Plan Year 2003

Office of Public Employee Health Insurance

OPEHI

Personnel Cabinet
Public Employee
Health Insurance Handbook

For Your Record

This Health Insurance Handbook has been created as a resource for your use not only during Open Enrollment but also during the year. Use this page to keep a record of anyone you may have talked with during Open Enrollment. This page is provided for your personal documentation and is in no way binding in the event of inconsistency with your application.

Agency Health Insurance Coordinator	**Phone #**	**Date of Call**
Carrier Contact	**Phone #**	**Date of Call**
OPEHI Contact	**Phone #**	**Date of Call**

Did you have to complete and turn in an application? If so, to whom did you give the application and on what date?

What carrier and plan type did you choose?

What county did you use to select your coverage?

What deduction will be taken from your check each month? Will the deduction be taken once or twice a month?

Keep this handbook and your copy of any applications you may have completed during Open Enrollment.

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HEALTH INSURANCE
ANNUAL OPEN ENROLLMENT PERIOD
PLAN YEAR 2003

ACTIVE EMPLOYEES

SEPTEMBER 16 – OCTOBER 4, 2002
(Deadline to turn in your application to your Health Insurance Coordinator is October 4, 2002)

RETIREES

SEPTEMBER 16 – OCTOBER 18, 2002
(Deadline to turn in your application to the appropriate Retirement System is October 18, 2002)

COBRA PARTICIPANTS

SEPTEMBER 16 – OCTOBER 18, 2002
(Deadline to turn in your applications to your health insurance carrier is October 18, 2002)

How do I use this handbook?

1. **PLEASE MAKE SURE YOU READ THE ENTIRE BOOK.** Your Health Insurance Handbook is your guide to making an informed choice for your health insurance coverage. Compare the plans carefully.

2. Read through the "New for 2003" (page 7-9) and the "Benefit Updates" (page 36-37) for a quick overview of the changes.

3. Review the Plan Types and Benefit Grids on pages 38-45 to determine the type of plan that will best meet your medical needs.

4. Review the availability chart on pages 12-16 to check plan availability in either the county where you live, work or, if applicable, a contiguous county (refer to page 8-9).

5. Review the rate chart on page 11 to check premiums.

A **contiguous county** is a county in Kentucky that shares any portion of its border with another county within the State of Kentucky listed in the "Contiguous County" chart on page 9

NEED HELP?

Call the OPEHI's Member Services Branch at
1-888-581-8834
1-502-564-6534

What Is This Information and Why Do I Need It?

This Health Insurance Handbook has been provided to help you understand what insurance options are available. Health insurance is one of your most valuable employee benefits. Familiarize yourself with the topics in this book and recognize your responsibility regarding eligibility and enrollment requirements.

The Office of Public Employee Health Insurance (OPEHI) within the Personnel Cabinet is responsible for administering the Public Employee Health Insurance Program. We hope you will find this information helpful, useful and easy to understand. Please contact OPEHI if you have any questions regarding your health insurance for 2003.

FAILURE TO MEET THE PLAN REQUIREMENTS MAY RESULT IN DENIED CLAIMS OR A BENEFIT REDUCTION TO YOU. READ THIS HANDBOOK AND YOUR CERTIFICATE OF COVERAGE (MEMBER HANDBOOK FROM YOUR CARRIER) CAREFULLY.

New for 2003

- **The service area for most carriers has changed.** Be sure to check the availability of your carrier in the county where you live or work or, if applicable, a contiguous county (refer to page 8-9). If your current carrier is no longer available in the county where you have selected your health insurance or doesn't offer your current plan type, you **MUST** complete a new application to change carriers or change your county selection, if applicable. Failure to do so will result in auto-assignment to the lowest cost Single Option A health insurance plan available in the county where you live. **Please Note**: Auto-assignment is to a single plan. Your spouse and/or other dependents will not be insured if you are auto-assigned.

- If it is necessary for you to complete an application for health insurance or a waiver for 2003, and you do not do so, your Health Insurance Coordinator will automatically assign (auto-assign) you to the lowest cost Single Option A plan available in the county in which you **live**. If you are auto-assigned, you will **NOT** be allowed to make a change in your health insurance until the next Open Enrollment period unless you experience a Qualifying Event that would allow you to do so.

- Employees/retirees who have a baby born on or after January 1, 2003 will be allowed up to 60 days to complete an application to add the newborn. If you plan to make any changes other than adding the newborn after the birth of a baby, the new application **MUST** be completed and signed no later than 30 days following the birth (e.g. adding additional eligible dependents).

- Persons wishing to make ANY change (including but not limited to: changing county selection, adding or removing dependents, changing levels of coverage, changing carriers, changing payment option or enrolling for the first time) in their health insurance coverage **MUST** complete a new application for 2003.

- If you waived your health insurance coverage in 2002, and you wish to waive for 2003, you **MUST** complete Sections I, V and VI of the 2003 Health Insurance Application.

- If you wish to participate, or continue to participate, in a Flexible Spending Account (FSA), you MUST complete the appropriate FSA enrollment form. This form is separate from your health insurance application. **Retirees are not eligible for participation in the Flexible Spending Accounts.**

- For active employees, applications signed after October 4, 2002 will not be accepted. For retirees of the Kentucky Retirement Systems, Judicial/Legislators Retirement plans, and Kentucky Teachers' Retirement System, applications signed after October 18, 2002 will not be accepted.

County Selection:

Legislation was passed during the 2002 Regular Legislative Session allowing employees who live **and** work in certain counties (referred to as contiguous counties) an additional choice in selecting their health insurance coverage.

Please read the following section carefully as it does not apply to all counties in the Commonwealth.

A contiguous county is a county in Kentucky that shares any portion of its border with another county within the State of Kentucky listed in the "Contiguous County" chart below.

What are my options if I live and work in a contiguous county?

If you live **and** work in any of the contiguous counties listed on the Contiguous County Chart on page 9, you may select your coverage in that county or in the county listed directly to the right that is highlighted in blue.

Example:

If you live **and** work in either of the 3 counties listed below:			You may also select plans available in Pike County
Martin	Knott	Letcher	Pike

This means, if you live **and** work in Martin County, you are eligible to select the plans available in Martin or Pike County.

Contiguous County Chart							
Contiguous Counties							Counties for Insurance Selection
Hart	Metcalfe	Monroe	Allen	Edmonson			Barren
Mercer	Garrard	Lincoln	Casey	Marion	Washington		Boyle
Trigg	Caldwell	Muhlenberg	Todd				Christian
Hancock	Ohio	McLean					Daviess
Scott	Bourbon	Clark	Madison	Jessamine	Woodford		Fayette
Martin	Johnson	Magoffin	Breathitt	Knott			Floyd
Bullitt	Nelson	Larue	Hart	Grayson	Breckinridge	Meade	Hardin
Union	Webster	McLean					Henderson
Crittenden	Webster	McLean	Muhlenberg	Caldwell			Hopkins
Oldham	Shelby	Spencer	Bullitt				Jefferson
Ballard	Carlisle	Graves	Marshall	Livingston			McCracken
Knott	Letcher	Harlan	Leslie	Clay	Owsley	Breathitt	Perry
Martin	Knott	Letcher					Pike
Laurel	McCreary	Wayne	Russell	Casey	Lincoln	Rockcastle	Pulaski
Allen	Simpson	Logan	Edmonson	Butler			Warren

If you are interested in choosing your coverage with a carrier in one of the counties in blue in the above Contiguous County chart, you MUST contact that carrier to obtain provider information. The carrier may not be offered in your live and work county. If you want to make this choice, you MUST complete a new health insurance application and you MUST mark “Contiguous County”.

Note: This legislation does not impact your benefits or your carrier’s provider network. This is simply an additional option for selecting coverage for employees who live **and** work in specific counties.

What Is The Monthly Employer/Retirement Contribution?

Employer/Retirement contribution

For the 2003 plan year, the monthly employer/retirement system contribution is $234.00. If you select coverage in a county where the lowest cost Single, Option A plan will cost more than $234.00, the employer/retirement contribution will be an amount equal to that cost (refer to the Rate Chart on page 11). If you are able to purchase a plan for less than $234.00, you will receive the monthly contribution of $234.00. Any excess funds may be available for a Health Care Flexible Spending Account, if you are eligible and you complete the appropriate application.

NOTE: The maximum monthly employer contribution to a Health Care Flexible Spending Account will be $234.00.

Payment options

State employees may choose to have their portion of the health insurance premium split between the two paychecks received each month (including single and cross-reference plans). This means one-half of the employee's share of the premium will be deducted from the check received on the 15th of the month and the other half will be deducted from the check received on the 30th of the month. Premiums are paid one month in advance. For example: Your first half of the January 2003 premium will be deducted from the check you receive on December 15, 2002. You may choose the twice-monthly option by marking the "Twice Monthly" box on the application in Section II, # 5. If no option is marked, you will be defaulted to twice monthly.

If you currently pay monthly and would like to pay twice monthly, you MUST complete a new application to receive the twice-monthly payment option.

Paying your premiums with tax free dollars (Premium Conversion)

State Employees – The Premium Conversion program allows you to pay your health insurance premiums with pre-tax dollars. This saves you money. You are automatically enrolled unless you sign a cancellation form. Anyone who has already cancelled out of this program and now wishes to participate MUST complete an enrollment form. Contact your Health Insurance Coordinator for a re-enrollment form.

It is your responsibility to make sure the correct deductions are coming out of your paycheck.

$$$$$$

2003 Health Insurance Rates

Once you have selected a plan, enter the three (3) digit code number that corresponds to that plan on the application in the boxes provided in Section II, #6, Plan Choice. For employer/retirement contribution information, refer to page 10.

CODE	HMO	SINGLE		PARENT PLUS		COUPLE		FAMILY	
		A	B	A	B	A	B	A	B
091	Bluegrass Family Health	331.12	298.00	496.68	447.00	745.04	670.52	827.80	745.04
101	CHA Health	315.04	283.68	472.56	425.52	708.84	638.28	787.60	709.20
151	Humana – MBP	342.80	308.52	514.20	462.84	771.28	694.20	857.00	771.36

CODE	POS	SINGLE		PARENT PLUS		COUPLE		FAMILY	
		A	B	A	B	A	B	A	B
092	Bluegrass Family Health	403.28	362.96	604.92	544.44	907.40	816.68	1008.20	907.40
102	CHA Health	354.56	319.20	531.84	478.80	797.76	718.20	886.40	798.00
162	Humana	467.76	421.00	701.64	631.56	1052.48	947.24	1169.44	1052.52

CODE	PPO	SINGLE		PARENT PLUS		COUPLE		FAMILY	
		A	B	A	B	A	B	A	B
333	Anthem Blue Access PPO	397.08	357.44	595.76	536.12	893.52	804.20	992.80	893.56
093	Bluegrass Family Health	278.76	250.88	418.12	376.32	627.24	564.52	696.92	627.24
103	CHA Health	269.44	242.56	404.16	363.84	606.24	545.76	673.60	606.40
143	Humana	292.00	262.80	438.00	394.24	657.00	591.32	730.00	657.04

THERE ARE NO OUT-OF-NETWORK SERVICES FOR THE EPO PLAN.

CODE	EPO	SINGLE	PARENT PLUS	COUPLE	FAMILY
335	Anthem Blue Access PPO	293.80	440.68	661.00	734.48
095	Bluegrass Family Health	215.24	322.88	484.28	538.12
105	CHA Health	211.04	316.56	474.84	527.60
145	Humana PPO	215.00	322.52	483.76	537.52

Commonwealth of Kentucky
Healthcare 2003
Availability Chart

	Anthem BC/BS				Bluegrass Family Health				CHA				Humana				Employer Contribution OR Lowest Cost Single Opt A Plan
	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	
	331	332	333	335	091	092	093	095	101	102	103	105	151	162	143	145	
1 - Adair																	$ 269.44
2 - Allen																	$ 278.76
3 - Anderson																	$ 269.44
4 - Ballard																	$ 278.76
5 - Barren																	$ 292.00
6 - Bath																	$ 269.44
7 - Bell																	$ 269.44
8 - Boone																	$ 269.44
9 - Bourbon																	$ 269.44
10 - Boyd																	$ 397.08
11 - Boyle																	$ 278.76
12 - Bracken																	$ 269.44
13 - Breathitt																	$ 269.44
14 - Breckinridge																	$ 278.76
15 - Bullitt																	$ 292.00
16 - Butler																	$ 278.76
17 - Caldwell																	$ 278.76
18 - Calloway																	$ 278.76
19 - Campbell																	$ 269.44
20 - Carlisle																	$ 278.76
21 - Carroll																	$ 292.00
22 - Carter																	$ 397.08
23 - Casey																	$ 269.44
24 - Christian																	$ 278.76
25 - Clark																	$ 269.44
26 - Clay																	$ 269.44

Blue highlighted areas indicate carrier's product that is available in the county

*See Additional Carrier Availability Grid for contribution information

Commonwealth of Kentucky
Healthcare 2003
Availability Chart

	Anthem BC/BS				Bluegrass Family Health				CHA				Humana				Employer Contribution OR Lowest Cost Single Opt A Plan
	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	
	331	332	333	335	091	092	093	095	101	102	103	105	151	162	143	145	
27 - Clinton																	$ 269.44
28 - Crittenden																	$ 278.76
29 - Cumberland																	$ 269.44
30 - Daviess																	$ 397.08
31 - Edmonson																	$ 278.76
32 - Elliott																	$ 397.08
33 - Estill																	$ 269.44
34 - Fayette																	$ 269.44
35 - Fleming																	$ 269.44
36 - Floyd																	$ 269.44
37 - Franklin																	$ 269.44
38 - Fulton																	$ 278.76
39 - Gallatin																	$ 269.44
40 - Garrard																	$ 278.76
41 - Grant																	$ 269.44
42 - Graves																	$ 278.76
43 - Grayson																	$ 278.76
44 - Green																	*
45 - Greenup																	$ 397.08
46 - Hancock																	$ 397.08
47 - Hardin																	$ 292.00
48 - Harlan																	$ 269.44
49 - Harrison																	$ 278.76
50 - Hart																	*
51 - Henderson																	$ 397.08
52 - Henry																	$ 278.76

Blue highlighted areas indicate carrier's product that is available in the county

*See Additional Carrier Availability Grid for contribution information

Commonwealth of Kentucky
Healthcare 2003
Availability Chart

	Anthem BC/BS				Bluegrass Family Health				CHA				Humana				Employer Contribution OR Lowest Cost Single Opt A Plan
	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	
	331	332	333	335	091	092	093	095	101	102	103	105	151	162	143	145	
53 - Hickman																	$ 278.76
54 - Hopkins																	$ 292.00
55 - Jackson																	$ 269.44
56 - Jefferson																	$ 292.00
57 - Jessamine																	$ 269.44
58 - Johnson																	$ 269.44
59 - Kenton																	$ 269.44
60 - Knott																	$ 269.44
61 - Knox																	$ 269.44
62 - Larue																	$ 292.00
63 - Laurel																	$ 269.44
64 - Lawrence																	$ 397.08
65 - Lee																	$ 269.44
66 - Leslie																	$ 269.44
67 - Letcher																	$ 269.44
68 - Lewis																	$ 269.44
69 - Lincoln																	$ 278.76
70 - Livingston																	$ 278.76
71 - Logan																	$ 278.76
72 - Lyon																	$ 278.76
73 - McCracken																	$ 278.76
74 - McCreary																	$ 269.44
75 - McLean																	$ 397.08
76 - Madison																	$ 269.44
77 - Magoffin																	$ 269.44
78 - Marion																	$ 278.76

Blue highlighted areas indicate carrier's product that is available in the county

*See Additional Carrier Availability Grid for contribution information

Commonwealth of Kentucky
Healthcare 2003
Availability Chart

	Anthem BC/BS				Bluegrass Family Health				CHA				Humana				Employer Contribution OR Lowest Cost Single Opt A Plan
	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	
	331	332	333	335	091	092	093	095	101	102	103	105	151	162	143	145	
79 - Marshall																	$ 278.76
80 - Martin																	$ 269.44
81 - Mason																	$ 269.44
82 - Meade																	$ 292.00
83 - Menifee																	$ 269.44
84 - Mercer																	$ 278.76
85 - Metcalfe																	$ 278.76
86 - Monroe																	$ 278.76
87 - Montgomery																	$ 269.44
88 - Morgan																	$ 269.44
89 - Muhlenburg																	$ 278.76
90 - Nelson																	$ 292.00
91 - Nicholas																	$ 269.44
92 - Ohio																	$ 278.76
93 - Oldham																	$ 278.76
94 - Owen																	$ 269.44
95 - Owsley																	*
96 - Pendleton																	$ 269.44
97 - Perry																	$ 269.44
98 - Pike																	$ 269.44
99 - Powell																	*
100 - Pulaski																	$ 269.44
101 - Robertson																	$ 269.44
102 - Rockcastle																	$ 269.44
103 - Rowan																	$ 269.44
104 - Russell																	$ 269.44

Blue highlighted areas indicate carrier's product that is available in the county

*See Additional Carrier Availability Grid for contribution information

Commonwealth of Kentucky
Healthcare 2003
Availability Chart

	Anthem BC/BS				Bluegrass Family Health				CHA				Humana				Employer Contribution OR Lowest Cost Single Opt A Plan
	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	
	331	332	333	335	091	092	093	095	101	102	103	105	151	162	143	145	
105 - Scott																	$ 269.44
106 - Shelby																	$ 292.00
107 - Simpson																	$ 278.76
108 - Spencer																	$ 292.00
109 - Taylor																	$ 278.76
110 - Todd																	$ 278.76
111 - Trigg																	$ 397.08
112 - Trimble																	$ 278.76
113 - Union																	$ 397.08
114 - Warren																	$ 278.76
115 - Washington																	$ 278.76
116 - Wayne																	$ 269.44
117 - Webster																	$ 292.00
118 - Whitley																	$ 269.44
119 - Wolfe																	$ 269.44
120 - Woodford																	$ 269.44

Blue highlighted areas indicate carrier's product that is available in the county

*See Additional Carrier Availability Grid for contribution information

Personnel Cabinet
Office of Public Employee Health Insurance

Additional Carrier Availability
for Plan Year 2003

County	Carrier	Products Offered by Additional Carrier	2003 Employer Contribution Published in Handbook	2003 Contribution Depending on Carrier Selected
Anderson	Bluegrass Family Health		$269.44	$269.44
	CHA Health		$269.44	$269.44
	Humana	HMO/POS/PPO/EPO		$269.44
Edmonson	Bluegrass Family Health		$278.76	$278.76
	Humana	PPO/EPO		$278.76
Green	**Bluegrass Family Health**	PPO *		$278.76
	Humana		$292.00	$292.00
Hart	**Bluegrass Family Health**	PPO *		$278.76
	Humana		$292.00	$292.00
Owen	Bluegrass Family Health		$269.44	$269.44
	CHA Health		$269.44	$269.44
	Humana	HMO/POS/PPO/EPO		$269.44
Owsley	Bluegrass Family Health		$278.76	$278.76
	CHA Health	HMO/POS/PPO/EPO		$269.44
	Humana	PPO/EPO		$278.76
Powell	**Bluegrass Family Health**	HMO/POS/PPO/EPO		$278.76
	CHA Health	HMO/POS/PPO/EPO		$269.44
	Humana		$292.00	$292.00

*Bluegrass Family Health is currently offering HMO, POS and EPO. The PPO product is additional product

Highlighted carriers are additional carriers

09/24/2002

General Provisions of the Public Employee Health Insurance Program

- Although there is a couple cross-reference level of coverage available, it may be less expensive to choose two single plans. You need to decide which is the best choice for you.

- Dependent children may be covered on your health insurance up to the age of 24 (end of month in which he or she turns 24) without regard to student status. Dependent children beyond age 24 must meet criteria outlined on page 18-19 to remain eligible for health insurance. Your dependent(s) over age 24 will be removed from your plan at the end of the month in which they turn 24. If removing this dependent from your plan will change your level of coverage, we recommend that you complete a new application to ensure you have the appropriate level of coverage. If a new application is not completed, you will be assigned to the appropriate couple or single plan depending on your current level of coverage.

- Except for Open Enrollment, dependents cannot be dropped from your plan unless a Qualifying Event(s) occurs allowing the removal of such dependents. Contact your Health Insurance Coordinator or OPEHI's Member Services Branch if you have questions regarding Qualifying Events.

- Dependents dropped from your plan during Open Enrollment are NOT eligible for COBRA continuation coverage unless the removal is due to a Qualifying Event (make sure your Health Insurance Coordinator knows that the change is related to a Qualifying Event instead of an Open Enrollment change). Only persons who are dropped from your plan due to a COBRA Qualifying Event, will be offered COBRA.

- If you are an active employee and live outside of Kentucky, but work in Kentucky, you must choose a carrier that is available in the Kentucky county where you work.

Who is Eligible to Participate in the Public Employee Health Insurance Program?

Eligible participants

Full time employees of the following agencies are eligible to participate:

- State Agencies
- Boards of Education
- Health Departments
- KCTCS
- Members of additional groups whose employers pay into a state-sponsored retirement system and have elected to participate in the Public Employee Health Insurance Program.

Retirees, under age 65, who draw a monthly retirement check from any of the following retirement systems are eligible to participate:

- Kentucky Retirement Systems (KRS)
- Kentucky Teachers' Retirement System (KTRS)
- Judicial Retirement Plan
- Legislators Retirement Plan

Other eligible participants

- Eligible COBRA participants.

Employees, retirees, COBRA participants and/or their dependents may only be covered under **one** state-sponsored plan.

Who can you cover under your state-sponsored health plan?

The following persons are considered dependents of an employee, retiree, or COBRA participant and are eligible for coverage under the employee's/ retiree's state-sponsored health plan:

- An employee's legal spouse,
- An employee's legal children (natural, adopted, step and foster) up to the age of 24 who meet the definition of a dependent child as follows:
  - The child must depend on the employee or spouse of the employee for 50% or more of his/her support and must also live with the employee in a parent-child relationship OR the employee or the spouse of the employee must have a court order or an administrative order from the Cabinet for Families and Children to provide for the health care expenses of the child. These dependent children will be covered through the last day of the month in which they turn 24 years of age.
- An employee's grandchildren who are considered dependents for federal tax purposes and for whom the employee has filed the required notarized statement;
- An employee's unmarried dependents who are incapable of self-support due to a physical or mental disability that occurred BEFORE the dependent's 24th birthday and who are also dependent upon the employee or retiree for support and maintenance are eligible to remain on the employee's or retiree's plan beyond the age of 24. A doctor's statement must be

provided with the application that documents: 1) that the child cannot work for a living because of a physical or mental disability, and 2) the date of onset of the illness. Your carrier may verify this annually.

For divorced employees who are both eligible for the Public Employee Health Insurance Program, the children can only be covered under one state-sponsored plan.

Benefit Fairs

The OPEHI will be conducting benefit fairs in the following locations: *

BOYD
September 25, 2002

CHRISTIAN
September 25, 2002

FAYETTE
September 18, 2002
3:30 p.m. – 6:00 p.m.

FRANKLIN
September 18, 2002
8:00 a.m. – 6:00 p.m.

JEFFERSON
September 17, 2002

LAUREL
September 12, 2002

PULASKI
September 20, 2002

WARREN
September 23, 2002

BREATHITT
September 9, 2002

DAVIESS
September 26, 2002

FLOYD
September 10, 2002

HARDIN
September 20, 2002

KENTON
September 23, 2002

MCCRACKEN
September 24, 2002

ROWAN
September 26, 2002

***Times are 2:00 – 6:00 p.m. unless otherwise indicated.**
Your Health Insurance Coordinator will have additional information regarding Benefit Fairs.

New Employee Information

As a new employee, what must I do?

New employees of:

- State Agencies
- Boards of Education
- Health Departments
- KCTCS

You have 30 days from the date you are hired to:

- Enroll in a plan that is offered in the county where you live or work or, if applicable, a contiguous county (refer to page 8-9);
- Waive (decline) coverage by completing Sections I, V and VI of the health insurance application.

Applications are available from your Health Insurance Coordinator.

Members of groups other than those listed above, please see your Health Insurance Coordinator for additional information.

What if I do not enroll in health coverage when I am first eligible?

If you do not turn in an enrollment form or waive no later than 30 days of your hire date, your Health Insurance Coordinator will auto-assign you to the lowest cost Single Option A plan available in the county in which you live. You will **NOT** be eligible to make a change in this plan until the next Open Enrollment Period unless you experience a Qualifying Event that would enable you to make the change.

If I do not use my employer contribution, can I use that money in a Flexible Spending Account?

If you do not use the entire employer contribution for your health insurance plan, or if you waive coverage, you may qualify for an employer contribution to a Health Care Flexible Spending Account. The money in this account may be used to pay for unreimbursed medical expenses for you and your family. For more information on the Flexible Spending Account program and to obtain an enrollment form, contact your Health Insurance Coordinator. Participation in the Flexible Spending Account program is NOT automatic. You must complete an enrollment form no later than 30 days of your employment.

Can I Waive My Health Insurance Coverage?

Yes, you have the option to waive coverage if you DO NOT want the state-sponsored health insurance. However, waiving is not automatic.

To waive coverage, you **MUST** complete Sections I, V and VI of the health insurance application and turn it in to your Health Insurance Coordinator either during the annual Open Enrollment period or no later than 30 days of your employment.

If you waive coverage because you are covered under another group plan and that coverage terminates (a Qualifying Event), you will be allowed to sign up for one of the state-sponsored health plans that is available in the county where you live or work or, if applicable, a contiguous county (refer to page 8-9). You must submit an application no later than 30 days after losing coverage. This applies even if that occurs during Open Enrollment. The effective date of coverage will be the first day of the first month from the date of the application.

If you wish to continue waiving your health insurance, you are required to complete Sections I, V and VI of the health insurance application every year during Open Enrollment. If you fail to complete the appropriate form during Open Enrollment you will be automatically assigned to the lowest cost Single Option A plan in the county in which you live. Retirees should refer to the Health Insurance Enrollment notice provided by the retirement systems for details on waivers and auto-assignments.

If I waive coverage, what will happen to the employer contribution?

If you waive your health insurance, you may be eligible to direct the employer contribution into a health care Flexible Spending Account (see below). However, in order to do so, you must complete a separate Flexible Spending Account application.

- State employees may direct the employer contribution of $234.00 to the Commonwealth Choice Health Care Spending Account.
- Board of Education employees should contact their Health Insurance Coordinator for more information about available Flexible Spending Accounts.
- Health Department employees should contact the Insurance Coordinator at their local Health Department about available Flexible Spending Accounts.
- KCTCS employees are eligible for a Flexible Spending Account Program. Contact your Health Insurance Coordinator for an enrollment form and booklet.
- Members of additional groups may be eligible for a Flexible Spending Account program. Contact your Health Insurance Coordinator.

Retirees are not eligible for participation in a Flexible Spending Account Program.

What Level of Coverage is Right for Me?

Participants in the Public Employee Health Insurance Program are eligible to enroll in the following levels of coverage:

Single – Covers the employee/retiree ONLY.

Parent Plus – Covers a married or single employee/retiree and one or more children, but does not cover the spouse (dependent information MUST be provided).

Couple – Covers an employee/retiree and his/her spouse; does not cover children (spouse information MUST be provided).

Couple Cross-Reference - If both husband and wife are eligible for the employer-paid health insurance coverage, they may choose to have both of their employer-paid premium amounts go toward a couple plan (spouse information MUST be provided).

Family – covers an employee/retiree, spouse and one or more children (dependent information must be provided).

Family Cross-Reference - If both husband and wife are eligible for the employer-paid health insurance coverage, and they also have children they wish to cover, they may choose to have both of their employer-paid premium amounts go toward a family plan (dependent information MUST be provided).

The following requirements must be met in order to cross-reference:

1. Both husband and wife must be eligible for state-sponsored health insurance from one of the following groups:

   - State Agency
   - Board of Education
   - Health Department
   - KCTCS
   - Members of additional groups whose employers pay into a state-sponsored retirement system and have elected to participate in the Public Employee Health Insurance Program.
   - Kentucky Retirement System members under age 65.
   - Kentucky Teachers' Retirement System members under age 65

2. Both must fill out an application requesting either couple or family (and indicate cross-reference). Both MUST elect coverage in the same county (in Section II, #3 of the Health Insurance Application). The two employer contributions (husband's and wife's) will be applied toward the cost of the couple or family plan and any additional premium will be divided evenly with half coming out of each spouse's check. Both employer contributions must be the same dollar amount.
3. Both must be covered by the same health insurance plan and at the same level of coverage.

NOTE: Recipients of the Judicial and Legislators Retirement Plans

are NOT eligible for cross-reference.

Reminder: You may not cross-reference with yourself.

What happens if I marry during the Plan Year and want to cross-reference with my new spouse but we are enrolled in different plans?

When two employees/retirees, enrolled in different plans, marry during the plan year, one of the employees/retirees will be allowed to change to the other spouse's plan so they may cross-reference. An application indicating this change **MUST** be made no later than 30 days after the marriage. Both spouses **MUST** complete a new application. All other requirements **MUST** be met.

What happens if my spouse becomes employed with a group participating in the Public Employee Health Insurance Program during the Plan Year?

You will now be eligible to cross-reference with the new employee. The new employee will have to choose the same plan as the current employee. An application indicating this change **MUST** be made no later than 30 days after the employee is hired. Both employees **MUST** complete a new application. All other requirements **MUST** be met.

Do I Have to do Anything During Open Enrollment and if so, What do I do?

YES, making sure you and your family have the health insurance coverage needed during 2003 is your responsibility. There are certain things that you MUST do during Open Enrollment to ensure you have the health insurance you elect. Failure to review your health insurance options may result in you and your family being covered by a plan you did not select or your family not being covered at all. **Use the following checklist while making a decision about your health insurance for 2003.**

- ❑ Review your current health insurance choices and the county in which you selected coverage (live or work). It is very important that you know this information. For example, if you selected your health insurance in the county in which you live, your carrier may not be available in that county in 2003, but it may be available in the county in which you work. If so, you MUST complete a new application to change your county selection. If you do not complete an application, you will be auto-assigned to the lowest cost Single Option A plan in the county where you live.

- ❑ Refer to pages 12-16 of this handbook to review which carriers are available in the county where you live or work or if applicable, a contiguous county (refer to page 8-9). If you are an employee and live outside of Kentucky, you must choose a carrier that is available in the Kentucky county where you work. If you are a retiree, you must choose a plan available where you live or if applicable, a contiguous county.

- ❑ Compare the benefits of each plan type: HMO, POS, PPO and EPO. Decide which one best meets your needs. Refer to pages 38-45 for a description of each plan type.

- ❑ Check the rate chart on page 11 of this handbook. Premiums have changed.

- ❑ Check the provider directory for each of the carriers available in the county where you live or work or if applicable, a contiguous county (refer to page 8-9) to see if your current doctor(s) participates with that carrier. Please call the doctor(s) of your choice to verify that he or she is still a participating provider with your specific plan, as provider directories are subject to change. Be specific when calling your doctor. Do not just ask if they participate with a specific carrier – specify the product (HMO, POS, PPO or EPO). Many carriers have different networks for different products. A doctor may not participate in all products. Keep in mind that providers may discontinue participating with carriers at any time during the year. This is not considered a Qualifying Event for purposes of changing your health insurance coverage.

- ❑ Prescription medications make up a large part of your personal medical expenses. It is important to get a copy of the new drug formulary (or preferred drug list) for 2003 from the carriers you are considering. This formulary is subject to change during the plan year with a 30-day notice to affected employees/retirees.

Where Will I Land?

What will happen if I do not complete an application during Open Enrollment for Plan Year 2003?

If you currently:	and you DO NOT complete the appropriate forms during Open Enrollment,	then on January 1, 2003, you will:
waive coverage	→	be auto-assigned to the lowest cost Single Option A health insurance plan available in your home county.
participate in a Flexible Spending Account	→	not be enrolled in the Flexible Spending Account for 2003, and deductions will not be taken.
are enrolled with a carrier that is no longer available in the county in which you selected coverage	→	be auto-assigned to the lowest cost Single Option A health insurance plan available in the county in which you live.
are enrolled with a carrier that will still be offered in your selected county for 2003	→	remain covered through that same carrier and the same plan at the same level of coverage. Deductions taken from your paycheck will change accordingly.

There are many changes in carrier availability for 2003. Carrier rates have changed. Be sure to read all information in this handbook and any information you receive from the carriers prior to making your decision.

Reminder: If you are auto-assigned, you will NOT be allowed to make changes to your health insurance until the 2004 Plan Year Open Enrollment or until you experience an appropriate Qualifying Event. All changes made to your health insurance due to a Qualifying Event must follow all Federal Laws and Regulations and the changes must be consistent with the Qualifying Event.

Effective Dates and Termination Dates

Effective Dates

Open Enrollment

What is the effective date of my coverage (when does my coverage begin)?

- Anyone making a change during this Open Enrollment period or any dependents added to your existing plan during Open Enrollment will have coverage beginning January 1, 2003.

New Employees

- For employees of:

  - State Agencies
  - Boards of Education
  - Health Departments
  - KCTCS

Coverage of a new employee or any person picking up coverage due to most Qualifying Events will begin the first day of the second calendar month following employment or the Qualifying Event.

Members of groups other than those listed above, please see your Health Insurance Coordinator regarding effective dates.

Qualifying Events

All coverage changes made outside of Open Enrollment due to a Qualifying Event are effective after the event with the exception of birth, adoption and placement for adoption. You must contact your Health Insurance Coordinator or the OPEHI Member Services Branch for the effective dates.

Termination Dates

When does coverage terminate (end)?

- Dependents who are dropped from your plan during this Open Enrollment period will be covered until December 31, 2002. **Dependents dropped during Open Enrollment are NOT eligible for COBRA, unless the reason for removal is a COBRA Qualifying Event. (Anticipation of legal separation or divorce may be an exception). Refer to page 27 for examples of Qualifying Events.**

- Coverage of dependents who are dropped from your plan **outside** of Open Enrollment, due to divorce or becoming ineligible under the policy, will stop at the end of the month of the disqualifying event. All other coverage ends the last day of the month following the month in which the Qualifying Event occurs.

- Employees who terminate employment or retire will be covered until the end of the month following the month of termination. EXAMPLE: If your termination date is in June, you are covered until July 31.

What if I Want to Make Changes In My Health Insurance Outside of Open Enrollment?

Qualifying Events

Remember – any request for a change to your health insurance **MUST** be made no later than 30 days after the Qualifying Event (except birth, which **MUST** be requested no later than 60 days).

Outside of Open Enrollment, you will not be allowed to make changes unless you experience one of the following:

- Marriage
- Divorce, legal separation or annulment
- Death of the employee, employee's covered spouse or employee's covered dependent(s)
- Birth, adoption, placement for adoption, guardianship or court-ordered coverage of dependent child(ren)
- Employee, employee's spouse or dependent(s) becomes entitled to, or loses, Medicare or Medicaid coverage
- Covered dependent is no longer eligible under the plan
- Employee, employee's spouse or employees dependent(s) changes employment status (commencement or termination of work, strike or lockout, commencement or return from unpaid leave of absence greater than 63 days)
- Employee moves out of plan service area
- Employee's spouse has a different Open Enrollment period

The changes you are allowed to make will depend on the Qualifying Event you experience. You must contact your Health Insurance Coordinator or the OPEHI Member Services Branch for additional information.

To request a change in coverage, complete a new application, attach appropriate documentation (i.e. proof of birth, marriage license, letter from spouse's employer giving date of termination, etc.) and turn it in to your agency's Health Insurance Coordinator no later than 30 days (60 days for birth) following the Qualifying Event.

Remember, your application MUST be signed no later than 30 days of the Qualifying Event (with the exception of birth which is 60 days). The inability to obtain supporting documents is not a reason for an extension.

- Applications dated after the 30-day deadline (60-day for birth) will **NOT** be accepted.
- Going on Family and Medical Leave is **NOT** a Qualifying Event to change your coverage (Example: from Family to Single) outside of Open Enrollment.

You will only be allowed to change carriers outside of Open Enrollment if:

- You move to a county where your carrier is not available; or
- You marry another employee who has a different carrier, and you wish to cross-reference. Refer to page 23 for requirements.

If you are cross-referenced with your spouse and either of you experience a Qualifying Event that will affect your insurance coverage, you must **BOTH** complete a new application no later than 30 days and turn it into your agency's Health Insurance Coordinator. (Example: the couple gets divorced, one or both reduces work hours, one or both goes on leave without pay, dependents are added or dropped from the plan, etc). **If one spouse terminates employment, the other spouse must complete a new application.**

If I get married, when will my spouse (and any eligible dependents) be added?

Coverage on your spouse (and any eligible dependents) added to your plan outside of Open Enrollment due to marriage will begin on the first day of the first month following the date of the signed application. The application must be signed no later than 30 days after the marriage or the spouse (and any eligible dependents) cannot be added until the next Open Enrollment Period.

COBRA Rights

If you and/or your dependent(s) lose your group health insurance coverage due to any of the reasons listed, you (or they) have the right to continue coverage at your (or their) own expense under COBRA.

Qualifying Events that entitle you to COBRA coverage	Length of Coverage
Termination of employee's employment (except for gross misconduct) (Former employee and covered dependents)	18 Months
Reduction of hours worked by the employee (Employee and covered dependents)	18 Months
Death of a covered employee (Surviving spouse and covered dependents)	36 Months
Divorce or legal separation from the covered employee* (Spouse and covered dependents)	36 Months
Employee becomes entitled to Medicare* (Spouse and covered dependents)	36 Months
Dependent child covered under plan, ceases to be an eligible dependent under the terms of the Plan *(e.g., reaches age limit, marries or otherwise loses dependent status)	36 Months
Persons considered to have total disability, according to Social Security	29 Months

***Employee's Responsibility – You must notify your agency's Health Insurance Coordinator within 60 days when one of these COBRA Qualifying Events occur, or you may jeopardize your COBRA rights.**

- **Electing COBRA** – Employees and/or their covered dependents who are entitled to COBRA coverage will be sent notification by the employee's agency. If COBRA is elected, the COBRA letter, election form, and a newly completed health insurance application must be submitted to the Insurance Coordinator within 60 days of notification or of the Qualifying Event, whichever is later. The initial premium payment, which must cover all payments back to the date of the Qualifying Event, must be submitted to the Insurance Coordinator within 45 days of the employee's COBRA elections. Subsequent payments should be sent directly to the carrier.

- **Employees with Disabilities** – COBRA allows persons considered to have a total disability (while waiting approval for Medicare) to maintain insurance for up to 29 months from the date of the Qualifying Event. The 11-month disability extension must be requested through the Personnel Cabinet, Office of Public Employee Health Insurance, before the original 18 months of COBRA expires.

- **Open Enrollment** – COBRA members are eligible for Open Enrollment. The current carrier will send information and an application to all COBRA members.

Grievance Procedures

Each carrier has established its own grievance/appeal procedure. The procedure is described in the carrier's Certificates of Coverage. Information on grievance/appeal procedures may also be obtained by calling the carrier's toll-free number.

Appeals to the Health Insurance Carrier

- If an employee is dissatisfied with any action or failure to act on the part of a health insurance carrier, the employee should file an appeal according to that health insurance carrier's appeals procedure.

Appeals to the Public Employee Health Insurance Grievance Committee

- Any employee who is dissatisfied with an action or failure to act in connection with eligibility for enrollment or disenrollment (Qualifying Events) in the Public Employee Health Insurance Program may file an appeal to the Public Employee Health Insurance Grievance Committee. You must do so within thirty (30) calendar days of the event or notice of the decision being protested.

- Appeals must be filed in writing to the Public Employee Health Insurance Grievance Committee, 200 Fair Oaks Lane, Suite 502, Frankfort, KY 40601.

- A written response will be mailed to the employee stating the decision of the Committee. All decisions by the Committee are final.

- The Committee will not review a second request unless additional relevant facts are provided.

- An appeal must include all items in the following list:

  - A statement specifically describing the issue(s) disputed by the employee;
  - A statement of the resolution requested by the employee;
  - All other relevant information; and
  - Any supporting documentation.

- Any appeal that does not include all necessary information will be returned to the employee without review.

Important Information Regarding YOUR Benefits

Which option is better for you and your family?

There's no easy answer to this question. However, be sure to consider the PPO since it combines the flexibility of provider choice with the added value of low in-network office visit co-payments, age-appropriate preventive care and lower premiums. While making your decision, be sure to consider your family's current and potential medical needs, how close your home is to medical facilities, your family situation, whether or not you have already established a relationship with a family physician, your need for preventive medical care and various other factors.

Provider Information

The carrier's provider directories and prescription formularies are subject to change throughout the year. Even though your physician may be participating with your carrier of choice as of January 1, that does not guarantee they will remain with the plan throughout the year. The plan you select will be the plan you will have for the entire year unless you experience an appropriate Qualifying Event (Refer to page 27) that would allow you to make a change. Providers may discontinue participation with carriers at anytime during the year. This contract change does not create a Qualifying Event.

Provider directories are also available on the carrier's respective websites (refer to page 63 for telephone numbers and website addresses). If you do not have Internet access, you may call the carriers customer service numbers for any updates.

Do not assume you have access to ALL PCPs, specialists and hospitals listed in your carrier's Provider Directory. Direct questions regarding physician and provider availability to your carrier.

Benefit Information

Maximum out of pocket expenses for HMO, POS and EPO will include all co-payments or co-insurance amounts except for prescription drugs.

Balance Billing

If you are enrolled in a POS or PPO plan and you use out-of-network providers, you may be "balance billed" for any amount not paid for by your insurance carrier. This means the provider (doctor or hospital, etc.) will bill you for the amount that your insurance carrier did not pay in addition to your co-payment or co-insurance after your deductible is met. Contact the carrier for additional information.

Out of Area Dependent Coverage

For HMOs and EPOs, if a dependent is attending an educational facility located outside of your carrier's service area, the student will be covered for emergencies ONLY while away at school. Students will receive emergency treatment (care that a prudent lay person would reasonably have cause to believe is an emergency

medical condition) at a hospital emergency room at the in-network benefits level. However, follow up care must be received according to plan guidelines. Students enrolled in managed care plans (HMO, POS or EPO) are required to use their primary care physician for all routine and non-emergency health care. All other urgent treatment services must be received at an appropriate facility, if one is available.

Pre-existing Conditions

Any employee, retiree, or dependent of an employee or retiree, who has had health insurance coverage for the previous twelve (12) months with less than a 63 consecutive day break in coverage, WILL NOT be subject to a pre-existing condition exclusion or limitation. However, an employee, retiree, or dependent of an employee or retiree, who has NOT had coverage for the past 12 months or has had a break in coverage of more than 63 consecutive days, WILL be subject to a pre-existing condition exclusion or limitation. Credit will be given on a month-by-month basis for any "qualifying prior coverage", such as another employer's health benefits plan, Medicare or Medicaid.

Pre-existing condition limitations do not apply to pregnancy, domestic violence, genetic information in the absence of a diagnosis for such a condition, and newborn children, adopted children or children placed for adoption who are under 24 years of age, IF covered within the applicable timeframes.

Co-payments, Co-insurance and Maximums

- Deductibles and out-of-pocket limits between in-network and out-of-network services are combined.
- Emergency room co-payment (but not co-insurance) is waived if admitted to the hospital.
- Deductibles, out-of-pocket limits, and co-payments/co-insurance accumulated with one carrier will transfer when an employee must select a new carrier during a plan year due to an appropriate Qualifying Event.
- Co-payments and co-insurance for prescription drugs do not apply to the maximum out-of-pocket limits.
- If the patient requests a brand name drug when a generic drug is prescribed, the patient pays the brand name co-pay plus the cost difference between the brand name and generic drug.

Medical Services

- Ultrasounds in excess of one per pregnancy require prior plan approval.
- Chiropractor visits are covered at the same benefit level as physician office visits (except annual visit limit applies to chiropractic exams). No referral is necessary.
- Infertility treatment services are not covered.
- Ambulance coverage is limited to ground transportation unless a life threatening situation exists where air ambulance is medically necessary.
- Kidney, cornea, bone marrow, heart, liver, lung, heart/lung and pancreas transplants are covered.

- Female members may self-refer to a network OB/GYN for a well-care visit (annually), Pap test (annually) and mammograms in accordance with the age guidelines listed on page 37.

Preventive Services

All plans will provide benefits for the following preventive services (refer to the benefit grids for details on co-pays, co-insurance and deductibles):

- Annual Pap test.
- Annual routine physical.
- A mammogram covered one time between the ages 35-39 and annually for persons 40 and older.
- Sigmoidoscopy covered at age 50 and every year thereafter.
- Cardiac risk profile blood test beginning at age 35 and every five years thereafter.
- Glucose serum test covered for all ages.
- EKG covered at age 40 and every year thereafter.
- PSA (prostate exam) covered at age 50 and every year thereafter.

REMINDERS

Become familiar with the requirements of your plan before you need to use it. Remember, if you have selected an HMO, POS or EPO, you may be required to go through your Primary Care Physician for referrals to specialists (except chiropractors) and other network providers. Please contact your carrier with questions.

Most plans require pre-certification for certain procedures such as overnight hospital stays, outpatient or elective surgery, diagnostic procedures, home health care services, etc. Under all plans, the doctor or hospital will usually see that pre-certification is taken care of as long as you use a network provider.

Many prescription drugs require prior authorization. Check with your carrier to determine if your prescription requires prior authorization.

What About Prescription Drug Coverage?

Mail Order Prescription Drug

- **Beginning in January 2003** each plan offered by the Commonwealth includes an optional Mail Order Prescription Drug benefit that provides for a 3-month or 90-day supply of maintenance drugs for the cost of a 2-month or 60-day supply (refer to page 36 for additional benefit information regarding the mail order prescription drug benefit).

Prescription Drug Coverage

- If the patient requests a brand name drug when a generic drug is prescribed, the patient pays the brand name co-pay plus the cost difference between the brand name and generic drug.

- The prescription co-payment purchased at a retail pharmacy applies to each one-month or 30-day supply.

- Each health insurance carrier has an established list of preferred drugs (formulary). This formulary is subject to change during the plan year. Decisions for inclusion on the preferred list are based on the drug's safety, effectiveness and cost. Some drugs require prior authorization before the carrier will cover any of the cost. **Remember, this preferred drug list varies by carrier and is subject to change during the year.**

- The prescription drug benefit offered by most plans usually covers FDA approved generic drugs, as well as many brand name drugs. Usually, several "non-preferred" medications are available without prior authorization upon payment of a higher co-payment. Each plan has certain drugs that, due to the nature of the medication, require prior authorization before the plan will cover any portion of the cost. These drugs are not automatically available for payment at the higher third tier co-payment. In most instances, only physicians may request prior authorizations as they are based on your medical history. Some plans also establish drug use guidelines in an effort to promote the appropriate use of certain medications. These guidelines may require you to try a drug that has been in use for a longer time before the plan will approve payment for a new and perhaps more expensive alternative.

50 Prescription Rule

- When an employee's health insurance contract has paid 50 co-payments/co-insurances in a calendar year for prescription drugs – excluding mail order prescriptions, additional co-payments/co-insurance for retail prescription drugs received during that plan year by any person covered under that contract will be reduced to the amounts provided on the following chart rather than the amounts on the benefit grids on page 38-45. This reduction may be approved at the point of sale or through reimbursement to the covered person no later than 31 days after the end of the plan year. Check with your carrier for the individual reimbursement policies.

PRESCRIPTION DRUG CO-PAYMENTS/CO-INSURANCE BEGINNING WITH THE 51ST COPAYMENT APPLICABLE TO A CONTRACT IN A CALENDAR YEAR

HMO	In-Network		Out-of-Network	
	Up to 50	51+	Up to 50	51+
Generic Brand Non-formulary	$10 $15 $30	$5 $10 $20	N/A	N/A

POS	Option A			
	In-Network		Out-of-Network	
	Up to 50	51+	Up to 50	51+
Generic Brand Non-Formulary	$10 $15 $30	$5 $10 $20	40%	30% co-ins.
POS	Option B			
	In-Network		Out-of-Network	
	Up to 50	51+	Up to 50	51+
Generic Brand Non-Formulary	$10 $15 $30	$5 $10 $20	50%	40% co-ins.

PPO	Option A			
	In-Network		Out-of-Network	
	Up to 50	50+	Up to 50	
Generic Brand Non-Formulary	$10 $15 $30	$5 $10 $20	40%	30% co-ins.
PPO	Option B			
	In-Network		Out-of-Network	
	Up to 50	50+	Up to 50	50+
Generic Brand Non-Formulary	$10 $15 $30	$5 $10 $20	50%	40% co-ins.

EPO	In-Network		Out-of-Network
	Up to 50	50+	
Generic Brand Non-Formulary	$25 $35 $50	$15 $25 $40	N/A

Benefit Updates

Newly Mandated Benefit Changes

Optional Mail Order Prescription Drug Benefit

Each plan offered by the Commonwealth includes an optional Mail Order Prescription Drug benefit that provides for a 3-month or 90-day supply of maintenance drugs for the cost of a 2-month or 60 day supply. The only maintenance drugs that may be dispensed through mail order are those for which there have been at least 3 claims for a 30-day supply within the last 4 months, or at least 1 claim for a 90-day supply in the last 6 months, including a mail order prescription. Further, the drug must be required for maintenance therapy as determined by the prescribing provider. The prescription must be written for a 90-day supply with refills, if necessary.

The mail order option shall not permit the dispensing of a controlled substance classified as Schedule II.

Hearing Aids and Related Services

Coverage shall be provided, subject to all applicable co-pays, co-insurance, deductibles, and out-of-pocket limits, for the full cost of one (1) hearing aid per hearing impaired ear up to $1,400 every thirty-six (36) months for hearing aids for insured individuals **under eighteen (18) years of age** and all related services which shall be prescribed by an audiologist and dispensed by an audiologist or hearing instrument specialist. The insured may choose a higher priced hearing aid and may pay the difference in cost above the provided $1,400 limit.

Coverage shall not be provided for a hearing aid claim if any health benefit plan has paid a claim for a hearing aid within the three (3) years prior to the date of the claim.

Dental Anesthesia

All plans now provide coverage for payment of anesthesia and hospital or facility charges for services performed in a hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nine (9) years, persons with serious mental or physical conditions, and persons with significant behavioral problems, where the admitting physician or treating dentist certifies that, because of the patient's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures. The same deductibles, co-insurance, network requirements, medical necessity provision, and other limitations as apply to physical illness benefits shall apply to coverage for anesthesia and hospital or facility charges covered in this section.

Coverage for routine dental care, including the diagnosis or treatment of disease or other dental conditions and procedures are not covered.

Inherited Metabolic Disease

All benefit plans provide coverage for amino acid modified preparations and low-protein modified food products for the treatment of inherited metabolic diseases as administered under the direction of a physician. Coverage is subject to an annual cap of twenty-five thousand dollars ($25,000) for medical formulas and a separate annual cap of four thousand dollars ($4,000) for low protein modified foods.

Additional Benefit Changes

Mammogram Coverage

All benefit plans provide coverage for:

- A mammogram one time between the ages 35 and 39;
- Annually for all women age 40 and over; and
- Women at risk – one mammogram per year.

Women at risk are described as follows:

- One with a personal history of breast cancer;
- One with a personal history of breast disease, which was benign upon biopsy;
- One whose mother, sister or daughter had breast cancer; or
- One who is 30 or over and has never given birth.

Dental and Vision Benefits

Beginning January 1, 2003, the Dental and Vision benefits will no longer be offered as a portion of the health insurance coverage for our group.

Plan Types Available

There are four (4) plan types available for the 2003 plan year. They are PPO, HMO, POS and EPO. A summary of the benefits and requirements of each plan is described on the following pages. Not all plan types are available in all counties. Please check the availability chart on page 12-16 for plan types available in your selected county.

PPO – Preferred Provider Organization

Under a PPO plan:

- You pay a co-payment for doctor's office visits and prescription drugs under Option A.
- Once the annual deductible is met, you will only pay a percentage of the cost (co-insurance) for all other services.
- You may use any provider in the network.
- You have the freedom to go outside your network, however, you will pay higher deductibles and your co-insurance will increase.
  - You may also be billed for the difference between your plan's payment schedule and the non-network provider's charges (balance billing).
- Your network providers will file claims for you.

PREVENTIVE SERVICES

Preventive services are available under your PPO benefits. Please refer to the Benefit Grid for applicable co-pays, deductibles, co-insurance and annual maximums.

2003 Benefit Grids

PPO Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		Single: $250 Family: $500	Single: $500 Family: $1,000	Single: $500 Family: $1,000	Single: $1,000 Family: $2,000
Maximum out-of-pocket for Covered Expenses (including deductible)	Co-payments for office visits, hospital emergency room visits, urgent care center visits services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits.	Single: $1,250 Family: $2,500	Single: $2,500 Family: $5,000	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit)- visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
		$400 maximum benefit per year		$300 maximum benefit per year	
	Diagnostic Testing (per visit)- laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay plus 20% co-ins	$50 co-pay plus 40% co-ins	$50 co-pay plus 25% co-ins	$50 co-pay plus 50% co-ins
	Emergency Room Physician	20% co-ins	40% co-ins	25% co-ins	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins*	20% co-ins*	25% co-ins*	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed.	$10 co-pay Hospital in-patient co-ins also applies.*	40% co-ins*	25% co-ins* Hospital in-patient co-ins also applies.*	50% co-ins*
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary		$20 generic $30 brand $60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness or injury.	50% co-ins*		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Home Health	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
		Limit 60 visits per year.		Limit 40 visits per year.	
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age				
	• Rehabilitative and Therapeutic care	$10 co-pay	40% co-ins*	25% co-ins*	50% co-ins*
	• Respite Care	50% co-ins*	50% co-ins*	50% co-ins*	50% co-ins*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Skilled Nursing Facility (per visit) – Limit 30 days per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.
Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.
Prior approval may be required for some services. Please contact your Carrier.

Plan Types Available

HMO – Health Maintenance Organization

The following requirements must be met under the HMO coverage:

- You MUST select a primary care physician from the plan's network of participating providers. Your primary care physician will manage your care and coordinate your referrals to network specialists and hospitals when necessary. With the exception of true emergencies, only care received through this network process will be considered a covered benefit.
- You may be required to obtain a referral to see a specialist (any doctor other than your primary care physician, gynecologist, or a chiropractor). You must consult with your selected carrier to confirm if a referral is required.
- Your costs are generally limited to a co-payment for routine doctor's office visits and most other medical services when using participating providers.
- You will not have to meet an annual deductible.
- Your network providers will file claims for you.

PREVENTIVE SERVICES

Preventive services are available under your HMO benefits. Please refer to the Benefit Grid for applicable co-pays.

2003 Benefit Grids

HMO Plans		Option A	Option B
Annual Deductible		None	None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $1,500 Family: $3,000
Lifetime Maximum Benefit		Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$100 co-pay	$250 co-pay
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay	$20 co-pay
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay	$20 co-pay
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay	$125 co-pay
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$50 co-pay	$50 co-pay
	Urgent Care Center (not hospital emergency room) (per visit)	$20 co-pay	$30 co-pay
	Ambulance (per use)	20% co-insurance	25% co-insurance
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	$20 co-pay Hospital in-patient co-pay also applies.
Prescription Drugs **Retail**	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	$10 generic $15 brand $30 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary	$20 generic $30 brand $60 non-formulary
Dental		Not Covered	Not covered
Vision		Not Covered	Not covered
Other Services	Audiometric – Only covered in conjunction with a disease, illness, or injury.	50% co-insurance	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay	$20 co-pay
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-insurance	25% co-insurance
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-insurance	25% co-insurance
	Home Health	20% co-insurance; Limit 60 visits per year.	25% co-insurance; Limit 40 visits per year.
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.	Covered same as Medicare benefit.
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $10 co-pay 50% co-insurance	 $20 co-pay 50% co-insurance
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	$250 co-pay

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

Plan Types Available

POS – Point of Service

The In-network benefits of a POS are similar to an HMO in that:

- You MUST select a primary care physician to manage your care and coordinate your referrals to network specialists and hospitals, if your plan so requires – check with your carrier.
- You are required to obtain a referral to see a specialist (any doctor other than your primary care physician or a chiropractor).
- Female members may self-refer to a network OB/GYN annually for a well-care visit and Pap test.
- You only pay a co-payment for most services when using a network provider.
- Your network providers will file claims for you.
- There are no deductibles to meet when using network providers.
- A POS also gives you the option to go outside the network of participating providers for services. If you do choose to go outside the network, the plan will pay for the services at a reduced rate after deductibles are applied. You may also be billed for the difference between your plan's payment schedule and the non-network provider's charges (balance billing).

PREVENTIVE SERVICES

Preventive services are available under your POS benefits. Please refer to the Benefit Grid for applicable co-pays, co-insurance and deductibles.

2003 Benefit Grids

POS Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		None	Single: $500 Family: $1,000	None	Single: $1,000 Family: $2,000
Maximum Out-of-Pocket for Covered Expenses (including deductible)	Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $2,500 Family: $5,000	Single: $1,500 Family: $3,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	$100 co-pay (per admission)	40% co-ins*	$250 co-pay (per admission)	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay (per visit)	40% co-ins*	$125 co-pay (per visit)	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay (per visit)	$50 co-pay plus 40% co-ins	$50 co-pay (per visit)	$50 co-pay plus 50% co-ins
	Emergency Room Physician	Covered in full	40% co-ins	Covered in full	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins	20% co-ins*	25% co-ins	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	40% co-ins* Hospital in-patient co-ins* also applies.	$20 co-pay Hospital in-patient co-pay also applies.	50% co-ins* Hospital in-patient co-ins* also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary		$20 generic $30 brand $60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness, or injury.	50% co-ins		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Home Health	20% co-ins Limit 60 visits per year.	40% co-ins*	25% co-ins Limit 40 visits per year.	50% co-ins*
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	$10 co-pay 50% co-insurance	40% co-ins* 50% co-insurance*	$20 co-pay 50% co-insurance	50% co-ins* 50% co-insurance*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	40% co-ins*	$250 co-pay	50% co-ins*

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.
Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.
Referrals and/or prior approval may be required for some services. Please contact your Carrier.

Plan Types Available

EPO – Exclusive Provider Organization

- EPO is designed to be more affordable by offering limited benefits (catastrophic coverage) with higher deductibles and co-pays.
- ALL services **MUST** be provided in-network.
- Preventive tests and immunizations **MUST** be provided by participating Health Departments if the Health Departments contract with your carrier. If the carrier does not have a contract with the appropriate Health Department, you may obtain services at your designated primary care physician or other participating provider, as permitted by the rules of your carrier.
- You must select a primary care physician – please confirm with your carrier.

PREVENTIVE SERVICES

Preventive services for the EPO may be mandated through county Health Departments. Contact your health insurance carrier to determine if services need to be obtained through the Health Department.

2003 Benefit Grids

EPO Plan		
Annual Deductible		None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$1,500 co-pay (per admission)
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	$25 co-pay (per visit)
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$500 co-pay (per visit)
	Diagnostic Testing (per visit) – laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$25 co-pay (per visit)
	Preventive Testing* – Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA.	50% co-insurance
	Immunizations* – All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults.	50% co-insurance
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$75 co-pay (per visit)
	Urgent Care Center (not hospital emergency room) (per visit)	$50 co-pay (per visit)
	Ambulance (per use)	$75 co-pay (per visit)
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval.	$25 co-pay (per visit) Hospital in-patient co-pay also applies.
Prescription Drugs **Retail**	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.	$25 generic $35 brand $50 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$50 generic $70 brand $100 non-formulary
Dental		Not covered
Vision		Not covered
Other Services	Audiometric	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 15 visits per year. No more than one visit per day.	50% co-insurance Limit 15 visits per year.
	Durable Medical Equipment (DME) and Prosthetic Devices	50% coinsurance
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	50% coinsurance
	Home Health	Covered in full. Limit 20 visits per year.
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $25 co-pay (per visit) 50% co-insurance
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.
	Physical Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Occupational Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Cardiac Rehabilitation Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Speech Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Skilled Nursing Facility (per admission) – Limit 20 days per year.	$1,500 co-pay

*Health Departments shall be given the right of first refusal. Note: Only services from network providers are covered.

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

What About Flexible Spending Accounts?

You may enroll in one or more flexible spending accounts (e.g. health and/or dependent care) offered by your employer. You may contribute specified amounts from your salary. Please contact your Health Insurance Coordinator for information.

The State will contribute a set amount toward your health insurance each month. If the plan you choose costs less than the employer contribution ($234.00), you may qualify to have the remaining amount deposited into a Health Care Spending Account. You must complete a separate enrollment form for the Flexible Spending Account program (in addition to the Health Insurance Application). Enrollment is not automatic and you must re-enroll each year.

Retirees are not eligible for participation in the Flexible Spending Accounts.

- **State Agency Employees** – You are eligible for the Commonwealth Choice Flexible Spending Account Program. Contact your Health Insurance Coordinator for a Commonwealth Choice enrollment form and handbook.

- **School Board Employees** – All boards may not offer this benefit. To find out if a Flexible Spending Account program is available to you, contact the Health Insurance Coordinator at your Board of Education. The flexible spending accounts for school employees are contracted by each Board of Education.

- **Health Department Employees** – Your are eligible for a Flexible Spending Account Program. Contact the Health Insurance Coordinator at your local Health Department.

- **KCTCS Employees** – You are eligible for a Flexible Spending Account Program. Contact your Health Insurance Coordinator for an enrollment form and booklet.

- Members of groups other than those listed above, please see your Health Insurance Coordinator for information regarding Flexible Spending Accounts.

Important Information for RETIREES of the Following Retirement Systems:

Kentucky Retirement System
Kentucky Teachers' Retirement System
Kentucky Judicial Retirement Plan
Kentucky Legislators Retirement Plan

Retiree Health Insurance
Annual Open Enrollment
Plan Year 2003

September 16 – October 18, 2002
(Your application must be received at the appropriate retirement system no later than October 18, 2002)

RETIREES LIVING OUT-OF-STATE

Retirees living out-of-state, except those living in a county bordering Kentucky, will have the opportunity to enroll in any of the POS or PPO plans offered by any of the carriers. You may have to pay out-of-network charges. Please contact your carrier for specific information.

Those enrolling in a POS or PPO should be cautioned that when you use the out-of-network providers, you may be "balance billed" for any amount not paid by the insurance carrier. This means the provider (doctor or hospital, etc.) may bill you for the amount that your insurance did not pay in addition to the amount of your co-payment or co-insurance. Your carrier's payment is made based on a fee schedule, which would normally be used

in Kentucky. The payment could be less than what is usually paid to providers in the state where you live.

Retirees Under Age 65

If you are a retiree under age 65, you may continue health insurance coverage at the group rate if you draw a monthly check from the Kentucky Retirement System, Kentucky Teachers' Retirement System, Judicial Retirement Plan or Legislators Retirement Plan.

You may choose any health carrier offered to active state employees as long as it is available in the county where you live or, if applicable, a contiguous county (refer to page 8-9). Retirees living out-of-state, except those living in a county bordering Kentucky, will have a choice of any POS or PPO plan offered by the carriers. You may have to pay out-of-network charges. Please contact your carrier for specific information.

During Open Enrollment you may choose to change from one available carrier to another, change your level of coverage, change your option selection or waive your coverage.

For information on Kentucky Retirement Systems' insurance benefits, call 1-800-928-4646, ext. 4520 or (502) 564-4646, ext. 4520. See pages 50-54 for further information on the Kentucky Retirement Systems.

For Teachers' Retirement benefits call 1-800-618-1687 or (502) 848-8500. See pages 55-57 for further information on the Kentucky Teachers' Retirement System.

For Judicial or Legislators Retirement benefits call (502) 564-5310.

Limitation on Receipt of State Insurance Contribution

Employees who retire and return to work in a full-time status with an agency that participates in the Public Employee Health Insurance Program will need to choose whether to be covered through the retirement system or their active employment. These employees will also need to complete an application declining coverage at one place or the other. Remember that the employee/retiree is only entitled to one state contribution and cannot

elect health insurance and an employer-sponsored flexible spending account.

Reemployed KTRS retirees MUST waive their KTRS insurance (see page 56).

Medicare and the Public Employee Health Insurance Program

Questions regarding coordination of benefits with Medicare should be directed to Medicare. Eligibility questions regarding Medicare and the Public Employee Health Insurance Program should be directed to the appropriate retirement system.

Contiguous Counties

Legislation was passed during the 2002 Regular Session regarding the selection of health insurance for members of the Public Employee Health Insurance Program. Retirees that live in the counties listed on the Contiguous County Chart on page 9 may select their coverage in the contiguous county.

Information for RETIREES of the Kentucky Retirement Systems

Retirees of KERS, SPRS, or CERS who return to work with an agency that participates in the Public Employee Health Insurance Program may not cross-reference with themselves or elect coverage through the retirement system and put their employer contribution into a flexible spending account. Retirees must choose to participate through the retirement system or the employer. Retirees must also waive coverage with either the retirement system or the employer, whichever is not selected to provide their health care coverage.

A beneficiary of a deceased hazardous retiree who is employed with an agency that participates in the Public Employee Health Insurance Program may only elect coverage through the retirement system or through his or her active employment. The beneficiary must choose coverage under the deceased retiree's account or elect coverage through employment and waive coverage on the other. This would also apply to beneficiaries of deceased retired legislators and judges who participated in the Kentucky Retirement Systems.

EXPLANATION OF KENTUCKY RETIREMENT SYSTEMS' BENEFITS

If you are a retiree or a beneficiary receiving retirement benefits from the Kentucky Employees Retirement System, the County Employees Retirement System or the State Police Retirement System and are under age 65, you are eligible to apply for the health insurance coverage described in this booklet. You may also continue coverage on your spouse or eligible dependents when they become eligible for Medicare until you become eligible for Medicare at age 65. The insurance companies and plans they offer will be the same for retirees as those offered to state employees in this booklet. However, the administrative procedures may not be the same as for state employees.

If you are retired from both Kentucky Retirement Systems (KRS) and Kentucky Teachers' Retirement System (KTRS), you should call the KRS office and speak with a retirement counselor before completing the enclosed application. Call 1-800-928-4646, ext. 4520 (if outside Franklin County) or 502-564-4646, ext. 4520.

If you plan to cross-reference your insurance coverage with your spouse and you are unsure how the premiums will be handled, you should call the KRS office and speak with a retirement counselor before you complete the enclosed application. Call 1-800-928-4646, ext. 4520 (if outside Franklin County) or 502-564-4646, ext. 4520.

The amount that KRS will contribute toward your health insurance premium depends upon your years of service credit with KRS. In addition, the KRS contribution will be different for retirees who were employed in hazardous positions. **(If you are receiving monthly benefits as the beneficiary of a deceased, non-hazardous retiree, KRS will pay no portion of your monthly contribution.)** If you are receiving monthly benefits as the beneficiary of a deceased, hazardous duty retiree, KRS may pay all or a portion of your monthly contribution. The maximum monthly contribution, as approved by the KRS Board of Trustees, can be found in the KRS OPEN ENROLLMENT NOTICE accompanying this booklet. The following breakdown reflects the percentages of approved contributions that KRS will pay, if eligible:

Years of Service with KRS	% of the Monthly Contribution rate paid by KRS
Less than 4 years	0%
4-9 years	25%
10-14 years	50%
15-19 years	75%
20 years or more	100%

You will find the insurance premiums for each carrier on page 11. When choosing a plan, compare the premium to the chart above and the KRS OPEN ENROLLMENT NOTICE to determine how much KRS will contribute toward the plan you select. Kentucky Retirement Systems does not participate in the bidding of the insurance premiums. Therefore, employees at KRS cannot address your questions regarding how the rates were determined.

Any portion of the insurance premium not paid by KRS will be deducted from your monthly retirement benefit. If the amount to be deducted is greater than your monthly benefit, KRS will bill you monthly for any additional premium owed.

Do not choose any coverage based on what you "hope" KRS will pay toward your premium. If you are uncertain about the amount the Kentucky Retirement Systems will pay toward the cost of your health insurance premium, you should call the Kentucky Retirement Systems office at 1-800-928-4646, ext. 4520 (if outside Franklin County) or 502-564-4646, ext., 4520.

KRS recipients are **not** eligible to participate in Flexible Spending Accounts. This health insurance is not available to former spouses, nor is this health insurance available to Alternate payees being paid by KRS under the provisions of a qualified domestic relations order. Former spouses and Alternate payees may have rights to health insurance coverage under COBRA.

All of the insurance companies available are on page 12-16. The different types of plans (HMO, POS, PPO, and EPO) are described in detail as well.

Please read this entire booklet before contacting the retirement office, or before making any decision on your coverage.

Please check closely to ensure that the company you have chosen is available **in the county where you live or, if applicable, a contiguous county (refer to page 8-9).**

The Open Enrollment deadline for you as a retiree may be different from the deadline quoted in this booklet for employees. Please refer to the enclosed KRS OPEN ENROLLMENT NOTICE for your deadline date. In order to assure that you receive the insurance coverage you desire your application must be in the KRS office by that date.

In addition to the enclosed information, you should receive provider booklets from the individual insurance companies. The participating doctors, pharmacies, and hospitals will be listed in these booklets for your use. Please check to make sure that your doctors, your pharmacy, and your hospital of choice are available to you through the company that you choose. If you do not receive this information soon, you should call the insurance company to request it. The Kentucky Retirement Systems cannot provide you with these booklets. Phone numbers for the insurance companies are listed on page 63.

Please refer to the enclosed KRS OPEN ENROLLMENT NOTICE for any additional information about your Open Enrollment choices. If you need further information you may call 1-800-928-4646, ext. 4520 (if outside Franklin County) or 502-564-4646, ext. 4520. During the Open Enrollment period our lines are always extremely busy. Please leave a message for a return call from a retirement counselor. Calls are returned in the order in which they are received, which may not be on the same day. Calling early during Open Enrollment will assist KRS in serving you better.

If you choose to participate in the Public Employee Health Insurance Program through the Kentucky Retirement Systems', **do not** send your completed application to the Personnel Cabinet, OPEHI or directly to the insurance carrier. Doing so will delay processing of your application. All applications with "Kentucky Retirement Systems" printed on the top of page number 1 should be returned to the address at the end of this section.

WARNING: Retirees living out-of-state and using out-of-network services under POS or PPO should be aware that they may be responsible for a greater portion of the doctor or hospital bills under these plans. The doctor or hospital may bill you for the amount that your insurance did not pay, in addition to the amount of your co-insurance. Your carrier's payment may be based on a fee schedule, which is used in Kentucky and could be less than what is usually paid to providers in the state where you now live. For less cost to you, check with your insurance carrier to see if it has networks where you live and if you can access them.

Questions regarding benefits and applications for health insurance through the Kentucky Retirement Systems should be directed to:

Kentucky Retirement Systems
Perimeter Park West
1260 Louisville Road
Frankfort, KY 40601-6124
1-800-928-4646, ext. 4520 (if outside Franklin County) or
502- 564-4646, ext. 4520

EXPLANATION OF KENTUCKY TEACHERS' RETIREMENT SYSTEM (KTRS) BENEFITS

You are eligible for health insurance explained in this handbook if you are retired from KTRS, are under age 65 and meet the KTRS eligibility for insurance criteria. This is the same health insurance coverage offered to active teachers, Kentucky Retirement Systems retirees under age 65 and public employees. Retirees eligible for Medicare (and not already enrolled under the KTRS Medicare Eligible Health Plan (MEHP) supplement) should contact KTRS to obtain further information on the KTRS Medicare Supplement.

The following general guidelines are offered to assist you in selecting your medical insurance coverage: 1) Check the availability chart on page 12-16 to determine what plans are offered in your ***county of residence or, if applicable, a contiguous county (refer to page 8-9)***; 2) Look at the 2003 Rate Chart on page 11 for the plans available in your county; and 3) Check the carrier's participating provider information. Each carrier providing coverage in your county should send you a provider booklet listing the participating hospitals and doctors. This provider booklet will assist you in choosing your carrier. If you have not received your provider booklet(s), you should contact the carrier(s) at the number(s) listed on page 63.

KTRS retirees are encouraged to contact the KTRS Call Center or a KTRS counselor if there are additional questions that have not been addressed in this handbook. A brief synopsis of KTRS retiree specific health insurance is offered on the following topics.

OUT-OF-STATE RETIREES

Retirees residing out of state may choose any POS or PPO offered by the state plan. If the carrier you select has a participating network where you live, you may be extended "in-network" benefits. Services obtained outside the network will be subject to "out-of-network" benefits. **It is strongly recommended that out-of-state retirees contact the carriers for further clarification of participating networks outside of Kentucky before making a choice.**

KTRS Supplement: Qualified retirees may receive a percentage of the KTRS contribution toward the cost of this insurance. If the cost of coverage is more than the KTRS supplement, the net amount will be deducted from the annuity or billed if necessary. Retirees are not eligible to participate in flexible spending accounts.

Cross-Reference

Retired teachers will have the option to cross-reference with the state group. Please refer to the Health Insurance Handbook for further information.

Re-employed retirees

As a result of the 2002 Legislative Session, all KTRS re-employed retired members who waive their retirement annuity, or are eligible for medical coverage through the Public Employee Health Insurance Program, are required to WAIVE health insurance coverage through the Kentucky Teachers' Retirement System.

Retirees with Service in more than one Retirement System

You are eligible for one contribution toward the cost of insurance. If you have service in more than one retirement system, you should elect coverage through only one system and waive with the other.

Terms You Need To Know

Balance Billing – If you are enrolled in a POS or PPO plan, and you use the out-of-network benefits, you may be "balance billed" for any amount not paid by the insurance carrier. This means the provider (doctor, hospital, etc.) may bill you for the amount that your insurance carrier did not pay in addition to the amount of your co-payment or co-insurance. Your carrier's payment is made based on a fee schedule, which would normally be used in Kentucky. This payment could be less than what is usually paid to providers in the state where you live or obtain services.

Co-insurance – A percentage of the charges due to the doctor, hospital, pharmacy, or other provider. This percentage may vary based on the services provided.

Co-payment – A set amount due to the doctor, hospital, pharmacy, or other provider at the time of service (e.g., $10.00 per office visit). This amount is not included in the deductible.

COBRA – (Consolidated Omnibus Budget Reconciliation Act of 1986) – Federal law which allows employees and their dependents to continue coverage after termination from the Public Employee Health Insurance Program.

Contiguous County – For the purpose of selecting the county of choice for your health insurance, a contiguous county is one that shares any portion of its border with another county within the Commonwealth of Kentucky.

Deductible – Initial amount of medical or hospital expenses you must pay before a health plan starts paying benefits.

Eligible Expenses – A provider's fee which: (A) is the provider's usual charge for a given service under the covered person's plan; (B) is within the range of fees charged by providers of similar training and experience for the same or similar service or supply within the same or similar limited geographical area; and (C) does not exceed the fee schedule developed by the carrier. The term "eligible expense" and "reasonable and customary charge" may be interchangeable.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition: (1) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency medical condition is: (1) a situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or (2) a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

Formulary – A list of FDA approved drugs selected on the basis of safety, clinical efficacy, and cost-effectiveness. An experienced committee of medical experts compiles the list for each carrier. Formularies may differ among carriers.

Generic Drugs – A drug that is equivalent to a brand name drug produced when patent protection lapses on the brand-name drug.

In-network – Physicians, pharmacies or drug stores, hospitals and other providers who have contracted with a particular carrier to provide services for persons covered on that particular plan.

In-patient Care – Care delivered to a patient who is officially admitted and occupies a hospital bed while receiving hospital care.

Maximum out-of-pocket – Maximum dollar amount the covered person will have to pay for covered medical expenses during the plan year. It does not include balance billing or certain PPO services.

Out-of-network – Physician, pharmacies or drug stores, hospitals, and other providers who have not contracted with a particular carrier to provide services. Persons choosing a POS or PPO plan may use an out-of-network provider at an added expense.

Pre-certification – Prior approval required for non-emergency medical and surgical hospital admissions. The program determines the diagnostic need for certain surgical and diagnostic procedures and approves appropriate lengths of stay for admissions.

Primary Care Physician – A network provider who is a practitioner specializing in family practice, general practice, internal medicine, or pediatrics; who supervises, coordinates and provides initial care and basic medical services to a covered person; initiates a covered person's referral for specialist services; and is responsible for maintaining continuity of patient care.

Qualifying Event – An event that may allow an employee/retiree to make a consistent change in their health insurance or, in some cases, their FSA.

Urgent Care – Medical care that is appropriate to the treatment of a non-life threatening illness or injury, but requires prompt medical attention.

Usual, Customary and Reasonable (UCR) – A provider's fee which: (a) is the provider's usual charge for a given service under the covered person's plan; (b) is within the range of fees charged by providers of similar training and experience for the same or similar service or supply within the same or similar limited geographical area; and (c) does not exceed the fee schedule developed by the carrier.

The Strength and Security of Anthem

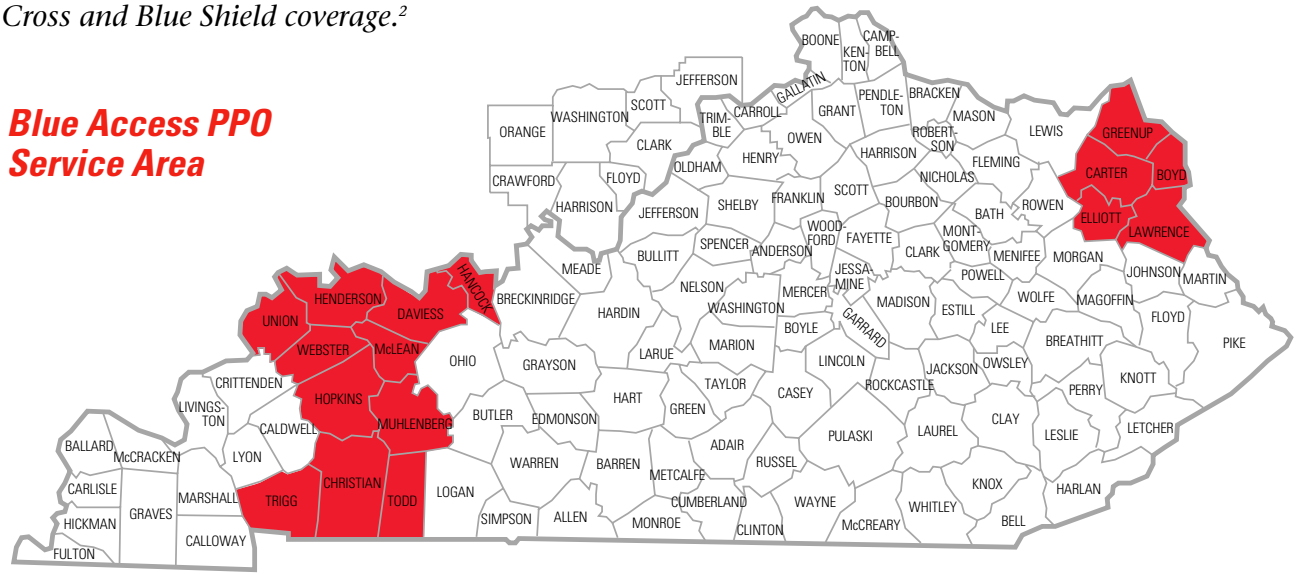
Anthem

Anthem Blue Cross and Blue Shield can offer the strength and security that comes with being among the largest, most experienced health benefits organizations in the nation.[1]

Visit our web site at www.anthem.com or call our toll-free line at (888) 650-4047.

More than 82 million members — that's one out of every four Americans — enjoy the benefits of Blue Cross and Blue Shield coverage.[2]

Blue Access PPO Service Area



Benefits	Blue Access℠ PPO	
Preventive Services	✔	Including well baby and well child care, and immunizations
Large Pharmacy Network	✔	Access to more than 50,000 local and chain pharmacies
Coverage While Traveling	✔	*BlueCard® Program* Connects members to health care providers when members are traveling or living outside of their Plan's service area. In most cases, members are held harmless and not balance billed after the payment is made to the provider.
Disease State Management Programs	✔	Maternity Program

Note: Some services may not be covered under your health plan. Please refer to your benefit plan certificate for details concerning benefits, limitations and exclusions.

An independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc. ® Registered marks Blue Cross and Blue Shield Association.

1 Blue Cross Blue Shield Association, *Brand Talk* 2 Blue Cross Blue Shield Association, press release, June 4,2002.

AHP-0442 Rev. 8/02

Bluegrass Family Health

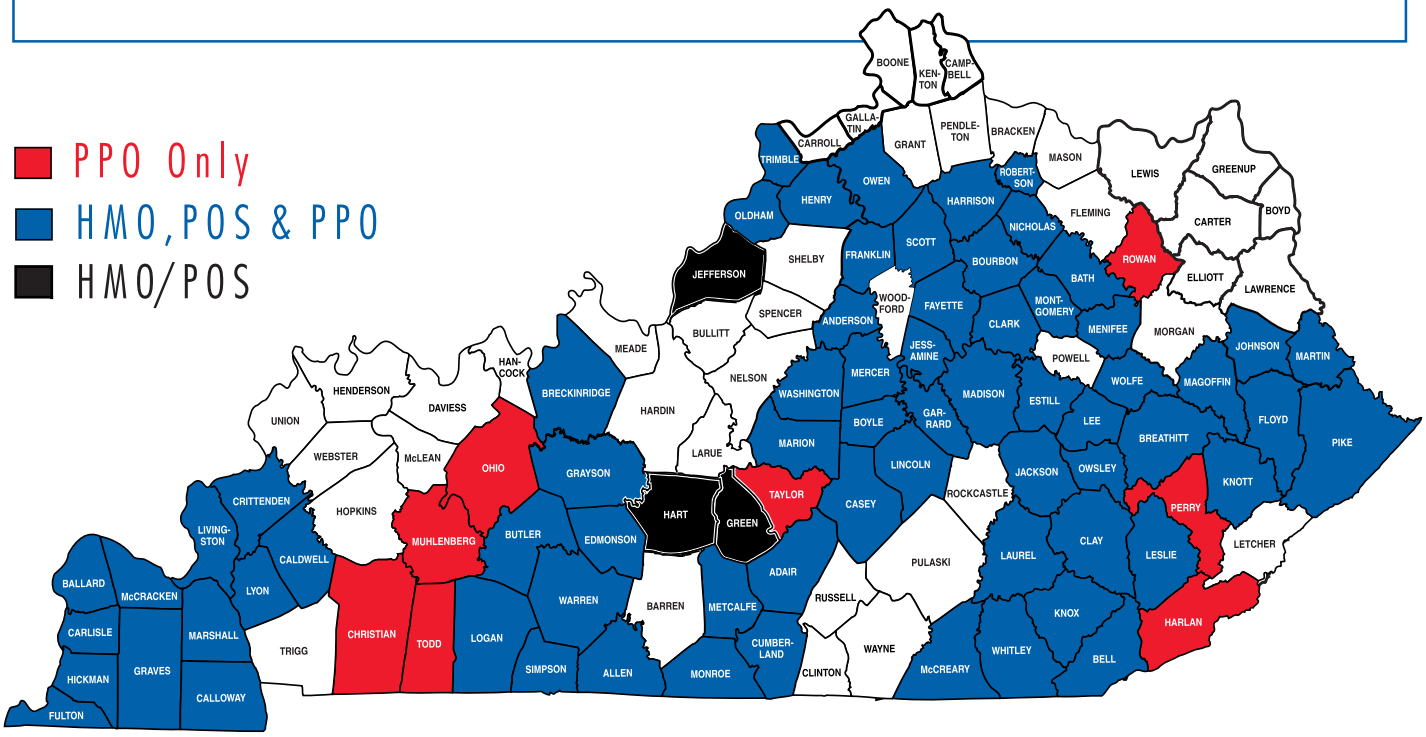
Why should you select Bluegrass Family Health as your Healthcare Plan?

- ☑ Offering Health Insurance to Commonwealth of Kentucky employees for 9 years
- ☑ Kentucky based company
- ☑ Not-for-profit health plan
- ☑ Competitive rates
- ☑ Survey results show that Bluegrass Family Health provides exceptional Customer Service
- ☑ Comprehensive provider network and service area

Visit Our Website at www.bgfh.com

Learn more about us:

- BFH now serves over 120,000 members, and we are continuing to grow.
- Employees and retirees who do not live in Kentucky need to make health plan selections very carefully. Bluegrass Family Health does not contract with out-of-state healthcare providers. Using out-of-state providers can result in significant out-of-pocket expenses for you and your family. (Example: You are responsible for the difference between Bluegrass Family Health's standard payment amount and the amount billed by the provider).



Please remember, if you *LIVE or WORK* in one of the above highlighted counties, you can select Bluegrass Family Health as your health plan. We hope you will consider Bluegrass Family Health as your health plan choice for the year 2003.

Our Customer Service Representatives are waiting to answer your questions:
(859) 269-4475 or (800) 787-2680

ADV.141.08/02

56 Counties Count on CHA Health

Shouldn't you? CHA Health is the one resource for healthcare services that gives you peace-of-mind.

With our **Assist America** product, you can travel worry free. It gives you access to emergency medical services when you're away from home.

With our online service, **myCHAinfo**, you have 24-hour access to your information, including the status of your claims and provider look-up. You also can get your questions answered fast and easy through our online customer service.

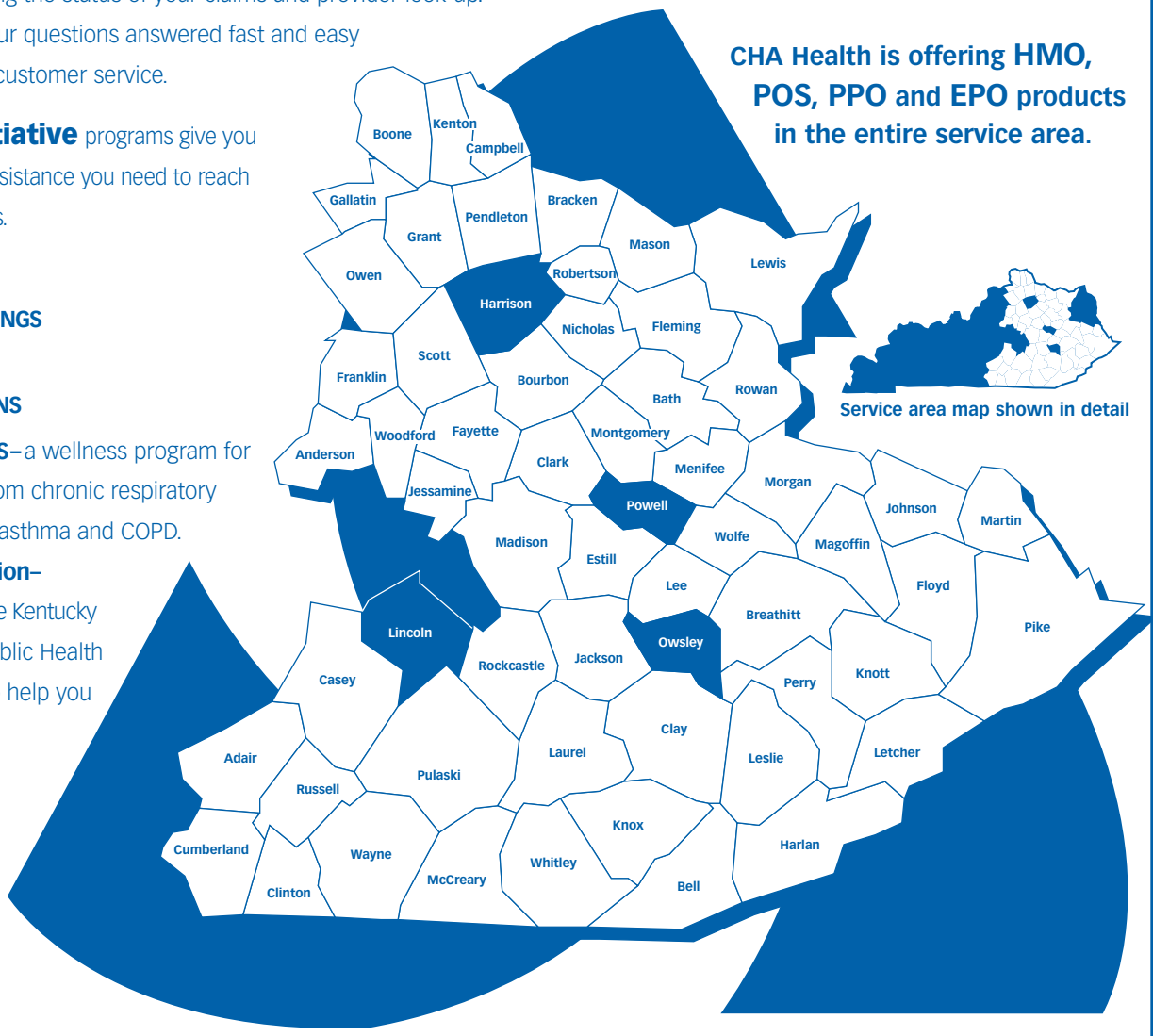
Our **Healthy Initiative** programs give you the resources and assistance you need to reach your healthcare goals.

- **NURSE 411**
- **HEALTHY BEGINNINGS**
- **HEALTHY HEART**
- **HEALTHY HORIZONS**
- **HEALTHY AIRWAYS**–a wellness program for those suffering from chronic respiratory diseases such as asthma and COPD.

Smoking Cessation–
CHA Health and the Kentucky Department for Public Health have partnered to help you quit smoking.

Low Cost Options
What's best for you? Check out our Option B products and our PPO and EPO plans.

CHA Health is offering HMO, POS, PPO and EPO products in the entire service area.



Service area map shown in detail

All eligible active employees must live or work in the CHA Health service area.

CHA HEALTH℠

For more information call toll-free at 800-840-3885.

Make the *Smart move* to Humana

With health care costs increasing, it's important to choose your health plan carefully. Humana offers plans, tools and services that can help you and your family make smart decisions about your health benefits.

Here are just a few good reasons to choose Humana:

Humana PPO benefits

Smart Move

- Humana's lowest-cost offering
- Full preventive benefits and office visit coverage
- Prescription drug copayments and mail-order benefits
- Low out-of-pocket maximums

Humana HMO benefits

Smart Move

- HMO B plan offers you the opportunity to
  - lower your premium cost
  - enjoy a high level of benefits with only small increases in copayments
- Predictable out-of-pocket costs

Humana services

As a Humana member, you receive more than a health plan. You have access to **www.humana.com** for physicians, hospitals and pharmacy networks, as well as the following services:

*My*Humana

Your personal online page, *My*Humana, includes your recent claims history, a summary of your plan benefits, risk assessment tools, and more.

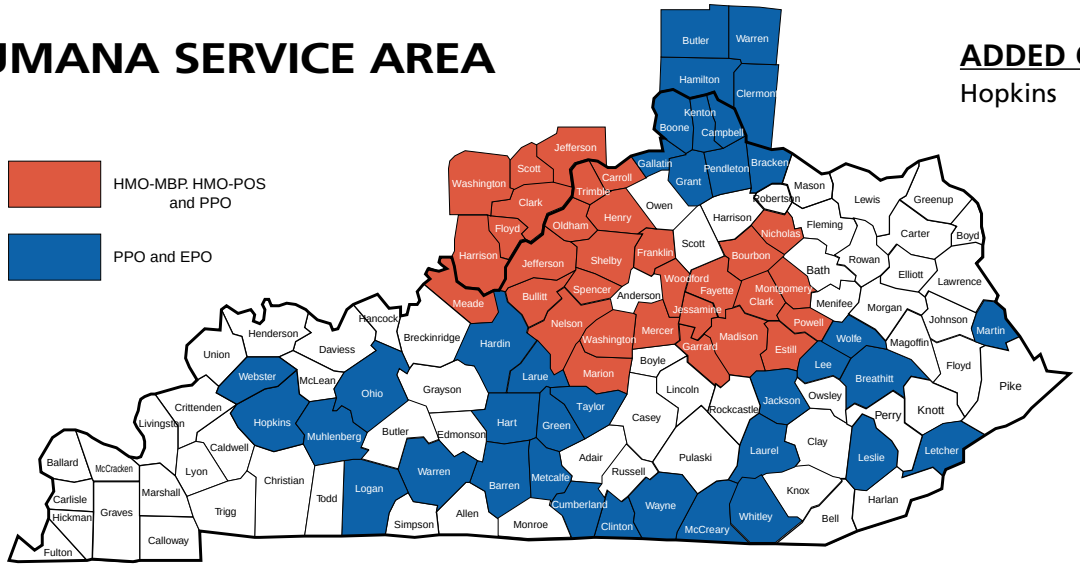
Maximize Your Benefit

This confidential online messaging system, a feature of *My*Humana, informs you of lower-priced alternatives to more expensive prescription drugs you may be taking.

Personal Nurse℠

Connects members to programs and resources, helps members maximize their health plan benefits, and reduces readmissions and ER visits.

HUMANA SERVICE AREA



ADDED COUNTIES

Hopkins Webster

Humana Customer Service: 1-800-4-HUMANA (1-800-448-6262)

Open Enrollment Hotline: 1-888-393-6765

HUMANA®

www.humana.com

GHC-13691

Offered and Insured by Humana Health Plan, Inc.

7/02

Helpful Phone Numbers and Websites

Office of Public Employee Health Insurance (OPEHI)
1-888-581-8834
1-502-564-6534
http://personnel.ky.gov/opehi.htm

Anthem Blue Cross Blue Shield
1-888-650-4047
1-502-261-0294
www.anthem.com

Bluegrass Family Health
1-800-787-2680
1-859-269-4475
www.bgfh.com

CHA Health
1-877-242-5978
1-859-232-8686
www.cha-health.com

Humana
1-800-448-6262
1-502-580-8100
www.humana.com

Kentucky Retirement System
1-800-928-4646
1-502-564-4646 ext. 4520
www.kyret.com

Kentucky Teachers' Retirement System
1-800-618-1687
1-502-573-3266
http://www.ktrs.org/medical.htm

Judicial/Legislators Retirement
1-502-564-5310

This handbook was prepared by:

The Staff of
Kentucky Personnel Cabinet
Office of Public Employee Health Insurance
(OPEHI)

The Commonwealth of Kentucky does not discriminate on the basis of race, color, national origin, sex, religion, age, or disability in employment of the provision of services.

This book is available in an accessible format upon request and is available on the Internet at:

http://personnel.ky.gov/opehi.htm

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