Kentucky Employees' Health Plan - 2011 Benefits Grid

Benefit Plan	Commonwealth Standard PPO		Commonwealth Maximum Choice (not available to Retirees)		Commonwealth Capitol Choice		Commonwealth Optimum PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Health Reimbursement Account (HRA)	Not Applicable		Single: $1,000; Parent Plus: $1,500; Couple $1,500; Family $2,000 Cross Ref. $2,000		Not Applicable		Not Applicable	
Up-Front Benefit Allowance	Not Applicable		Not Applicable		$500 per Family Member	Not Applicable	Not Applicable	
Annual Deductible	Single $500 Family $1,500	Single $1,500 Family $3,000	Single $2,300 Family $3,455	Single $2,300 Family $3,455	Single $575 Family $1,725	Single $1,150 Family $3,455	Single $345 Family $690	Single $690 Family $1,380
Annual Out-of-Pocket Maximum	Single $3,500 Family $7,000	Single $5,000 Family $9,500	Single $3,455 Family $5,185	Single $4,600 Family $6,900	Single $2,300 Family $6,900	Single $3,800 Family $9,400	Single $1,295 Family $2,590	Single $2,590 Family $5,185
	Excludes prescription drug Co-Pays and all other Co-Pays		All covered expenses apply to the out-of-pocket maximum		Excludes prescription drug Co-Pays and all other Co-Pays		Excludes prescription drug Co-Pays and all other Co-Pays	
Co-Insurance	Plan: 75% Member: 25%	Plan: 50% Member: 50%	Plan: 90% Member: 10%	Plan: 60% Member: 40%	Plan: 80% Member: 20%	Plan: 60% Member: 40%	Plan: 85% Member: 15%	Plan: 70% Member: 30%
Doctor's Office Visits	Deductible then 25%*	Deductible then 50%*	Deductible then 10%*	Deductible then 40%*	Co-Pay: $20 PCP; $25 Specialist	Deductible then 40%*	Co-Pay: $15 PCP; $20 Specialist	Deductible then 30%*
Physician Care (Inpatient/ Outpatient/Other)	Deductible then 25%*	Deductible then 50%*	Deductible then 10%*	Deductible then 40%*	Deductible then 20%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*
Diagnostic Tests **In Doctor's Office** (Same Site/ Same Day as Office Visit)	Deductible then 25%*	Deductible then 50%*	Deductible then 10%*	Deductible then 40%*	Office Visit Co-Pay	Deductible then 40%*	Office Visit Co-Pay	Deductible then 30%*
Other Laboratory	Deductible then 25%*	Deductible then 50%*	Deductible then 10%*	Deductible then 40%*	Deductible then 20%*	Deductible then 40%*	$15 Co-Pay	Deductible then 30%*
Inpatient Hospital (Semi-Private Room)	Deductible then 25%*	Deductible then 50%*	Deductible then 10%*	Deductible then 40%*	$115 Co-Pay per Admission plus Deductible*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*
Outpatient Hospital/Surgery	Deductible then 25%*	Deductible then 50%*	Deductible then 10%*	Deductible then 40%*	$55 Co-Pay plus Deductible*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*
ER Physician Care	Deductible then 25%*	Deductible then 50%*	Deductible then 10%*	Deductible then 40%*	Deductible only	Deductible only	15%*	Deductible then 30%*
Emergency Room	$50 Co-Pay then Deductible then 25%*	$50 Co-Pay then Deductible then 50%*	Deductible then 10%*	Deductible then 40%*	$115 Co-Pay plus Deductible*	$115 Co-Pay plus Deductible*	$85 Co-Pay then 15%*	$85 Co-Pay then Deductible then 30%*
	Co-Pay waived if admitted				Co-Pay waived if admitted		Co-Pay waived if admitted	
Ambulance	Deductible then 25%*	Deductible then 25%*	Deductible then 10%*	Deductible then 10%*	Deductible then 20%*	Deductible then 20%*	Deductible then 15%*	Deductible then 15%*

Urgent Care Center (Facility)	Deductible then 25%*	Deductible then 50%*	Deductible then 10%*	Deductible then 40%*	$50 Co-Pay	Deductible then 40%*	$20 Co-Pay	Deductible then 30%*
Mental Health	Treated the same as any other health condition. See specifics related to physician specialists, inpatient and outpatient services.							
Allergy Injections	Deductible then 25%*	Deductible then 50%*	Deductible then 10%*	Deductible then 40%*	$10 Co-Pay	Deductible then 40%*	$15 Co-Pay	Deductible then 30%*
Maternity Care (See SPD for Specifics)	Deductible then 25%*	Deductible then 50%*	Deductible then 10%*	Deductible then 40%*	$20 Co-Pay (office visit pregnancy diagnosed) Delivery Charge: Deductible then 20%*	Deductible then 40%*	$15 Co-Pay (office visit pregnancy diagnosed) Delivery Charge: Deductible then 15%*	Deductible then 30%*
Routine Well Child Care (0-18 Years Old)	Covered at 100%	Covered at 100%	Covered at 100%	Not Covered	$15 Co-Pay	Deductible then 40%*	$10 Co-Pay	Deductible then 30%*
Routine Well Adult Care (Over 18)	Covered at 100%	Covered at 100%	Covered at 100%	Not Covered	$15 Co-Pay	Deductible then 40%*	$10 Co-Pay	Deductible then 30%*
Autism Service (Benefits payable based on services rendered)	Ages 1 through 6 Annual Maximum $50,000 Ages 7 through 21 Monthly Maximum $1,000		Ages 1 through 6 Annual Maximum $50,000 Ages 7 through 21 Monthly Maximum $1,000		Ages 1 through 6 Annual Maximum $50,000 Ages 7 through 21 Monthly Maximum $1,000		Ages 1 through 6 Annual Maximum $50,000 Ages 7 through 21 Monthly Maximum $1,000	
Durable Medical Equipment	Deductible then 25%*	Deductible then 50%*	Deductible then 10%*	Deductible then 40%*	Deductible then 20%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*
Therapy Services (Per Visit; Physical, Occupational, Speech)	Deductible then 25%*	Deductible then 50%*	Deductible then 10%*	Deductible then 40%*	Deductible then 20%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*
	Maximum of 30 visits per calendar year, per therapy service type		Maximum of 30 visits per calendar year, per therapy service type		Maximum of 30 visits per calendar year, per therapy service type		Maximum of 30 visits per calendar year, per therapy service type	
Chiropractic Care	Deductible then 25%*	Deductible then 50%*	Deductible then 10%*	Deductible then 40%*	$20 Co-Pay	Deductible then 40%*	$15 Co-Pay	Deductible then 30%*
	Maximum of 26 visits per calendar year; no more than 1 visit per day		Maximum of 26 visits per calendar year; no more than 1 visit per day		Maximum of 26 visits per calendar year; no more than 1 visit per day		Maximum of 26 visits per calendar year; no more than 1 visit per day	
Prescription Drugs	***Administered by Express Scripts***							
30-Day Supply Tier 1 - Generic Tier 2 - Formulary Tier 3 - Non-Formulary	25% Min $10 - Max $25 Min $20 - Max $50 Min $35 - Max $100	Not Applicable	Each Tier: Deductible then 10%*	Each Tier: Deductible then 40%*	$10 $25** $45**	Not Applicable	$10 $25** $45**	Each Tier: 30%
90-Day Supply (Retail or Mail Order) Tier 1 - Generic Tier 2 - Formulary Tier 3 - Non Formulary	25% Min $20 - Max $50 Min $40 - Max $100 Min $70 - Max $200	Not Applicable	Each Tier: Deductible then 10%	Not Applicable	$15 $45 $90	Not Applicable	$15 $45 $90	Not Applicable

Note: The boxed areas of the grid are components of each plan most often used by members when making a plan choice, but are not all inclusive of plan options. Please refer to the **KEHP Summary Plan Descriptions (SPDs) for a complete list of benefits**. KEHP has made every attempt to ensure the accuracy of the benefits outlined in this Benefits Grid. However, if an error has occurred, the benefits outlined in the 2011 SPDs will determine how benefits are paid. Benefits are subject to the terms, conditions, limitations and exclusions set forth in the SPDs.
* Applies to out-of-pocket maximum **After the 75th prescription has been filled, excluding mail order, the prescription drug co-pays will reduce to $20 (Tier 2) and $35 (Tier 3).