

Commonwealth of Kentucky
Public Employee Health Insurance Program
Sixth Annual Report

Prepared for:
Commonwealth of Kentucky
Governor
General Assembly
And
Chief Justice of the Supreme Court

October 1, 2006

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EXECUTIVE SUMMARY

The Purpose of this Report: Scope and Process

In accordance with the provisions of KRS 18A.226(5)(b) enacted by the 2000 General Assembly as a part of Senate Bill 288, this document comprises the sixth Annual Report from the Kentucky Group Health Insurance Board to the Governor, the General Assembly, and the Chief Justice of the Supreme Court on the status of the Public Employee Health Insurance Program.

The report includes:

- A review of the history and development of the Public Employee Health Insurance (PEHI) Program.
- A summary of experience for the Commonwealth's PEHI Program for the 2005 calendar year with comment on the first six months of 2006 experience.
- A detailed analysis of pharmacy benefits.
- A summary of legislated health insurance benefit mandates and other mandates passed by recent General Assemblies that affect the Public Employee Health Insurance Program.

To prepare this report, research was jointly conducted by the Department for Employee Insurance (DEI) and PricewaterhouseCoopers LLP (PwC). It has been reviewed by the Board and modified to incorporate a full and accurate representation of the Board's findings and recommendations.

Please refer to the *Glossary* at the end of this report for definitions of terms used in the body of the report.

BACKGROUND AND HISTORY

The *Health Insurance Market for Employees and Retirees of Kentucky State Government – Research Report No. 286*, prepared by the Program Review & Investigations Committee Staff and dated August 12, 1999, provides the following historical context for the Commonwealth’s Public Employee Health Insurance (PEHI) Program:

The Commonwealth first contributed funds for the health insurance premiums of its employees in 1972. From that time until the mid 1980’s, Blue Cross & Blue Shield was the only insurance carrier offered to the state group. After experimenting with two HMO plans in 1981 and 1983, the Personnel Cabinet made more than a dozen additional plans, mostly HMOs, available to employees in 1984. Still, the indemnity plan offered by Blue Cross & Blue Shield was the dominant plan chosen. Of the 90,000 employees eligible for state-provided insurance in 1987, 64,000, or 71 percent, were enrolled in the Blue Cross & Blue Shield Key Care indemnity plan.*

In September 1987, Blue Cross & Blue Shield notified state officials of its intention to cancel the Key Care plan on October 15, 1987. This led to a decision by state policymakers to self-fund the healthcare program under the name Kentucky Kare.

* *Note: The Commonwealth first contributed funds for the health insurance premiums of teachers in 1972. However, the Commonwealth began contributing funds for the health insurance premiums of other state employees prior to 1972.*

As part of extensive changes to health insurance laws adopted in HB 250, the 1994 General Assembly established the Kentucky Health Purchasing Alliance (Health Purchasing Alliance), which became effective for “Public Employee Health Insurance (PEHI) Program” members effective July 1, 1995. Under the Health Purchasing Alliance, from mid-1995 through 1998 PEHI Program members had a choice of five Kentucky Kare options. In addition, PEHI Program members could also choose from among four HMO options, four POS options, or five PPO options—all offered through a variety of insurance carriers.

Due to mounting losses under Kentucky Kare as a result of adverse selection resulting from diminishing enrollment, the 1998 General Assembly enacted House Bill 315 which dissolved the Health Purchasing Alliance effective December 31, 1998. This led to the Commonwealth re-establishing an independent healthcare program for PEHI Program members called the “Commonwealth Public Employee Health Insurance Program.”

Modifications to the PEHI Program, 1999 to 2006

Beginning in 1999, the PEHI Program offered two HMO options (A and B), two POS options (A and B) and two PPO options (A and B) through insured arrangements with seven insurance carriers including Advantage Care, Aetna, Anthem, Bluegrass Family Health, CHA Health, Humana, and Pacificare. In addition, two indemnity plan options were offered to out-of-state retirees through Anthem.

In 2000:

All of these plan options continued to be offered, with the following principle adjustments:

- An EPO option was added to provide PEHI Program members with the choice of a plan with a lower employee premium contribution.
- The insurance carrier, Aetna, was no longer offered by the Program as an outcome of the 2000 Request for Proposal (RFP) process.
- A feature was added to all plan options that reduced the prescription drug co-payments after a member pays 50 co-payments in a year for themselves or covered family members.
- Coverage of outpatient mental health/chemical dependency services was expanded from:
 - 30 to 45 visits annually for the “A” options, and
 - 21 to 36 visits annually for the “B” options.
- Out-of-state retirees were allowed to enroll in any POS or PPO option offered by any of the Commonwealth’s insurance carriers since no carrier was willing to insure an indemnity plan for those retirees.
- The Commonwealth revised its member subsidy policy to provide for a subsidy that was at least equal to the Single premium rate for the lowest cost Option A in every county.

In 2001:

- The insurance carriers offering health insurance coverage to members of the PEHI Program changed as follows:
 - Aetna was re-introduced as a healthcare option for the PEHI Program in twenty-eight Kentucky counties.
 - Anthem expanded its PPO service area for members by fourteen counties.
 - Advantage Care ceased to exist.
 - Pacificare stopped offering health insurance to anyone in Kentucky.
 - Bluegrass Family Health expanded its service area for members by nine counties.
 - CHA withdrew its HMO and POS options from twenty-three counties; however, it introduced PPO options in four eastern counties in eastern Kentucky where it previously offered only HMO and POS options.
 - Humana discontinued its KPPA HMO for PEHI Program members.
- The following changes were made to the benefits offered by the plan:
 - Prescription drug co-payments in the PPO B option were reduced. For generic drugs, the member’s co-payment decreased from \$15 to \$10, for brand name drugs from \$20 to \$15, and for non-formulary drugs from \$40 to \$30.

- The cost for members in the PPO A option for diagnostic tests, performed in a setting other than a physician's office, was changed from a 20% co-insurance after meeting the annual deductible, to a flat \$10 co-payment.
- Inpatient (per day) and outpatient (per visit) limits on mental health and substance abuse services were eliminated from all the PEHI Program's health insurance options, in accordance with House Bill 268 enacted by the 2000 General Assembly.
- Benefit coverage for amino acid preparations and low-protein modified food products was added to all of the PEHI Program's plan options pursuant to House Bill 202 enacted by the 2000 General Assembly.

In 2002:

- In response to requests from Legislators and members of the Commonwealth's PEHI Program, the Commonwealth adopted two new requirements that must be met before a prospective health plan (bidding as part of the RFP process) could be offered to members of the PEHI Program in a particular county. Before it can be offered in a county, a health plan must:
 - Include at least one hospital in that county in its network, provided one or more hospitals exist in the county and any other bidder includes at least one of those hospitals in its network; and
 - Include at least 25% of the largest number of physicians in any other bidder's network for that county.
- In an effort to lessen the potential impact of adverse selection (i.e., when a person takes the likelihood that they'll need medical care into account when choosing a health plan, often resulting in "more costly" individuals in one option and "less costly" in another), the Commonwealth stipulated that a health plan's B option premium rates must be at least 5% lower, but no more than 10% lower than the A option premium rates for the same plan type (i.e., HMO, POS or PPO) and coverage level (i.e., Single, Parent Plus, Couple or Family).
- The following changes in carrier offerings occurred:
 - As in 2001, Anthem expanded its PPO service area for PEHI Program members by fourteen counties.
 - Aetna was discontinued as an offering for PEHI Program members in eleven counties.
 - While Bluegrass Family Health's HMO and POS options were newly offered in five counties, these options were discontinued in three counties. Bluegrass Family Health's PPO option was no longer available in one county where it was available in 2001. However, this option was newly introduced in eight counties.
 - CHA's HMO and POS options were discontinued in fourteen counties and newly added in thirteen counties. Its PPO options were added in four counties, but discontinued in the four counties where offered in 2001, due to provider contracting difficulties.
 - Humana's HMO and POS options were no longer available in three counties where offered in 2001 and its PPO options were discontinued in ten counties.

In 2003:

- Again, in response to requests from Legislators and members of the PEHI Program, the Commonwealth tightened the network requirements applicable to 2003 bids:
 - The 2002 RFP hospital requirement was continued.
 - However, to qualify as an offered health plan in a particular county in 2003, a health plan's network had to:
 - Include at least 25% of the largest number of primary care physicians in any other bidder's network bidding for the same plan type (i.e., HMO, POS or PPO) for that county; and
 - Include at least 40% of the largest number of specialist physicians in any other bidder's network bidding for the same plan type (i.e., HMO, POS or PPO) for that county, provided any bidder has more than five specialists in a county.
- Aetna did not respond to the Commonwealth's RFP, as it was not willing to continue to provide health insurance to members of the Commonwealth's PEHI Program. This affected eighteen counties and about 8,500 employees/retirees.
- Anthem withdrew from fifty counties, affecting around 15,600 employees and retirees.
- Bluegrass Family Health extended coverage to eight additional counties; however, due to either the Commonwealth's more stringent network requirements or termination of some providers' contracts, Bluegrass Family Health wasn't an option in six counties in 2003 where it was available in 2002.
- While CHA did not extend its service area to include more Commonwealth counties in its 2003 bid, it did extend its HMO and POS options to six additional counties and its PPO option to 46 additional counties. However, it failed to meet the Commonwealth's 2003 network requirements in two counties where it was available in 2002.
- Humana extended coverage (PPO only) to two additional Western Kentucky counties. However, due to its failure to meet the Commonwealth's 2003 network requirements, Humana failed to qualify in 2003 as an option in fourteen counties where it had been available in 2002.
- The following changes were made to the benefits offered by the plan:
 - Coverage of dental services was limited to care required as a result of an accidental injury, including anesthesia and hospital services that are medically required to safely provide dental care for children below the age of nine and persons with serious mental or physical conditions.
 - As specified in SB 152, enacted by the 2002 General Assembly, coverage was added for hearing aids and related services for persons under the age of eighteen, up to one hearing aid per impaired ear, up to \$1,400 every 36 months.

- Coverage limits were revised for low-protein modified foods and medical formulas for individuals with inherited metabolic diseases.
- Coverage of routine vision care was eliminated.
- A mail order pharmacy feature was added to allow members to receive a 3-month supply of maintenance prescription drugs for a 2-month co-payment.
- Finally, as enacted by the 2002 General Assembly:
 - Through HB 821, PEHI members were allowed to select coverage in a contiguous county and receive the Commonwealth's subsidy for that county, if the hospital in the county where member lived and worked did not offer certain services and a hospital in the contiguous county did.
 - Through HB 846:
 - restricted PEHI employees and retirees to one state subsidy for health insurance,
 - required entities participating in the PEHI Program to sign a contract with the Personnel Cabinet, and
 - allowed PEHI members to select coverage in a contiguous county and receive the Commonwealth's subsidy for that county, if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does (same provision as HB 821).

In 2004:

- The 2003 RFP hospital requirement was continued; however, the physician network requirements were modified such that the specialist physician network requirement only had to be met in counties where at least one bidder reported ten or more specialists, rather than in counties with five or more specialists as applied in 2003.
- The point at which members' prescription drug co-payments are reduced was increased from 50 co-payments per year, for a member and all his/her covered family members combined, to 75.
- Coverage was not available through Anthem under the PEHI Program. This affected sixteen counties where Anthem offered PPO coverage to PEHI members in 2003
- Humana:
 - Discontinued offering HMO or POS options to PEHI members, except in six northern Kentucky counties.
 - Failed to meet the Commonwealth's network requirements, with respect to its PPO options, in three counties where it offered PPO coverage to PEHI members in 2003.
 - Extended PPO coverage options in forty counties.

- Bluegrass Family Health failed to meet the Commonwealth’s network requirements in one county where it offered PPO coverage to PEHI members in 2003; however, it extended PPO coverage options in eight counties, and HMO and POS options in four counties.
- CHA newly offered HMO, POS, and PPO options in two counties.
- Through the Governor’s executive order, the Commonwealth provided a health insurance subsidy for employees electing the PPO A option dependent health insurance under the lowest cost carrier in the 21 counties where the cost of this coverage exceeded the cost in the other 99 counties. This subsidy was set to an amount in each affected county that resulted in all employees paying the same employee contribution, for all coverage tiers, for the lowest cost PPO A option.
- Legislation enacted by the 2003 General Assembly:
 - Through HB 95, the requirement that an employee’s employment must be in the same county as his/her residence for the employee to be eligible to elect coverage in an adjacent county and receive the Commonwealth’s subsidy for that county, if the hospital in the county where the member lives does not offer certain services and a hospital in the adjacent county does, was removed.
 - Through HB 430, the service required for SPRS, CERS and KERS participants to be eligible to participate in the PEHI Program was increased from five years to ten years for individuals hired on or after July 1, 2003.

In 2005:

- The Request for Proposal (RFP) was released with the following benefit changes:
 - The benefit options for the HMO, POS, and EPO plan types were removed.
 - The RFP included three (3) PPO Options for which bids were requested. These options include and are entitled:
 - “Commonwealth Essential”
 - “Commonwealth Enhanced”
 - “Commonwealth Premier”

(Please refer to the 2005 Plan section of Appendix A for a description of each of these options.)
- The RFP was released requesting carrier bids across six different scenarios. The scenarios were:
 - One vendor, per geographic region, under a fully-insured arrangement;
 - One vendor, statewide, under a self-insured arrangement;
 - One vendor, per geographic region, under a self-insured arrangement;
 - One vendor, statewide, under a fully-insured arrangement;

- One vendor, per geographic region, under a fully-insured arrangement (with alternate network access requirements, noted below); and
- One vendor, per geographic region, under a self-insured arrangement (with alternate network access requirements, noted below).

Please refer to Appendix B, 2005 Geographic Regions, for a map showing the geographic regions.

A *fully-insured arrangement* is the type of healthcare funding arrangement currently used by the Commonwealth. It requires insurers to assume the full risk of all the state employee healthcare costs in exchange for premium payments from the state. In contrast, a *self-insured arrangement* is one in which no insurance company collects premiums or assumes risk. Instead, the state would—in effect—act as its own insurance company, assume the cost risk and pay actual claims with the money normally earmarked for insurance company premiums.

- For scenarios one through four, the following network requirements had to be met:
 - Hospital Requirement: If one or more hospitals exist in a county, the vendor must have at least one of the county's hospitals in its network, unless no bidder for the county, under the scenario being considered, have any of that county's hospitals in its network.
 - Physician Requirement: The vendor must have at least 25% of the county's PCP's in its network. If there are ten or more specialist physicians submitted as practicing in the county, the vendor must have at least 40% of the county's specialist physicians in its network.
- For scenarios one and three the following requirements were in addition to the above:
 - Must meet both hospital and physician network requirements in 85% of the counties within the region and in counties where at least 85% of the group members reside.
- For scenarios two and four, the following requirements were in addition to the above:
 - Must meet both hospital and physician network requirements in each of the eight in-state regions in 85% of the counties within a region and in counties where at least 85% of the group members reside.
- For scenarios five and six, the following network requirements had to be met:
 - Hospital Network Requirement: The vendor must have at least one network hospital in 75% of the counties having a hospital in each region.
 - PCP Network Requirement: The vendor must have at least eight PCPs per 1,000 eligible Commonwealth members per region. Additionally, each vendor must have at least one PCP in each county where it has a hospital.
 - Specialist Network Requirement: Vendor must have at least six specialists per 1,000 eligible Commonwealth members per region.
- Contracts were signed and the following carriers were awarded the following regions:
 - Anthem was awarded Region 1 and Region 2 under a self-insured basis.

- United Healthcare was awarded Region 3 and Region 6 under a fully-insured basis.
- Bluegrass Family Health was awarded Region 4 and Region 5 under a fully-insured basis.
- CHA Health was awarded Region 7 and Region 8 under a fully-insured basis.
- For the first time in many years, Humana was not awarded any area in the Commonwealth.
- For the first time, the employee's cost for health insurance was based on their salary.
- For the first time, the Commonwealth offered an additional subsidy to employees that did not smoke.
- Out-of-state retirees were assigned to the county of their last employment for purposes of selecting healthcare. This created concern from the out-of-state retirees who worked for the state or for those that retired from Regions 4, 5, 7 and 8 because Bluegrass Family Health and CHA Health were regional carriers and did not immediately have a nationwide network. This caused members to accept out-of-network benefits.
- Because this was the first major benefit change in a number of years, state employees and teachers (led by the Kentucky Education Association) held protests throughout the Commonwealth, many were bused to Frankfort for a day of protest and teachers threatened to strike.
- After several weeks, Governor Fletcher called the General Assembly into a special session to deal with the shortage of money available to fund the program. As a result of the special session, HB 1 was passed. In summary, HB 1 made the following:
 - Retained the Commonwealth Essential Option Plan and removed the Commonwealth Preferred and Commonwealth Premium Options.
 - Restored the 2004 PPO A plan benefits as the Commonwealth Enhanced Option.
 - Offered the Commonwealth Premier Option.
 - Provided additional funding for these three options, including additional dependent subsidies.
 - Set the employee contributions as outlined in HB 1.
 - Restored the employer contribution to the healthcare FSA for employees waiving coverage to \$234.
 - Required the Personnel Cabinet to submit the benefits for the 2006 Plan Year to the Employee Advisory Committee thirty (30) days prior to the release of the Request for Proposal.
 - Created the Blue Ribbon Panel on Public Employee Health Benefits for the purpose of examining all aspects of health benefits available to public employees including the procurement process, benefits offered, plan membership, implementation, maintenance and administration of the plan; alternative methods of providing benefits and services, and any other issues related to public employee health benefits the panel determines to be relevant.

In 2006:

- An RFP for the 2006 Plan Year was released, marking a dramatic change in the Commonwealth's strategy for providing employee healthcare benefits. This RFP solicited bids for:
 - A single vendor to provide Third Party Administration (TPA) services on a state-wide basis;
 - A single vendor to provide Pharmacy Benefits Administration (PBA) services on a state-wide basis; and
 - A single vendor to provide administrative services for Flexibles Spending Accounts (FSA), HIPAA and COBRA. The contract for these services was to be awarded to the vendor for medical TPA services, but was structured as a separate contract to provide flexibility to the Commonwealth in future years.
- The Commonwealth moved from a program that had historically been fully-insured to a program that was self-insured statewide.
- Emphasis was placed on experience with a large employer group, having at least 100,000 covered lives.
- A national provider network was also critical to a successful bid, to ensure adequate provider networks for out-of-state retirees.
- To provide further emphasis to this change in direction, the plan was given a name change, and is now called the "Kentucky Employees Health Plan".
- Benefits for 2006 would remain the same as those offered in 2005, with the same three benefit plan options available:
 - "Commonwealth Essential"
 - "Commonwealth Enhanced"
 - "Commonwealth Premier"
- Contracts were awarded and signed as follows:
 - Humana was awarded a contract for medical claims administration
 - Humana was also awarded a contract for administration of Flexible Spending Accounts, HIPAA and COBRA
 - Express Scripts was awarded a contract for pharmacy benefits administration
- For the first time, contracts were awarded for a multi-year term. The initial term of the contracts was 30 months, with eight (8) optional one-year renewals – meaning the contracts could be in place for ten and one-half years.
- None of the insurance carriers who had provided coverage in 2005 were awarded contracts for 2006:

- Bluegrass Family Health and CHA Health did not meet the minimum vendor requirements and were ineligible to bid; and
- Anthem and United HealthCare were not selected.
- The incentive for those employees who don't smoke was continued in 2006, with a \$15 per month incentive for employees with single (employee-only) coverage, and a \$30 per month incentive for employees who chose to cover their dependents.
- Employee contributions did not change from 2005 to 2006. The Commonwealth absorbed any claims or other costs in 2006 that are above the employee contributions.
- The Commonwealth's contribution for those employees who waive coverage was reduced again, from \$234 per month, to \$200 per month, for the period July-December.
- Legislation passed during the 2006 Regular Session of the General Assembly (HB380) mandated a 12% reduction in the employer contribution amount for July-December, effectively reducing total monthly premium equivalents by about \$10 million per month, to about \$85 million. There was no corresponding decrease in employee contributions.

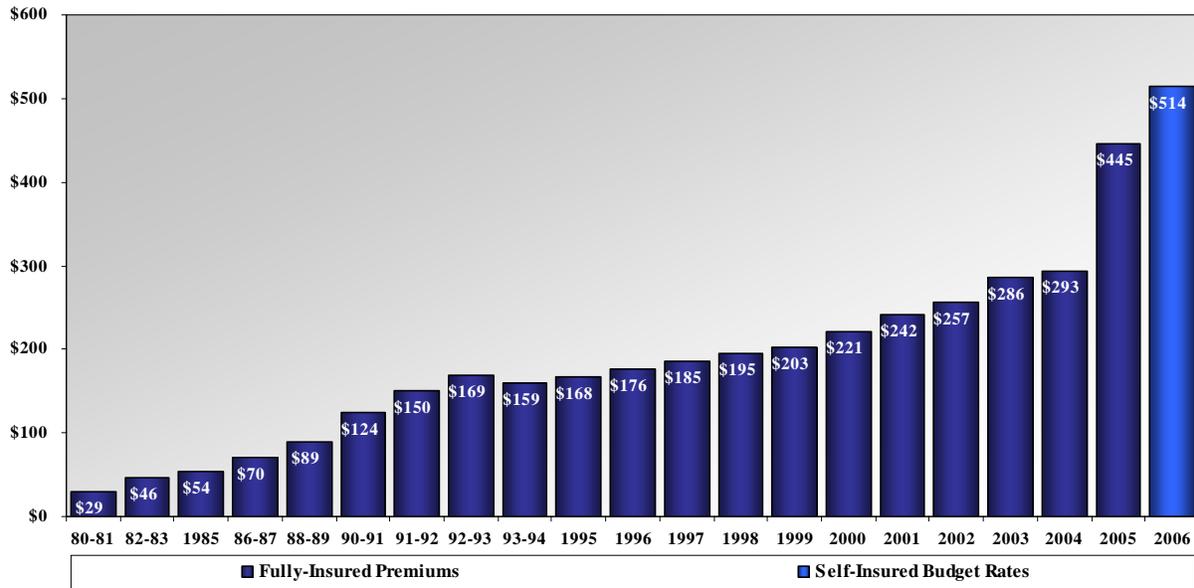
Historical Per Employee / Retiree Commonwealth Health Plan Subsidies

The Commonwealth's per employee subsidy from the 1980 plan year through 2006 is illustrated in Exhibit I below. The Commonwealth's average monthly subsidy toward the cost of an employee's health insurance coverage (for those who have elected coverage) has risen from \$9.72 per month in 1972 to \$468 in 2005 and a projected \$467 in 2006.

The Commonwealth significantly increased its subsidy for employee health insurance in 2005. Even with this increase there was not a significant decrease in the number of employees waiving coverage.

Exhibit I

Historical Commonwealth Per Employee Per Month (PEPM) Health Benefit Subsidy For Those Electing Coverage



Source: Fifth Annual Report and Commonwealth's enrollment and claims data aggregated by MedStat.

Commonwealth subsidies through 2005 are based on the total fully-insured premium amounts paid by the PEHI program less employee contributions. In 2006 the benefit plans' funding changed from a fully-insured basis to a self-insured basis, effectively removing the insurance companies' margins from the cost basis. The basis for the self-insured costs in 2006 is incurred claims plus administrative fees, without an insurance company margin. This change in funding had the effect of maintaining the Commonwealth's estimated 2006 subsidy at roughly the same level as experienced with the fully-insured 2005 premium.

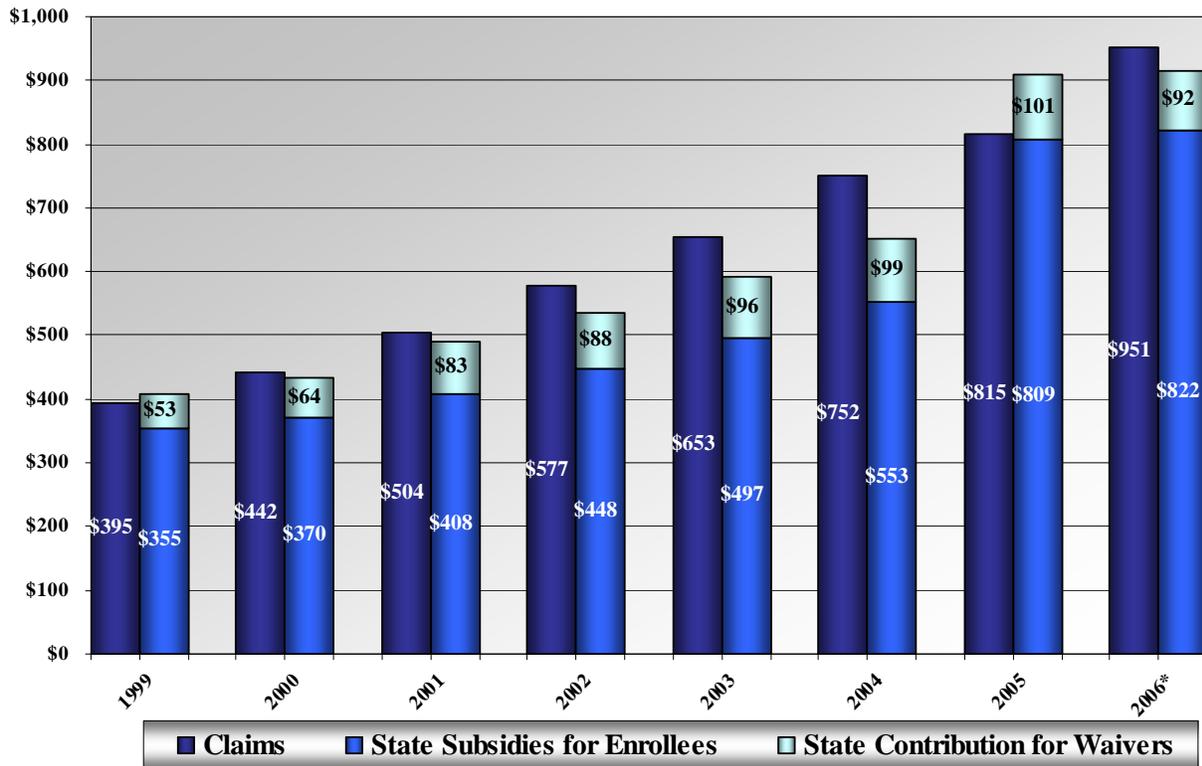
PEHI Program Aggregate Costs, 1999 to 2006

The total dollars in health insurance incurred claims paid by the insurers covering members of the PEHI Program in 1999 through 2005 and by the Commonwealth's self-funded program in 2006 are identified in the "Claims" bars in Exhibit II. For 2006 the annual claims have been estimated based on the 2006 experience year to date, projected to the end of the year.

Also shown are the contributions made by the Commonwealth into the healthcare FSAs for employees who have waived coverage.

Exhibit II

Historical Annual PEHI Program Claims and Net Commonwealth Costs (\$Millions)



Source: Claims reported by the Commonwealth’s insurers and compiled by MedStat and enrollment reported by the Commonwealth.

* 2006 figures reflect estimates based on January through June 2006 claims experience, projected to year end.

Exhibit II includes the amounts the Commonwealth expended in subsidies in 1999 through 2006 (estimated) for all members of the PEHI Program. The section of each bar labeled “State Subsidies for Enrollees” reflects the amounts subsidized by the Commonwealth for those individuals who elected health insurance through the PEHI program. The lighter section at the top of this bar identifies the Commonwealth’s contribution to a healthcare flexible spending account for all eligible individuals who waived health insurance through the PEHI program, as well as contributions to other health insurance for retirees waiving coverage.

The amounts shown as the Commonwealth’s subsidies include the portion of the PEHI program premiums paid by all of the employers and retirement systems for individuals eligible to participate in the Public Employee Health Insurance Program. ***These amounts assume that all participating groups apply the same employer subsidy policy as applies to state and school district employees.***

Finally, all retirees are assumed to receive the maximum subsidy amount applicable to non-hazardous duty retirees.

Employee contribution rates for 2006 did not change from 2005. Exhibit III provides a table of monthly employee contribution rates for both 2005 and 2006 by plan option, coverage tier, and non-smoker versus smoker status. The previous estimate of the Commonwealth’s subsidy in 2005 and 2006 was based on total costs incurred offset by these employee contributions.

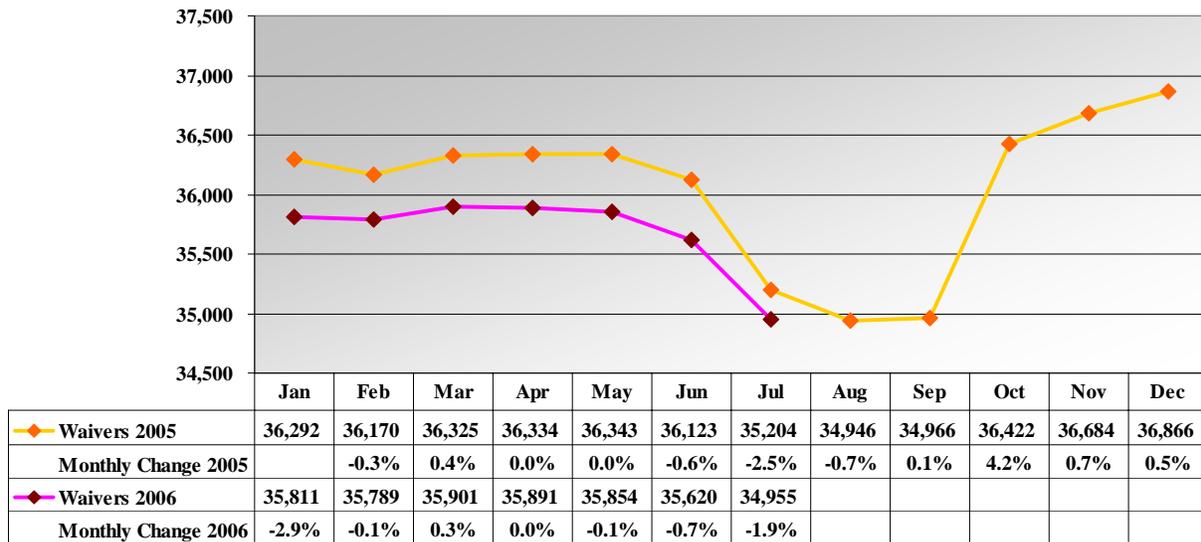
Exhibit III

2005 and 2006 Monthly Employee Contribution Rates

		Monthly Employee Contribution Rates				
		Single	Couple	Parent Plus	Family	Cross Ref
2005 Rates						
Essential Plan:						
Non-Smoker			\$259.52	\$55.00	\$320.14	\$0.00
Smoker			\$289.52	\$85.00	\$350.14	\$15.00
Enhanced Plan:						
Non-Smoker		\$0.00	\$357.72	\$114.00	\$429.24	\$9.72
Smoker		\$15.00	\$387.72	\$144.00	\$459.24	\$24.72
Premier Plan:						
Non-Smoker		\$18.20	\$398.66	\$170.38	\$474.74	\$33.08
Smoker		\$33.20	\$428.66	\$200.38	\$504.74	\$48.08
2006 Rates						
Essential Plan:						
Non-Smoker			\$259.52	\$55.00	\$320.14	\$0.00
Smoker			\$289.52	\$85.00	\$350.14	\$15.00
Enhanced Plan:						
Non-Smoker		\$0.00	\$357.72	\$114.00	\$429.24	\$9.72
Smoker		\$15.00	\$387.72	\$144.00	\$459.24	\$24.72
Premier Plan:						
Non-Smoker		\$18.20	\$398.66	\$170.38	\$474.74	\$33.08
Smoker		\$33.20	\$428.66	\$200.38	\$504.74	\$48.08

The Commonwealth provides employees who waive coverage with a deposit into their healthcare flexible spending account (FSA) to be used to pay for health care expenses incurred out-of-pocket. For 2005 this monthly amount was \$234; for 2006 the \$234 amount was maintained for the months January through June, and then decreased to \$200 per month for the remainder of 2006. Exhibit IV shows the monthly waiver participation for the period January 2005 through July 2006. 2005 exhibited significant waiver participation seasonality month to month, a pattern than appears to be repeating for 2006.

Exhibit IV
2005 and 2006 Monthly Coverage Waiver Participation



Source: Commonwealth's enrollment data.

The Commonwealth's contribution to the healthcare flexible spending accounts of individuals who waived health insurance also includes forfeitures from these accounts. Actual end of year forfeitures resulting from the "use it or lose it" rule represent an offset to this cost, and have historically equaled approximately 5% of the total amount shown as the state contribution for waivers in Exhibit II.

THE COMMONWEALTH HEALTH INSURANCE PROGRAM

An Examination of 2005 Experience

This section of the report provides a summary of the trends identified from claims and enrollment data submitted by the insurance carriers providing health insurance coverage to those participating in the Commonwealth's Public Employee Health Insurance (PEHI) Program. This summary of relevant information and trends is based on health benefits data for the Commonwealth compiled by MedStat. Note that the analysis below does not reflect fully-insured premiums, but actual claims experience incurred within the health plans offered by the Commonwealth.

A Note about 2005 and 2006 Claims Experience

Claims for medical and pharmacy services and supplies received by PEHI Program members in 2005 as shown in this report differ from that shown in last year's report due to the fact that this year's report includes complete 2005 data (defined as claims incurred in 2005 and paid through June 2006; claims incurred in 2005 but not yet paid as of the end of June have been estimated).

Claims for medical and pharmacy services and supplies received by PEHI Program members in 2005 that were not paid as of June 30, 2006 (i.e., incurred but not reported claims, or IBNR claims) have been actuarially estimated and included as part of this report.

At the time of the writing of this report, 2006 claims data were available through June 2006. Calendar year 2006 claims experience was estimated by applying the claims seasonality observed in 2005 to the six months of claims experience available in 2006. "Seasonality" refers to variations in claims payments over the course of a year resulting from the timing of meeting deductibles (lower levels of claims early in the year) and maximum out-of-pocket limits (higher levels of claims later in the year).

Throughout this report, unless otherwise noted, references to "claims" reflects incurred claims (both paid and not yet paid), rather than just claims paid.

Medical & Pharmacy Trends for 2005

Key Findings & Considerations

The key findings and considerations from our Medical and Pharmacy Analysis from 2004 to 2005 are as follows:

- The aggregate percentage increase (or "trend") in medical and pharmacy claims costs from 2004 to 2005 (inclusive of estimated IBNR) was 7.4% (reflective of total claims cost increase, not just the Commonwealth's expenditures).
- Claims costs have more than doubled from 1999 to 2005.
- The Commonwealth's medical and pharmacy claim costs were being driven primarily by hospital inpatient and outpatient services (53.6% in 2005), which is consistent with today's healthcare norms and 2004 experience.

- In-network utilization, at 96.5%, is higher than industry expectations, and represents an increase from the 94% experienced in 2004. The Commonwealth has a comprehensive network and strong utilization of that network.
- Utilization, by place of service (hospital, physician, etc.) remained relatively consistent from 2004 to 2005.
- 2005 Insurance Premiums increased by 28.5%. Note that this increase relates only to the fully-insured premium rate, and does not relate to changes in claims from 2004 to 2005.

Additional facts and figures in support of these findings, along with additional analysis, are provided in the sections below.

Detailed Findings

As a whole, the Commonwealth's health insurance carriers issued payments to medical providers (excluding pharmacies) of approximately \$632.1 million in calendar year 2005 for services received by PEHI Program members. This represents an aggregate increase of 8.2% (7.3% per member per month) over calendar year 2004, which—in turn—followed a 15.1% increase from 2003 to 2004, and an 11.9% increase from 2002 to 2003. The aggregate increase differs from the PMPM increase given that it includes growth related to the increased number of members covered by the program.

Payments for the PEHI Program pharmacy benefits increased by 8.6% in aggregate (7.7% per member per month) from \$168.1 million in 2004, to \$182.6 million in 2005. The increase from 2003 to 2004 was 15.8% increase, and the increase from 2002 to 2003 was 17.7%. These year-to-year cost increases for medical and pharmacy benefits are summarized below in Exhibit V.

Exhibit V 2003 – 2005 Claims Experience

Public Employee Health Insurance Program Historic Experience						
	2003	% Change	2004	% Change	2005	% Change
Aggregate						
Medical Claims	\$507,455,720	11.9%	\$584,015,270	15.1%	\$632,078,698	8.2%
Rx Claims	\$145,128,110	17.7%	\$168,061,796	15.8%	\$182,552,968	8.6%
Total Claims	\$652,583,830	13.1%	\$752,077,066	15.2%	\$814,631,666	8.3%
Premiums Paid	\$694,293,552	10.6%	\$740,994,630	6.7%	\$952,279,912	28.5%
Covered Lives	226,399	0.3%	227,917	0.7%	229,870	0.9%
Per Member Per Month						
Medical Claims	\$187	11.6%	\$214	14.3%	\$229	7.3%
Rx Claims	\$53	17.3%	\$61	15.0%	\$66	7.7%
Total Claims	\$240	12.8%	\$275	14.5%	\$295	7.4%
Premiums Paid	\$256	10.3%	\$271	6.0%	\$345	27.4%
Loss Ratio	94.0%		101.5%		85.5%	

Source: Claims and premiums reported by the Commonwealth's insurers and enrollment reported by the Department for Employee Insurance compiled by MedStat.

The average annual trend experienced by the Commonwealth over the 2003 to 2006 period has been 12.1%. This figure is based on claims experience through June 2006, adjusted for IBNR claims and expected claims seasonality for the remainder of 2006. The trend measurement is based on annual change in the PMPM claims, and has not been adjusted for (a) changes in insurers and underlying networks and discount rates, (b) changes in plan design provisions, and (c) changes in underlying demographics such as selection by option and/or coverage tier. In short, the trend figures presented here are measures of how the underlying claims have changed for the Commonwealth over the 2003 through 2006 period.

By comparison, participants in Segal Company's 2005 *Health Plan Cost Trend Survey* recently reported actual 2005 experience as an update to previously published projections. The reported aggregate medical and pharmacy cost benchmark increases nationwide were 12.6% for actual total medical expenditures and 12.2% for actual pharmacy costs.

Because pharmacy expenditures have increased in general at a higher rate than other healthcare expenses over the last three years, pharmacy service expenditures have grown as a percentage of the Commonwealth's total healthcare expenditures from 21.4% in 2002, to 22.2% in 2003, to 22.3% in 2004, and to 22.4% in 2005. By further comparison, pharmacy claims expenditures comprised 18.1% of PEHI Program members' healthcare claims in 1999.

Total healthcare claims (medical and pharmacy) increased in aggregate by 8.3% from 2004 to 2005. This followed an increase of 15.2% from 2003 to 2004 and 13.1% from 2002 to 2003. In 2005, these expenditures totaled almost \$815 million. Again, by further comparison, health insurance claims totaled a little less than \$395 million in 1999.

In just six years the PEHI Program's claims cost have more than doubled, even though there was little change in the number of covered individuals over that time period.

Fully Insured Premium Increases

While claim payments to medical providers form the majority of a health plan's expenditures, every health plan—whether insured or self-insured—incur operational expenses for claims payment, network management, care management, and associated services. Between 1999 and 2005 the Commonwealth had fully-insured all of its health options. Therefore, the total expenditures paid by the Commonwealth and participating PEHI Program members to purchase health insurance were the fully-insured premiums paid to the insurance carriers bearing the risk for the Program.

In calendar year 2002, these premium payments totaled roughly \$628 million. This reflected an increase from 2001 of 12.5%. In calendar year 2003, these premium payments totaled roughly \$694 million, an increase from 2002 of 10.6%. In calendar year 2004, premium payments totaled \$741 million, reflecting a 6.7% increase from 2003. In calendar year 2005, the premium payments significantly increased to approximately \$952 million, an increase of 28.5% over 2004.

The Commonwealth's 2001 to 2002 premium increase of 12.5% was lower than the cost increase reported by employers that participated in Segal's *Health Plan Cost Trend Survey*, and the Commonwealth's 2002 to 2003 premium increase of 10.6% was slightly lower than the average reported by 2003 survey respondents (14.5%). The Commonwealth's 2003 to 2004 premium increase of 6.7% is well below the average reported by the 2004 survey respondents (13.6% for medical and 13.3% for pharmacy).

Medical Loss Ratio

Over the three year period 2002 through 2004, payments for medical supplies and services received by PEHI Program members increased at a faster pace than premiums paid to the Commonwealth's insurance carriers. This trend was reversed in 2005 (in prior years the premiums paid by the Commonwealth to its insurers had not kept up with overall cost). As a result, the loss ratio had gone up dramatically through 2004. In 2001, the loss ratio was at 90.2%; it had increased to 91.9% in 2002, and increased again to 94.0% in 2003. In 2004, the PEHI Program's loss ratio increased to 101.5%. The 85.5% loss ratio experienced in 2005 returned the fully-insured basis for the PEHI Program to a level desired by the Commonwealth's insurers.

In the marketplace generally, the future year's fully-insured premiums quoted by the insurance carriers would be expected to be set such that the premiums would recoup any deficits ("deficit" defined as the excess of the actual loss ratio over the typical carriers target level of 85% to 90%) incurred in previous years. However, in the Commonwealth's situation, it does not appear as if the selected insurance carriers set 2005 rates to attempt to recoup previous year deficits.

From 2004 to 2005 the Commonwealth's premiums increased 28.5%, well in excess of general healthcare inflation for the same period. The actual "loss ratio" (i.e., incurred claims divided by premiums paid) for 2003 was 94%, an amount well above the range desired by insurance carriers providing operating and risk margins. Typically carriers target premiums so that the loss ratio is maintained between 85% and 90%. The realized 94% loss ratio in 2003 would have potentially warranted a premium increase of more than 6.7% for 2004. The 2004 loss ratio of 101.5% in effect, meant that the premiums received from the Commonwealth and members did not cover the claims cost incurred, much less the required operating and risk margins. With the 28.5% increase in premium in 2005, the loss ratio experienced was 85.5% and was within the desired 85% to 90% loss ratio target sought by health insurers for fully-insured plans.

2006 Transition to Self Insurance

In 2006 the Commonwealth has begun self-insuring the program. Therefore, the premium equivalent rates for this year reflect the cost of claims, administration or other services, without any margin for insurance company risk. This change in funding arrangement is transparent to members as it has no impact on plan design. It is designed to only change the funding approach by the Commonwealth, and benefits the Commonwealth by (1) removing insurance premium profit and margin, (2) permits greater flexibility in plan design, and (3) more closely relates costs to claims activity.

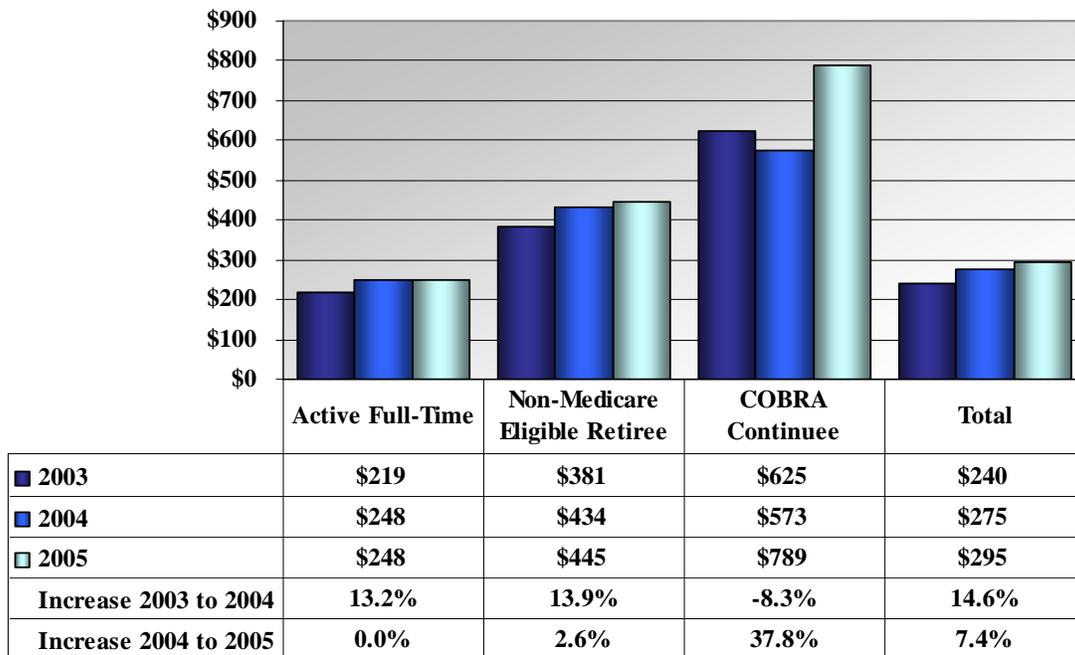
Claims Payment by Type of Enrollee

As noted above, PMPM medical and pharmacy claims increased from 2004 to 2005 by 7.4%. Exhibits VI, VII, and VIII provide similar summaries of the PMPM cost increases for 2003 through 2005 for actives, retirees, and COBRA continuees, split into medical and pharmacy combined (Exhibit VI), medical only (Exhibit VII), and pharmacy only (Exhibit VIII). Claims for non-Medicare eligible retirees in 2005 were approximately 1.8 times higher than those of active employees, while claims for COBRA continuees were approximately 3.2 times that of active employees.

The overall increase comprises the mix of active employees and non-Medicare eligible retirees (COBRA participants are also included, however the number of COBRA participants is too small to impact the overall averages). Between 2004 and 2005 (and, in fact, for several years prior to 2004) there has been a gradual migration from the active employee group to the non-Medicare eligible retiree group. As a result, the above 7.4% increase should be recognized to also include the impact of the gradual aging of the covered population. This issue will be discussed in more detail later.

Exhibit VI

Total Medical and Pharmacy Claims Paid Per Member Per Month (PMPM)

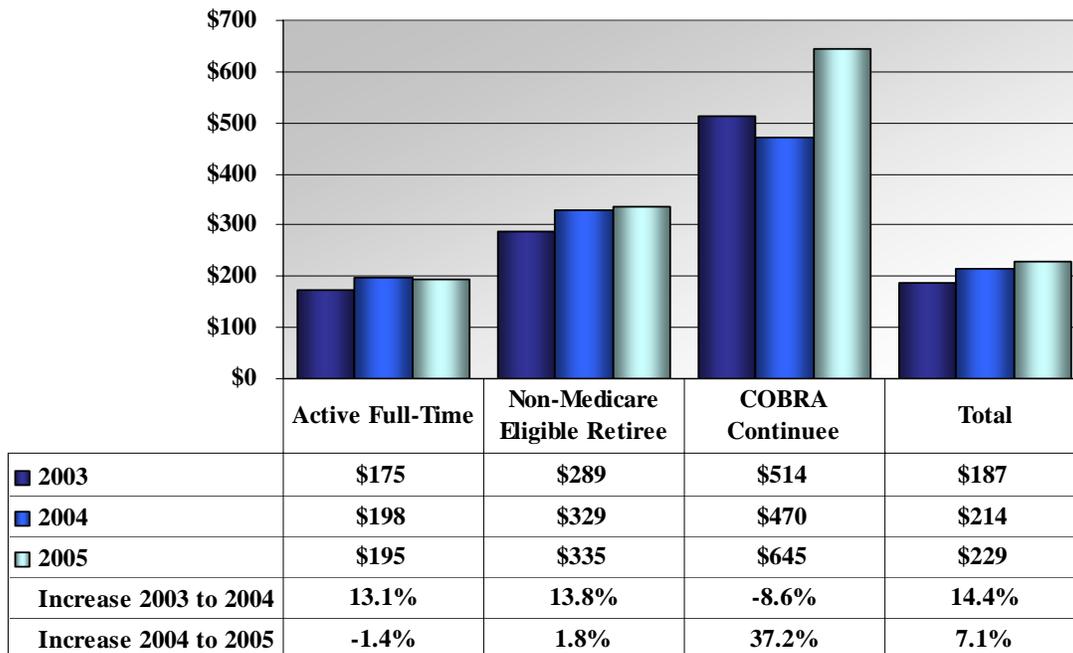


Source: Claims reported by the Commonwealth's insurers and enrollment reported by the Department for Employee Insurance compiled by MedStat

When looking at medical claims only (Exhibit VII), the average PMPM change from 2004 to 2005 for each of the active employee and non-Medicare eligible retiree groups was nearly flat (1.4% decrease for actives, 1.8% increase for retirees). Non-Medicare eligible retiree medical and COBRA medical claims in 2005 were approximately 1.7 and 3.3 times that of the active employees, respectively.

Exhibit VII

Medical Claims Paid Per Member Per Month

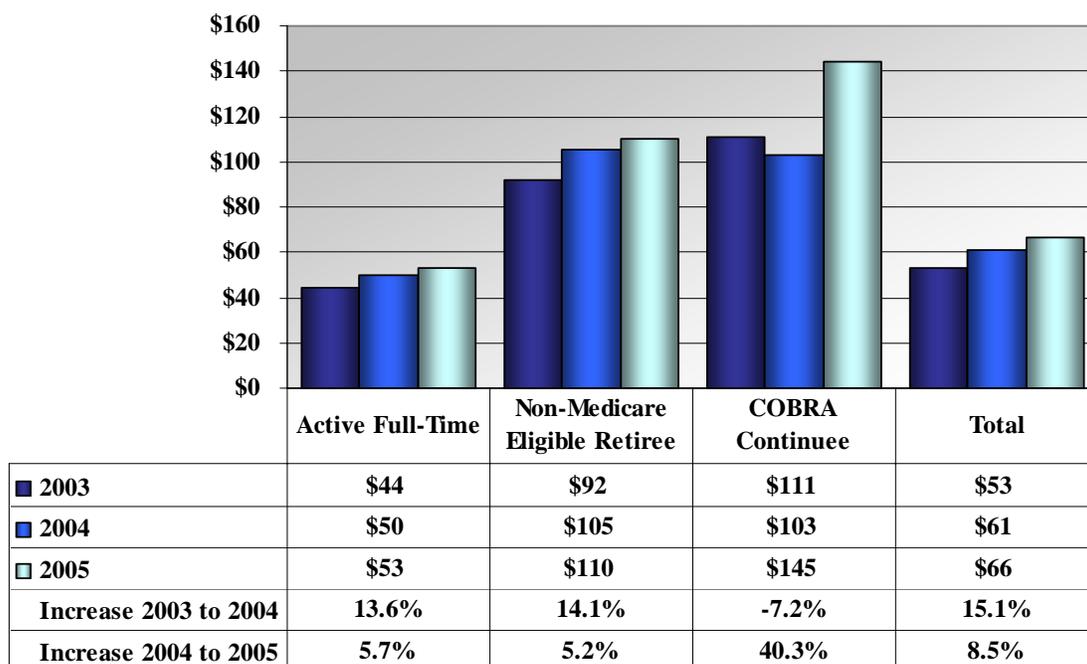


Source: Claims reported by the Commonwealth's insurers and enrollment reported by the Department for Employee Insurance compiled by MedStat.

Similarly, when looking at pharmacy claims only (Exhibit VIII), the average PMPM change from 2004 to 2005 for each of the active employee and non-Medicare eligible retiree groups increased by 5.7% and 5.2%, respectively. Non-Medicare eligible retiree pharmacy and COBRA pharmacy claims in 2005 were approximately 2.1 and 2.7 times that of the active employees, respectively.

Exhibit VIII

Pharmacy Claims Paid Per Member Per Month



Source: Claims reported by the Commonwealth's insurers and enrollment reported by the Department for Employee Insurance compiled by MedStat.

Claims By Place of Service

The distribution of claims by place of service has not changed appreciably from 2004 to 2005. As the population gradually ages and as retirees comprise a larger proportion of the population the portion of total claims in the prescription drug, inpatient hospital, and other facility would be expected to grow. Exhibit IX shows the paid claims distribution by provider place of service.

Exhibit IX

Claims Distribution by Place of Service

	Public Employee Health Insurance Program Historic Experience Split by Place of Service			
	2004	% of Total	2005	% of Total
Paid Claims				
Inpatient Hospital	\$180,706,598	24.0%	\$190,427,104	23.4%
Outpatient Hospital - ER	\$27,698,334	3.7%	\$24,070,766	3.0%
Outpatient Hospital - Non-ER	\$186,129,981	24.7%	\$215,340,163	26.4%
Other Facility (e.g. SNF, Hospice, ESRD)	\$3,986,003	0.5%	\$5,576,312	0.7%
Professional - Office	\$138,641,755	18.4%	\$155,449,296	19.1%
Professional - All Other	\$46,852,600	6.2%	\$41,215,057	5.1%
Prescription Drugs	\$168,061,796	22.3%	\$182,552,968	22.4%
Total Claims	\$752,077,066		\$814,631,666	

Source: Commonwealth's claims data aggregated by MedStat; adjusted for incurred but not reported claims.

Enrollment/Demographic Analysis

Key Findings & Considerations

The key findings and considerations from our Enrollment and Demographic Analysis from 2004 to 2005 are as follows:

- The 2005 population is only slightly older than the 2004 population. This general aging of the covered population would be actuarially expected to produce a 1.0% increase in costs when compared against an age-static population.
- The number of enrolled employees/non-Medicare eligible retirees has increased slightly year over year.
- The percentage of enrollees electing employee only coverage has decreased, with an increase in employee plus spouse and family coverage
- The ratio of the number of dependents enrolled to the number of employees enrolled has been consistent from 2004 to 2005 to 2006.
- It has been noted in the past that some Medicare eligible plan participants (dependents of non-Medicare eligible retirees) do not have Medicare as their primary coverage (*“primary” coverage refers to the plan that pays first, with secondary coverage only paying after the primary plan has paid*), and that the PEHI Program coverage is being used as the primary insurance in those instances. As the proportion of non-Medicare eligible retirees grows (and with them, presumably, Medicare eligible dependents) there will be an added cost impact due to the PEHI plans being used as the primary coverage.
- While non-Medicare eligible retirees account for 22.1% of plan membership in 2005, they account for:
 - 32% of medical costs
 - 37% of pharmacy costs
 - 33% of total health care costs
- The percentage of eligible employees opting out of coverage is consistent with national norms; however, other employers are typically able to achieve this percentage with significantly lower (or no) incentives.
- Plan options and the employee contribution levels were revised for 2005. Employee contributions have not changed between 2005 and 2006.

Additional facts and figures in support of these findings, along with some additional analysis, are provided in the section below.

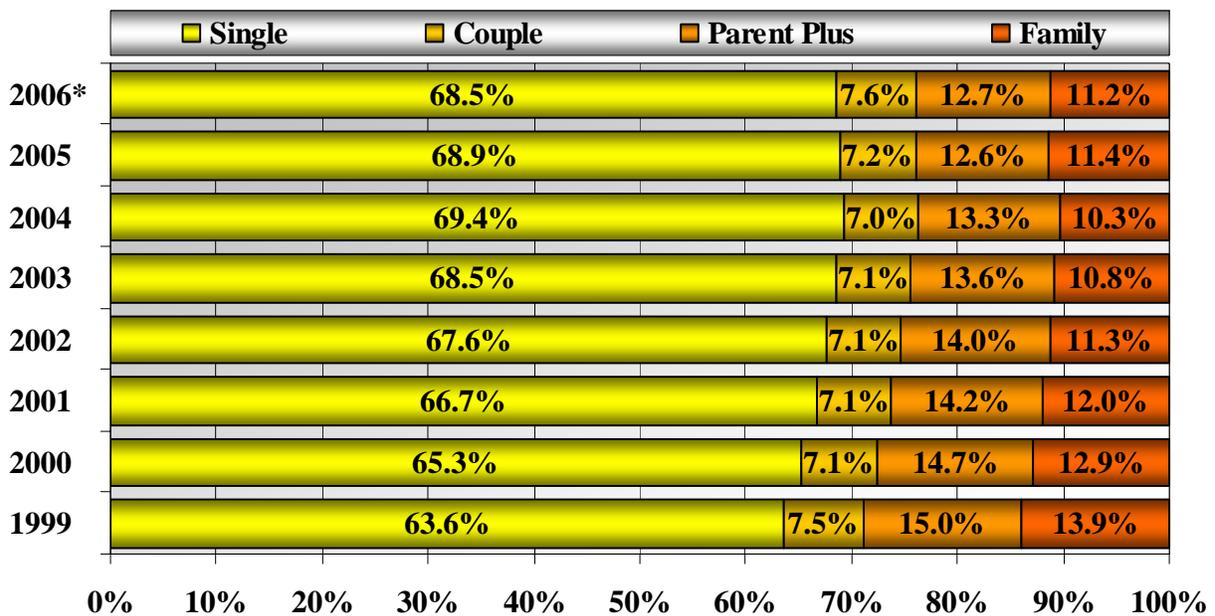
Detailed Findings

The number of employees / non-Medicare eligible retirees in the PEHI Program electing health insurance increased from about 137,024 in 2001 to 143,920 in 2004, 143,911 in 2005, and 146,814 in 2006 (year to date average for 2006). The count for 2005 remained essentially

unchanged from 2004. As illustrated in Exhibit X, in 2005, for the first time since 1999, the percentage of plan enrollees who elected employee only coverage declined slightly, while the percentage of enrollees electing couple coverage increased slightly and the percentage electing employee plus family coverage increased by a percentage point, a shift based on the patterns seen over the last 6 years. Enrollment in 2006 continues the shift seen in 2005 with fewer employees electing single coverage and more employees electing couple and parent plus coverage. Historical patterns are likely the result of:

- The impact of the Commonwealth’s historical subsidy structure – the Commonwealth paid the full cost of single coverage under the lowest cost option provided, the Enhanced Plan (the Essential Plan is not available for single only coverage), but did not directly subsidize any portion of the cost of dependent health insurance coverage;
- The frozen contributions in 2006 versus 2005 contributed to the shift into coverage tiers with dependents (Parent Plus and Family); and
- A continuing increase in the number of retirees covered under the Program contributed to the shift from the single and parent plus coverages to couple coverage.

Exhibit X
Enrollment By Coverage Tier



Source: Commonwealth’s enrollment reported by the Department for Employee Insurance and aggregated by MedStat.

The shift in enrollment seen in 2005 can most likely be attributed to the shift in subsidy strategy for dependents. The Commonwealth, in 2005, provided a richer dependent subsidy than was provided in 2004, perhaps impacting the shift from single coverage to couple coverage, and from parent plus to family coverage.

Group Composition

The group composition of the enrollment in the PEHI Program has changed in 2005. There was a decrease from 2004 to 2005 in the number of active members employed in aggregate by state agencies, school boards, and health departments, continuing the decline seen in prior years (though 2006 year to date has shown a significant increase in active members). The number of members participating through KERS and KTRS increased measurably from 2003 to 2005, as illustrated in Exhibit XI. The increase in retirees from 2005 to 2006 has not been as significant, but still is growing faster than the active group. While retirees and their covered dependents comprised 14.3% of the total insured PEHI Program in 1999, by the end of June 2006 they comprised 22.1% of the group.

Exhibit XI

Average Number of Covered Members By Group

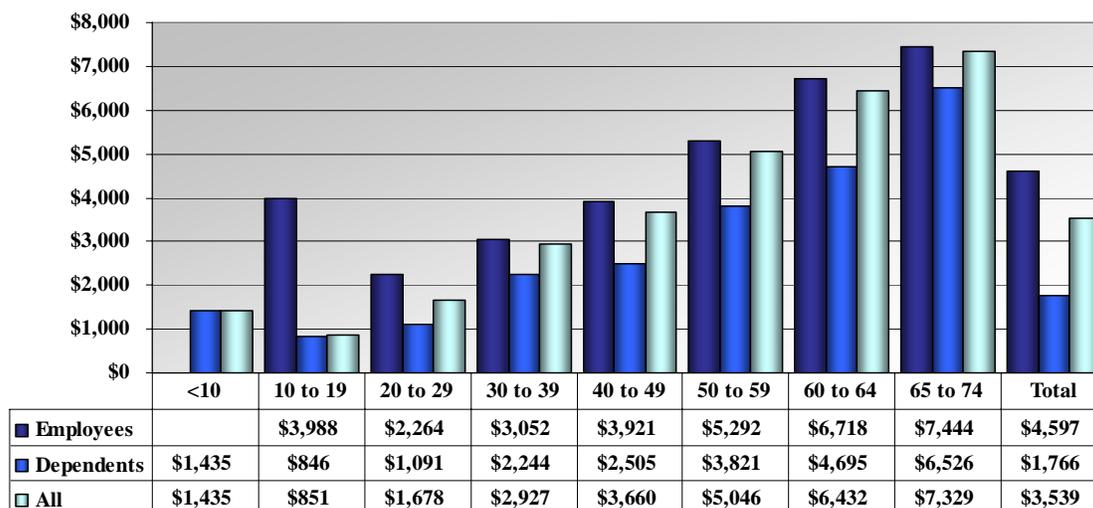
Average Covered Members by Group (Includes Dependents)									
	2004			2005			2006 (6 Months)		
	Average Lives	% of Total	% Change	Average Lives	% of Total	% Change	Average Lives	% of Total	% Change
By Covered Group									
State Employees	53,291	23.4%	-4.5%	52,372	22.8%	-1.7%	53,071	22.6%	1.3%
School Boards	111,845	49.1%	-1.2%	112,148	48.8%	0.3%	116,039	49.5%	3.5%
Health Departments	4,043	1.8%	-2.2%	4,049	1.8%	0.1%	4,051	1.7%	0.1%
KERS	28,887	12.7%	9.8%	31,419	13.7%	8.8%	32,601	13.9%	3.8%
KTRS	18,261	8.0%	4.0%	19,007	8.3%	4.1%	19,143	8.2%	0.7%
KCTCS	4,200	1.8%	16.5%	4,529	2.0%	7.8%	4,909	2.1%	8.4%
Quasi/Local Govt	6,048	2.7%	27.0%	5,674	2.5%	-6.2%	4,263	1.8%	-24.9%
COBRA	1,341	0.6%	17.1%	673	0.3%	-49.8%	424	0.2%	-37.0%
Total	227,917		0.6%	229,870		0.9%	234,501		2.0%
By Covered Status									
Actives	179,428	78.7%	-1.1%	178,771	77.8%	-0.4%	182,333	77.8%	2.0%
Retirees	47,149	20.7%	-1.1%	50,425	21.9%	6.9%	51,744	22.1%	2.6%
COBRA	1,341	0.6%	17.1%	673	0.3%	-49.8%	424	0.2%	-37.0%
Total	227,917		0.6%	229,870		0.9%	234,501		2.0%

Source: Commonwealth's enrollment data aggregated by MedStat.

Due to the impact that age has on an individual's health care costs (as noted in the Annual Report last year) this increase in retiree membership has significant cost implications for the Commonwealth's PEHI Program. As illustrated in Exhibit XII, the average annual 2005 health care claims expenses incurred by someone in the Commonwealth's program whose age was between 60 and 64 (\$6,432) was almost four times that of someone between the ages of 20 and 29 (\$1,678).

Exhibit XII

2005 Demographics—Employee and Dependent Member Medical Claims by Age



Source: Commonwealth's enrollment and claims data aggregated by MedStat

The higher than average proportion of female adults covered by the Program also contributes to the overall costs. Exhibit XIII shows the gender mix and average ages for the Commonwealth membership over the 2004, 2005, and 2006 years. Note that the corresponding pharmacy PMPY claims are illustrated in the Pharmacy section of this report.

Exhibit XIII

Population Demographics—Key Statistics

Actives, Non-Medicare Eligible Retirees, and COBRA Participants	Commonwealth		
	2004	2005	2006
Average Employee Age	47.3	47.6	47.7
Average Member Age	39.4	39.5	39.5
Employee Percentage Male	35.6%	35.3%	35.2%
Member to Employee Ratio	1.6	1.6	1.6
% of Covered Members Who Are:			
Adult Male	27.3%	27.2%	27.3%
Adult Female	46.8%	47.0%	47.1%
Children	25.9%	25.8%	25.6%

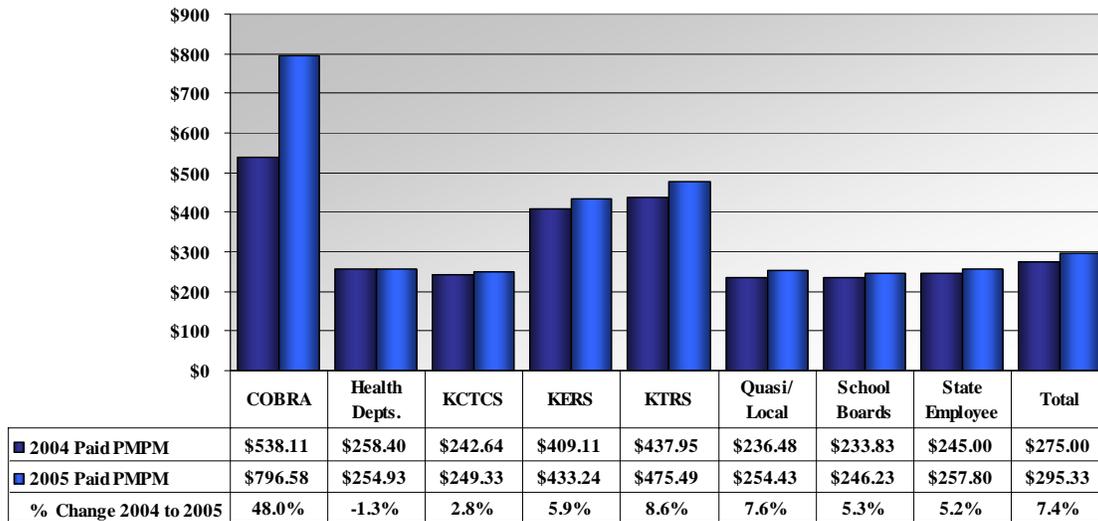
Source: Commonwealth's enrollment data aggregated by MedStat.

While the Kentucky Community and Technical College System (KCTCS) is still not a significant percentage of the total group that participates in the PEHI Program, the number of KCTCS covered individuals continues to increase. When KCTCS was formed as an entity separate from the University of Kentucky (UK), individuals in this group were given the option of remaining in the UK benefits plan or joining the PEHI Program. Individuals hired after this separation have only been eligible to join the PEHI Program. Therefore, since 1999, this group has grown from 2,340 covered lives to 4,909 by the end of June of 2006.

Exhibits XIV, XV, and XVI illustrate the per member per month costs for medical plus pharmacy, medical only, and pharmacy only, respectively, for the various covered groups in 2004 and 2005.

Exhibit XIV

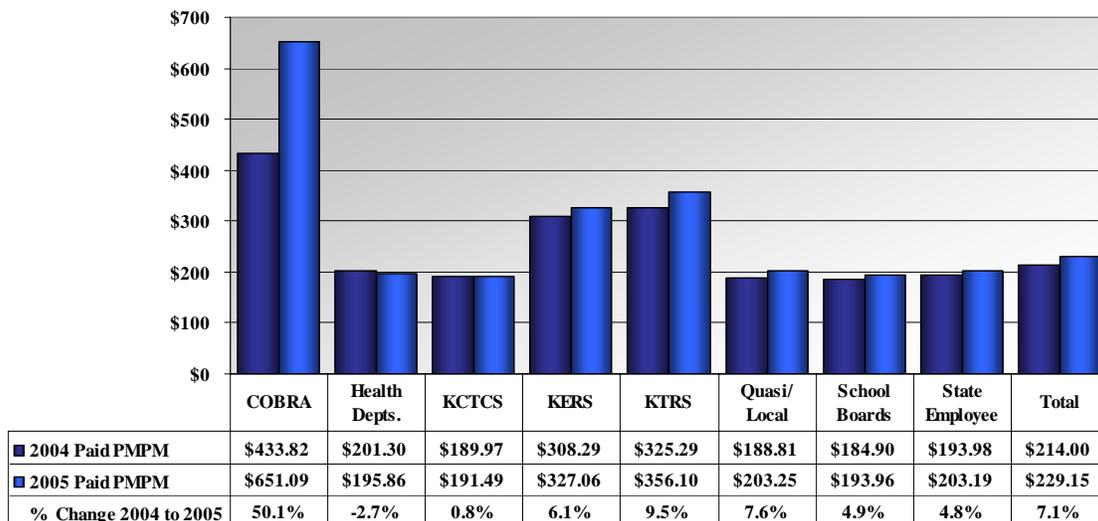
Medical and Pharmacy Claims Paid Per Member Per Month—Covered Groups



Source: Commonwealth's enrollment and claims data aggregated by MedStat.

Exhibit XV

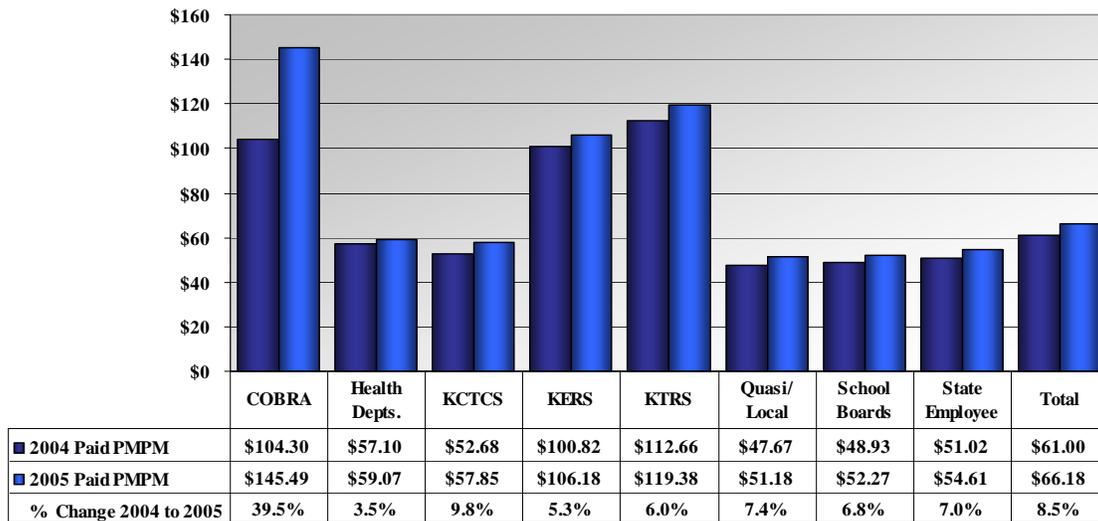
Medical Claims Paid Per Member Per Month—Covered Groups



Source: Commonwealth's enrollment and claims data aggregated by MedStat.

Exhibit XVI

Pharmacy Claims Paid Per Member Per Month—Covered Groups

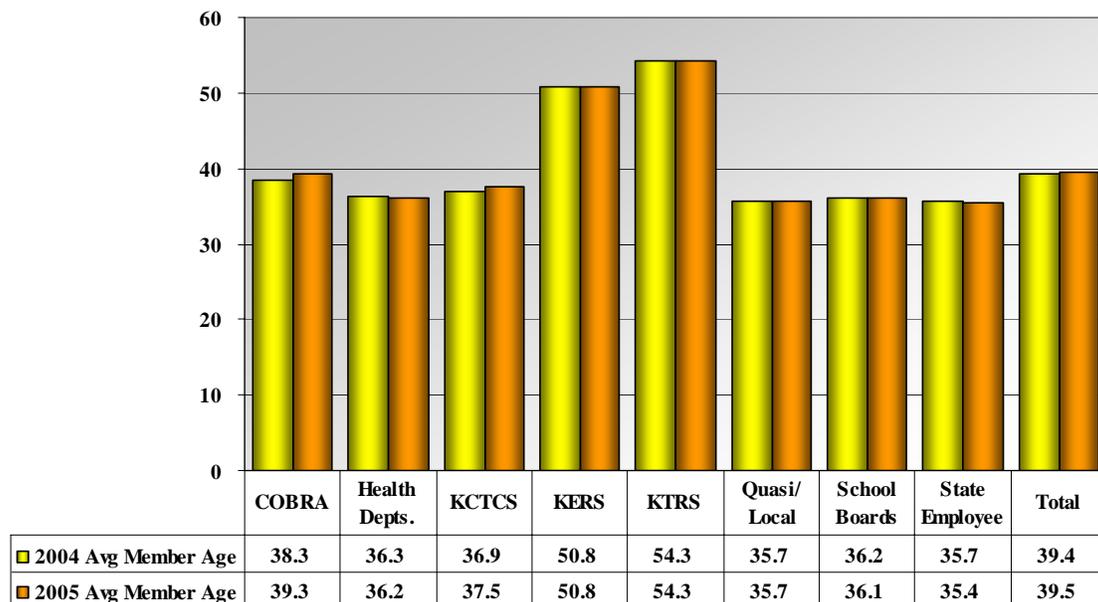


Source: Commonwealth's enrollment and claims data aggregated by MedStat.

Exhibit XVII provides, for each coverage group, the average ages of the members in 2004 and 2005. In general the average ages for members has not appreciably changed from 2004 to 2005.

Exhibit XVII

2004 and 2005 Average Member Age—By Group



Source: Commonwealth's enrollment data aggregated by MedStat.

The impact of these demographic drivers on expected health care costs per employee are as follows:

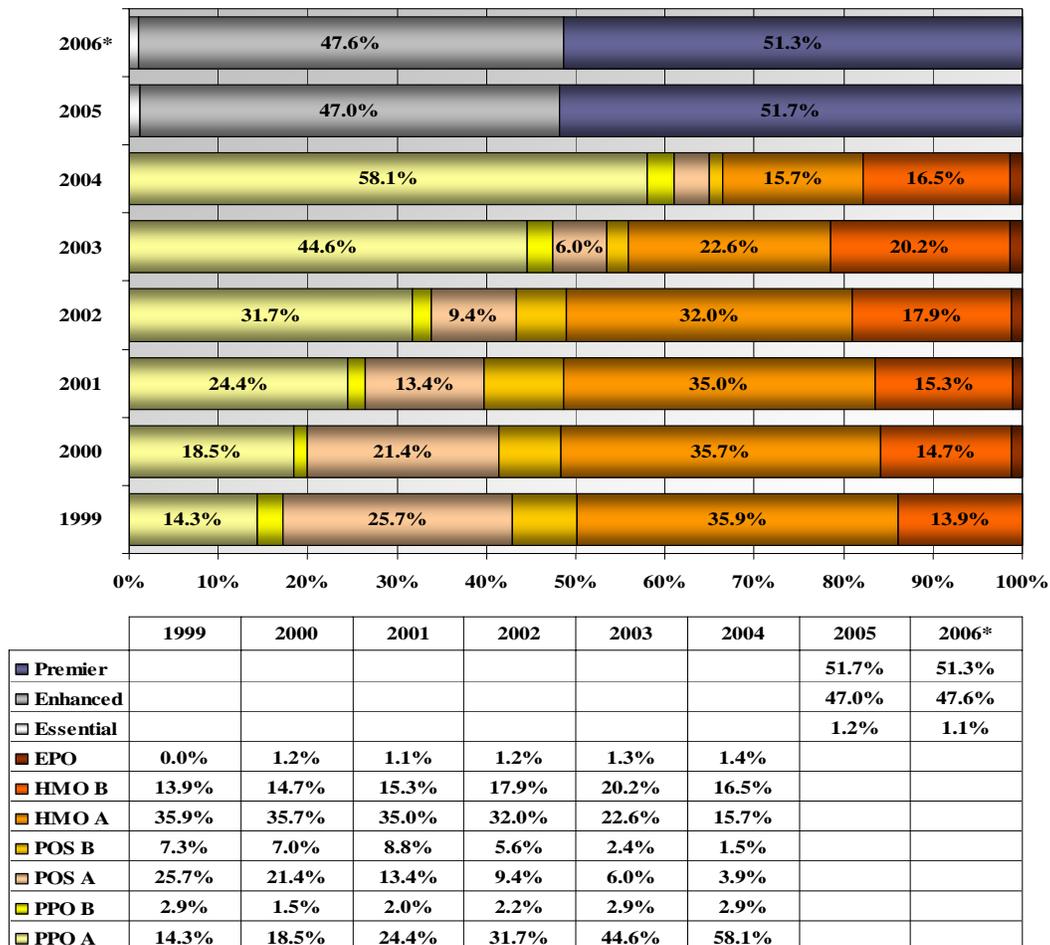
- Employee Status. 73.8% of all covered elections are for active employees; 77.8% of all members are covered under elections for active employees.
- Average Employee Age and Gender of Covered Adults. The average age of employees enrolled in the Program in 2005 was 47.7 (increase from average of 47.3 for 2004). For the Commonwealth, based on the age distribution and the proportion of non-Medicare eligible retirees covered, costs increase about 3.6% on average per year of age. Based on the change in average age from 2004 to 2005, costs increased approximately 1% due solely to the underlying age distribution.

Enrollment by Option

The PEHI Program's enrollment by plan/option from 1999 through the first quarter of 2006 is illustrated below in Exhibit XVIII.

Exhibit XVIII

1999 - 2006 Enrollment By Plan Option



Source: Commonwealth's enrollment aggregated by MedStat.

* January through June 2006 data only.

Until 2003, approximately 50% of PEHI Program members chose to enroll in an HMO option. In 2003, this declined to 42.8%. With Humana's withdrawal of HMO and POS options in most areas of the Commonwealth in 2004, the decline in HMO enrollment accelerated, leaving about 32.2% enrolled in HMO A or B in that year. The HMO B option enrollment percentage increased steadily from 1999 (13.9%) to 2003 (20.2%); however, this trend reversed in 2004 when HMO B enrollment dropped to 16.5%, again spurred by Humana's discontinuance of HMO and POS options in most geographic areas of the Commonwealth.

Point of Service (POS) enrollment had declined dramatically each year since 1999. From a high of 33% of the group in 1999, the percentage enrolled in a POS option had declined to only 5.4% by 2004, the last year it was offered as an option.

Conversely, PPO Option A enrollment grew steadily from 14.3% in 1999 to 24.4% in 2001. In 2002, PPO Option A enrollment increased significantly to 31.7%. This increase was even more dramatic in 2003 when PPO Option A enrollment grew to over 44% and in 2004, when almost 59% of those enrolled in the PEHI Program elected PPO option A. The percentage enrolled in the PPO B option has hovered around 2% to 3% since 1999.

The percentage enrolled in the EPO plan, first introduced in 2000, remained virtually constant from 2000 through 2004, the last year it was offered as an option (around 1% of the group).

In 2005 a new set of plan options were introduced, all of which were PPO plans (Essential, Enhanced, and Premier). The Enhanced PPO plan option in 2005 matched the 2004 PPO Option A. Enrollment in the Enhanced and Premier plans was nearly even in 2005 (47.0% and 51.7%, respectively). There was relatively low enrollment in the Essential Plan (1.2%). The enrollment in 2005 into the richer options produced an overall increase in coverage:

- 58% of the 2004 plan participants migrated to a plan in 2005 with a richer design;
- 33% moved from the PPO A option to the equivalent PPO Enhanced Plan in 2005, effectively keeping the same coverage as before;
- Only 9% moved to a plan with a less rich design.

Enrollment by option in 2006 was substantially consistent with enrollment by option in 2005 (though as noted earlier, there was a change in distribution by coverage tier from 2005 to 2006, per Exhibit X).

Large Claims Analysis

Key Findings & Considerations

The key findings and considerations from the Large Claims Analysis from 2004 and 2005 are as follows:

- The PEHI Program's large claim experience is in line with benchmarks. However, the proportion of low utilizers (\$0 to \$1,000 in claims) is substantially lower than expected. Note that the benchmark figures reflect submitted claims while the Commonwealth experience reflects paid claims. This difference would produce the most dramatic difference is actual versus benchmark measurement for the 2 smallest dollar claims bands, but would not impact the comparison above \$5,000 in claims.
- While only 0.7% of members had claims totaling over \$50,000 in 2005, these members consumed almost 24% of the Commonwealth's total paid claims expense for 2005.
- The PEHI Program's large claim experience for 2005 corresponds closely to the expected number of claimants at the various actuarial benchmark claims levels.
- Approximately 17% of the population is generating approximately 77% of the medical and drug claims costs.

Additional facts and figures in support of these findings, along with some additional analysis, are provided in the section below. Note that the 2005 benchmarks have not been adjusted to match the age, sex, and adult/child ratio characteristics of the Commonwealth's population. The benchmarks shown are based on PricewaterhouseCoopers' normative claims distribution data encompassing eight million lives.

Exhibit XIX

Large Claim Analysis—2004 and 2005 Claim Payments Stratified by Claim Amount

Range of Benefit Payments	2004 Actual			2005 Actual			2005 Benchmarks	
	Members	% of Members	% of Claims	Members	% of Members	% of Claims	Members	% of Members
\$0 - \$1,000	116,932	44.8%	5.4%	104,249	47.1%	4.0%	139,512	67.2%
\$1,000 - \$2,000	43,131	16.5%	7.2%	35,702	16.1%	5.1%	20,327	9.8%
\$2,000 - \$5,000	52,430	20.1%	18.4%	43,538	19.7%	14.3%	23,194	11.2%
\$5,000 - \$10,000	26,795	10.3%	18.9%	21,697	9.8%	17.5%	12,994	6.3%
\$10,000 - \$20,000	12,775	4.9%	16.2%	9,948	4.5%	16.7%	7,195	3.5%
\$20,000 - \$50,000	6,279	2.4%	16.1%	4,631	2.1%	18.7%	3,418	1.6%
\$50,000 - \$100,000	1,671	0.6%	8.8%	1,113	0.5%	11.1%	620	0.3%
\$100,000 - \$200,000	540	0.2%	5.4%	352	0.2%	7.1%	179	0.1%
\$200,000 - \$300,000	125	0.0%	2.1%	67	0.0%	2.5%	44	0.0%
\$300,000 - \$400,000	35	0.0%	0.8%	27	0.0%	1.4%	19	0.0%
\$400,000 - \$500,000	11	0.0%	0.3%	7	0.0%	0.5%	12	0.0%
\$500,000 - \$750,000	8	0.0%	0.4%	11	0.0%	1.0%	6	0.0%
\$750,000 - \$1,000,000	0	0.0%	0.0%	0	0.0%	0.0%	3	0.0%
\$1,000,000 - \$2,000,000	0	0.0%	0.0%	1	0.0%	0.2%	1	0.0%
Over \$2,000,000	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%

Commonwealth 2005 PEHI Plan experience less than benchmark (# of members in payment range)

Commonwealth 2005 PEHI Plan experience more than benchmark (# of members in payment range)

Source: Commonwealth's enrollment and claims data aggregated by MedStat.

Detailed Findings

In 2005 17.0% of members incurred claims over \$5,000. The associated benefits for these members amount to 76.9% of claims paid in 2005. Members with claims over \$50,000 comprise only 0.7% of all members, but their benefit costs account for 23.8% of the claims paid in 2005. Compared against actuarial benchmarks of large claims distributions, the Commonwealth experience above \$10,000 follows an expected distribution.

Exhibit XX

2005 Distribution by “User-Type”

		Low Users	Medium Users	High Users	Very High Users
		\$0 - \$1,000	\$1,000 - \$5,000	\$5,000 - \$100,000	>\$100,000
Commonwealth	% Payments	4.0%	19.4%	64.0%	12.6%
2005 Net Payments	% Members	47.1%	35.8%	16.9%	0.2%
2005 Benchmarks	% Members	67.2%	21.0%	11.7%	0.1%
Difference	% Members	-20.1%	14.8%	5.2%	0.1%

Similarly, when compared against actuarial norms by “user type,” the Commonwealth’s incidence of catastrophic claims (defined as claims in excess of \$100,000) is comparable to actuarial norms. The percentage of low volume users is below actuarial norms.

Diagnosis & Wellness Issues

Key Findings & Considerations

The key findings and considerations regarding diagnosis & wellness issues from 2004 to 2005 are as follows:

- Wellness screenings in 2005 have increased slightly over 2004.
- With the exception of mammograms for retirees and cholesterol screenings for retirees and COBRA participants, PEHI Program wellness screening rates are significantly below Healthy People 2010 goals. Long-term health benefits potentially can result from screenings. If the active population were to pursue these screenings at a rate closer to the “Healthy People 2010” levels, the Commonwealth could potentially see savings in health costs for these participants in 2 to 3 years.
- A high proportion of costs are provided for treatment of employees whose diagnoses fall into a short list of major diagnostic categories. This list has remained constant from 2004 to 2005. This may indicate that disease management improvement should be targeted in the primary diagnosis categories of circulatory (heart), musculoskeletal (lower back), and respiratory (asthma).

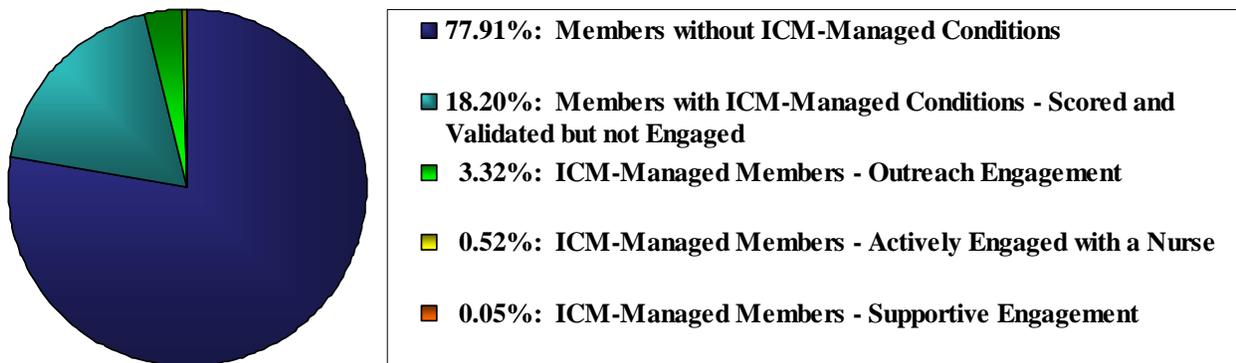
Disease Management: ActiveHealth Management Experience (2006)

Additional information related to the Commonwealth's PEHI program as tabulated and provided by Humana's disease management group, ActiveHealth Management, through its Informed Care Management (ICM) program is included in the section below. This information relates to the disease management efforts during the first six months of 2006. Some ICM reports are provided on 6-month year to date bases, and others on 2Q2006 bases.

The ICM program was implemented January 2006. As such, it should be noted that the program is immature, and that the results reported here may not be indicative of longer term experience.

During the three-month period April through June 2006 the total average number of covered members was approximately 235,000. Exhibit XXI shows the breakout of the total membership across various levels of disease management activities.

Exhibit XXI
2Q2006 ICM Program Activity Summary



Source: Commonwealth's participation data reported by ActiveHealth Management for the period April through June 2006.

The following definitions explain the above categories:

- Members without ICM-Managed Conditions: Members whose available clinical data indicates that they have not been diagnosed with an ICM-Managed condition.
- Members with ICM-Managed Conditions - Scored and Validated but not Engaged: Members whose available claims data indicate that they have been diagnosed with an ICM-managed condition, but who are not participating in ICM (i.e., either they have opted out of the program, their clinical data indicates that they would not benefit by participating in the program, or they will become participants in the program at a later date).
- ICM-Managed Members - Outreach Engagement: Members in this phase have not yet engaged with a nurse. These members receive welcome letters, condition-specific brochures, general health information brochures, newsletters, and Care Consideration letters. Members in this status also receive phone calls encouraging them to discuss their health conditions with a nurse, if a phone number is provided/available.
- ICM-Managed Members - Actively Engaged with a Nurse: Members who are participants in the ICM program, and have engaged with a nurse. These members receive welcome letters, condition-specific brochures, general health information brochures, newsletters, and Care Consideration letters. Members in this status also work with a nurse on the telephone on a scheduled basis. The nurse assesses the member, develops a plan of care and provides interventions to the member based on that member's specific health status. The member receive follow up letters after each engagement summarizing the engagement. The follow up letters include brochures specific to the member's needs.

- **ICM-Managed Members - Supportive Engagement:** Members in this phase receive Care Considerations via the ICM program as well as program newsletters. Many of the members in this program have worked with a nurse and successfully achieved their healthcare goals. Members may return to Active Nurse Engagement at anytime should their condition change or they develop a new ICM-Managed condition.

For the PEHI membership, less than 1% were actively managed by the ICM program (engaged with a nurse or already in a supportive engagement process). Nearly 78% of all members in this period did not have any conditions that would be addressed in the ICM program.

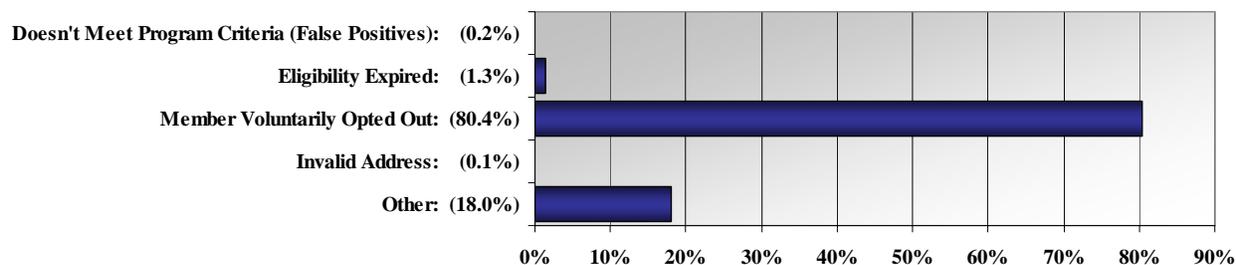
More than 21% of all members have conditions that could potentially be managed by the ICM program but have yet to be engaged (18.2% not yet engaged, and 3.3% that have not yet had discussions with program nurses). Therefore, there appears to be sufficient numbers of PEHI members to be managed, though they have not yet been engaged by the program.

Of the 10,709 members engaged in the ICM program during the first six months of 2006, 1,237 members were no longer participating as of June 30, 2006. There was a 11.6% opt out rate during the first six months of 2006.

For the disease management program to be more effective a lower opt out rate would be desired. Exhibit XXII breaks out the 1,237 ICM program drop-outs by reason of termination.

Exhibit XXII

Causes of Termination During First Six Months of 2006 From the ICM Program

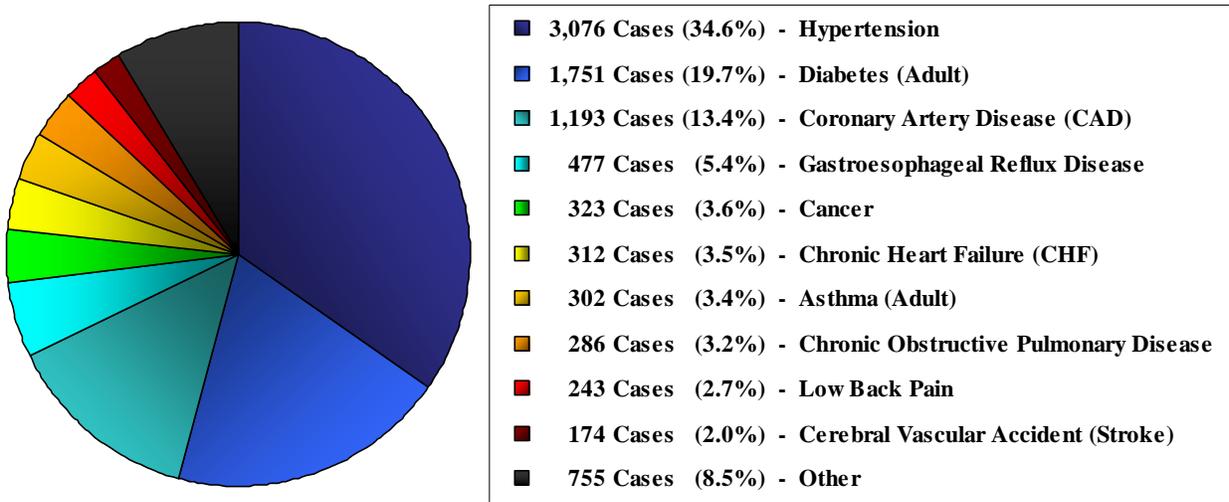


Source: Commonwealth's participation data reported by ActiveHealth Management for the period January through June 2006.

The vast majority of program terminations occurred due to voluntary member opt outs (80.4%). While it is not known why these members voluntarily opted out from the program, such an understanding could improve the effectiveness of the ICM program for the PEHI population by reducing the number of voluntary opt outs in the future.

The types of diseases and conditions being treated by the ICM program are highlighted in Exhibit XXIII. The top ten such conditions (based on number of members with that condition) are shown.

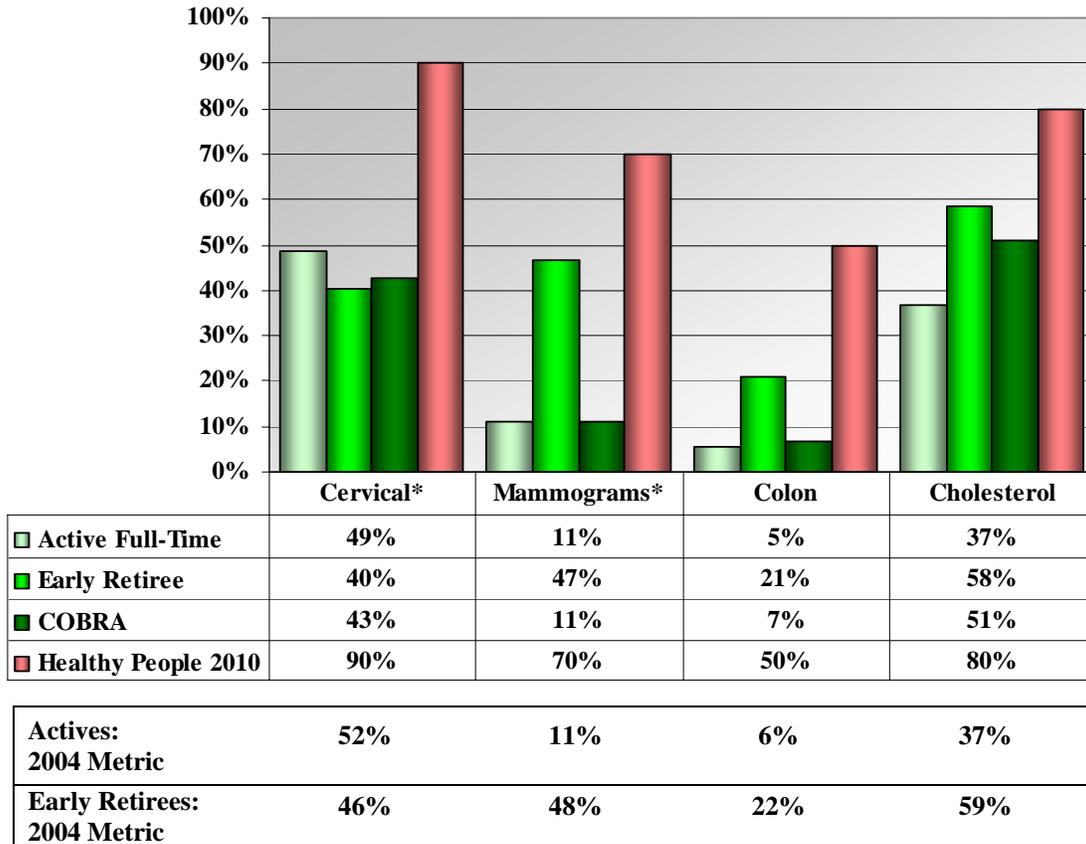
Exhibit XXIII
Identified Conditions by Member 2Q2006



Source: Commonwealth's participation data reported by ActiveHealth Management for the period April through June 2006.

Of the 9,136 members engaged in the ICM program, 8,892 have identified conditions. Over 34% are being treated for hypertension. Nearly 20% are being treated for diabetes. And over 13% are being treated in the ICM program for coronary artery disease. The top three conditions comprise over two thirds of all members engaged in the ICM program.

Exhibit XXIV
2005 Wellness Screening Utilization



Source: Commonwealth's enrollment and claims data aggregated by MedStat; "Healthy People 2010" study.
 * Results and Benchmarks per adult female population

"Healthy People 2010" is a set of national health objectives to achieve over the first decade of the new century. Created by scientists both inside and outside of Government, it identifies a wide range of public health priorities and specific, measurable objectives. It can be used by many different people, states, communities, and others to develop health improvement programs.

"Healthy People 2010" is built upon initiatives that began over 20 years ago. The 1979 Surgeon General's Report, "Healthy People" and "Healthy People 2000: National Health Promotion and Disease Prevention Objectives" served as the basis for state and community plans. Like its predecessors, Healthy People 2010 was developed through a broad consultation process, based on scientific knowledge and designed to measure programs over time.

"Healthy People 2010" is designed to achieve two primary goals:

- Goal 1: Increase Quality and Years of Healthy Life
- Goal 2: Eliminate Health Disparities

For early retirees, there was a drop in utilization of wellness screenings in 2005 compared against 2004 for each of the four criteria shown above. For active adults there was a drop in

2005 by 3% for cervical cancer screenings; the other measures in 2005 for active members remained consistent with measures in 2004.

Population Health Indicators

The Kaiser Family Foundation has tabulated, state by state, the prevalence of certain lifestyle activities and health status conditions. This information further supports the need for a focus on wellness and healthy behavior. In several areas it is clear that lifestyle correlates closely to health status. The exhibits that follow provide several such correlations using 2005 data compiled by the Centers for Disease Control. Note that the data provided here are state-wide population information, and not reflective of the specific PEHI program or its members.

Additionally, the Health Management Research Center (HMRC) at the University of Michigan has conducted studies over the last 20 years on the financial relationship between lifestyle characteristics and health status. Lifestyle characteristics that can contribute to higher health care claims are shown in Exhibit XXV.

Exhibit XXV

Health Risks and Behaviors

Health Risk Measure	High Risk Criteria
Alcohol	More than 14 drinks/week
Blood Pressure	Systolic >139 mmHg or Diastolic >89 mmHg
Body Weight	Body mass index (BMI) at or more than 27.5%
Cholesterol	Greater than 239 mg/dl
Existing Medical Problem	Heart, Cancer, Diabetes, Stroke
HDL	Less than 35 mg/dl
Illness Days	>5 days last year
Life Satisfaction	Partly or not satisfied
Perception of Health	Fair or poor
Physical Activity	Less than one time/week
Safety Belt Usage	Using safety belt less than 100% of time
Smoking	Current smoker
Stress	High

Source: University of Michigan Health Management Research Center study.

The HMRC studies defined “Low Risk” individuals as people who meet 2 or less of the above high risk criteria, “Medium Risk” individuals as those with 3 or 4 of the above high risk criteria, and “High Risk” individuals as those with 5 or more of the above high risk criteria. On average, Medium Risk individuals incur health care claims at 1½ times the level of Low Risk individuals. High Risk individuals incur health care claims at over 2½ times the level of Low Risk individuals.

To the extent that a benefit plan provides long term programs (defined by HMRC as programs in which the individual actively participates for 3 or more years) and rewards to incent people to address the above high risk criteria, savings resulting from improved health status can be realized by the benefit plan, reducing overall health care costs. The exhibits that follow focus on four of the above health risk measures (shown in red above).

The following is included in each exhibit:

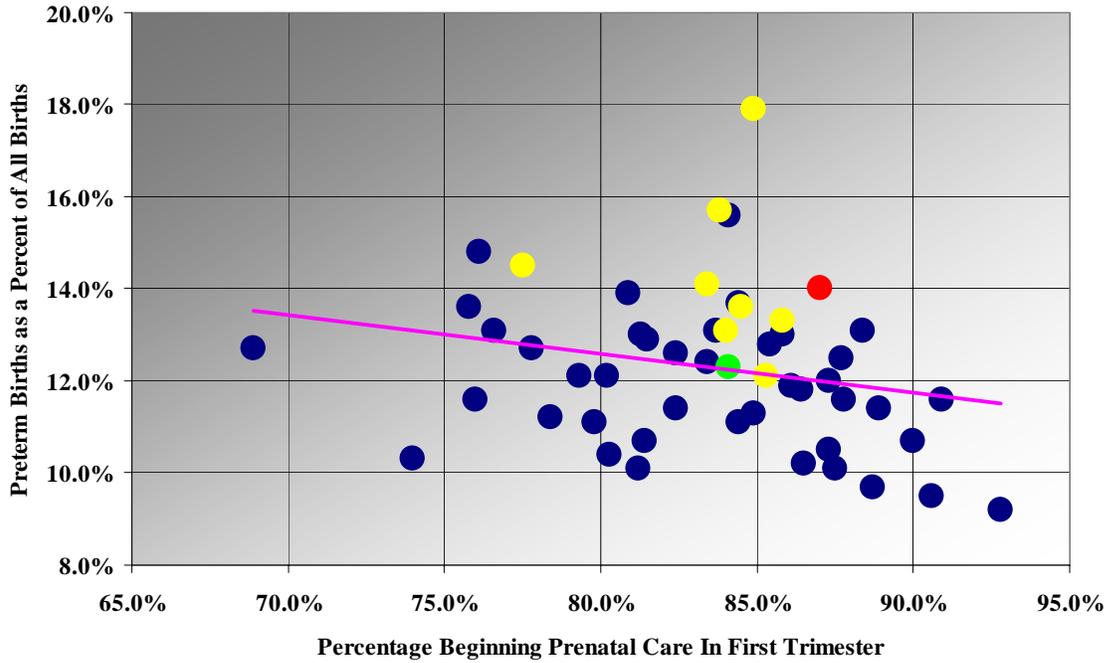
- Kentucky: Shown in Red.
- Neighboring States: Shown in Yellow. Consists of Alabama, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia
- All Other States: Shown in Blue.
- US National Average: Shown in Green.

For each chart in the exhibit a correlation line has been included to illustrate the approximate correlation between the two factors shown on each chart.

A more detailed table follows each chart in the exhibit providing the Kentucky, Neighboring State, and US National Average measures for the lifestyle and health status metrics.

Exhibit XXVI

Correlation Between First Trimester Prenatal Care and Preterm Births



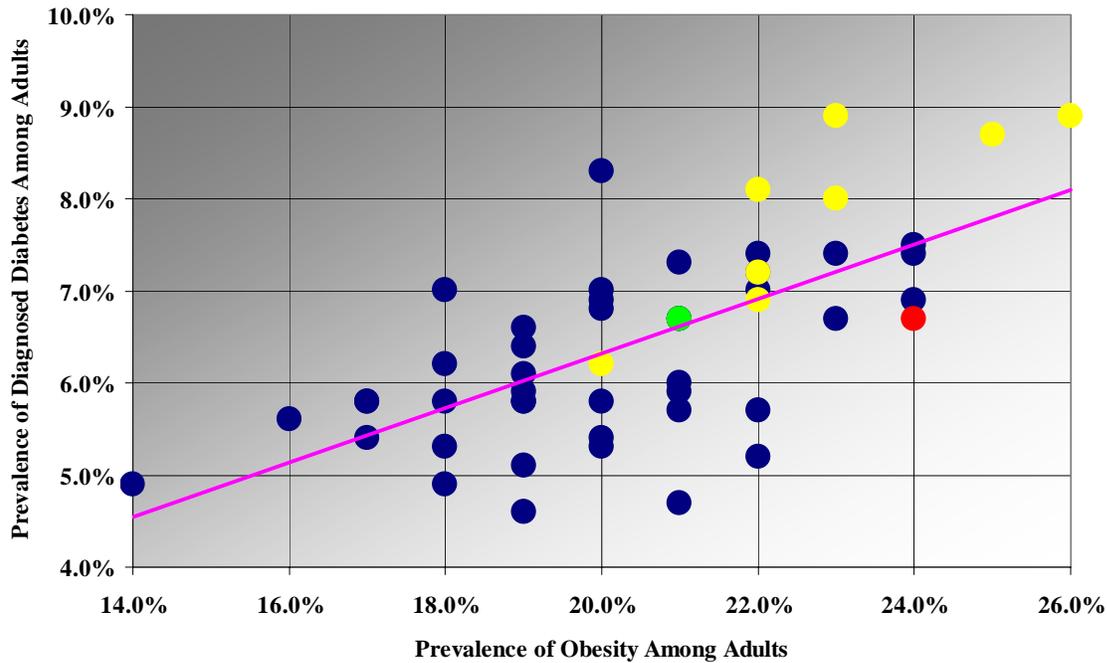
	Percentage Beginning Prenatal Care In First Trimester	Preterm Births as a Percent of All Births
Kentucky	87.0%	14.0%
Alabama	83.8%	15.7%
Georgia	84.0%	13.1%
Mississippi	84.9%	17.9%
North Carolina	84.5%	13.6%
South Carolina	77.5%	14.5%
Tennessee	83.4%	14.1%
Virginia	85.3%	12.1%
West Virginia	85.8%	13.3%
United States	84.1%	12.3%

Source: Kaiser Family Foundation, www.statehealthfacts.org, 2003 data.

Kentucky has a larger percentage of its residents beginning prenatal care in the first trimester than most states (and is leading all eight states in its comparison group), however, it has not experienced a better than average rate of preterm births.

Exhibit XXVII

Correlation Between Adult Obesity and Prevalence of Adult Diagnosed Diabetes



	Prevalence of Obesity Among Adults	Prevalence of Diagnosed Diabetes Among Adults
Kentucky	24.0%	6.7%
Alabama	23.0%	8.9%
Georgia	22.0%	7.2%
Mississippi	26.0%	8.9%
North Carolina	22.0%	6.9%
South Carolina	22.0%	8.1%
Tennessee	23.0%	8.0%
Virginia	20.0%	6.2%
West Virginia	25.0%	8.7%
United States	21.0%	6.7%

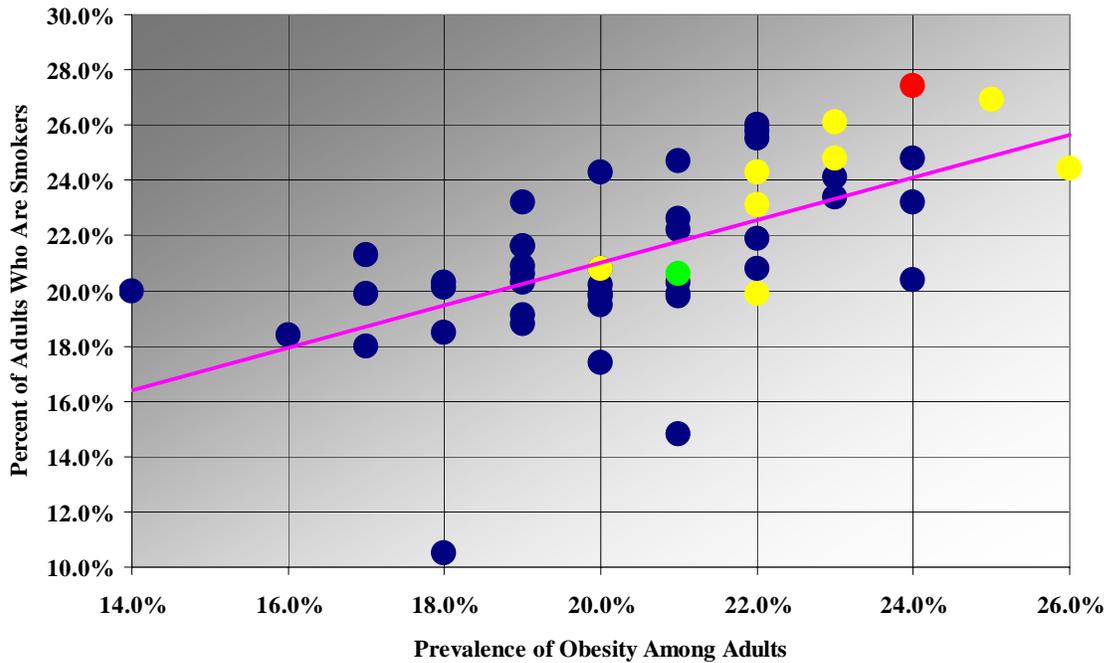
Source: Kaiser Family Foundation, www.statehealthfacts.org, 2001 and 2002 data.

Kentucky has among the largest percentages of obesity among adults in the country (24%). Only West Virginia (25%) and Mississippi (26%) have higher prevalences. As a lifestyle factor, obesity is correlated to a number of health conditions. However, for states with similar prevalences of obesity Kentucky’s has a much smaller prevalence of diagnosed diabetes among adults than that experienced by other states. Obesity is one of the high risk criteria identified by the HMRC.

Among the comparison state group, Kentucky has one of the highest prevalences of obesity, but one of the lowest prevalences of diabetes. Nonetheless, Kentucky is in the 60th percentile for diabetes in the US (i.e., 60 percent of states have lower measures).

Exhibit XXVIII

Correlation Between Adult Obesity and Percent of Adults Who Are Smokers



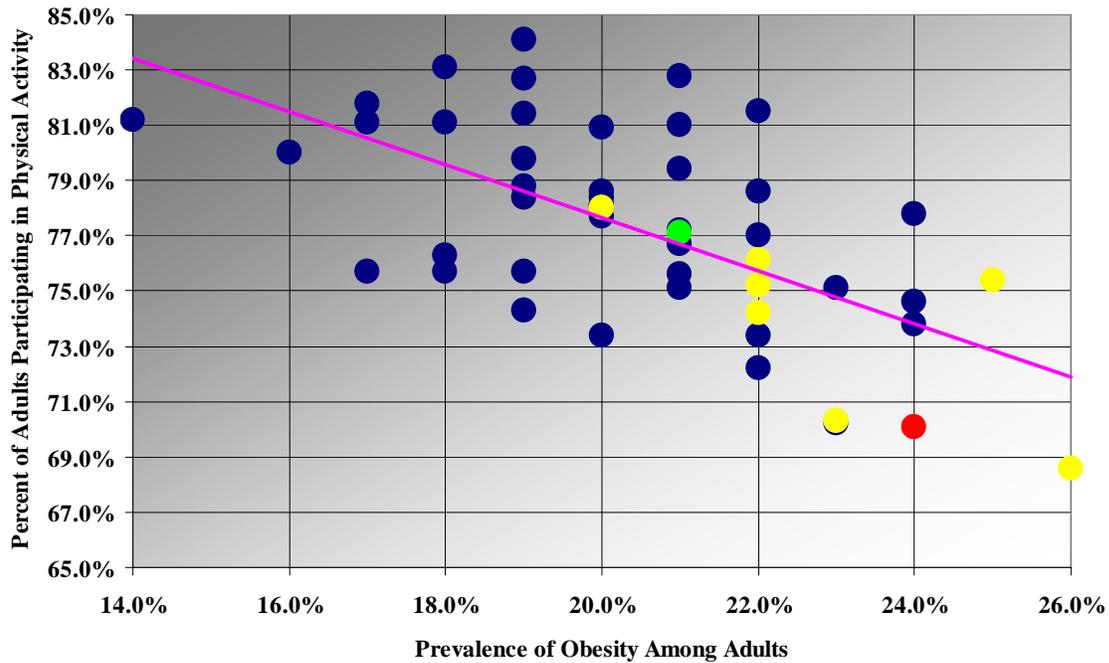
	Prevalence of Obesity Among Adults	Percent of Adults Who Are Smokers
Kentucky	24.0%	27.4%
Alabama	23.0%	24.8%
Georgia	22.0%	19.9%
Mississippi	26.0%	24.4%
North Carolina	22.0%	23.1%
South Carolina	22.0%	24.3%
Tennessee	23.0%	26.1%
Virginia	20.0%	20.8%
West Virginia	25.0%	26.9%
United States	21.0%	20.6%

Source: Kaiser Family Foundation, www.statehealthfacts.org, 2001 and 2004 data.

Kentucky has the highest percentage of adults who are smokers in the nation. As noted above, Kentucky also has one of the largest percentages of obesity among adults in the country (24%). While the PEHI program differentiates its employee contributions between smokers and non-smokers, the differential is not sufficient to cover the expected difference in claims for smokers versus non-smokers. Smoking is one of the high risk criteria identified by the HMRC.

Exhibit XXIX

Correlation Between Adult Obesity and Adults Participating in Physical Activity



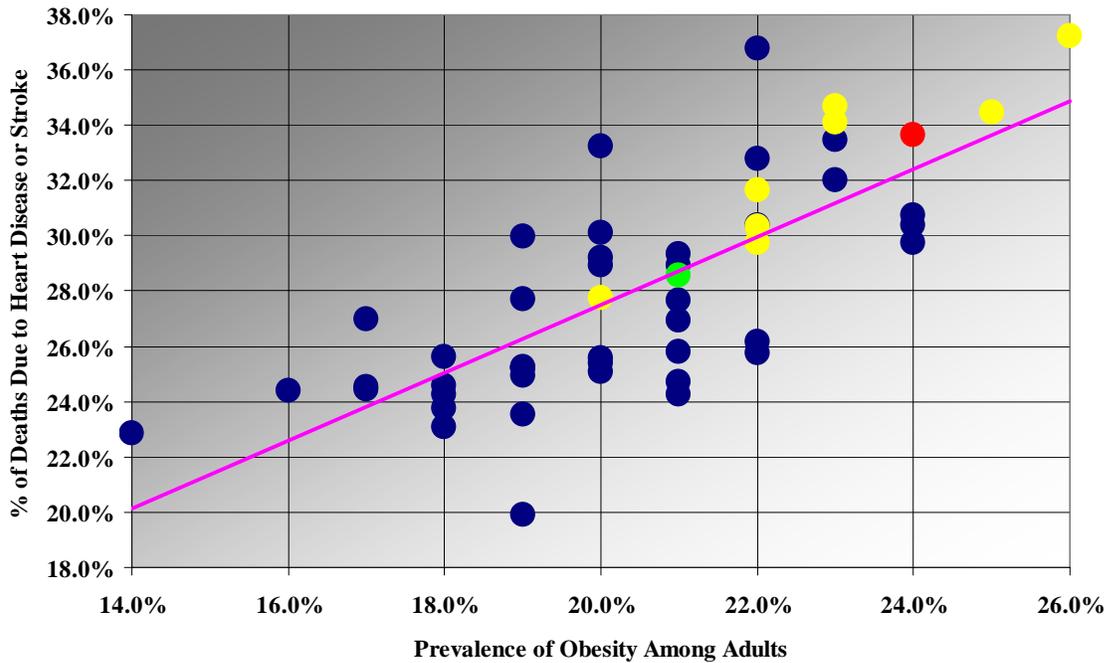
	Prevalence of Obesity Among Adults	Percent of Adults Who Are Participating In Physical Activity
Kentucky	24.0%	70.1%
Alabama	23.0%	70.3%
Georgia	22.0%	74.2%
Mississippi	26.0%	68.6%
North Carolina	22.0%	75.2%
South Carolina	22.0%	76.1%
Tennessee	23.0%	70.3%
Virginia	20.0%	78.0%
West Virginia	25.0%	75.4%
United States	21.0%	77.1%

Source: Kaiser Family Foundation, www.statehealthfacts.org, 2001 and 2004 data.

Kentucky has the second lowest percentage of adults who have participated regularly in physical activity (only Mississippi has a lower percentage). This characteristic correlates closely with the percentage of obesity among adults reported by Kentucky. Lack of regular physical activity is one of the high risk criteria identified by the HMRC.

Exhibit XXX

Correlation Between Adult Obesity and Deaths Due to Heart Disease or Stroke



	Prevalence of Obesity Among Adults	Percent of Deaths Due to Heart Disease or Stroke
Kentucky	24.0%	33.6%
Alabama	23.0%	34.7%
Georgia	22.0%	31.6%
Mississippi	26.0%	37.2%
North Carolina	22.0%	29.8%
South Carolina	22.0%	30.4%
Tennessee	23.0%	34.1%
Virginia	20.0%	27.7%
West Virginia	25.0%	34.5%
United States	21.0%	28.6%

Source: Kaiser Family Foundation, www.statehealthfacts.org, 2001 and 2003 data.

Kentucky has the sixth highest percentage of deaths attributable to heart disease or stroke (only Oklahoma, Alabama, Mississippi, Tennessee, and West Virginia have higher percentages). Again, this characteristic correlates closely with the percentage of obesity among adults reported by Kentucky. Obesity is one of the high risk criteria identified by the HMRC.

Diagnostic Categories

The top eight Major Diagnostic Categories (MDCs) represent approximately 69% of the total net medical payments made by the Commonwealth. This distribution of claims by MDC is reflective of the high average age of the covered population. The high ranks of Circulatory, Musculoskeletal, and Digestive MDCs (Exhibit XXXI) suggest that potential care management programs related to these diagnoses for example, cardiac care, lower back, ulcer, are worthy of further review.

Exhibit XXXI

Diagnosis Issues—2004 and 2005 Top 25 Major Diagnostic Categories (MDC)

Major Diagnostic Category	% Claims Distribution	
	2004	2005
Circulatory	15.60%	15.18%
Musculoskeletal	14.32%	14.57%
Digestive	10.16%	10.09%
Health Status	7.39%	6.36%
Skin, Breast	6.18%	5.91%
Nervous	6.10%	5.89%
Respiratory	5.14%	5.31%
Kidney	4.60%	5.29%
Ear, Nose, Mouth & Throat	4.58%	4.84%
Metabolic	3.70%	3.90%
Female Reproductive	4.17%	3.75%
Myeloproliferative Diseases	2.95%	3.45%
Pregnancy, Childbirth	2.85%	2.81%
Liver, Pancreas	2.83%	2.77%
Eye	1.88%	1.85%
Newborns	1.76%	1.74%
Blood	1.38%	1.51%
Mental	1.39%	1.30%
Infections	0.89%	1.28%
Injuries, Poisonings	0.88%	1.00%
Male Reproductive	0.80%	0.83%
Alcohol/Drug Use	0.18%	0.17%
~Missing/Invalid Diagnosis	0.15%	0.13%
Burns	0.11%	0.07%
HIV Infections	0.02%	0.01%
Total	100.00%	100.00%

Source: Commonwealth's claims data aggregated by MedStat.

Detailed Pharmacy Experience

Key Findings & Considerations

- Pharmaceutical expenditures have been increasing steadily for the PEHI Program year over year, and 2005 was no exception. As in 2004, the Program's 2005 pharmacy cost increase outpaced the increase in cost for the other services covered.
- Increases in pharmacy usage for the Program have more than offset other shifts in the pharmaceutical environment that may have helped limit cost growth, such as the increasing use of generics, the over-the-counter (OTC) availability of the allergy drug, Claritin, and heartburn drug, Prilosec, and a drop in the use of drugs associated with safety and cost/benefit concerns like hormone replacement products and arthritis treatments (e.g., Vioxx).
- The use of generic medication continues to rise for the Program, continuing a positive trend from prior years and increasing to a 2005 generic fill rate (GFR) of 49.2%, up from 45.9% in 2004. The 2006 6-month generic fill rate has further increased to 52.8%. With more drugs becoming available in generic form in the near future, programs that encourage generic use should be maintained.
- The Program also saw its use of single-source brand drugs continuing its declining trend, dropping from 45.9% in 2004 to 44.2% in 2005. The 2006 6-month single-source brand rate has decreased further to 41.4%.

Additional facts and figures in support of these findings, along with some additional analysis, are provided in the following section.

Detailed Findings

A summary of year over year trends for the Commonwealth's pharmacy claims experience in aggregate are illustrated in Exhibit XXXII

Exhibit XXXII Key Statistics

	Annual Experience				
	2003	2004	2005	2004 vs. 2003	2005 vs. 2004
Total Ingredient Cost	\$190,157,293	\$226,025,398	\$237,894,937	18.9%	5.3%
Total Plan Cost	\$145,128,110	\$168,061,796	\$182,552,968	15.8%	8.6%
Total Eligible Members	226,399	227,917	229,867	0.7%	0.9%
Total Claims	3,930,564	4,160,895	4,108,150	5.9%	(1.3%)
Mail Claims	46,621	45,822	69,359	(1.7%)	51.4%
Retail Claims	3,883,943	4,115,073	4,038,791	6.0%	(1.9%)
Brand Claims	2,192,928	2,253,058	2,086,205	2.7%	(7.4%)
Generic Claims	1,737,636	1,907,837	2,021,945	9.8%	6.0%
Days Supply		112,948,808	112,408,843		(0.5%)
Days Supply per Claim		27.1	27.4		0.8%
Generic Dispensing Rate	44.2%	45.9%	49.2%	1.7%	3.4%
Generic Substitution Rate		84.7%	88.2%		3.5%
Mail Order Utilization	1.2%	1.1%	1.7%	(0.1%)	0.6%
Retail Copayment per Claim		\$15.39	\$14.94		(3.0%)
Retail Member Cost Share		28.0%	26.0%		(7.2%)
Mail Copayment per Claim		\$32.46	\$29.31		(9.7%)
Mail Member Cost Share		20.4%	15.8%		(22.5%)
Total Copayment per Claim		\$15.58	\$15.18		(2.6%)
Total Member Cost Share	27.9%	27.8%	25.5%	(0.4%)	(8.4%)
Plan Cost per Member	\$636.00	\$732.00	\$794.17	15.1%	8.5%
Plan Cost PMPM	\$53.00	\$61.00	\$66.18	15.1%	8.5%
Plan Cost per Claim	\$36.92	\$40.39	\$44.44	9.4%	10.0%
Claims PMPY	17.4	18.3	17.9	5.2%	(2.1%)

Source: Commonwealth's enrollment and claims data aggregated by MedStat.

Observations from the key statistics summary include:

- Aggregate trend experience for 2004-2005 is 8.6%. Per member per month increases were 8.5%. The trend was lower than the 2003-2004 trend.
- The number of claims PMPY in 2005 was 17.9.

- Total membership count remained relatively consistent year over year.
- The use of generic medication is increasing to a 2005 Generic Fill Rate of 49.2%.
- Mail order usage is still quite low at 1.7%, but increasing each year. 2006 6-month usage has increased to 2.2%.
- Use of brand-name drugs where generic is also available (i.e., “multi-source brand”) decreased in 2005 to over 6.6%, due to the increased use of Generics. It is still high for the Program’s demographic, a rate below 3% would be expected.
- Retail dispensing fees in 2005 averaged \$1.75 per script. There was no mail order dispensing fee in 2005. Note that the ingredient cost figures incorporated in this report do not include dispensing fees, but the plan costs and claims amounts do include dispensing fees.
- The Cost Per Day figures in 2005 indicated that mail is a more expensive distribution channel for the Commonwealth, despite deeper discounts. The 2005 Net Cost per Day at Retail was \$1.61, versus the 2005 Net Cost per Day at Mail of \$1.82. This is only due to the lower cost sharing rate at Mail (vs. Retail). The 2006 6-month Net Cost per Day at Retail has increased to \$1.83, and Net Cost per Day at Mail decreased to \$1.62 making mail a more economical distribution channel due, in part, to the increased discounts received for generic drugs in the mail setting.

Demographic Impact

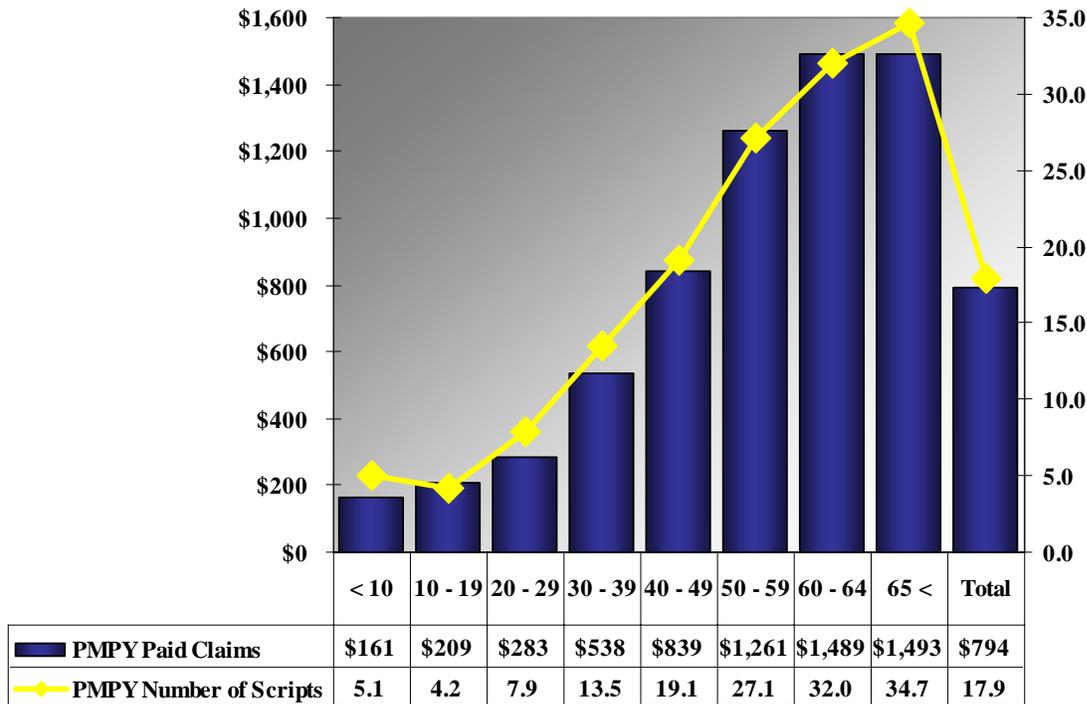
The PEHI Program’s average member age in 2005 was 39.5 and increasing, and it is estimated to be at or above 40 within the next 3 years, thereby moving cost and utilization into a higher age band (Exhibit XXXIII). The average age of covered employees is significantly higher in 2005 at 47.6, and this is also trending upward.

In 2005 the average age band of 30-39 has a plan cost average of \$538 and an average number of prescriptions of 13.5 PMPY. The 40-49 age band, however, has an average plan cost of \$839 and average number of prescriptions of 19.1 PMPY.

As would be expected, older populations tend to use more chronic medications and thus have more prescriptions PMPY. The chart below illustrates the Commonwealth’s utilization in the 50-74 year age bands to be well beyond industry norms, which typically range up to 26 claims PMPY on average. Note that the industry norms included here have not been adjusted to match the age, sex, and adult/child ratio characteristics of the Commonwealth's population.

Exhibit XXXIII

2005 Distribution of Plan Claims and Number of Prescriptions, PMPY by Age



Source: Commonwealth's enrollment and claims data aggregated by MedStat.

Membership and corresponding total expenditures are similarly consolidated in the older age bands. While the average member age is 39.5, the largest percentage of membership falls into an age band of 50-59 years, representing nearly 25.8% of membership and 40.9% of total prescription drug plan cost (\$1,261 PMPY), as reflected in Exhibit XXXIV.

Exhibit XXXIV

2005 Distribution of Membership and Percent of Total Drug Plan Claims by Age

Age Group	Members	% of Total Members	% of Net Pay Rx
< 10	19,451	8.46%	1.72%
10 to 19	27,955	12.16%	3.19%
20 to 29	25,770	11.21%	4.00%
30 to 39	28,684	12.48%	8.45%
40 to 49	40,324	17.54%	18.54%
50 to 59	59,254	25.78%	40.91%
60 to 64	22,801	9.92%	18.59%
65 to 74	5,632	2.45%	4.60%
Total	229,870	100.00%	100.00%

Source: Commonwealth's enrollment and claims data aggregated by MedStat.

Drug Utilization and Disease States

A concentration of prescription drug plan cost can also be reviewed by drug specific utilization and corresponding disease states being treated. For the PEHI Program in 2005, the top 30 drugs ranked by cost represented 40.2% of total plan claims in 2005 and 27.4% of prescriptions. By comparison the top 30 drugs ranked by cost in 2004 represented 37.3% of total plan claims, and 26.4% of prescriptions. The top 30 drugs are in Exhibit XXXV, and the Top 10 therapeutic categories and corresponding plan costs are provided in Exhibit XXXVI.

Exhibit XXXV Top 30 Drugs

Product Name	2003		2004		2005		Net Pay Change	
	Rank	Net Pay PMPM	Rank	Net Pay PMPM	Rank	Net Pay PMPM	2004 vs. 2003	2005 vs. 2004
LIPITOR	1	\$2.49	1	\$2.90	1	\$3.13	16.7%	7.8%
ENBREL	42	\$0.28	22	\$0.53	2	\$1.50	89.3%	186.0%
EFFEXOR-XR	6	\$1.02	3	\$1.42	3	\$1.41	38.9%	-0.7%
NEXIUM	12	\$0.67	7	\$1.03	4	\$1.31	54.0%	26.8%
SINGULAIR	7	\$0.87	6	\$1.10	5	\$1.29	25.9%	17.6%
PROTONIX	10	\$0.74	10	\$0.84	6	\$1.22	13.0%	45.4%
ZOCOR	2	\$1.81	4	\$1.35	7	\$1.19	-25.2%	-12.1%
ZOLOFT	5	\$1.09	5	\$1.23	8	\$1.12	12.4%	-8.6%
PREVACID	3	\$1.67	2	\$1.48	9	\$1.07	-11.5%	-27.9%
AVANDIA	13	\$0.64	13	\$0.73	10	\$0.91	13.3%	24.9%
PLAVIX	19	\$0.49	12	\$0.76	11	\$0.90	55.4%	19.1%
WELLBUTRIN XL	n/a	n/a	16	\$0.64	12	\$0.88	n/a	36.4%
ACTOS	15	\$0.62	11	\$0.79	13	\$0.87	26.1%	10.9%
TOPAMAX	18	\$0.49	15	\$0.66	14	\$0.85	34.7%	29.8%
LEXAPRO	37	\$0.29	17	\$0.64	15	\$0.76	118.5%	19.0%
GABAPENTIN	n/a	n/a	144	\$0.09	16	\$0.70	n/a	682.4%
ZYRTEC	21	\$0.47	20	\$0.53	17	\$0.69	13.5%	29.9%
ALLEGRA	4	\$1.23	9	\$0.96	18	\$0.65	-21.7%	-32.1%
ADVAIR DISKUS 250/50	32	\$0.36	26	\$0.47	19	\$0.59	31.6%	24.2%
FOSAMAX	26	\$0.44	18	\$0.55	20	\$0.55	24.4%	0.5%
LOTREL	24	\$0.45	21	\$0.53	21	\$0.53	19.5%	0.1%
FLONASE	31	\$0.36	27	\$0.45	22	\$0.53	25.4%	16.6%
NORVASC	23	\$0.45	24	\$0.51	23	\$0.52	13.4%	2.7%
COPAXONE	49	\$0.21	57	\$0.26	24	\$0.52	20.0%	101.4%
LEVAQUIN	30	\$0.36	31	\$0.40	25	\$0.51	9.3%	27.9%
TRICOR	38	\$0.29	28	\$0.44	26	\$0.51	53.0%	14.9%
MOBIC	97	\$0.13	56	\$0.26	27	\$0.49	102.7%	87.9%
IMITREX	25	\$0.45	25	\$0.50	28	\$0.48	12.6%	-4.4%
TOPROL XL	43	\$0.28	34	\$0.36	29	\$0.45	30.3%	26.0%
ZETIA	n/a	n/a	38	\$0.32	30	\$0.44	n/a	36.4%

Source: Commonwealth's enrollment and claims data aggregated by MedStat

Exhibit XXXVI
2005 Top 10 Therapeutic Class Summary

Class Rank	Medstat Therapeutic Class (Intermediate)	Description	Net Paid	Scripts	Patients	Net Paid per Rx	Net Paid per Patient
1	Antihyperlipidemic Drugs, NEC	Treatment of High Cholesterol	\$19,809,023	258,389	36,529	\$76.66	\$542
2	Psychother, Antidepressants	Antidepressants/Mental Health	\$16,341,446	299,736	43,743	\$54.52	\$374
3	Unclassified Agents, NEC	Miscellaneous Disease Treatments	\$14,373,740	116,548	25,006	\$123.33	\$575
4	Gastrointestinal Drug Misc,NEC	Ulcer Therapy/Heartburn	\$13,437,763	121,713	22,769	\$110.41	\$590
5	Anticonvulsants, Misc	Treatment of Epilepsy	\$7,319,345	54,916	9,536	\$133.28	\$768
6	Antidiabetic Agents, Misc	Treatment of Diabetes	\$6,798,920	99,890	12,039	\$68.06	\$565
7	Antihistamines & Comb, NEC	Treatment of Allergies	\$5,599,155	182,091	59,934	\$30.75	\$93
8	Adrenals & Comb, NEC	Treatment of Asthma (steroids)	\$4,567,737	83,788	36,588	\$54.52	\$125
9	Cardiac, Calcium Channel	Treatment of High Blood Pressure	\$4,497,715	116,476	15,983	\$38.61	\$281
10	Analg/Antipyr,Nonstr/Antiinflm	Pain and Inflammation (non-narcotic)	\$4,170,829	118,631	41,429	\$35.16	\$101
Top 10 Total			\$96,915,673	1,452,178		\$66.74	
Grand Total			\$182,589,881	\$4,108,150		\$44.45	
Top 10 Percent of Total			53.1%	35.3%			

Source: Commonwealth's enrollment and data claims aggregated by MedStat. All claims represented, including those classified by MedStat as "OTC and/or missing".

Breaking the average number of prescriptions per person into single source brand, multi-source brand and generics, trends are similar to those seen in the aggregate data analysis (Exhibit XXXVII). Use of brand single source and brand multi source drugs is on the decline, and use of generics is increasing.

Exhibit XXXVII
Prescription Drug Utilization Detail by Drug Classification

	Average Scripts Per Person		
	2004	2005	% Change
Retail			
Brand Single Source	8.3	7.7	-6.4%
Brand Multi Source	1.5	1.2	-22.6%
Total Brand	9.8	8.9	-8.9%
Generic	8.3	8.7	4.6%
Total All	18.1	17.6	-2.7%
Mail Order			
Brand Single Source	0.1	0.2	47.5%
Brand Multi Source	0.0	0.0	28.7%
Total Brand	0.1	0.2	45.1%
Generic	0.1	0.1	59.5%
Total All	0.2	0.3	50.1%
Retail and Mail Order			
Brand Single Source	8.4	7.9	-5.7%
Brand Multi Source	1.5	1.2	-22.0%
Total Brand	9.9	9.1	-8.2%
Generic	8.4	8.8	5.1%
Total All	18.3	17.9	-2.1%

Source: Commonwealth's enrollment and claims data aggregated by MedStat.

Contributing to the mix of drugs used by the members are environmental changes, such as the introduction of new drugs (driving a higher plan cost) and new generics (lowering plan cost). Based on the Program's historical experience, maximizing utilization of generics represents a significant opportunity to manage overall plan cost.

While patent expiration does not equal generic availability, several highly utilized drugs are scheduled for patent expiration over the next several years (Exhibit XXXVIII).

Exhibit XXXVIII

Drugs Losing Patent Protection (Generics Become Available)

Year	Brand Name	Manufacturer	Use
2006	Zocor	Merck	Hyperlipidemia (High Cholesterol)
	Zoloft	Pfizer	Depression
	Pravachol	Bristol-Myers-Squibb	Hyperlipidemia (High Cholesterol)
	Toprol-XL	AstraZeneca	Hypertension, CHF
	Zofran	GlaxoSmithKline	Nausea
	Allegra-D	Sanofi-Aventis	Allergies
	Ditropan XL	Otrho-McNeill	Overactive Bladder
	Activella	Novo Nordisk	Hormone replacement
2007	Norvasc	Pfizer	Hypertension
	Ambien	Sanofi-Aventis	Insomnia
	Zyrtec	Pfizer	Allergies
	Imitrex	GlaxoSmithKline	Migraine headache
	Lotrel	Novartis	High blood pressure
	Paxil CR	GlaxoSmithKline	Depression
	Coreg	GlaxoSmithKline	Hypertension
	Proscar	Merck	BPH
	Precose	Bayer	Type 2 diabetes
2008	Advair Diskus	GlaxoSmithKline	Asthma, COPD
	Risperdal	Janssen	Schizophrenia
	Fosamax	Merck	Osteoporosis
	Depakote	Abbott	Seizure disorder, bipolar disorder
	Mobic	Boehringer Ingelheim	Arthritis
	Serevent	GlaxoSmithKline	Asthma, COPD
	Effexor	Wyeth-Ayerst	Depression, anxiety
	Tegretol-XR	Novartis	Seizures
	Requip	GlaxoSmithKline	Parkinson's disease
	Tarka	Abbott	High blood pressure
	Mavik	Abbott	High blood pressure
	Kytril	Roche	Chemotherapy-induced nausea / vomiting

Source: 2006 Medco Drug Trend Report

Summary of 2005 Key Medical and Pharmacy Cost Drivers and Observations

- 17% of the population is driving 77% of the costs.
- Between 2004 and 2005, the actuarial value of the benefits increased (plan provisions and the Commonwealth's subsidy). The combined impact of these changes was an approximate 19.6% increase in actuarial value.
- The majority of employees migrated to 2005 plans with a greater actuarial value than the plan that they utilized in 2004.
- The opt-out incentive provided by the Commonwealth is greater than what is the norm, and may be greater than the level necessary to provide the incentive to opt out.
- The Commonwealth's older than average population is driving cost increases. This cost increase is being off-set by the low level of dependents covered by the plans. However, this older population is moving into the most expensive age band (e.g., 50-59).
- Heart, musculoskeletal, and digestive conditions are the top three diagnostic categories (40% of the costs) experienced by the population.
- Wellness screenings are below national goals.
- Non-Medicare eligible retirees consume a higher than average share of costs and services when compared to the group as a whole. Non-Medicare eligible retirees represent 22% of plan membership and consume 33% of total health care cost.
- Pharmacy costs continued to increase in 2005, but utilization (scripts per member per year) decreased slightly from 2004 to 2005.
- Mandatory generic substitution provisions are already in place. KRS 217.822 requires dispensing of generic drugs unless prescribed as "dispensed as written – DAW" or the brand is requested by the patient.

LEGISLATIVE MANDATES

The Department of Insurance provided the summary in Exhibit XXXIX of twenty-nine mandated health insurance benefits that currently exist in Kentucky's statutes.

Exhibit XXXIX

Kentucky Mandated Health Insurance Benefits	
Newborn Coverage	KRS 304.17-042, KRS 304.18-032, KRS 304.32-153, and KRS 304.38-199. Coverage for newborn children from the moment of birth, including necessary care and treatment of medically diagnosed inherited metabolic diseases for newborns—KRS 304.17A-139(2)
Inherited Metabolic Disease	KRS 304.17A-139(4). Coverage for amino acid modified preparation and low protein modified food products for treatment of inherited metabolic diseases for conditions listed in KRS 205.560, if prescription drugs are covered. Benefits can be limited to \$4,000 per year for low-protein modified foods and \$25,000 per year for medical formulas.
Ambulatory Surgical Centers	KRS 304.17-317, KRS 304.18-035, & KRS 304.32-156. Coverage for treatment at ambulatory surgical centers.
Optometrists, osteopaths, physicians, podiatrists, and chiropractors	KRS 304-17-035, KRS 304.18-095, KRS 304.32-157 & KRS 304.38-195. KRS 304.17A-275 requires that coverage be provided for services provided by osteopaths. Osteopaths can also be PCP's. Services of these providers to be covered as described.
Chiropractors	KRS 304.17A-170 & 171. Access to chiropractors in network plans.
Dentists	KRS 304.17-315, KRS 304.18-097, KRS 304.32-157 & KRS 304.38-1937. Services of dentists to be covered as described.
Temporomandibular Joint Disorder	KRS 304.17-319, KRS 304.18-0365, KRS 304.32-1585 & KRS 304.38-1937. Coverage for specific services related to TMJ and associated disorders. Also see Administrative Regulation 806 KAR 17:090.
Screening Mammography	KRS 304.17-316, KRS 304.18-098, KRS 304.32-1591 & KRS 304.38-1935. Screening mammography at specific intervals. KRS 304.17-316(2)(b) requires mammography coverage at any age for a covered person diagnosed with breast cancer.
Breast Cancer	KRS 304.17-3165, KRS 304.17A-135, KRS 304.18-0985, KRS 304.32-1595 & KRS 304.38-1936. Coverage for the treatment of breast cancer, including ABMT.
Breast reconstruction coverage, endometriosis and endometritis	KRS 304.17-3163, KRS 304.18-0983, KRS 304.38-1934, KRS 304.32-1593 & KRS 304.17A-134. Coverage for the treatment of breast reconstruction.
Psychologists and Clinical Social Workers	KRS 304.17-3185, KRS 304.18-0363, KRS 304.32-166 & KRS 304.38-1933. Services of these providers to be covered as described.

Kentucky Mandated Health Insurance Benefits	
Registered nurse first assistant benefits	KRS 304.17A-146. Health benefit plans that cover surgical first assisting benefits or services must provide coverage for a registered nurse first assistant who performs the services within the scope of their license.
Conversion benefits	2002 Ky. Acts, Chapter 351, Section 9. Maximum benefits of at least \$500,000 for conversion policies—KRS 304.18-120(1). Minimum benefits—806 KAR 17:260.
Work Related Illness/Injuries	KRS 304.12-250. No contract can exclude coverage solely on the basis that the health condition is work related.
Disabled Children	KRS 304.17-310. Individual health insurance contracts must continue coverage for disabled children beyond the limiting age. Although this statute is applicable only to individual contracts, group carriers commonly use it.
Adopted Children	KRS 304.17-140. Coverage for legally adopted children or children under court-appointed guardianship.
Human Immunodeficiency Virus	KRS 304.12-013(5). No insurer or HMO may exclude or limit coverage for AIDS, etc.
Maternity Coverage	KRS 304.17A-145. Specified length of hospital stay following vaginal/cesarean deliveries.
Cochlear Implants	KRS 304.17A-131. Coverage for cochlear implants.
Autism	KRS 304.17A-143. Coverage for autism, including respite services.
Diabetes	KRS 304.17A-148. Coverage for diabetic services, supplies, and training.
Women's Health	KRS 304.17A-134, KRS 304.17-3163, KRS 304.18-0983, KRS 304.32-1593 & KRS 304.38-1934. Breast reconstruction, endometriosis, endometritis, and bone density testing.
Domestic Violence	KRS 304.17A-155. Claims may not be denied or considered pre-existing on the basis of domestic violence.
Hospice	KRS 304.17A-250(8). Coverage for hospice care equal to Medicare benefits.
Telehealth services	KRS 304.17A-138. (Effective when the plans are issued or renewed after July 15, 2001)
Mental health coverage	KRS 304.17A-661. Large group health benefit plans must cover mental illness the same as physical illness, if they provide mental illness benefits.
Physician assistant benefits	KRS 304.17A-1473. Health Benefit Plans that cover surgical first assisting or intraoperative surgical care services must provide coverage for the services of a physician assistant. (Effective for Health Benefit Plans issued or renewed on or after July 15, 2001.)

Kentucky Mandated Health Insurance Benefits	
Anesthesia and hospital or facility charges	2002 Ky. Acts, Chapter 199. Requires coverage for payment of anesthesia and hospital or facility charges in connection with dental procedures for children below the age of nine, persons with serious mental or physical conditions and persons with significant behavioral problems in all health benefit plans that provide coverage for general anesthesia and hospitalization services.
Hearing aids and related services	2002 Ky. Acts, Chapter 106, Section 1(2). Requires coverage for hearing aids and related services for persons under 18 years of age for the full cost of one hearing aid per impaired ear up to \$1,400 every 36 months.

Source: Kentucky Department of Insurance

In addition to the mandated benefits outlined in Exhibit XXXIX, there are other statutory requirements that affect the Public Employee Health Insurance Program. Exhibit XL provides a brief outline of the key provisions of the mandates enacted by the 2000 General Assembly that apply to health insurance programs. The provisions of those bills for which there is no check mark in the column titled “Impacts Commonwealth Plan” were covered by the Commonwealth’s Public Employee Health Insurance Program prior to the enactment of the mandate.

Exhibit XL

Health Insurance Mandates Enacted By 2000 General Assembly		
	Impacts PEHI Program	Key Provisions
HB 9		Mammography coverage
HB 177		Coverage of Telehealth services
HB 202	✓	<ul style="list-style-type: none"> ▪ Newborn coverage from moment of birth ▪ Treatment of inherited metabolic diseases including amino acid preparations and low-protein modified food products
HB 268	✓	Mental Health Parity
HB 281		Coverage of services provided by registered nurse first assistants
HB 390	✓	<ul style="list-style-type: none"> ▪ Utilization review rules ▪ Independent external review
HB 757	✓	<ul style="list-style-type: none"> ▪ Hold harmless and continuity of care upon contract termination ▪ Drug formulary summary required at enrollment ▪ Network access requirements modified ▪ Prudent lay person standard for emergency services
SB 279	✓	▪ Prompt payment of medical claims
SB 335	✓	▪ Coverage of certified surgical assistants

In addition to the health insurance mandates, Senate Bill 288, enacted by the 2000 General Assembly:

- Created the Kentucky Group Health Insurance Board.
- Required the Personnel Cabinet to develop healthcare data collection and analysis capabilities.
- Stipulated the conditions under which groups may leave the Public Employee Health Insurance Program.
- Revised the definition of “employee” with respect to the Commonwealth’s healthcare and flexible spending account benefits.
- Required the Personnel Cabinet to report annually to the General Assembly on the financial stability of the Commonwealth’s Public Employee Health Insurance Program.
- Required unused flexible spending account funds to be transferred to the state health insurance plan’s appropriation account.
- Required carriers bidding to offer healthcare coverage to members of the Public Employee Health Insurance Program to rate all such members as single entity, except for those retirees whose former employers insure their active employees outside the Public Employee Health Insurance Program.
- Precluded certain individuals who are eligible for participation in the Public Employee Health Insurance Program as a retiree from receiving the state health insurance subsidy as an active employee as well.

Additional mandates enacted by the 2001, 2002, and 2003 General Assemblies affect the Commonwealth’s Public Employee Health Insurance Program. These are summarized briefly in Exhibit XLI.

Exhibit XLI

Legislation Enacted by the 2001, 2002, 2003, and 2006 General Assemblies that Impacts the Public Employee Health Insurance Program		
Year Enacted	Bill	Key Provisions
2001	HB 97	The Office of Public Employee Health Insurance was established under the Personnel Cabinet.
2001	HB 138	Coverage of physician assistants assisting in surgery.
2001	HB 145	Personnel Cabinet and Cabinet for Families and Children to prepare recommendations regarding allowing foster parents to participate in the Public Employee Health Insurance Program.
2002	HB 39	Coverage of anesthesia and hospital or facility charges in connection with dental procedures for children below the age of nine, persons with serious mental or physical conditions and persons with significant behavioral problems.

Legislation Enacted by the 2001, 2002, 2003, and 2006 General Assemblies that Impacts the Public Employee Health Insurance Program

Year Enacted	Bill	Key Provisions
2002	HB 163	Expands Kentucky Group Health Insurance Board to include: <ul style="list-style-type: none"> ▪ The Director of the Administrative Office of the Courts ▪ KRS retiree ▪ KTRS retiree ▪ Active teacher ▪ Active state employee ▪ Active classified education support employee
2002	HB 369	Mail order prescription drug coverage for Public Employee Health Insurance Program.
2002	HB 395	Revised caps for inherited metabolic diseases to be \$4,000 annually for low-protein modified foods and \$25,000 annually for medical formulas.
2002	HB 801	Entities that join the Kentucky Retirement System must join the Public Employee Health Insurance Program for their active employees.
2002	HB 821	<ul style="list-style-type: none"> ▪ Personnel Cabinet to study whether to allow health insurance bidders to bid different rates in different geographic areas of the Commonwealth. ▪ Allows Public Employee Health Insurance members to select coverage in a contiguous county and receive the state subsidy for that county if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does.
2002	HB 846	<ul style="list-style-type: none"> ▪ Restricts individuals to one state subsidy for health insurance. ▪ Entities participating in the Public Employee Health Insurance Program must sign a contract with the Personnel Cabinet. ▪ Expands the Advisory Committee of State Health Insurance Subscribers to include 2 members from the Kentucky Association of Counties and 2 from the Kentucky League of Cities. ▪ Directs the LRC to study the cost to members of the state health insurance group as a result of entities covering their retirees under the Public Employee Health Insurance Program but not their active employees and recommend administrative procedures to collect this cost from these entities. ▪ Directs the LRC to study the Public Employee Health Insurance Program. ▪ Allows Public Employee Health Insurance members to select coverage in a contiguous county and receive the state subsidy for that county if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does.
2002	SB 152	Coverage for hearing aids and related services for persons under 18 years of age for the full cost of one hearing aid per impaired ear up to \$1,400 every 36 months.
2002	SCR 34	Directs the Interim Joint Committee on Banking and Insurance to study the feasibility of self-funding at least one health insurance option for state employees.

Legislation Enacted by the 2001, 2002, 2003, and 2006 General Assemblies that Impacts the Public Employee Health Insurance Program		
Year Enacted	Bill	Key Provisions
2003	HB 95	Removes the requirement that an employee's employment must be in the same county as his residence for the employee to be eligible to elect coverage in an adjacent county and receive the state subsidy for that county, if the hospital in the county where the member lives does not offer certain services and a hospital in the adjacent county does.
2003	HB 183	Requires that the sponsor of a bill that contains a mandated health benefit request, have prepared, and attach a financial impact statement before final consideration by a standing committee.
2003	HB 370	Required the Commonwealth's Public Employee Health Insurance Program to include a scenario that allows regional rating in its 2004 health insurance Request for Proposal, with regions defined as the partnership regions designated by the Department for Medicaid Services.
2003	HB 430	For individuals hired on or after July 1, 2003, increased the service required of participants in SPRS, CERS or KERS from a minimum of 5 years to 10 years to be eligible to participate in the Commonwealth's retiree health insurance program.
2006	HB131	Includes provision to pay optometrists the same amount as physicians or osteopaths when the services provided are rendered by an optometrist.
2006	HB131	Adds language requiring the Kentucky Employees Health Plan to be in compliance with certain provisions of the Insurance Code, including appeals & grievance procedures, utilization review, claims payment, and emergency medical care.
2006	HB380	Reduced the employer contribution for 2006 health insurance premiums by 12% for the period July – December, 2006.
2006	HB380	Provided explicit statutory authority to establish a self-insured health plan for public employees.
2006	HB380	Requires the plan to be established by administrative regulations.
2006	HB380	Provides appeal rights for formulary changes, and ensures independent review of any proposed changes in formulary.
2006	HB380	Establishes a Trust Fund for the plan, and defines the allowable expenses to be paid by the Trust Fund.
2006	HB380	Requires a Health Reimbursement Account to be provided for those employees who waive coverage under the Plan, to be funded by the employer at an amount no less than \$175 per month.
2006	HB380	Requires an audit of the Trust Fund within 90 days of the end of each Fiscal Year.
2006	HB380	Establishes quarterly reporting requirements for the Plan.

No additional benefit mandates were enacted by the 2004 General Assembly. In fact, House Bill 650 created a new statute in Subtitle 17A that imposed a 3-year moratorium on new mandated benefits beyond those statutorily required on July 13, 2004.

Conclusions

There are a significant number of legislative mandates that apply to the Commonwealth's Public Employee Health Insurance Program. The impact of many of these mandates on the program's costs is difficult to discern. And, although the discernible cost of some mandates may be low in a given year, significant variation can result from year to year. Finally, the ability to determine the cost of discrete provisions is highly dependent on providers appropriately classifying the expenses and insurance carriers accurately recording the expenses. Therefore, the cost impact can easily be understated.

CONCLUSIONS

This section provides a consolidated summary of the conclusions presented in the previous sections of the report.

Board Recommendations

- The Board recommends that the due date for the Annual Report to the Governor be extended from October 1 each year to December 1.

General Observations on the PEHI Program

- Claims costs generated by the PEHI Program over the 2003 through 2006 periods have demonstrated an average annual healthcare trend rate of 12.1%.
- Claims costs generated by the PEHI Program as from 1999 to 2005 have more than doubled. This has occurred with little change to the size of the population covered.
- The increase in medical and pharmacy claims costs in 2005 was lower than national survey benchmarks and significantly lower than experienced in 2004.
- The insurance carriers that provided coverage in 2004, in aggregate experienced a medical claims loss ratio of over 101.5%. In 2005 medical loss ratios were 85%. This was achieved with a 28.5% increase in premiums.
- 17% of the PEHI Program population is generating 77% of the claims cost. Effective care and cost management strategies in the future should focus on the disease states, medical and pharmacy services required by this population. Wellness and disease management efforts should focus on reducing the cost of this population.
- Wellness screenings for the population continue to be significantly below national wellness organization's goals. The Commonwealth of Kentucky population as a whole has some serious health lifestyle issues that directly correlate to higher costs.
- Pharmacy utilization continues to be higher than expected. In 2005 generic drug utilization has improved compared to 2004. In 2005 brand drug utilization has decreased compared to 2004.
- The Board is encouraged by the early performance and future potential of the self-insured plan. The ongoing commitment of the Board is to keep member benefits as consistent as plan finances will allow.

GLOSSARY

Allowed Charge: The amount paid in total to a healthcare provider for services received by a health plan member. This amount includes both the health plan's payment and the member's cost sharing (deductible, co-payment, co-insurance, etc.). This is the total amount billed by a healthcare provider for a covered service, after the application of the health plan's negotiated discount, but prior to any member cost-sharing.

Benchmark: A comparison metric based on the health care industry's experiences and practices. Note that the benchmarks included in this report have not been adjusted to match the age, sex, and adult/child ratio characteristics of the Commonwealth's population.

Brand Name Drug: A trademarked drug for which the manufacturer holds the patent or has purchased the rights to manufacture from the patent holder. Brand name drugs are generally more expensive than generics. A single-source brand name drug is a drug that is only produced by one manufacturer and for which a generic equivalent is not available. Multi-source brand name drugs are drugs produced by more than one manufacturer, as generic equivalents are available.

Capitation: A set amount of money paid to a provider of service based on membership demographics rather than payment based on services provided.

Claim: A billed amount for services or goods obtained from a healthcare provider. Unless otherwise noted in this report, "claim" refers to incurred claims inclusive of amounts that have not yet been reported and/or paid.

COBRA Beneficiaries: Individuals who no longer meet the eligibility requirements for healthcare coverage through a group health plan, but by federal statute, are eligible to continue their healthcare coverage for a period of time under the employer's healthcare program by paying 102% of the total premium rate.

Co-Payment: A stipulated dollar amount that a health plan member must pay out of pocket when healthcare services, supplies, or prescription drugs are received.

Coinsurance: A percentage of the cost of covered healthcare services, supplies, or prescription drugs that a health plan member must pay out of pocket.

Coverage Tier (also referred to as Coverage Level): The choices available to employees with respect to the individuals they wish to cover under an employer's health insurance program. Under the Commonwealth's Public Employee Health Insurance Program, the following tiers (or levels) apply:

- Single: coverage for only the employee or retiree
- Couple: coverage for the employee or retiree and his/her spouse
- Parent Plus: coverage for the employee and all eligible children
- Family: coverage for the employee or retiree, his/her spouse and all eligible children

Dependent Subsidy: When an employer specifically pays a portion, or all, of the dependent premium for an employee, this is an *explicit dependent* subsidy. When the differential between single and dependent healthcare premium rates is less than the differential between employee/retiree healthcare claims and dependents' healthcare claims, an *implicit dependent subsidy* exists.

Exclusive Provider Organization (EPO): These plans require services to be received from a healthcare provider that participates in the health plan's network in order for the service to be covered by the plan. Depending on the insurance carrier chosen, the participant may or may not have to designate a primary care physician to coordinate his/her care. Beginning January 1, 2000, EPO Option C was added to the Commonwealth's Public Employee Health Insurance Program.

Formulary: A preferred list of medications developed by a health plan or Pharmacy Benefit Manager (PBM) to guide physician prescribing and pharmacy dispensing. This list is periodically updated by the PBM to add or remove drugs.

Flexible Spending Account (FSA): A flexible spending account or reimbursement account is funded by employee salary reductions, employer contributions or both. Amounts placed in these accounts are used to provide reimbursement for eligible expenses incurred by the employee or eligible beneficiaries for specified benefits during a plan year.

Fully Insured (also referred to as Insured or Fully Funded): When a health plan assumes the financial risk associated with medical expenses for an employer group in exchange for the premiums paid by the group.

Generic Drug: A drug whose therapeutic ingredients are the same as a brand name drug, but which is sold under a name that is not trademarked. Generic drugs are usually less expensive than their brand name counterpart.

Health Maintenance Organization (HMO): These plans require services to be received from a healthcare provider that participates in the health plan's network in order for the service to be covered by the plan. Participants in these plans must select a primary care physician to coordinate their care. For the majority of the services covered by the HMO, participants pay a specified dollar amount (co-payment) at the time services are received.

Medical Loss Ratio (also referred to as Loss Ratio): The ratio between the incurred claims paid by a health plan and the premium taken in by the health insurer. Example: An insurance company receives \$100,000 in premium for a month and pays out \$89,000 in claims—the Medical Loss Ratio is 89% ($\$89,000/\$100,000$).

Out-of-Pocket Limit: A specified dollar amount present in some health plan provisions that limits the amount of out-of-pocket expenses a plan participant pays in a Plan Year for covered health care services. Once the participant reaches the out-of-pocket limit, the health plan pays 100% of his/her covered healthcare expenses for most or all services.

Pharmacy Benefit Manager (PBM): An organization that functions as a third party administrator for a health plan's pharmacy claims, contracts and management.

PMPM (Per Member Per Month): A measure of costs as expressed as total costs divided by total number of covered lives (employees, spouses, and dependent children).

Point of Service (POS): These plans mimic the benefits of the HMO options, provided an individual receives services from a healthcare provider that has contracted with the health plan and services are coordinated through the primary care physician designated by the individual. Unlike the HMO options, the POS options provide coverage for services received from a provider that is not in the health plan's network, at a higher cost sharing percentage to the insured.

Preferred Provider Organization (PPO): These plans require lesser cost sharing from participants, if covered services are received from a healthcare provider that participates in the health plan's network. Coverage is provided for services received from a provider that is not in the health plan's network, with participants paying a larger proportion of the cost of covered services. Unlike POS plans, PPOs do not require referrals from a participant's primary care physician. The PPOs offered under the Commonwealth's Public Employee Health Insurance Program provide the same benefits for services received in a network physician's office and for prescription drugs as do the HMO and POS options. However, for services received in a network hospital or surgical center, PPO participants pay a percentage of the cost of services received (co-insurance) after paying an annual deductible, rather than a specified dollar co-payment. The amount of co-insurance that a participant pays annually is capped by the PPO plan's out-of-pocket limit.

Premium: The monetary amount paid by an employee or the employer for health insurance benefits. It is routinely paid on a monthly basis. In an insured program, the amount paid to an insurance company in exchange for its payment of all healthcare costs covered under the terms of the health plan and for administrative services. For large groups, like the Public Employee Health Insurance Program, premiums are determined based on the healthcare services consumed by the plan's members in the past and the prices charged by healthcare providers. If the premiums charged by the insurer are less than the actual healthcare costs incurred by the plan's members and the insurer's operating costs, the insurer loses money. The premium includes both the employer's subsidy and the employees' contributions for health insurance.

Premium Equivalent: Analogous to "Premiums", Premium Equivalents reflect the expected actuarial costs for a plan option and coverage tier under a self-insured arrangement.

Primary Care Physician: For purposes of the applying the Commonwealth's qualifying network requirements, a primary care physician includes: family practice physicians, general practice physicians, pediatricians, and internists.

Provider Network: A list of contracted health care providers, unique to a health plan, from which an insured can obtain services that are covered under an HMO or are covered at a preferred benefit level under a POS or PPO.

Self Insured (also referred to as Self Funded): A health plan whose medical claims' financial risk is assumed by the employer and not by the health plan.

Specialist Physician: For purposes of the applying the Commonwealth's qualifying network requirements, a specialist physician includes all physicians other than: family practice physicians, general practice physicians, pediatricians, and internists.

Stop Loss Coverage: Stop loss coverage is insurance that covers a health plan's expenses above a specified amount, either for each covered individual (specific coverage) or for the plan as a whole (in aggregate). This coverage is also referred to as **Excess Loss Coverage**.

Third Party Administrator (TPA): An organization that performs health insurance administrative functions (e.g. claims processing) for a plan or an employer. The TPA may also provide the healthcare provider network.

Unescorted Retirees: Individuals who participate in a state sponsored retirement program are eligible to participate in the Public Employee Health Insurance Program. These retirees include not only former employees of state agencies and school districts, but also former employees of cities, counties, and municipalities that participate in the County Employees Retirement System (CERS) and former employees of regional universities. Health insurance coverage for the pre-65 retirees of the Commonwealth's KTRS, KERS, SPRS and CERS programs is provided through the same program that covers active state employees. However, active employees of the Commonwealth's regional universities do not participate in the Public Employee Health Insurance Program, neither do active employees of most of the cities, counties and municipalities that participate in the CERS program. Rather, these entities maintain separate health insurance programs for their active employees. In the analysis conducted by the Segal Company in October 2002 at the request of the Interim Joint Committee on State Government, the term "unescorted retirees" was assigned to this group of retirees.

Waiver: An eligible employee or retiree who declines health care coverage through his/her employer for a plan year. Often the employee obtains health care coverage through another means, typically a spouse's employer or an individual.

APPENDICES

Appendix A – Plan Design Provisions

2002 Public Employee Health Insurance Program Benefit Provisions

HMO Plans		Option A	Option B
Annual Deductible		None	None
Maximum out-of-pocket for Covered Expenses	Co-insurance amounts for dental, vision, audiometric, and autism respite services do not apply to the out-of-pocket limits. 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	Co-pay applies to each 1-month 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
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person, per plan year; one set of bitewing x-rays per person per plan year.	50% co-insurance; \$100 maximum benefit per plan year.	Not covered
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-insurance; \$75 maximum benefit per plan year.	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
	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 Respite Services–\$500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care.	50% co-insurance	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.

2002 Public Employee Health Insurance Program Benefit Provisions (continued)

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-insurance amounts for dental, vision, audiometric, and autism respite 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. 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	40% co-ins*	\$20 co-pay	50% co-ins*
		Hospital in-patient co-pay also applies.	Hospital in-patient co-ins* also applies.	Hospital in-patient co-pay also applies.	Hospital in-patient co-ins* also applies.
Prescription Drugs	Co-pay applies to each 1-month 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*
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person per plan year. One set of bitewing x-rays per person per plan year.	50% co-ins \$100 maximum benefit per year		Not covered	
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-ins \$75 maximum benefit per year		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*
	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 Respite Services-\$500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care.	50% co-insurance	50% co-insurance*	50% co-insurance	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*

2002 Public Employee Health Insurance Program Benefit Provisions (continued)

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 and coinsurance amounts for dental, vision, audiometric and autism respite 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) \$400 maximum benefit per year	40% co-ins*	\$20 co-pay (per visit) \$300 maximum benefit per year	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; 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	Co-pay applies to each 1-month 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*
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person per plan year. One set of bitewing x-rays per person per plan year.	50% co-ins* \$100 maximum benefit per year		Not covered	
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-ins* \$75 maximum benefit per year		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*
	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 Respite Services—\$500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative 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*	

2002 Public Employee Health Insurance Program Benefit Provisions (continued)

Exclusive Provider Option		Option C
Annual Deductible		None
Maximum out-of-pocket for Covered Expenses	Coinsurance amounts for autism respite services do not apply to the out-of-pocket limits. 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; 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	Copay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.	\$25 generic \$35 brand \$50 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
	Home Health	Covered in full. Limit 20 visits per year.
	Autism Respite Services–\$500 maximum monthly benefit for children 2 - 21 years of age for respite and rehabilitative care.	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	

2003 Public Employee Health Insurance Program Benefit Provisions

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 <ul style="list-style-type: none"> • 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.

2003 Public Employee Health Insurance Program Benefit Provisions (continued)

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* Limit 40 visits per year.	25% co-ins	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.

2003 Public Employee Health Insurance Program Benefit Provisions (continued)

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) \$400 maximum benefit per year	40% co-ins*	\$20 co-pay (per visit) \$300 maximum benefit per year	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*	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* 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-ins*	40% co-ins* 50% co-ins*	25% 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.

2003 Public Employee Health Insurance Program Benefit Provisions (continued)

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 child care, 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 <ul style="list-style-type: none"> • 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.

2003 Public Employee Health Insurance Program Benefit Provisions (continued)

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 <ul style="list-style-type: none"> 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.

2003 Public Employee Health Insurance Program Benefit Provisions (continued)

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 <ul style="list-style-type: none"> • 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	
	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.

2003 Public Employee Health Insurance Program Benefit Provisions (continued)

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 child care, 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) \$400 maximum benefit per year	40% co-ins*	\$20 co-pay (per visit) \$300 maximum benefit per year	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*	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* 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-ins*	40% co-ins* 50% co-ins*	25% 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.

2003 Public Employee Health Insurance Program Benefit Provisions (continued)

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 child care, 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 <ul style="list-style-type: none"> • 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.

2004 Public Employee Health Insurance Program Benefit Provisions

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 <ul style="list-style-type: none"> • 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

2004 Public Employee Health Insurance Program Benefit Provisions (continued)

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	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*
	Retail				
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	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*	\$20 co-pay	50% co-ins*
	• Respite Care	50% co-insurance	50% co-insurance*	50% co-insurance	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*	

2004 Public Employee Health Insurance Program Benefit Provisions (continued)

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 child care, 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) \$400 maximum benefit per year	40% co-ins*	\$20 co-pay (per visit) \$300 maximum benefit per year	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*	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* 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-ins*	40% co-ins* 50% co-ins*	25% 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*

2004 Public Employee Health Insurance Program Benefit Provisions (continued)

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 <ul style="list-style-type: none"> • 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

2005 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Essential	
	In-Network	Out-of-Network
Annual Deductible	Single - \$750 Family - \$1,500	Single - \$1,500 Family - \$3,000
Out-of-pocket maximum (excludes prescription drug expenses and emergency room co-payments)	Single - \$3,500 Family - \$7,000	Single - \$7,000 Family - \$14,000
Lifetime maximum	Unlimited	
In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas, or mental health and chemical dependency services)	25%*	50%*
Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy; injections, lab fees, X-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	25%*	50%*
Diagnostic testing – laboratory tests, X-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	25%*	50%*
Ambulatory hospital and outpatient surgery services – 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.	25%*	50%*
Preventive care – annual gynecological exam, well child care, and routine physical early detection tests, subject to age and periodicity limits.	Plan pays 100% up to a maximum of \$200 per covered individual. Plan pays 100% of eligible immunizations.	
Emergency services		
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 25%*	\$50 co-pay plus 50%*
Emergency room physician charges	25%*	50%*
Urgent care center treatment	25%*	50%*
Ambulance services	25%*	50%*
Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval.	25%*	50%*
Prescription drugs – Retail (30 day supply)	25%	
	Min	Max
Generic	\$10	\$25
Preferred Brand	\$20	\$50
Non-preferred Brand	\$35	\$100
Prescription drugs – Mail Order (90 day supply)	25%	
	Min	Max
Generic	\$20	\$50
Preferred Brand	\$40	\$100
Non-preferred Brand	\$70	\$200
Audiometric services in conjunction with a disease, illness or injury	25%*	50%*
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*

2005 Public Employee Health Insurance Program Benefit Provisions (Continued)

Covered Services	Commonwealth Essential	
	In-Network	Out-of-Network
Autism Service		
Rehabilitative and therapeutic care services	25%*	50%*
Respite care for children ages two through 21 (\$500 maximum per month)	25%*	50%*
Hospice care – subject to precertification by the plan	Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*
Prosthetic devices	25%*	50%*
Home health – limited to 60 visits per year	25%*	50%*
Physical therapy – limited to 30 visits per year	25%*	50%*
Occupational therapy – limited to 30 visits per year	25%*	50%*
Cardiac rehabilitation therapy – limited to 30 visits per year	25%*	50%*
Speech therapy – limited to 30 visits per year	25%*	50%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*
Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of \$1,400 per ear	25%*	50%*

*services subject to deductible

2005 Public Employee Health Insurance Program Benefit Provisions (Continued)

Covered Services	Commonwealth Enhanced		Commonwealth Premier		
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Annual Deductible (excludes office visit co-pay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - \$250 Family - \$500	Single - \$500 Family - \$1,000	Single - \$250 Family - \$500	Single - \$500 Family - \$1,000	
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - \$1,250 Family - \$2,500	Single - \$2,500 Family - \$5,000	Single - \$1,000 Family - \$2,000	Single - \$2,000 Family - \$4,000	
Lifetime maximum	Unlimited		Unlimited		
In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	20%*	40%*	10%*	30%*	
Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, immunizations, injections, lab fees, x-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	\$10 co-pay	40%*	\$10 co-pay	30%*	
Outpatient diagnostic testing – laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	\$10 co-pay	40%*	\$10 co-pay	30%*	
Ambulatory hospital and outpatient surgery services – 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%*	40%*	10%*	30%*	
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	\$10 co-pay per visit	40%*	\$10 co-pay per visit	30%*	
	\$400 maximum benefit per covered individual per plan year		\$400 maximum benefit per covered individual per plan year		
Emergency services					
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 20%	\$50 co-pay plus 40%	\$50 co-pay plus 10%	\$50 co-pay plus 30%*	
Emergency room physician charges	20%	40%	10%	30%*	
Urgent care center treatment	\$20 co-pay	40%*	\$20 co-pay	30%*	
Ambulance services	20%*	20%*	10%*	30%*	
Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit co-pay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no co-pay required.	\$10 co-pay	40%*	\$10 co-pay	30%*	
	in-hospital care co-insurance applies*		in-hospital care co-insurance applies*		
Prescription drugs – Retail (30 day supply)	Generic	\$10**	40%	\$10**	30%
	Preferred Brand	\$15**	40%	\$15**	30%
	Non-preferred Brand	\$30**	40%	\$30**	30%
Prescription drugs – Mail Order (90 day supply)	Generic	\$20		\$20	
	Preferred Brand	\$30		\$30	
	Non-preferred Brand	\$60		\$60	
Audiometric services in conjunction with a disease, illness or injury	50%*	50%*	10%*	30%*	

2005 Public Employee Health Insurance Program Benefit Provisions (Continued)

Covered Services	Commonwealth Enhanced		Commonwealth Premier	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	\$10 co-pay	40%*	\$10 co-pay	30%*
Autism Service				
▪ Rehabilitative and therapeutic care services	\$10 co-pay	40%*	\$10 co-pay	30%*
▪ Respite care for children ages two through 21 (\$500 maximum per month)	50%*	50%*	10%*	30%*
Hospice care – subject to precertification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	20%*	40%*	10%*	30%*
Prosthetic devices	20%*	40%*	10%*	30%*
Home health – limited to 60 visits per year	20%*	40%*	10%*	30%*
Physical therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Occupational therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Cardiac rehabilitation therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Speech therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Skilled nursing facility services – limited to 30 days per year	20%*	40%*	10%*	30%*
Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of \$1,400 per ear	20%*	40%*	10%*	30%*

* Subject to annual deductible

** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to \$5 generic, \$10 preferred brand and \$20 non-preferred brand.

2006 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Essential	
	In-Network	Out-of-Network
Annual Deductible	Single - \$750 Family - \$1,500	Single - \$1,500 Family - \$3,000
Out-of-pocket maximum (excludes prescription drug expenses and emergency room co-payments)	Single - \$3,500 Family - \$7,000	Single - \$7,000 Family - \$14,000
Lifetime maximum	Unlimited	
In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas, or mental health and chemical dependency services)	25%*	50%*
Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy; injections, lab fees, X-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	25%*	50%*
Diagnostic testing – laboratory tests, X-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	25%*	50%*
Ambulatory hospital and outpatient surgery services – 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.	25%*	50%*
Preventive care – annual gynecological exam, well child care, and routine physical early detection tests, subject to age and periodicity limits.	Plan pays 100% up to a maximum of \$200 per covered individual. Plan pays 100% of eligible immunizations.	
Emergency services		
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 25%*	\$50 co-pay plus 50%*
Emergency room physician charges	25%*	50%*
Urgent care center treatment	25%*	50%*
Ambulance services	25%*	50%*
Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval.	25%*	50%*
Prescription drugs – Retail (30 day supply)	25%	
	Min	Max
Generic	\$5	\$25
Preferred Brand	\$15	\$50
Non-preferred Brand	\$30	\$100
Prescription drugs – Mail Order (90 day supply)	25%	
	Min	Max
Generic	\$10	\$50
Preferred Brand	\$30	\$100
Non-preferred Brand	\$60	\$200
Audiometric services in conjunction with a disease, illness or injury	25%*	50%*
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*
Autism Service		

2006 Public Employee Health Insurance Program Benefit Provisions (Continued)

Covered Services	Commonwealth Essential	
	In-Network	Out-of-Network
Rehabilitative and therapeutic care services	25%*	50%*
Respite care for children ages two through 21 (\$500 maximum per month)	25%*	50%*
Hospice care – subject to precertification by the plan	Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*
Prosthetic devices	25%*	50%*
Home health – limited to 60 visits per year	25%*	50%*
Physical therapy – limited to 30 visits per year	25%*	50%*
Occupational therapy – limited to 30 visits per year	25%*	50%*
Cardiac rehabilitation therapy – limited to 30 visits per year	25%*	50%*
Speech therapy – limited to 30 visits per year	25%*	50%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*
Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of \$1,400 per ear	25%*	50%*

*services subject to deductible

2006 Public Employee Health Insurance Program Benefit Provisions (Continued)

Covered Services	Commonwealth Enhanced		Commonwealth Premier	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit co-pay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - \$250 Family - \$500	Single - \$500 Family - \$1,000	Single - \$250 Family - \$500	Single - \$500 Family - \$1,000
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - \$1,250 Family - \$2,500	Single - \$2,500 Family - \$5,000	Single - \$1,000 Family - \$2,000	Single - \$2,000 Family - \$4,000
Lifetime maximum	Unlimited		Unlimited	
In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	20%*	40%*	10%*	30%*
Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, immunizations, injections, lab fees, x-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	\$10 co-pay	40%*	\$10 co-pay	30%*
Outpatient diagnostic testing – laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	\$10 co-pay	40%*	\$10 co-pay	30%*
Ambulatory hospital and outpatient surgery services – 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%*	40%*	10%*	30%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	\$10 co-pay per visit	40%*	\$10 co-pay per visit	30%*
	\$400 maximum benefit per covered individual per plan year		\$400 maximum benefit per covered individual per plan year	
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 20%	\$50 co-pay plus 40%	\$50 co-pay plus 10%	\$50 co-pay plus 30%*
Emergency room physician charges	20%	40%	10%	30%*
Urgent care center treatment	\$20 co-pay	40%*	\$20 co-pay	30%*
Ambulance services	20%*	20%*	10%*	30%*

Covered Services	Commonwealth Enhanced		Commonwealth Premier	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit co-pay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no co-pay required.	\$10 co-pay in-hospital care co-insurance applies*	40%*	\$10 co-pay in-hospital care co-insurance applies*	30%*
Prescription drugs – Retail (30 day supply)				
Generic	\$5**	40%	\$5**	30%
Preferred Brand	\$15**	40%	\$15**	30%
Non-preferred Brand	\$30**	40%	\$30**	30%
Prescription drugs – Mail Order (90 day supply)				
Generic	\$10 \$30		\$10 \$30	
Preferred Brand	\$60		\$60	
Non-preferred Brand				
Audiometric services in conjunction with a disease, illness or injury	50%*	50%*	10%*	30%*
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	\$10 co-pay	40%*	\$10 co-pay	30%*
Autism Service				
▪ Rehabilitative and therapeutic care services	\$10 co-pay	40%*	\$10 co-pay	30%*
▪ Respite care for children ages two through 21 (\$500 maximum per month)	50%*	50%*	10%*	30%*
Hospice care – subject to precertification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	20%*	40%*	10%*	30%*
Prosthetic devices	20%*	40%*	10%*	30%*
Home health – limited to 60 visits per year	20%*	40%*	10%*	30%*
Physical therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Occupational therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Cardiac rehabilitation therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Speech therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Skilled nursing facility services – limited to 30 days per year	20%*	40%*	10%*	30%*
Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of \$1,400 per ear	20%*	40%*	10%*	30%*

* Subject to annual deductible

** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to \$5 generic, \$10 preferred brand and \$20 non-preferred brand.

Appendix B – 2005 Geographic Regions

Commonwealth counties were aggregated geographically into eight regions for 2005, where each region was served by a single insurance company's managed care network. The county assignments and assigned carriers are shown below.

