's low risk in losing your hard-earned money. Carryover funds do not count toward the annual contribution maximum of $2,850.
- You have a 90-day run-out period until March 31, 2024, to request reimbursement for eligible FSA expenses that occurred between January 1, 2023, and December 31, 2023. Any of your funds that are in excess of $570 that are not used before the run-out period will be forfeited.
- Use your FSA to pay for eligible medical expenses for family members who are considered a tax dependent, even if they are not enrolled in your health plan.

Covered Expenses

- Medical and prescription co-payments.
- Medical and prescription expenses, including over-the-counter (OTC) medications, feminine products, and certain protective equipment, such as face masks and hand sanitizer.
- Certain dental fees.
- Orthodontic treatment.
- Vision fees, including eyeglasses.
- Co-insurance.
- Wheelchairs, crutches, and walkers.

For a full list of covered expenses, go to **healthequity.com**.

Who Is Eligible

- Employees of state agencies or school boards.
- Employees of certain quasi-governmental agencies.

Contact your Insurance Coordinator for details.

Who Is Not Eligible

- Retirees.
- Employees of an agency that does not participate in KEHP's FSA/HRA program with HealthEquity.

You can use the EZ Receipt app to submit reimbursement or to have HealthEquity pay your provider directly using the Pay-My-Provider option.

- If you have not actively elected a Healthcare FSA contribution for two years, your Healthcare FSA will terminate and you will lose any carryover balance.
- Funds from a HealthEquity Healthcare FSA will be used before funds from an HRA.
- Do not use your VISA debit card in 2023 to pay for 2022 expenses.

Child and Adult Daycare FSA

Cut Your Child and Adult Daycare Costs

If you need a child or adult daycare to care for your loved ones while you work, then a Child and Adult Daycare FSA may be right for you. You know how expensive that care can be. But, with a Child and Adult Daycare FSA, you can save money on eligible childcare and adult daycare expenses by using pre-tax dollars.

With a Child and Adult Daycare FSA, you elect an amount to be deducted pre-tax from your paycheck to use to pay eligible expenses below:

- Child or adult care (during work hours only)
- Preschool
- Summer day camp
- Before and after-school care
- Elder daycare expenses for dependent adults

Just elect to enroll, then choose the amount you wish to contribute to this account. The minimum amount you can contribute is $120 per year, up to the maximum amount per year that is based on your tax-filing status:

- Married, filing a joint return - $5,000
- Head-of-household - $5,000
- Married, filing separate returns - $2,500

You can arrange for convenient direct payments to your provider using the Pay-My-Provider option on the EZ Receipts app, or you can pay child and adult daycare expenses yourself and request reimbursement.

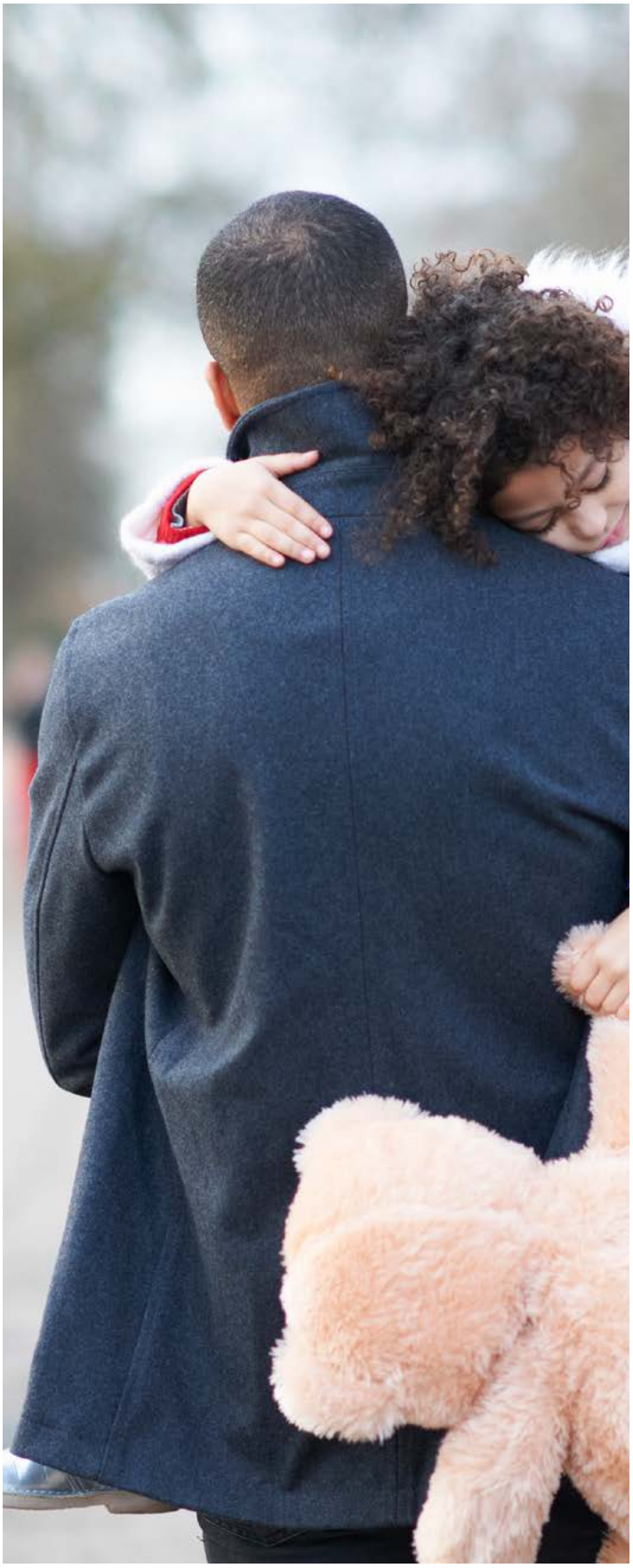
Who Is Eligible

- Employees of state agencies or school boards.
- Employees of certain quasi-governmental agencies.

Contact your Insurance Coordinator for details.

Who Is Not Eligible

- Retirees.
- Employees of an agency that does not participate in KEHP's FSA/HRA program with HealthEquity.



LivingWell Promise

All planholders are required to complete the LivingWell Promise between January 1, 2023, and July 1, 2023. New employees with an effective date later than January 1, 2023, are not required to complete the Promise.

To complete the Promise, all you have to do is either:

- Take the WebMD online health assessment at **KEHPlivingwell.com**. The health assessment only takes about 10 minutes to complete and asks various health and lifestyle questions; or
- Receive a biometric screening from your physician, lab, or clinic. This is a blood test to check your cholesterol, triglycerides, and glucose. Your Body Mass Index (BMI) is then determined by your waist circumference, height, and weight.

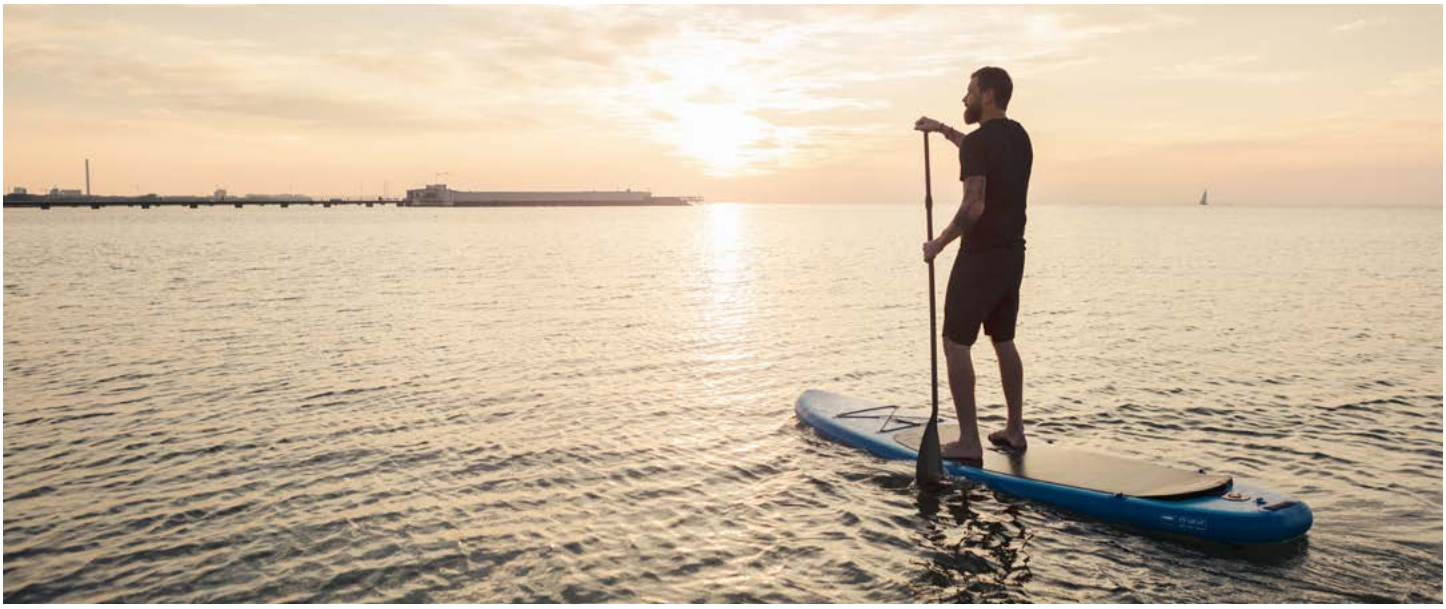
Note that you will not get credit for completing the Promise if you do it during Open Enrollment. The Promise must be completed between January 1, 2023, and July 1, 2023.

By completing the Promise, you:

- Earn up to a $480 premium discount ($40 a month) for plan year 2024;
- Open the door to begin earning up to $200 ($100 for dependent spouses) in engagement rewards for participating in health and wellness activities, and
- Earn $25 in engagement rewards if you complete the Promise by receiving a biometric screening.

Health Action

If you are a cross-reference member, both spouses must fulfill the Promise.



Benefit Programs
Additional benefits at no extra cost to you!

DIABETES BENEFITS

Lark

The Kentucky Employees' Health Plan, through its medical vendor, Anthem, has partnered with Lark to offer a diabetes prevention program at no extra cost to you. After a brief survey, if you are determined to be at risk for type 2 diabetes and enroll in the Lark program, you will receive:

- Access to a customized program through a convenient mobile app.
- 24/7 coaching to help develop habits to lose weight, manage stress, eat healthier, sleep better, and increase activity.
- Personalized feedback and daily check-ins.
- Educational information about prediabetes and preventing type 2 diabetes.
- Tips for managing everyday stress.

Receive a free smart scale upon enrollment and a free Fitbit after reaching certain milestones. See if you qualify at **lark.com/anthem**.

DSMES

Diabetes Self-Management Education and Support (DSMES) is available to you if you have already been diagnosed with type 1 or type 2 diabetes by your health care provider. No deductible, no co-insurance, and no additional cost to you! DSMES is an educational program for diabetes self-care, as developed through evidence-based practices. DSMES can be taught in a group or an individual setting and can be offered in person or online. Services are typically provided by a registered dietitian or a certified diabetes educator. The DSMES program format includes weekly classes that focus on learning to eat healthier, being physically active, monitoring blood sugar levels, coping with the emotional side of diabetes, problem solving, reducing the risk for other health problems, and many other related topics. Ask your physician about how to find a DSMES provider near you.

TELEHEALTH AND PHONE SUPPORT

Telehealth through LiveHealth Online

Healthcare at home or on the go. Get fast, easy, virtual doctor visits whenever you need them. There is no additional cost to you through LiveHealth Online.

LiveHealth Online lets you have a video visit with a board-certified medical doctor, psychiatrist, or therapist from your computer with a camera, tablet, or smartphone.

Feeling under the weather? Have a health question? With LiveHealth Online, the doctor comes to you. In some cases, no appointments are needed. No traveling to a doctor's office and no sitting in the waiting room.

See some common conditions that can be treated using LiveHealth Online:

- Cold and flu symptoms
- Allergies
- Sinus infections
- Migraines
- Upper respiratory infections
- Bronchitis

Go to **livehealthonline.com** and log in or download the free app to register. Select LiveHealth Online Medical and choose the doctor you'd like to see.

Call **888-548-3432** or **844-784-8409**.

24/7 NurseLine

If you have an emergency or questions for a nurse, you can call 24/7. The NurseLine provides you with accurate health information anytime of the day or night. You will receive one-on-one counseling with experienced nurses via a convenient toll-free number, **877-636-3720**. A staff of experienced nurses is trained to address common healthcare concerns such as medical triage, education, access to healthcare, diet, social and family dynamics, and mental health issues.

Specifically, the 24/7 NurseLine features:

- A skilled clinical team — a registered nurse (RN) who helps assess your systems, understands medical conditions, ensures you receive the right care in the right setting, and refers you to programs and tools appropriate for your condition;
- Bilingual RNs, language line, and hearing-impaired services;
- Access to the AudioHealth Library, containing hundreds of audiotapes on a wide variety of health topics;
- Proactive callbacks within 24 to 48 hours, referrals to 911 emergency services, poison control, and identification of emergency or urgent care for children; and
- Referrals to relevant community resources.

Telehealth through Providers Other than LiveHealth Online

Telehealth is also a covered benefit with any network provider that offers telehealth. You will be responsible for any cost-share, including your deductible, co-payment, and co-insurance, if you use a telehealth service other than LiveHealth Online or 24/7 NurseLine.

MATERNITY CARE

Future Moms

The Future Moms program is available to expectant mothers at no additional cost to KEHP members! Future Moms:

- Helps expectant mothers focus on early prenatal interventions, risk assessments, and education;
- Includes special management emphasis for expectant mothers at the highest risk for premature birth or other serious maternal issues; and
- Gives access to nurse coaches supported by pharmacists, registered dietitians, social workers, and medical directors.

Future Moms supports mothers in having a healthy pregnancy and provides guidance to help you to make the best decisions for you. Call toll free at **844-402-5347** to sign up once you know you are pregnant. One of Anthem's registered nurses will help you begin.

With Future Moms, you'll receive:

- 24/7 phone access to a nurse coach who can talk with you about your pregnancy and answer your questions;
- Your Pregnancy Week by Week, a book to show you what changes you can expect for you and your baby over the next nine months; and
- Useful tools to help you, your doctor, and your Future Moms nurse coach track your pregnancy and spot possible risks.

Lactation Support through LiveHealth Online

Receive lactation support through LiveHealth Online. You'll have a live health visit with a lactation consultant or registered dietitian for personalized postpartum nutrition and lactation support. Contact LiveHealth Online for lactation and nutrition support at **888-548-3432**.

MENTAL AND BEHAVIORAL HEALTH

RethinkCare

Raising kids is tough! RethinkCare provides family support when you need it.

Through RethinkCare, you gain 24/7 access to virtual consultations with a dedicated behavior expert and unlimited use of the website filled with step-by-step videos, resources, and digital training, tips, articles, and exercises developed to help families raise more resilient children. All parents are welcome to use this program, which provides specialized support for families caring for children with learning, social or behavioral challenges, or developmental disabilities. The program has no age restriction, requires no diagnosis, and is completely confidential.

RethinkCare offers:

- Ongoing consultations with learning and behavior experts who specialize in working with parents across a broad spectrum of needs.
- Web and mobile access to how-to videos and resources to teach crucial skills.
- Exclusive content developed to assist your child with socialization, social and emotional learning, academics, and more.
- Catalog of goal-based training focused on parental and family well-being. Train practical, repeatable skills through micro-learning.

Get started any time. Visit **connect.rethinkcare.com/sponsor/kehp** and use enrollment code "KEHP." Email **support@rethinkcare.com** for assistance in signing up or if you have questions.

LiveHealth Online Behavioral Health

Get fast, easy, virtual psychiatrist and therapist visits whenever you need them. There is no additional cost to you through LiveHealth Online Behavioral Health.

LiveHealth Online lets you have a video visit with a board-certified psychiatrist or therapist from your computer with a camera, tablet, or smartphone.

Some common conditions that can be treated using LiveHealth Online Behavioral Health include:

- Anxiety
- Depression
- Grief
- Panic attacks
- Medication, for those 18 years and older, to help manage a mental health condition

No traveling to a doctor's office and no sitting in the waiting room.

For LiveHealth Online Behavioral Health, you can schedule an appointment online, 7 a.m. to 11 p.m. Call **888-548-3432** or **844-784-8409**.

Learn to Live

Built on the proven principles of cognitive behavioral therapy (CBT), Anthem provides digital tools that are available anywhere, anytime. These tools can help you identify thoughts and behavior patterns that affect your emotional well-being – and work through them. You'll learn effective ways to manage stress, depression, anxiety, substance use, and sleep issues.

Personalized, one-on-one coaching: Team up with an experienced coach who can provide support and encouragement by email, text, or phone.

Build a support team: Add friends or family members as teammates. They can help you stay motivated and accountable while you work through programs.

Practice mindfulness on the go: Receive weekly text messages filled with positivity, tips, and exercises to improve your mood.

Live and on-demand webinars: Learn how to improve mental well-being with useful tips and advice from experts.

Take an assessment to find the program that's right for you. To access our Emotional Well-being Resources:

- Log in to **anthem.com** or the **Sydney Health** app, go to **My Health Dashboard**, choose **Programs**, and select **Emotional Well-being Resources**.
- From there, you will be transferred to the Learn to Live website, where you can register with an email address and password.

Behavioral Health Resource Center and Substance Abuse Disorder Resource Line

If you or someone you know is a KEHP member with a substance use concern, call **855-873-4931**. A staff member will connect you with a clinical expert trained in substance use disorder treatment. You can talk with these experts confidentially about:

- Treatment options;
- Other health or behavioral issues you're having;
- Finding doctors or treatment centers in your health plan that specialize in substance use disorder; and
- Online and mobile tools that can help you during and after treatment.

The support line is open 24/7 – so help is available, day or night.

TOBACCO CESSATION

Are you ready to quit tobacco? You don't have to do it alone. KEHP has many resources available, including nicotine replacement therapies with no cost-share! You can also get prescription medications to help you quit. For more information about this program and available resources to help you quit tobacco, call **844-402-5347**.

Over the Counter

You can get over-the-counter nicotine replacement therapies, without a prescription, at no cost if you meet all of the following requirements:

- You are a member of KEHP;
- You are a tobacco user (Planholder and/or dependent), 18 years old or older, and listed as a tobacco user on the KEHP health insurance form; and
- You attend all regularly scheduled sessions from an approved program to quit tobacco.

Call **888-581-8834** for more information.

Prescription Medications

You can get prescription medications to help you with quitting tobacco as well! You need a prescription from your doctor and the medication needs to be on the preventive services list that you can find by visiting **here**. Tobacco cessation prescriptions on the preventive services list are available at no cost to you.

To take the first step and get more information about the programs available, visit **here** or call **844-402-5347**.

JOINT AND BACK PAIN

Hinge Health

Hinge Health is a virtual exercise therapy program designed to address back, knee, hip, neck, or shoulder pain. It's convenient and fits your schedule — it can be done anywhere, at any time.

The Hinge Health program is available at no additional cost to you and your eligible dependents enrolled in a KEHP medical plan. Visit HingeHealth.com/KEHP, or call 855-902-2777 for more information.

Apply

- Visit **hingehealth.com/kehp**
- Fill out the questionnaire
- Expect a follow-up email within 24-48 hours

Program Acceptance

- Receive a welcome text from your coach
- Wait for your kit to arrive within 1-2 weeks

Receive Kit

- Log in to the app and begin the Hinge Health program
- Schedule your initial call with your Health Coach

UK Healthcare Acupuncture

UK Healthcare Integrative Medicine and Health and KEHP are piloting an acupuncture program at no cost to KEHP members! Services must be provided at UK for acupuncture to be covered. Members can receive up to a maximum of 13 visits in 2023, based on the member's treatment plan. No physician referral is required.

Just call UK Healthcare Integrative Medicine and Health at **859-323-HEAL (4325)**.

EARN CASH AND PREMIUM DISCOUNTS!

SmartShopper

EARN CASH by shopping for your healthcare. Save money on medical care depending on where you go. Prices are not the same for medical tests, and costs for procedures can vary from hundreds to thousands of dollars — all based on where you go for the service. SmartShopper earns you cash incentives (from $25 to $850) for seeking care at lower-cost locations for MRIs, surgeries, colonoscopies, and more! And now, there are even more locations available for you to save money. All you have to do is shop online or call a Personal Assistant for guidance and scheduling assistance. Call **855-869-2133** for details or go online at **smartshopper.com** for more information about earning cash and using this program.

Wellness Rewards

Through WebMD, the Plan's wellness partner, you can earn up to $480 in premium discounts when you complete the LivingWell Promise by July 1. You can also earn up to $200 and your spouse can earn up to $100 in LivingWell engagement rewards for activities like getting a preventive dental visit, completing education sessions, participating in health coaching, participating in step goals, and other challenges.

The LivingWell program makes it easier to enjoy the little moments that add up to greater health. Tools are available to help you spend more time being active, enjoying healthy meals, connecting with loved ones, and living a fuller life! Go to **KEHPlivingwell.com** and register today! Call **866-746-1316** if you need registration assistance.

Terms You Should Know

Co-insurance

Means your share of the cost for covered services that is a percentage of the Maximum Allowed Amount that you must pay. You pay the Co-insurance after you meet your Deductible.

Example: Your plan has a 20% Co-insurance on an office visit amount of $100. In this case, your Co-insurance Cost-Share of the Maximum Allowed Amount would be $20, after you have met your Deductible. The plan would then cover the remaining 80% of the Maximum Allowed Amount, or $80.

Co-payment

Means a fixed dollar amount that is your share of the cost for certain Covered Services. Co-payments do not apply to the Deductible, but do apply to the Maximum Out-of-Pocket. Only the LivingWell PPO plan utilizes Co-payments.

Cost-Share

Means that portion of payment for Covered Services that is your responsibility. Depending on the plan you choose, Cost-Share includes your Deductible, Co-payments, and Co-insurance. Your Cost-Share may vary depending on whether you receive Covered Services from a Network or an Out-of-Network Provider.

Covered Services

Means medically necessary medical care and prescription drugs that are covered under your health plan. Please see the Medical Benefit Booklet and Summary Plan Description for your plan, for more information.

Deductible

Means the amount you must pay for Covered Services before your plan will begin to pay. After you have met your plan's Deductible, you will only be responsible for your Co-insurance and any applicable Co-payment. Some Covered Services, such as preventive care, will be covered by your plan at 100%, without regard to the Deductible.

Evidence of Insurability (EOI)

Means a questionnaire that documents the overall health of an employee or an employee's spouse who is seeking to increase their optional life insurance coverage limits. The Evidence of Insurability questionnaire, sometimes referred to as a Statement of Health, is a form provided by MetLife, and is used by MetLife to evaluate the life insurance application.

Formulary

Means a list of prescription drugs covered by a plan offering prescription drug benefits.

Maximum Allowed Amount

Means the maximum dollar amount that the plan will pay for Covered Services provided by a Network or Out-of-Network Provider. The Maximum Allowed Amount may be established by a contract between Anthem or Caremark with a Network Provider or by the plan's coverage rules as outlined in the Medical Benefit Booklets or the Summary Plan Descriptions.

Maximum Out-of-Pocket

Means the maximum amount that you will pay out of pocket for Covered Services under your plan during a given calendar year. When the Maximum Out-of-Pocket is reached, the plan will pay 100% of the Maximum Allowed Amount for Covered Services, and you are no longer responsible for any Cost-Share.

Medical Benefit Booklet

Means the document that lists the Covered Services for each plan offered by the KEHP as well as the rights and responsibilities of members of the health plan, including but not limited to Deductibles, Co-insurance, Co-payments, preauthorization requirements, coverage exclusions, and claim denial appeal procedures.

Network Provider

Means a physician, health professional, hospital, pharmacy, or other individual, organization, and/or facility that has entered into a contract, either directly or indirectly, with Anthem or Caremark, to provide Covered Services through negotiated reimbursement arrangements.

Out-of-Network Provider

Means a physician, health professional, hospital, pharmacy, or other health care provider that has not entered into a contract, either directly or indirectly, with Anthem or Caremark, to provide Covered Services at the time such Covered Services are rendered.

Qualifying Event

Means a life event, such as marriage or birth of a child, that, upon occurrence, will enable an employee to enroll in, change, or terminate health, life, dental, or vision insurance coverage outside the open enrollment period or the enrollment period for newly hired employees.

Summary Plan Descriptions

Means the document that lists the prescription drugs covered under each plan offered by the KEHP as well as the rights and responsibilities of members of the health plan, including but not limited to Deductibles, Co-insurance, Co-payments, preauthorization requirements, coverage exclusions, and claim denial appeal procedures. A Summary Plan Description is also available for Health Flexible Spending Accounts, Child and Adult Daycare Flexible Spending Accounts, and Health Reimbursement Arrangements.

New Employee Deadlines

As a new full-time employee, you have 35 days from your date of hire to elect health, FSA, life, dental, and vision insurance.

If you fail to make a health insurance election within the 35 days, you will be placed in a default plan with Single coverage. The default health insurance plan for 2023 is the LivingWell Basic CDHP with no HRA. You will also be enrolled in Basic Life Insurance coverage if your employer participates in the Commonwealth's life insurance program.

Dental and Vision coverage are not automatically assigned.

Qualifying Events

KEHP is a federally regulated, Section 125 Cafeteria Plan, which enables you to pay your health, dental, and vision insurance premiums and your Flexible Spending Account contributions with pre-tax dollars. Under Cafeteria Plan rules, there are only three times you can change or cancel your benefit elections during the plan year:

- During the enrollment period when you first become eligible for benefits (see New Employee Deadlines);
- During the annual Open Enrollment period; or
- If you experience a life event, referred to as a Qualifying Event.

What is a Qualifying Event?

A Qualifying Event is a life-changing event or a change in status such as:

- Marriage
- Having or adopting a child
- Divorce
- Loss of other group health insurance
- Court order requiring coverage
- Spouse has a different Open Enrollment period

Other less common qualifying events may apply. If you are unsure whether you have experienced a qualifying event that will allow you to change your insurance benefits, contact your Insurance Coordinator or Health Resource Generalist for additional information.

What you Need to Know About Qualifying Events

Qualifying events can be complicated, and at times, difficult to understand. There are restrictions on the types of changes you can make due to federal qualifying event rules. For instance, a change in a life event or status may not entitle you to change the amount you contribute to a Flexible Spending Account. For that reason, it is very important that you be aware of the following rules and contact your Insurance Coordinator or Human Resource Generalist as quickly as possible after experiencing a qualifying event:

1. Any change in your plan option or coverage level **must be consistent** with the qualifying event you have experienced. For example, you cannot request to remove a dependent from your plan due to birth or adoption.
2. Qualifying Events have **strict deadlines**. Qualifying events require that you complete the Employee Benefits Enrollment Change Form and submit it to your Insurance Coordinator or Human Resource Generalist within 35 calendar days of the event date.
3. All qualifying events (except death) require **supporting documentation**. The supporting documentation required for a Qualifying Event will depend on the type of Qualifying Event. Supporting documentation must be submitted together with the Employee Benefits Enrollment Change Form.
4. If you do not sign and date the required Employee Benefits Enrollment Change Form within the deadline, you will not be permitted to make the requested change until the next Open Enrollment period.

Contact your Insurance Coordinator or Human Resource Generalist for questions, assistance, and additional information about Qualifying Events.

Qualifying Events and Other Insurance Benefits

In general, a qualifying event that permits a change in health insurance will also permit a change in dental and vision insurance. Likewise, a qualifying event that permits a change in health insurance will, in most instances, permit a change in life insurance including making a change to or adding optional insurance coverage.

Anthem Optional Dental Insurance

You may choose optional employer-sponsored, employee-paid, dental insurance administered by Anthem. Dental benefits not only protect your teeth but also can support overall health. Some conditions, like heart disease, can have warning signs in the mouth and gums.[1] Our dental plan gives you all the benefits you need for a healthy mouth and more.

Your dental plan includes:

- Access to a large number of dentists in the plan.
- An extra cleaning if you're pregnant, have diabetes, or another qualifying condition.
- A benefit for a brush biopsy that can help diagnose oral cancer.
- No out-of-pocket costs for cleanings, X-rays, or other preventive care services when you see a dentist in the plan.
- Easy-to-use online tools, including a Dental Health Assessment, Dental Cost Estimator, and Ask a Dental Hygienist.
- Teledentistry, 24 hours a day, 7 days a week, 365 days a year. Using technology and telecommunications, employees can get dental care remotely, without the need to go to a dentist's office.
- Orthodontic benefits now include at-home clear aligners — Ortho@Home — providing a simple, more budget-friendly option in the Gold plan for children up to age 18.

	Bronze[2]	Silver[2]	Gold[2]
Your Dental Plan at a Glance	**In/Out-of-Network[3]**	**In/Out-of-Network[3]**	**In/Out-of-Network[3]**
Annual Benefit Maximum	$750	$1,000	$1,500
Annual Deductible	$50	$50	$50
Orthodontia (only for children up to 18)	Not covered	Not covered	$1,500
Diagnostic and Preventive Services	100%/100% of allowable amount[3]	100%/100% of allowable amount[3]	100%/100% of allowable amount[3]
Basic Services	50%/50% of allowable amount[3]	80%/80% of allowable amount[3]	80%/80% of allowable amount[3]
Oral Surgery (Simple)	50%/50% of allowable amount[3]	80%/80% of allowable amount[3]	80%/80% of allowable amount[3]
Major Services[4] (including Complex Oral Surgery, Porcelain Crowns, and Implants)	Not covered	50%/50% of allowable amount[3]	50%/50% of allowable amount[3]
Annual Maximum Carryover	Not covered	Not covered	Covered
No waiting periods for basic or major services. Up to 24-month waiting period missing tooth clause.[4]			

1 Harvard Health Publishing website, *Gum disease and heart disease: The common thread* (accessed July 2022): **health.harvard.edu**.
2 In-network rates for each tier, out-of-network reimbursement limitations may apply.
3 Difference in charged amount and out-of-network allowable amount can result in balance billing.
4 For replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

Monthly Dental Rates for 2023

Monthly Rates	Bronze	Silver	Gold
Employee only	$14.08	$21.40	$28.40
Employee + spouse	$25.68	$40.62	$54.90
Employee + child(ren)	$33.40	$45.92	$70.00
Family	$49.28	$68.26	$102.10

Anthem Optional Vision Insurance

You may choose optional employer-sponsored, employee-paid, vision insurance administered by Anthem. Routine eye checkups are about more than making sure you can see clearly. They're also important to overall health, safety, and learning. Even if you can see well, regular eye exams are important to help keep your eyes healthy — and catch other health problems early.[1]

With Blue View Vision℠, you have access to one of the country's largest networks of eye doctors and eye-care retailers. This makes it easy to get eye care at the best time for you.

- 39,000 eye doctors in the Insight Network.[2]
- 28,000 locations.[2]
- Online shopping at Glasses.com, ContactsDirect.com, Lenscrafters.com, Targetoptical.com, ray-ban.com/insurance, and 1-800 CONTACTS®.
- National network of optical retail stores like LensCrafters®, Target Optical®, and most Pearle Vision® stores.

Your vision benefits cover:

- Adult routine eye exam.
- Frames and either eyeglass lenses or contact lenses for adults.
- Pediatric routine eye exams.
- Frames and either eyeglass lenses or contact lenses for covered children up to age 26. For children up to age 19, Transitions® lenses are included to protect their eyes from harmful UV rays and polycarbonate lenses at no extra cost.

	Bronze[3]	Silver[3]	Gold[3]
Exam with dilation as necessary	$10 co-pay	$10 co-pay	$10 co-pay
Frames	$125 allowance and 20% off any remaining balance	$150 allowance and 20% off any remaining balance	$150 allowance and 20% off any remaining balance
Eyeglass lenses: single vision, bifocal, trifocal, lenticular	$25 co-pay	$10 co-pay	$10 co-pay
Standard progressive lens	Standard fixed price/discount	Standard fixed price/discount	$20 co-pay
Contact lenses			
Conventional	$150 allowance, 15% off balance over $150	$150 allowance, 15% off balance over $150	$175 allowance, 15% off balance over $175
Disposable	$150 allowance	$150 allowance	$175 allowance
Medically necessary	Covered in full	Covered in full	Covered in full
Frequency			
Examination	Once every calendar year	Once every calendar year	Once every calendar year
Lenses or contact lenses	Once every calendar year	Once every calendar year	Once every calendar year
Frame	Once every two calendar years	Once every two calendar years	Once every calendar year

Monthly Rates	Bronze	Silver	Gold
Employee only	$5.52	$6.46	$13.12
Employee + spouse	$10.94	$12.80	$26.14
Employee + child(ren)	$11.22	$13.12	$26.80
Family	$16.64	$19.48	$39.82

1 American Optometric Association website, *Evidence-Based Clinical Practice Guideline, Comprehensive Adult Eye and Vision Examination 2015* (accessed July 2022): **aoa.org**.
2 Internal data, 2021.
3 In-network rates for each tier, out-of-network reimbursement limitations may apply.

Life Insurance with MetLife

As a Commonwealth of Kentucky public employee, your participating employer provides $20,000 of basic life insurance coverage to eligible employees at no cost to you. In addition to the free $20,000 of life coverage, you have the option to purchase additional life insurance for you and your eligible dependents. The basic and optional employee term life insurance plans also provide accidental death and dismemberment (AD&D) benefits, providing additional financial protection in the event of death or injury caused by certain injuries.

Life insurance is not part of open enrollment this year, but you can make changes anytime. You can add or increase optional life insurance on yourself, your spouse, or your dependents as long as you provide a satisfactory Evidence of Insurability (Statement of Health) on you and your spouse. You can also enroll in life insurance if you are a new employee, or if you have a life-changing event, such as gaining a new child, getting married, or getting divorced.

Check with your employer to see if they participate in the Commonwealth's life insurance program.
Remember to keep your life insurance beneficiary information updated in KHRIS ESS.

Optional Life Insurance for Employees

As an employee, if you desire to purchase additional life insurance in addition to the free $20,000, you can select from the options below:

Employee Coverage Options and Monthly Premiums

Age	$10,000	$25,000	$50,000	$100,000	$150,000
16 — 29	$0.92	$2.28	$4.60	$9.18	$13.76
30 — 39	$1.94	$4.86	$9.72	$19.44	$29.16
40 — 59	$4.28	$10.70	$21.40	$42.80	$64.20
Ages 60 and over	$6.98	$17.48	$34.96	$69.90	$104.86

Optional Life Insurance for Dependents

As an employee, you may purchase life insurance on your spouse and dependents. You can select from the available plan options below:

Dependent Coverage Options and Monthly Premiums

Qualified Dependent	Dependent Option 1	Dependent Option 2	Dependent Option 3	Dependent Option 4	Dependent Option 5	Dependent Option 6	Dependent Option 7	Dependent Option 8
Spouse	$10,000	$20,000	$50,000	$10,000	$20,000	$50,000	$0	$0
Child under 6 months	$2,500	$2,500	$2,500	$0	$0	$0	$2,500	$2,500
Child 6 months to age 26	$5,000	$10,000	$10,000	$0	$0	$0	$5,000	$10,000
Premium	$8.18	$16.34	$35.90	$6.54	$13.04	$32.60	$2.70	$5.40

Deferred Compensation

Kentucky Deferred Comp
Kentucky's *official* supplemental retirement plan

Put this benefit to work for you

What is Kentucky Deferred Compensation?

Kentucky Deferred Compensation (KDC) is a tax-deferred retirement savings plan offered to all state employees, public school employees, university employees, and employees of local political subdivisions that have elected to participate.

Why participate?

Chances are Social Security benefits, plus your state and other system retirement, will not provide enough income to maintain your current standard of living. By contributing to a supplemental retirement plan, you consistently save with the goal of having additional income at retirement. KDC helps bridge the gap between what you'll collect from your pension and what you need for retirement.

Easy contributing — Contribute as little as $30 per month or $15 per pay.

Convenient — Contributions are automatically deducted from your paycheck.

Tax advantages — No federal or state income taxes on pre-tax contributions and earnings until the money is paid to you.

Low cost — As a KY State Government program, there is no profit incentive, and savings are passed on to participants.

Accessible — Manage your account online anytime, day or night.

Personal service — Local Retirement Specialists are available across the Commonwealth.

Easy enrollment — Only one form and a few minutes to begin.

1	2	3
Help me do it[1]	**Do it myself**	**Do it for me[2]**
Target Date Retirement Funds from Vanguard	**Your own strategy**	**Nationwide ProAccount®**
• Invest in the fund that's closest to the year in which you expect to retire or take a distribution. • The fund is managed, automatically rebalanced, and designed to become gradually more conservative as the selected data approaches.	• Define your investment goals and strategy. • Select funds from KDC's Investment Guide. • Use the My Investment Planner℠ tool for free investment recommendations that are right for you.[2] • Opt for automatic rebalancing to keep investments in line with your goals. • Spend the time and energy to manage your own investments.	• Professional investment managers select funds from KDC's lineup based on your age, risk tolerance, and investment goals. • These managers actively manage your account according to the information you provide. • Wilshire, a leading provider of investment products and services, actively manages your account, including periodic rebalancing according to the information you provide. • Pay for this service through an additional asset management fee deducted from your account balance each quarter.

Employees can enroll anytime. Let us help. Call 800-542-2667 or 502-573-7925 or find us online at kentuckydcp.ky.gov.

1 The Vanguard Target Retirement Funds Invest in a wide variety of underlying funds to help reduce investment risk. Their expense ratio represents a weighted average of the expense ratios and any fees charged by the underlying mutual funds in which the Vanguard Target Retirement Funds invest. The Vanguard Target Retirement Funds do not change any expenses or fees of their own. Like other funds, Vanguard Target Retirement Funds are subject to market risk and loss. Loss of principle can occur at any time, including before, at or after the target date. There is no guarantee that target date funds will provide enough income for retirement.

2 Investment advice for Nationalwide ProAccount is provided to plan participants by Nationwide Investment Advisors LLC (NIA), an SEC-registered investment advisory. NIA has retained Wilshire Associates as the Independent Financial Expert for Nationwide ProAccount. Wilshire Associates is not an affiliate of NIA or KDC.

3 Nationwide Investment Advisor LLC (NIA) is not affiliated with Wilshire Associates or KDC.

Investing involves market risk, including possible loss of principal. No investment strategy or program can guarantee a profit or avoid loss. Actual results will vary depending on your investment and market experience.

KDC Retirement Specialists are Registered Representatives of Nationwide Investment Services Corporation (NISC), member FINRA. Nationwide representatives cannot offer investment, tax, or legal advice. You should consult your own counsel before making retirement plan decisions.

NRM-17372KY-KY (08/19)

Contact Information

Support During Open Enrollment

Department of Employee Insurance (DEI) Open Enrollment Hotline
888-581-8834 OR **502-564-6534**

Extended hours and the five phone options below are only available during **Open Enrollment: October 10 to October 28**

Open Enrollment Hours for Assistance (Eastern Time)

Monday, Oct. 10 to Friday, Oct. 14, 7:30 a.m. to 4:30 p.m.
Monday, Oct. 17 to Friday, Oct. 21, 7:30 a.m. to 6:00 p.m.
Monday, Oct. 24 to Friday, Oct. 28, 7:30 a.m. to 8:00 p.m.

You can choose from one of these five options:

Option 1: Kentucky Public Pensions Authority
Option 2: KHRIS User ID and password reset
Option 3: Benefit questions for Anthem (medical, dental, and vision), HealthEquity, or CVS Caremark
Option 4: Technical assistance such as browser or compatibility errors
Option 5: Department of Employee Insurance (DEI) for all other inquiries

Website Addresses

Personnel Cabinet — **personnel.ky.gov**
KEHP — **kehp.ky.gov**
Vision and Dental Insurance — **personnel.ky.gov** (then select "**Benefits**")
Well-being — **KEHPlivingwell.com**

Support Outside of Open Enrollment

Department of Employee Insurance **888-581-8831** or **502-564-6534**
Monday to Friday, 7:30 a.m. to 4:30 p.m., except Commonwealth holidays.

Contact Information

Partners and Programs	Phone Numbers	Websites
24/7 NurseLine	877-636-3720	
Acupuncture @ UK Healthcare Integrative Medicine and Health	859-323-HEAL (4325)	
Anthem – Health Insurance	844-402-5347	**anthem.com/kehp**
Behavioral Health Resource Center and Substance Use Disorder Resource Line	855-873-4931	
COBRA	878-678-4881	**healthequity.com**
CVS/Caremark – Prescriptions	866-601-6394	**caremark.com**
Dental and Vision Insurance	844-402-5347	**anthem.com**
Future Moms - Maternity care	844-402-5347	**anthem.com**
HealthEquity – FSA and HRA	877-430-5519	
Hinge Health – Digital alternative to physical therapy	855-902-2777	**hingehealth.com/kehp**
Judicial Retirement Plan	502-564-5310	
Kentucky Community & Technical College System	859-256-3100	
Kentucky Public Pension Authority	800-928-4646 502-696-8800	**kyret.ky.gov**
Kentucky Deferred Compensation	800-542-2667	**kentuckydcp.ky.gov**
Lark – Diabetes Prevention Program	844-402-5347	**lark.com/anthem**
Legislative Retirement Plan	502-564-5310	
LiveHealth Online Medical and Behavioral Health	888-548-3432 844-784-8409	
MetLife Life Insurance	800-638-6420	
PrudentRx (only for LivingWell PPO plan)	800-578-4403	
RethinkCare - Family support	800-714-9285	**connect.rethinkcare.com/sponsor/kehp**
SmartShopper – Transparency, shop for better pricing	855-869-2133	**smartshopper.com**
Teachers' Retirement System	800-618-1687 502-848-8500	**trs.ky.gov**
Tobacco Cessation	800-618-1687 502-848-8500	**trs.ky.gov**
WebMD – Well-being	844-402-5347 888-581-8834	

Legal Notices

As a member of the Kentucky Employees' Health Plan (KEHP), you have certain legal rights. Several of those rights are summarized below. Please read these provisions carefully. To find out more information, you may contact the Department of Employee Insurance, Member Services Branch at ***(888) 581-8834*** *or* ***(502) 564-6534*** *or visit* ***kehp.ky.gov.***

A. NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS

Under the Health Insurance Portability and Accountability Act (HIPAA), you have "special enrollment" rights if you have a loss of other coverage or you gain a new dependent. In addition, you may qualify for a special enrollment in KEHP under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

1. HIPAA Special Enrollment Provision - Loss of Other Coverage

If you decline enrollment for yourself or your eligible dependent(s) (including your spouse) because of other health insurance or group health plan coverage (regardless of whether the coverage was obtained inside or outside of a Marketplace), you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 35 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

2. HIPAA Special Enrollment Provision - New Dependent as a Result of Marriage, Birth, Adoption, or Placement for Adoption

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependent(s). However, you must request enrollment within 35 days after the marriage, birth, adoption, or placement for adoption.

3. CHIPRA Special Enrollment Provision – Premium Assistance Eligibility

If you or your children are eligible for Medicaid or the Children's Health Insurance Program (CHIP) and you're eligible for health coverage from your employer, Kentucky may have a premium assistance program that can help pay for coverage using funds from the state's Medicaid or CHIP programs. If you or your dependent(s) are eligible for premium assistance under Medicaid or CHIP, as well as eligible for health insurance coverage through KEHP, your employer must allow you to enroll in KEHP if you aren't already enrolled. This is called a "special enrollment" opportunity, and you **must request coverage within 60 days of being determined eligible for premium assistance**. In addition, you may enroll in KEHP if you or your dependent's Medicaid or CHIP coverage is terminated because of loss of eligibility. An employee must request this special enrollment within 60 days of the loss of coverage. You can find more information and the required CHIP notice at kehp.ky.gov (Resources/Docs, Forms, and Legal Notices link).

B. WELLNESS PROGRAM DISCLOSURE AND NOTICE

LivingWell is KEHP's voluntary wellness program available to all persons who enroll in a KEHP health insurance plan and their enrolled spouse. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease. Those federal rules include the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health assessment (or "HA") that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). In lieu of completing an HA, you may complete a biometric screening, which will include a blood test to check your cholesterol and blood glucose levels. You are not required to complete the HA or to participate in the biometric screening or any other medical examination. However, employees who choose to participate in the LivingWell wellness program will receive an incentive in the form of discounted employee premium contributions for the employee's health insurance coverage. Although you are not required to complete the HA or participate in the biometric screening, only employees who do so will receive the discounted health insurance premiums.

Additional incentives in the form of gift cards, consumer goods, and other prizes may be available for employees who participate in certain health-related activities such as walking challenges or quitting smoking. In addition, KEHP offers discounted, monthly employee premium contribution rates to non-tobacco users. Each KEHP member has at least one opportunity per Plan Year to qualify for the monthly premium contribution discount.

KEHP is committed to helping you achieve your best health. Incentives for participating in KEHP's LivingWell wellness program are available to all persons who enroll in a KEHP health insurance plan and their enrolled spouse. If you are unable to participate in any of the health-related activities, or you think you might be unable to meet a standard to earn an incentive under the LivingWell wellness program, you may request a reasonable accommodation or an alternative standard. Contact the Department of Employee Insurance, Member Services Branch at **(888) 581-8834** or **(502) 564-6534** and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same incentive that is right for you in light of your health status.

Protections from Disclosure of Medical Information: KEHP is required by law to maintain the privacy and security of your personally identifiable health information. KEHP does not collect or retain personal health or medical information through its LivingWell wellness program unless it is part of an audit, compliance, or customer service review; however, KEHP may receive and use aggregate information that does not identify any individual in order to design programs based on health risks identified in the workplace and that are aimed at improving the health of KEHP members. KEHP will never disclose any of your personal information either publicly or to your employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program. You will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who may receive your personally identifiable health information are persons employed by WebMD (KEHP's wellness administrator) and Anthem (KEHP's third-party medical administrator). This may include nurses in Anthem's disease management program and health coaches in WebMD's health coaching program. Disclosure of your personally identifiable health information to these persons is necessary in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records; information stored electronically will be encrypted; and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach. In the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you as soon as it is feasible after discovery of the breach.

C. THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

COBRA continuation coverage is a continuation of KEHP coverage when it would otherwise end because of a life event, also called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Qualified beneficiaries may elect to continue their coverage under the plan for a prescribed period of time on a self-pay basis. **Each qualified beneficiary has 60 days to choose whether or not to elect COBRA coverage, beginning from the later of the date the election notice is provided, or the date on which the qualified beneficiary would otherwise lose coverage under KEHP due to a qualifying event.** The KEHP's third-party COBRA administrator is HealthEquity. To learn more about COBRA and your rights under COBRA, please refer to the Medical Benefit Booklet, or go to **kehp.ky.gov** (Resources/Docs, Forms, and Legal Notices link).

D. THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

Your plan, as required by WHCRA, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information regarding this coverage, please refer to your Medical Benefit Booklet, or go to **kehp.ky.gov** (Resources/Docs, Forms, and Legal Notices link).

E. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORNS' ACT)

Under federal law, group health plans generally may not restrict benefits for a hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 (or 96, as applicable) hours. In any case, health insurance plans may not require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 (or 96) hours.

F. HIPAA PRIVACY NOTICE

KEHP gathers and collects demographic information about its members such as name, address, and social security numbers. This information is referred to as individually identifiable health information and is protected by HIPAA and related privacy and security regulations. HIPAA requires KEHP to maintain the privacy of your protected health information (PHI) and notify you following a breach of unsecured PHI. In addition, KEHP is required to provide to its members a copy of its Notice of Privacy Practices (NPP) outlining how KEHP may use and disclose your PHI to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. The NPP also informs members about their rights regarding their PHI and how to file a complaint if a member believes their rights have been violated. KEHP's Notice of Privacy Practices and associated forms may be obtained by visiting **kehp.ky.gov** (Resources/Docs, Forms, and Legal Notices link).

G. KEHP PRESCRIPTION DRUG COVERAGE AND MEDICARE-NOTICE OF CREDITABLE COVERAGE

KEHP has determined that KEHP's prescription drug coverage is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

H. NOTICE OF AVAILABILITY OF SUMMARY OF BENEFITS AND COVERAGE (SBC)

As an employee or retiree, the health benefits available to you represent a significant component of your compensation/retirement package. Those benefits also provide important protection for you and your family in the case of illness or injury. KEHP offers a variety of health coverage options, and choosing the option that is right for you and your family is an important decision. To help you make an informed health coverage choice, KEHP publishes a Summary of Benefits and Coverage (SBC). For easier comparison, the SBC summarizes important information about your health coverage options in a standard format. The SBCs are only a summary. You should consult KEHP's Summary Plan Descriptions and Medical Benefit Booklets to determine the governing contractual provisions of the coverage. KEHP's SBCs are available on KEHP's website at **kehp.ky.gov** (Health Insurance/Docs, Forms, and Legal Notices). A paper copy is also available, free of charge, by contacting the Department of Employee Insurance, Member Services Branch at **(888) 581-8834** or **(502) 564-6534**.

I. WAIVER HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

If an employer participates in the Waiver Health Reimbursement Arrangement (HRA) program through KEHP, an employee may elect to waive KEHP health insurance coverage and choose a Waiver HRA that is funded by the employer, up to $2,100 a year. There are two Waiver HRA options: the Waiver General Purpose HRA and the Waiver Limited Purpose HRA (formerly called the Waiver Dental/Vision Only HRA). An employee is eligible for the Waiver General Purpose HRA only if the employee, and the employee's spouse and dependents, if applicable, have other group health plan coverage. An employee that elects a Waiver General Purpose HRA must attest that the employee and, if applicable, the employee's spouse and dependents are enrolled in another group health plan that provides minimum value. A "group health plan" refers to coverage provided by an employer, an employer organization, or a union. A "group health plan" does not include individual policies purchased through the Marketplace or governmental plans such as TRICARE, Veteran's Benefits, Medicare, or Medicaid. A group health plan that provides "minimum value" means the plan pays at least 60% of the total allowed cost of covered benefits/services and participants or members in the plan are required to pay no more than 40% of the total allowed cost of covered benefits/services. An employee that elects a Waiver General Purpose HRA and that ceases to be covered under another group health plan that provides minimum value is required to notify KEHP within 35 days of the date that the other group health plan coverage ceased. In this event, coverage under the Waiver General Purpose HRA will be terminated, and the employee may elect a KEHP health insurance plan option or the Waiver Limited Purpose HRA. Each employee is permitted to permanently opt out of and waive future reimbursements from the Waiver General Purpose HRA at least annually during open enrollment.

KEHP Tobacco Use Declaration

The Commonwealth of Kentucky is committed to fostering and promoting wellness and health in the workforce. As part of KEHP's LivingWell wellness program, KEHP offers a monthly discount in health insurance premium contribution rates for non-tobacco users. You are eligible for the non-tobacco-user premium contribution rates provided you certify, during the health insurance enrollment process, that you or any other person over the age of 18 to be covered under your plan has not regularly used tobacco within the past six months. "Regularly" means tobacco has been used four or more times per week on average excluding religious or ceremonial uses. "Tobacco" means all tobacco products including, but not limited to, cigarettes, pipes, chewing tobacco, snuff, dip, cigars, and any other tobacco products regardless of the method of use. "KEHP Health Insurance Enrollment Application" refers to any method of enrolling in KEHP health insurance coverage including submitting a paper application, completing and submitting an application online, or enrolling in KEHP health insurance coverage through an online enrollment system such as KHRIS.

Whether you complete your KEHP health insurance enrollment online or submit a paper application, you are required to certify that all attestations regarding tobacco use are accurate. By completing the enrollment process, you certify the following:

1. I have truthfully answered all questions in my KEHP Health Insurance Enrollment Application regarding tobacco use by me, my spouse, and my dependents 18 years of age and over. My KEHP Health Insurance Enrollment Application accurately reflects the use of tobacco products in the past six months regarding myself and persons to be covered as a spouse or dependent under my insurance plan.
2. If I am completing my KEHP Health Insurance Enrollment Application during open enrollment, I understand that the tobacco-user premium contribution rates will apply beginning January 1, 2023, if I answered "Yes" to the tobacco use question.
3. If I am completing my KEHP Health Insurance Enrollment Application as a newly hired employee, I understand that the tobacco-user premium contribution rates will apply beginning on the first day of the second month after my hire date, if I answered "Yes" to the tobacco use question.
4. I understand that it is my responsibility to notify KEHP of any changes in my tobacco use or that of my spouse or a dependent covered under my insurance plan, including notification to KEHP if all tobacco users become ineligible for coverage or are otherwise terminated during the Plan Year. Notification shall be made by completing a Tobacco Use Change Form.
5. I understand that if I or a spouse or dependent to be covered under my insurance plan currently use tobacco products and stop using tobacco products during the Plan Year, I will be eligible for the discount non-tobacco premium contribution rates on the first day of the month following the signature date on the Tobacco Use Change Form certifying that neither I nor my spouse/dependent(s) regularly used tobacco products during the six months prior to completion of the Tobacco Use Change Form. Both cross-reference planholders must sign the Tobacco Use Change Form.
6. I understand that if I answered "No" to the tobacco use question and either I or a spouse or dependent covered under my insurance plan becomes a regular tobacco user at any time, I must notify KEHP and my contribution rates will be adjusted to the tobacco-user premium contribution rates on the first day of the month following the signature date on the Tobacco Use Change Form.
7. I understand that the tobacco use question is a part of my KEHP application for health insurance coverage. Any person who knowingly, and with the intent to defraud, files an application for insurance containing any materially false information, or who conceals, for the purpose of misleading, information concerning any fact material to the application, commits a fraudulent insurance act which is a crime.
8. I understand that if I fail to answer the tobacco use questions truthfully, KEHP may adjust my contribution rates retroactively to apply the applicable higher tobacco-user premium contribution rates. Upon written notification, I will pay to KEHP the difference between the tobacco-user and the non-tobacco user premium contribution rates for the period for which I falsely certified eligibility for the non-tobacco user premium contribution rates.
9. The KEHP offers monthly discounted premium contribution rates to non-tobacco users as a part of its LivingWell wellness program. Each KEHP member has at least one opportunity per Plan Year to qualify for the discount. KEHP is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Department of Employee Insurance at **(888) 581-8834** or **(502) 564-6534** and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Terms and Conditions

Below are the Terms and Conditions for participation in group life, dental, vision, and health insurance coverage administered by the Department of Employee Insurance (DEI).

An Employee and Retiree (where applicable) may affix a signature to a paper copy of the KEHP Health Insurance Enrollment Application, the Group Life Insurance Application, the Group Dental or Vision Applications, or an electronic version of the applications. By typing your name on an electronic application or by logging in and using your unique KHRIS User ID and enrolling through the Employee Self-Service portal, you are agreeing to conduct enrollment in life, health, dental, and vision insurance coverage by electronic means, thereby creating a legal and binding contract, as well as consenting to receiving any and all records or disclosures in electronic form at the election of DEI or your employer as described in Section AA below. By affixing your signature in either manner, you understand and agree that:

A. PLAN YEAR. The 2023 Plan Year begins January 1, 2023 and ends at midnight on December 31, 2023.

B. EFFECTIVE DATE OF ELECTIONS. If you are electing a health plan, dental plan, vision plan, or a Flexible Spending Account (FSA) during open enrollment, the coverage will be effective January 1 of the following Plan Year. If you are a new employee or a newly eligible employee electing insurance coverage or an FSA outside of open enrollment, the FSA and your insurance coverage will be effective the first day of the second month after a new employee or newly eligible employee is eligible to enroll. Employees enrolling in life insurance must be actively at work, full time, on the day the employee's insurance is scheduled to begin.

C. PLAN INFORMATION. You have read and understood the 2023 Benefits Selection Guide (BSG). Plan rules and limitations are contained in the KEHP Summary Plan Descriptions (SPD) or Medical Benefit Booklets (MBB) and the Summary of Benefits and Coverage (SBC). Life, dental, and vision insurance rules and limitations are outlined in Certificates of Coverage (CoC). All benefits for your eligible dependents and you will be provided in accordance with the rules and limitations in the SPDs, MBBs, BSG, SBCs, and CoCs. You will abide by all terms and conditions governing participation, membership, and receipt of services from the plan(s) in which you have enrolled and as set forth in the SPD, MBB, and CoC. In the event of a conflict between the terms of coverage stated in the SPDs, the MBBs, the BSG, the SBCs, and the CoCs, the terms of coverage stated in the SPDs or MBBs and CoCs will govern.

D. THIRD PARTY ADMINISTRATORS. DEI uses third parties, including Anthem, CVS/Caremark, HealthEquity, WebMD, SmartShopper, and Metropolitan Life Insurance Company (MetLife) to provide certain administrative functions. DEI may communicate with you directly or through these third parties about your insurance coverage, your benefits, or health-related products or services provided by or included in the Commonwealth's group health, dental, vision, or life insurance plans.

E. CROSS-REFERENCE. The cross-reference payment option for health insurance is available to spouses who are both eligible to participate in KEHP and have at least one dependent. If your spouse and you elect the cross-reference payment option for health insurance, you are planholders with family coverage. Upon a loss of eligibility by either spouse, the remaining planholder will default to a parent-plus coverage level. The cross-reference payment option ceases upon loss of eligibility or employment by either spouse/planholder.

F. DEPENDENT ELIGIBILITY. You certify that each enrolled dependent meets the dependent eligibility requirements as set forth in the SPDs, MBBs, and CoCs. DEI will require supporting documentation to verify the eligibility of any dependent enrolled or requesting to be enrolled in benefits. Spouses and stepchildren are subject to re-verification every 24 months. Your failure to properly document dependent eligibility will result in the termination of the unverified dependent from your insurance plan(s).

G. CHANGING ELECTIONS. The elections indicated by your KEHP Health Insurance Enrollment Application, Group Dental or Vision Application, Group Life Insurance Application, or online enrollment may not be changed or cancelled during the Plan Year without a permitted Qualifying Event.

H. DEDUCTION FROM EARNINGS. When you enroll in insurance coverage (health, dental, vision, or life) or an FSA, you authorize your employer to deduct from your earnings the amount required to cover your employee contribution to the FSA and insurance coverage you elected, including any arrears you may owe. Deductions for FSA and the employee contributions to health, dental, and vision insurance are made on a pre-tax basis unless you sign a Post-Tax Request Form. Deductions for life insurance premiums are made on a post-tax basis.

I. PRIORITY OF PAYMENTS. Any moneys submitted to DEI that you intend to be used to fund your FSA or pay for insurance premium contributions may first be used to pay other priority debts that may be due and owing, such as taxes and child support.

J. CHILD AND ADULT DAYCARE FSA ELECTION AND CARRYOVER. If you choose a Child and Adult Daycare FSA, you are eligible to seek reimbursement, as authorized by 26 U.S.C. Sections 21 and 129, for dependent care expenses. You may elect to contribute up to $2,500 (or $5,000 in the case of an Employee who is married and filing jointly) into a Child and Adult Daycare FSA for Plan Year 2023. The Child and Adult Daycare FSA may only reimburse eligible dependent care expenses that are incurred during the applicable coverage period. Funds in your Child and Adult Daycare FSA may only be used to reimburse eligible child and adult daycare expenses and may not be refunded upon termination of the FSA for any reason. Funds contributed into a Child and Adult Daycare FSA will not carryover to the next plan year.

K. HEALTHCARE FSA ELECTION AND CARRYOVER. You may elect to contribute up to $2,850 into a Healthcare FSA for Plan Year 2023 to pay for eligible health care expenses not paid for by your health insurance plan. Unused amounts of at least $50 and up to a maximum of $570 remaining in your Healthcare FSA at the end of the Plan Year will carry over to the next Plan Year and may be used to reimburse you for eligible expenses that are incurred during the subsequent Plan Year. You may use the Healthcare FSA carry over amounts whether or not you elect a Healthcare FSA for the subsequent Plan Year. Amounts over $570 remaining in your Healthcare FSA at the end of the Plan Year are forfeited. All funds remaining in a Healthcare FSA account where there have been no new contribution elections for two consecutive Plan Years will be forfeited.

L. HEALTHEQUITY HEALTHCARE CARD. HealthEquity will administer FSAs and HRAs for the 2023 Plan Year and will issue a HealthEquity Healthcare Card to you for the payment of eligible Healthcare FSA and HRA expenses. Your HealthEquity Healthcare Card will be suspended if requested claim verification is not sent to HealthEquity within ninety (90) days after the card swipe. You agree to follow all rules and guidelines established by the Plan concerning the HealthEquity Healthcare Card. The Plan reserves the right to deny access to the card, require repayment, deduct/withhold from your paycheck, and offset your Healthcare FSA or HRA if you fail to verify a claim.

M. WAIVING HEALTH INSURANCE COVERAGE. If you elect to waive KEHP health insurance coverage, with or without a Waiver Health Reimbursement Arrangement (HRA), you are doing so voluntarily. If your employer participates in the Waiver HRA program, there are two options available: the Waiver General Purpose HRA and the Waiver Limited Purpose HRA. You understand that you will be eligible for the Waiver General Purpose HRA only if you have other group health plan coverage. You further understand that your spouse and eligible dependents, if applicable, cannot be covered under the Waiver General Purpose HRA unless your spouse and dependents also have other group health plan coverage.

N. WAIVER GENERAL PURPOSE HRA RULES. If you elect a Waiver General Purpose HRA, you declare that you and your spouse and dependents, if applicable, are enrolled in another group health plan that provides minimum value. A "group health plan" refers to coverage provided by an employer, an employer organization, or a union. A "group health plan" does not include individual policies purchased through the Marketplace or governmental plans such as TRICARE, Veteran's Benefits, Medicare, or Medicaid. A group health plan that provides "minimum value" means the plan pays at least 60% of the total allowed cost of covered benefits/services and participants or members in the plan are required to pay no more than 40% of the total allowed cost of covered benefits/services. If you elect a Waiver General Purpose HRA and cease to be covered under another group health plan that provides minimum value, you agree to notify KEHP within 35 days of the date that the other group health plan coverage ceased. In this event, coverage under the Waiver General Purpose HRA will be terminated and you may elect a KEHP health insurance plan option or the Waiver Limited Purpose HRA. Unused funds remaining in the Waiver General Purpose HRA upon termination are forfeited. You are permitted to permanently opt out of and waive future reimbursements from the Waiver General Purpose HRA at least annually at open enrollment.

O. HRA CARRYOVER. Waiver HRAs: Unused amounts up to and including $2,100 remaining in your Waiver HRA at the end of the Plan Year may be carried over to the next Plan Year provided you are eligible to elect an HRA. CDHP Integrated HRAs: Unused amounts up to and including $7,500 remaining in your CDHP Integrated HRA at the end of the Plan Year may be carried over to the next Plan Year. You must elect the same type of HRA in a subsequent Plan Year for the funds to carry over.

P. WAIVER HRA/FSA FUNDS AFTER TERMINATION. You may use funds remaining in a Waiver HRA or FSA after termination to reimburse you for eligible expenses incurred during the coverage period and prior to termination of the HRA or FSA. Upon termination of employment, including retirement, the remaining amounts in a Waiver HRA and FSA are forfeited, except that you may be reimbursed for any eligible expenses incurred prior to the last day of the last pay period worked, provided that you file a claim by March 31 following the close of the Plan Year in which the expense was incurred.

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Q. HRA AND FSA EXPENSE REIMBURSEMENT. An HRA and/or Healthcare FSA may only reimburse you for medical expenses, as authorized by 26 U.S.C. Sections 105(b) and 213(d), that are incurred during the applicable coverage period. Federal law now permits you to use your HealthEquity card to pay for over-the-counter (OTC) medications, drugs, menstrual care products, and certain personal protective equipment such as face masks, hand sanitizer, and sanitizing wipes. The Waiver Limited Purpose HRA may only reimburse you for eligible dental and vision expenses. If you have an FSA and an HRA, funds for eligible expenses will be reimbursed from your FSA first before being reimbursed from your HRA.

R. HRA AND FSA RUN-OUT PERIOD. You have a 90-day run-out period (until March 31) for reimbursement of eligible FSA and HRA expenses incurred during the period of coverage.

S. MINIMUM ESSENTIAL COVERAGE. KEHP provides plan options that, under the Affordable Care Act, constitute minimum essential coverage that is affordable and provides a minimum value. As such, by receiving an offer of coverage through your employer, neither you, your spouse, nor your dependent(s) are eligible for a health insurance premium tax credit if purchasing insurance through the Marketplace.

T. COORDINATION OF KEHP HEALTH PLANS AND MEDICARE COVERAGE. In general, the four KEHP plan options and the Waiver General Purpose HRA must pay primary to Medicare. The Waiver Limited Purpose HRA pays secondary to Medicare.

U. LIVINGWELL PROMISE. Federal law allows KEHP to reward members who participate in the KEHP's LivingWell wellness program. In 2023, all three KEHP health plans are a part of the KEHP's LivingWell wellness program and require completion of the LivingWell Promise in order to receive premium discounts in Plan Year 2024.

If you fulfilled your LivingWell Promise in 2022, you will receive a monthly premium discount of $40.00 in 2023. If you did not fulfill your LivingWell Promise, you will not receive a monthly premium discount of $40.00 in 2023.

If you elect a KEHP health plan in 2023, you must complete either (1) an online WebMD Health Assessment; OR (2) a biometric screening between January 1, 2023, and July 1, 2023, to receive a premium discount in 2024.

If you are a new employee with a hire date after January 1, 2023, and you choose a LivingWell plan option outside of open enrollment, you will not be required to complete the LivingWell Promise to receive the premium discount in 2024.

V. INSURANCE DEPENDENT ELECTIONS AND PREMIUM REFUND. It is your responsibility to timely notify DEI that either your dependent or your spouse is no longer eligible for life insurance coverage. (See the eligibility provisions CoC for more information on eligibility). "Timely" notice means that you advised DEI that a dependent or spouse is no longer eligible for insurance coverage within 90 days of the loss of eligibility. Upon notice that a dependent or spouse is no longer eligible for insurance coverage, DEI will refund your premium back to the date that eligibility ceased, up to a maximum of 90 days.

W. HIPAA. You have rights under HIPAA regarding the protection of your health information. KEHP will comply with the HIPAA Privacy and Security rules, and uses and disclosures of your protected health information will be in accordance with federal law. KEHP may use and disclose such information to business associates or other third parties only in accordance with KEHP's Notice of Privacy Practices available at kehp.ky.gov (Resources/Docs, Forms, and Legal Notices link).

X. FRAUD WARNING. Any person who knowingly, and with the intent to defraud, files an application for insurance containing any materially false information (including a forged signature or incorrect signature date), or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime. You can be held responsible for any fraudulent act that you could have prevented while acting within your duties related to obtaining employer-sponsored health, dental, vision, and life insurance, and it may be used to reduce or deny a claim or to terminate your coverage. Information contained in your life insurance benefit elections, if incorrect or misleading, may void the policy effective as of the date of issuance.

Y. ACKNOWLEDGEMENT. You have fully read these Terms and Conditions, the KEHP Legal Notices, and the KEHP Tobacco Use Declaration. Your signature on the KEHP Health Insurance Enrollment Application, the Group Dental or Vision Applications, the Group Life Insurance Application, or your electronic signature used for online enrollment certifies that all information provided during this enrollment opportunity is correct to the best of your knowledge.

Z. EXCEPTIONS MAY APPLY. Exceptions may apply to employees of certain employers participating in KEHP's health plan and the Commonwealth's group dental, vision, and life insurance benefits. Exceptions may also apply to KTRS, KPPA, KCTCS, LRP, and JRP retirees. Please refer to the participation rules of your employer or retirement system for further information.

AA. CONSENT TO ELECTRONIC DISCLOSURES. You consent to receiving any and all communications, including records, disclosures, or coverage information (or any portion of the same) in electronic form, including by email or through KHRIS, at the election of DEI, the Insurance Coordinator/Human Resource Generalist communicating on DEI's behalf, or a vendor utilized by DEI or your employer for the administration of your insurance benefits. You may still receive paper documents from time to time, or may be required to complete and sign paper documents. You also acknowledge that you may print or save any electronic communication or agreement for your records and later review. You must have access to a computer and web browser that is sufficiently up to date to access the KEHP/KHRIS website and access to an email that accepts external email. You may request a paper copy of any electronic record or disclosure by contacting your employer's insurance coordinator. A fee may be charged for each paper copy. You may withdraw consent to obtain electronic records and notices by contacting your employer's insurance coordinator with the request and filling out any necessary form.

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