Kentucky Employees' Health Plan

Thirteenth Annual Report

Prepared for the Commonwealth of Kentucky
Governor, General Assembly,
and Chief Justice of the Supreme Court

December 13, 2013

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EXECUTIVE SUMMARY

This Thirteenth Annual Report of the Kentucky Group Health Insurance Board (KGHIB), prepared for the Governor, General Assembly, and Chief Justice of the Supreme Court of the Commonwealth of Kentucky, provides an overview of the 2012 Kentucky Employees' Health Plan (KEHP) cost and service usage, as well as a look at changes in plan performance from prior years. The report also includes a look at the first six months of plan experience in 2013, historical information on plan designs, legislative mandates, and commentary on the KGHIB's focus in a post-federal healthcare reform world.

Highlights of KEHP Experience in 2012 and the First Half of 2013

KEHP 2012 costs continue to trend upward, at a higher rate than the previous year, though a decrease is expected in 2013.

- In 2012 KEHP's paid claims cost for medical and pharmacy benefits was approximately $1.531 billion in total. This is 4.1% higher than the plan cost in 2011 – 4.3% for medical costs and 3.4% for pharmacy costs. Membership remained nearly constant over this same period, meaning the per member per month (PMPM) costs increase at the same rate.
- The first 6 month of 2013 show a decrease of 2.4% over the total plan cost for the first 6 months of 2012 - 2.7% decrease for medical costs and 1.4% decrease for pharmacy costs. On a per member per month (PMPM) basis, which adjusts for the 1.3% decrease in enrollment from 2012 to 2013, the KEHP paid claims cost trends are expected to be 1.4% for medical claims and neutral for pharmacy – a 1.1% decrease in total.
- Overall, KEHP's allowed cost trends continued to be 2 to 3% lower than industry averages.

KEHP's cost-sharing percentages have moved toward the national averages in recent years. KEHP pays a greater percentage of the cost for employees and a slightly lesser percentage for members in employee plus dependent(s) tiers than national averages.

- The KEHP's average monthly subsidy (or portion of the total cost paid by the plan) for each employee's health insurance coverage has increased, on average, from $729 in 2012 to $742 in 2013, a 1.8% increase. The employee's portion of the cost has risen from $144 in 2012 to $148 in 2013, a 2.8% increase.
- Compared to national averages, KEHP pays a greater percentage of the cost for employees and a slightly lesser percentage for members in employee plus dependent(s) tiers.

KEHP membership growth has slowed and is expected to decline in 2013. The portion of members who are children continues to increase and the number of employees waiving coverage under KEHP continues to decline.

- Membership in KEHP remained level from 2011 to 2012 and is estimated to decrease by 1.3% from 2012 to 2013. During these same time periods, the total number of employees has decreased implying that the plan is covering more dependents. In fact, the percentage of members who are children has increased from 28.1% in 2010 to 30.4% in 2012 and projected to increase to 31.1% in the first 6 month of 2013, likely due, in part, to healthcare reform.
- The number of employees who elect to waive coverage continues to decline from 25,690 in 2009 to 22,596 in 2012 and 21,787 for the first 6 month of 2013, likely due, in part, to the erosion of the value of the benefit as inflation increases.

KEHP spends the largest portion of its total claims cost for hospital outpatient care. Inpatient service cost increases at a higher rate than other service types.

- KEHP's claims distribution across inpatient hospital, outpatient hospital, physician, other medical, and pharmacy goods and services remained relatively consistent from 2009 to 2012. There is a slight shift to inpatient service due to higher inpatient cost trend.
- KEHP's outpatient PMPM claims, the largest component of cost, increased at a rate of 4.6%. Inpatient services increased 6.9%, physician services increased 1.5% and pharmacy costs increased 3.4%.

Clinical conditions related to heart disease, arthritis, and respiratory conditions, such as asthma, continue to be prevalent in KEHP's population.

- A significant portion of plan cost has been attributable to largely the same clinical conditions since 2004.
- Musculoskeletal conditions such as arthritis, circulatory conditions and digestive conditions top the list.
- Members with these three clinical conditions are responsible for 38% of the plan's 2012 medical claims cost.
- Given that KEHP provides coverage to a significant percentage of the people of Kentucky, these conditions reflect the health challenges of the overall Commonwealth population.

KEHP's pharmacy costs continue to rise, partially due to increased cost shifting.

- Allowed prescription drug charges, defined as total discounted charges less charges for non-covered drugs, increased by 1.5% from 2011 to 2012, less than the trends of several years prior. However, member costs have decreased 6.8% over this same period, leaving the KEHP to shoulder a greater share of the cost. KEHP's portion of the pharmacy costs increased 3.4% from 2011 to 2012.
- The allowed cost trend for the first 6 months of 2013 has been -1.7%. The member cost share for pharmacy claims decreased by 3.1%, so KEHP's portion of the costs decreased by 1.4% over this same period.

Benchmark Results

Executive summary was filed on October 1st. It's important to point out that this report is based on a new benchmark report which was not available when the executive summary was filed. For the executive summary, we used Truven benchmark report that compares KEHP's medical and prescription drug claims to Truven's Custom Southeast Region Normative group. For this report, we used Truven benchmark report that compares KEHP's medical and prescription drug claims for active population against the active population for other Truven clients, separated by public and private sectors.

Truven benchmarked several statistics for KEHP's active population. Due to changes in methodology made by Truven, this year's benchmark results may not be comparable to last year's results. The data shows that the KEHP's total allowed cost PMPY is 2.7% lower than that of other clients in the public sector and 8.5% higher than other private sector clients. In general, KEHP's plans cover a younger population with smaller family size and more females than other Truven client's in the public sector. At younger ages, females have higher average claim costs than males, due to maternity. KEHP's risk score is roughly equivalent to clients in the public sector and higher than other clients in the private sector.

KEHP members have lower incidences of bipolar disorder and HIV infection than both the US and government benchmarks, but higher incidences of most other diseases, such as Hypertension and Osteoarthritis. KEHP member's inpatient admission rate and outpatient utilization rate are both higher than Truven client's in public sector and private sector.

Healthcare Reform

Healthcare Reform was signed into law in March 2010. The first wave of employer-based compliance has passed with many changes having been executed in 2011. Since then, the focus has been on reporting compliance and operational issues such as providing Summary of Benefits and Coverage to participants, defining W-2 reporting of the value of health coverage for members and providing notices of options in the exchange. However, there are many rules and guidance still outstanding on these provisions that are required to move forward. The next substantial change will take place in 2014, when individual mandates and the state exchanges go into effect.

The Obama Administration announced on July 2, 2013 that the employer mandate under the Patient Protection and Affordable Care Act (Affordable Care Act) will be delayed until 2015, thus giving employers an extra year to comply with the law's complicated hours-tracking and related reporting rules. On July 9, the Internal Revenue Service (IRS) followed up with a Notice (2013-45) spelling out the specifics of the delay.

The delay means that employers will have an additional year to offer health insurance coverage to their full-time employees before the IRS will assess penalties, known as the employer shared responsibility payment. Employers also will have an additional year to comply with the information reporting provisions that require employers to provide information to the IRS regarding the health insurance coverage offered to their full-time employees. That information will, in part, determine whether those employees are entitled to subsidized health insurance and whether employers are liable for an employer shared responsibility payment. It should be noted that the transition relief does not delay the effective date for other provisions of the Affordable Care Act, such as the requirement that individuals purchase health insurance or pay a penalty.

Governor Steve Beshear issued an executive order to create a state-based health benefit exchange to best meet the needs of Kentuckians. Kynect is a program run by the Kentucky Office of the Health Benefit Exchange within the Cabinet for Health and Family Services. Kynect will provide simple, one-stop shopping for individuals and small businesses to purchase health insurance and receive payment assistance or tax credits.

The open enrollment for Kynect began on October 1, 2013, and runs through March 31, 2014, with coverage beginning as soon as January 2014. As of early November 2013, 40,572 members enrolled in new health

coverage, including Medicaid and private insurance; 2,610 members enrolled in standalone dental plans; 33,561 members enrolled in Medicaid and 7,011 members enrolled in a qualified health plan.

Board Recommendations

For this year's report, Board members were surveyed and ranked the importance of its Guiding Principles. The Board recommends that the KEHP continue to follow the guiding principles stated below, presented in ranked order importance:

1. Provide uniform coverage across the Commonwealth
2. Encourage wellness and healthy lifestyles
3. Provide preventive care at little or no cost
4. Strive to hold down costs for family and dependent coverage, while balancing the management of the single subscriber's (plan holder's) premium levels as top priority
5. Improve chronic disease care
6. Educate members about plans that are more appropriate for their health needs
7. Provide members with quality PPO and consumer-driven options
8. Provide plan alternatives that are accessible for retirees

The Board continues to support the recommendations made in the Twelfth Annual Report. These recommendations from last year's Annual Report are listed below.

1. Continuing to explore alternative methods for controlling plan costs of the plans and improving the health of members.
2. Evaluating programs and options for improving the clinical and administrative quality of programs and services.
3. Improving communication to members.
4. Developing a long-term policy for funding strategies to ensure that adequate funds are budgeted each year towards the self-insured plans.
5. Evaluating the impact of federal healthcare reform measures.
6. Increasing focus on wellness initiatives.
7. Improving education of membership about plan options, mechanics of healthcare, and selecting the most appropriate plan option and medical services.
8. Continue to explore making the healthcare system, including cost, more transparent and easier to understand by membership.

INTRODUCTION

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 Thirteenth Annual Report from the Kentucky Group Health Insurance Board (KGHIB or the Board) to the Governor, the General Assembly, and the Chief Justice of the Supreme Court. The report contains information on the status of the Public Employee Health Insurance Program (PEHI), renamed the Kentucky Employees' Health Plan (KEHP) in 2007.

The report includes:

- A review of the 2012 KEHP experience
- A look at plan experience for the first six months of 2013
- A perspective on sustainability in a post-reform world

The appendix to this report contains the following information:

- A review of the history and development of the KEHP program
- A list of historical Employee Contribution rates
- A summary of legislated health insurance benefit mandates and other mandates passed by recent General Assemblies that affect KEHP
- A glossary of terms
- An index of the exhibits found in this report

Research was jointly conducted by the Department of Employee Insurance (DEI) and Aon Hewitt to prepare this report. The report 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.

2012 KEHP Experience

This section of the Annual Report provides a summary of cost and usage trends experienced by KEHP in 2012. The 2011-2013 information is based on self-insured KEHP claims reported by the plan administrators. These claims and enrollment data were compiled by the Truven database. Any data from a prior year was taken directly from the Twelfth Annual Report, as data prior to 2011 was no longer available in the Truven database at the time of this writing.

A Note about 2013 Claims Experience

At the time that this report was written, incurred 2013 claims data was available through June 2013, with three months of run-out (paid through September 2013).

Throughout this report, unless otherwise noted, references to "paid claims" mean claims incurred within the specified time frame regardless of when the claims were paid. Furthermore, all references to claims and KEHP subsidies exclude the experience related to the stand-alone Waiver HRA plan, unless otherwise noted. Analyses included in this annual report do not include the financial impacts of third party claims administration or network access fees.

KENTUCKY EMPLOYEES' HEALTH PLAN EXPERIENCE

Summary of KEHP Program Costs

Key Findings

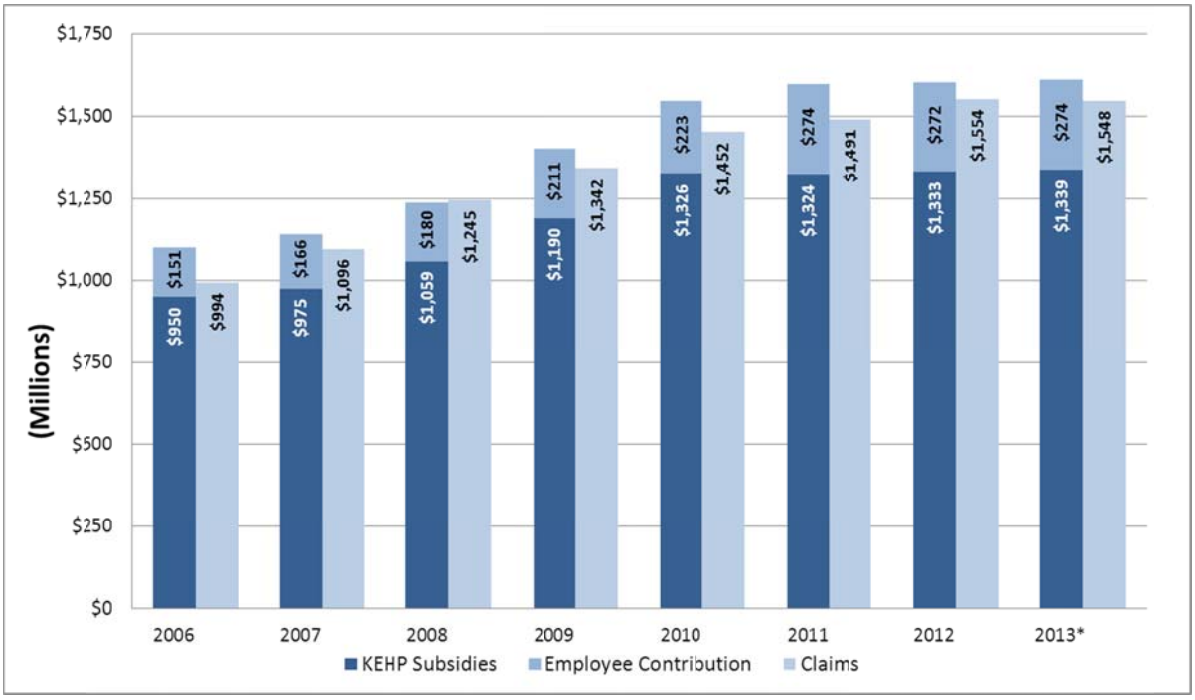
- Over the past several years, KEHP claims and expenses have been fairly close to the budgeted costs.
- KEHP subsidy levels have moved closer to the benchmark norms for both employee and dependent coverage from 2007 to 2013.

Summary of Total Costs

KEHP's total incurred claims, KEHP's subsidy (The amount paid by the plan, excluding the amount paid by the participant), and employee contributions are shown in Exhibit 1 (The total incurred claims paid by KEHP's self-funded program are identified as "Claims"). Administrative fees are not included in these figures. For 2013, only the first 6 months of incurred data was available at the time of the writing of this report.

Exhibit 1 identifies the total subsidy amounts KEHP paid in 2006 through 2012, as well as the first 6 months of 2013 for all members of KEHP, the total annual employee contributions and the aggregate claims costs incurred. The figures included in this exhibit represent millions of dollars.

Exhibit 1 - Aggregate KEHP Paid Claim Costs versus KEHP Subsidies and Employee Contribution ($Millions)



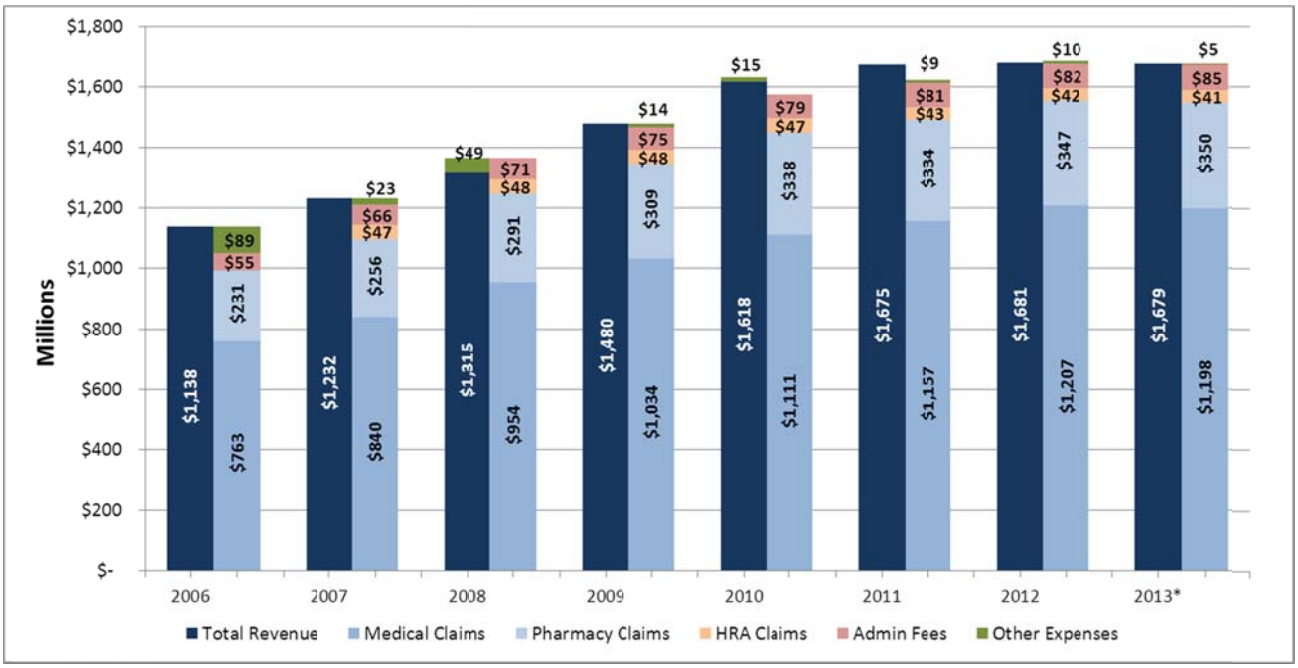
Source: Tenth Annual Report, KEHP's claims data aggregated by Truven, Aon Hewitt Projections of Trust Balances
**2013 claims are based on Aon Hewitt's projections for KEHP*

Since KEHP changed the funding from fully insured to self-insured in 2006, claim costs have exceeded the total employee plus employer contributions (premiums) only once, in 2008. A look at the first six months of available data for 2013 shows this trend continuing, though this observation may change as the 2013 plan year progresses.

Year by Year Trust Fund Balances

Exhibit 2 shows the KEHP Plan Year Balances from 2006 to 2013, using Aon Hewitt's projections incorporating the Trust Fund Report as of September 2013.

Exhibit 2 - Plan Year Balances as of September 30, 2013



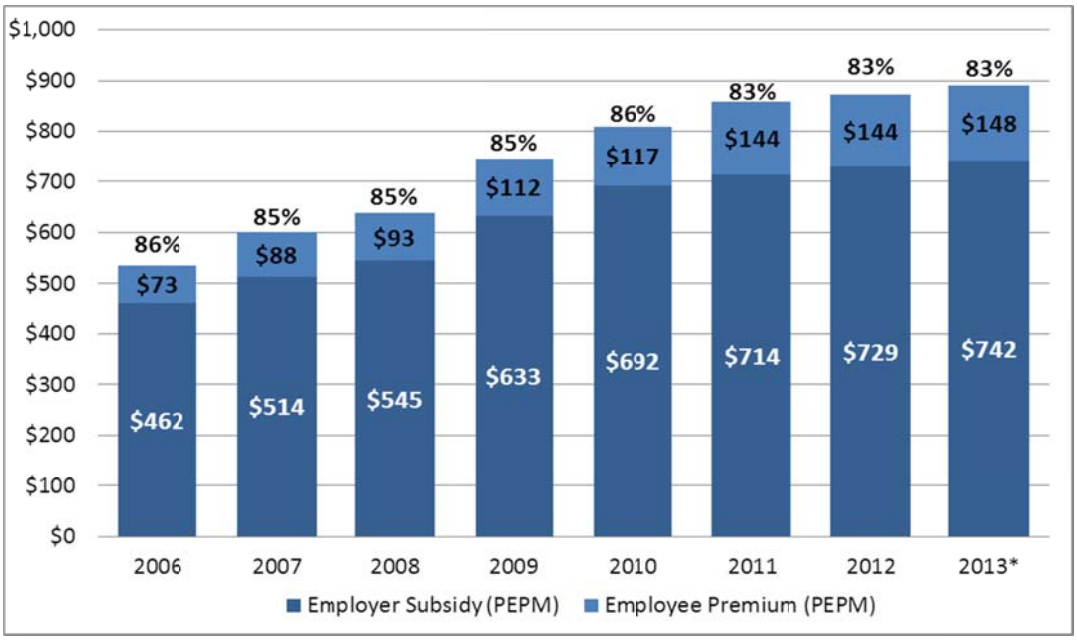
Source: KEHP Trust Cash Transactions from September 2013, Aon Hewitt Projections

With the exception of 2008 and 2012, KEHP has had modest surpluses each year from 2006 on. Note that in 2008 and 2010 the category 'Other Expenses' was negative, as this field includes balance transfers between years. Plan year 2013 is projected to be breakeven with the use of ERRP funds. ERRP funds are included in other expenses category.

Historical Per Employee KEHP Subsidies

KEHP's per employee per month (PEPM) subsidy, Employee PEPM Premium, and KEHP's subsidy percentage (% of total contributions from KEHP) from 2006 through 2013 are illustrated in Exhibit 3.

Exhibit 3 - Historical KEHP (PEPM) Health Benefit Subsidy Paid For Those Electing Coverage



Source: Tenth Annual Report and KEHP's claims and enrollment data aggregated by Truven
**2013 figures reflect estimates based on six months of 2013 claims experience*

The KEHP average monthly subsidy toward the cost of an employee's health insurance coverage has risen from $462 per month in 2006 to $729 in 2012 and is projected to increase to $742 per month for 2013. Above each year's bar is the percentage of KEHP's subsidy. In 2011, the members began to pay a slightly larger percentage of the total premiums, with the KEHP subsidy dropping from 86% in 2010 to 83% afterwards.

KEHP Subsidy Benchmarks

Exhibit 4 compares the KEHP subsidies to national averages for government employers.

Exhibit 4 - KEHP Subsidies Compared to Government Sector Benchmarks

	2009		2010		2011		2012		2013	
	Kaiser	KEHP	Kaiser	KEHP	Kaiser	KEHP	Kaiser	KEHP	Kaiser	KEHP
Employee Only	90.0%	96.3%	91.0%	95.9%	89.0%	91.7%	88.0%	91.8%	87.0%	92.0%
Employee + Dependents	79.0%	75.4%	75.0%	76.3%	77.0%	75.3%	76.0%	75.8%	76.0%	75.6%
Overall	**84.2%**	**85.3%**	**82.9%**	**85.9%**	**82.8%**	**83.3%**	**81.7%**	**83.5%**	**81.2%**	**83.4%**

Source: KEHP's claims data aggregated by Truven, and Benchmarks from Kaiser Family Foundation Employer Health Benefits surveys

In 2013, KEHP is projected to cover 83.4% of total costs (92.0% for single coverage and 75.6% blended for the employee + dependent coverage tiers). The KEHP subsidy for enrollees with single coverage has consistently been higher compared to government sector averages. The subsidy for those with dependent coverage has fluctuated between being above and below the average. The KEHP subsidy level has moved closer to the benchmark norms for both employee and dependent coverage from 2009 to 2013. For example, KEHP's subsidy was 6.3 percentage points higher than the national average for single coverage in 2009, reducing to 2.7 percentage points in 2011. In 2012, the difference widened to 3.8% and in 2013 this difference is expected to grow to 5.0 percentage points. The subsidy difference for employee plus dependent coverage was 3.6 percentage points lower than the national average in 2009, narrowing to 0.2 percentage point differences in 2012 and 0.4 in 2013.

Enrollment / Demographics Analysis

Key Findings

- The number of covered employees dropped slightly in 2012, though total membership remained level.
- The number of children covered by the plan has grown, though the average age of employees has remained mostly level.
- Though membership in the Optimum PPO plan has declined recently, it continues to be the most popular plan, due to employee perception of it being the richest plan, offering lower deductible and cost-sharing features.
- The number of employees who have waived coverage under KEHP continues to decline.

Key Statistics

Exhibit 5 shows some key demographic statistics for the KEHP population.

Exhibit 5 - Population Demographics—Key Statistics

	KEHP Membership (Actives, Non-Medicare Eligible Retirees and COBRAs Participants)						
	2010	**2011**	**2012**	**2012 vs. 2011**	**Jan - Jun, 2012**	**Jan - Jun, 2013**	**2013 vs. 2012**
Total Enrollment:							
Employees	159,547	159,116	156,887	-1.4%	158,302	154,640	-2.3%
Members	265,876	270,422	270,400	0.0%	271,725	268,158	-1.3%
Average Age:							
Employees	48.0	48.3	48.3	0.1%	48.3	48.3	-0.1%
Members	37.9	38.0	38.1	0.3%	38.0	38.1	0.3%
Demographic Splits:							
Employee Percentage Male	34.5%	34.4%	34.3%	-0.1%	34.3%	33.9%	-0.4%
Member to Employee Ratio	1.67	1.70	1.72	2.4%	1.72	1.73	1.0%
% of Covered Members Who Are:							
Adult Male	26.4%	26.0%	25.5%	-0.5%	25.6%	25.1%	-0.5%
Adult Female	45.5%	44.7%	44.1%	-0.6%	44.3%	43.8%	-0.5%
Children	28.1%	29.3%	30.4%	1.1%	30.1%	31.1%	1.0%

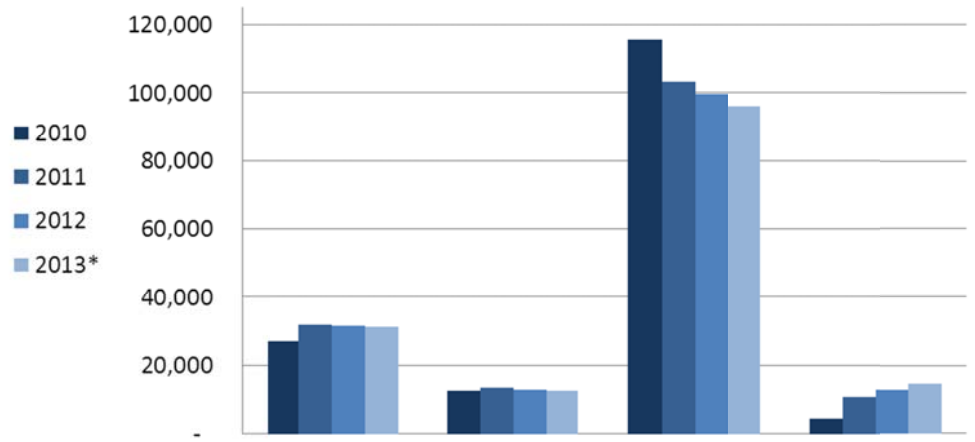
Source: KEHP's enrollment data aggregated by Truven

Total enrollment for KEHP's plans remained level from 2011 to 2012, though the first 6 months of 2013 show a small decrease of 1.3% over the prior year. The average member to employee ratio continues to increase slightly from 1.67 in 2010 to 1.72 in 2012. The first 6 months of 2013 show another slight increase, to 1.73. The percentage of children covered by the Plan continues to grow year over year as well.

Enrollment by Plan

Exhibit 6 shows KEHP enrollment by plan option from 2010 through the first six months of 2013

Exhibit 6 - Employee Enrollment by Plan



2012	Capitol Choice	Maximum Choice	Optimum PPO	Standard PPO
Employees Average Age	46.8	42.0	50.4	42.9
Members % Male	38.0%	46.3%	40.4%	45.4%
Member to EE ratio	1.44	2.23	1.75	1.85

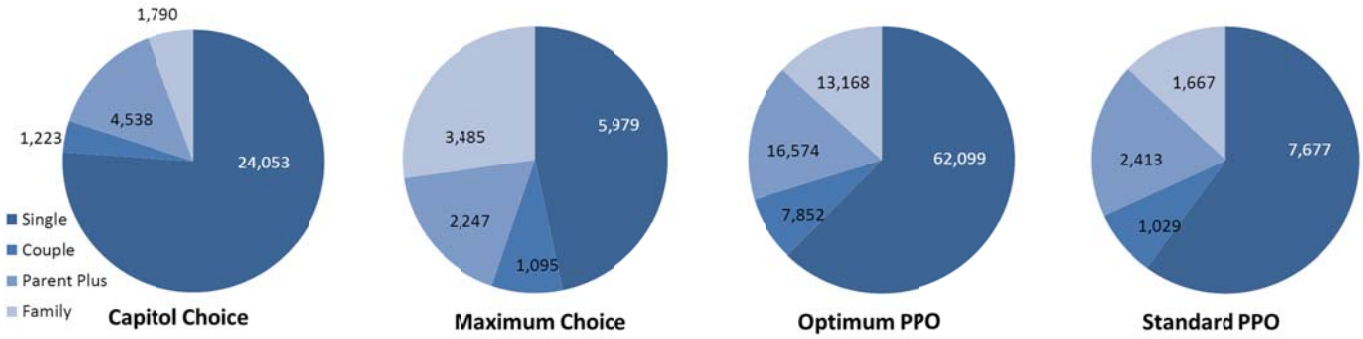
Source: KEHP's enrollment aggregated by Truven
**2013 figures include January through June 2013 data only*

Other than a small enrollment shift from the Optimum PPO plan to the Standard PPO plan in 2012, the enrollments for the Capitol Choice and Maximum Choice plans remain fairly consistent.

Optimum PPO Plan is perceived to be the richest plan, as it offers the lowest deductible and cost-sharing provisions even though it requires the highest monthly employee premiums. In reality, the Maximum Choice Plan provides the highest level of benefits. Premium adjustments can result in enrollment shifts between plan options.

Exhibit 7 shows the plan compositions by tier.

Exhibit 7 – Employee Enrollment by Coverage Tier and Plan, 2012



Source: KEHP's enrollment data aggregated by Truven

Singles comprise a larger portion of the Capital Choice Plan than on average, and the same is true of families in the Maximum Choice Plan.

Group Composition

Exhibit 8 shows some key statistics for KEHP's groups, for 2011 to 2013.

Exhibit 8 - Key Statistics by Group

	Number of Employees					2012 Key Statistics			2013 Key Statistics		
Group	2011	2012	2013 (6 Months)	2013 % of Total	2013 vs. 2012	Employee Ave. Age	Member to EE ratio	Members % Male	Employee Ave. Age	Member to EE ratio	Members % Male
Actives	**114,060**	**113,708**	**113,815**	**73.6%**	**0.1%**	**44.5**	**1.84**	**41.3%**	**44.7**	**1.86**	**41.3%**
School Boards	73,763	73,659	73,934	47.8%	0.4%	44.8	1.86	38.5%	44.9	1.88	38.6%
State Employees	30,758	30,605	30,525	19.7%	-0.3%	43.6	1.79	47.5%	43.8	1.80	47.6%
Quasi/Local Govt	3,549	3,473	3,457	2.2%	-0.5%	44.3	1.80	46.6%	44.4	1.81	47.1%
KCTCS	3,384	3,524	3,598	2.3%	2.1%	47.4	1.84	44.9%	47.5	1.84	44.5%
Health Departments	2,606	2,447	2,301	1.5%	-6.0%	45.3	1.84	32.5%	45.5	1.83	32.2%
Retirees	**44,801**	**42,910**	**40,575**	**26.2%**	**-5.4%**	**58.3**	**1.41**	**40.7%**	**58.3**	**1.39**	**40.3%**
KERS	29,107	27,897	26,211	16.9%	-6.0%	57.5	1.48	44.6%	57.5	1.44	44.5%
KTRS	15,695	15,013	14,365	9.3%	-4.3%	59.8	1.29	33.5%	59.9	1.29	32.6%
COBRA	203	215	195	0.1%	-9.2%	48.7	1.82	37.3%	48.4	1.77	36.0%
Unknown	47	48	49	0.0%	0.3%	59.6	1.28	40.0%	59.6	1.29	32.4%
Total	**159,116**	**156,887**	**154,640**	**100.0%**	**-1.4%**	**48.3**	**1.72**	**41.1%**	**48.3**	**1.73**	**41.0%**

Source: KEHP's enrollment data aggregated by Truven

The participating groups' composition changed very little over the last several years, with small increases in the average employee age for nearly every group.

Historical Number of Eligible Individuals Who Waive Enrollment in KEHP

KEHP provides a monthly waiver deposit into a Health Reimbursement Account (HRA) for eligible employees who waive KEHP coverage. These accounts are intended to pay for eligible out-of-pocket healthcare expenses. In 2006 the monthly deposit was $234 for the months January through June, and then decreased to $200 for the remainder of 2006; in 2007, the amount decreased to $175 per month, where it has remained through 2013.

Exhibit 9 shows the annual waiver participation for 2009 through 2013.

Exhibit 9 - 2009 through 2013 Monthly Coverage Waiver Participation

	2009	2010	2011	2012	2013*
Average # Employees	**25,690**	**24,032**	**23,561**	**22,596**	**21,787**
% Change	N/A	-6.5%	-2.0%	-4.1%	-3.6%
HRA Waiver Contributions	$55,664,486	$52,205,724	$47,847,608	$47,805,725	$45,752,933
HRA Waiver Claims	$48,451,870	$46,916,579	$42,551,710	$42,354,215	$41,177,640
HRA Waiver Claims PEPM	$157.17	$162.69	$150.50	$156.20	$157.50
% Change	N/A	3.5%	-7.5%	3.8%	0.8%

Source: KEHP Trust Fund Summaries, 2013 contributions and claims are projected

With the $175 waiver per month remaining constant since 2007, the value of the waiver incentive has continued to decline as inflation erodes the incentive purchasing price. The incentive reduction and the rise in healthcare costs were the primary factors resulting in few people waiving coverage. Additionally, KEHP spouses who were provided healthcare coverage through their employers may have seen their situations change and need coverage under the program. These factors may have all contributed to the steady decline in waiver participation, resulting in lower waiver contributions and claim costs.

Medical & Pharmacy Trends

Key Findings

- Allowed cost trends continue to be lower than industry averages.
- Overall, on a PMPM basis, most costs are increasing at low rates.

Medical and Pharmacy Claims Cost Increases

Exhibit 10 shows some key statistics for medical and pharmacy claims, split between allowed cost and plan cost.

Exhibit 10 - 2009 – 2012 Claims Experience

	2009	2010	2011	2012	2012 vs. 2011	Jan - Jun, 2012	Jan - Jun, 2013	2013 vs. 2012
Allowed Cost - Medical	$1,145,734,178	$1,228,602,091	$1,291,621,070	$1,335,657,929	3.4%	$659,365,028	$642,745,142	-2.5%
Allowed Cost - Rx	$376,804,254	$405,081,858	$418,625,520	$424,897,045	1.5%	$212,603,936	$209,054,860	-1.7%
Total Allowed Cost	**$1,522,538,432**	**$1,633,683,950**	**$1,710,246,590**	**$1,760,554,974**	**2.9%**	**$871,968,964**	**$851,800,002**	**-2.3%**
Plan Paid - Medical	$1,018,422,840	$1,092,570,741	$1,129,150,874	$1,177,955,911	4.3%	$572,102,886	$556,495,107	-2.7%
Plan Paid - Rx	$315,768,145	$344,959,438	$341,781,007	$353,321,327	3.4%	$174,168,748	$171,814,632	-1.4%
Total Plan Paid	**$1,334,190,985**	**$1,437,530,179**	**$1,470,931,881**	**$1,531,277,238**	**4.1%**	**$746,271,634**	**$728,309,738**	**-2.4%**
Covered Members	**259,196**	**265,876**	**270,422**	**270,400**	**0.0%**	**271,725**	**268,158**	**-1.3%**
Allowed Cost PMPM - Medical	$368.36	$385.08	$398.03	$411.63	3.4%	$404.43	$399.48	-1.2%
Allowed Cost PMPM - Rx	$121.15	$126.96	$129.00	$130.95	1.5%	$130.40	$129.93	-0.4%
Total Allowed Cost PMPM	**$489.51**	**$512.04**	**$527.03**	**$542.58**	**3.0%**	**$534.84**	**$529.41**	**-1.0%**
Plan Paid PMPM - Medical	$327.43	$342.44	$347.96	$363.03	4.3%	$350.91	$345.88	-1.4%
Plan Paid PMPM - Rx	$101.52	$108.12	$105.32	$108.89	3.4%	$106.83	$106.79	0.0%
Total Plan Paid PMPM	**$428.95**	**$450.56**	**$453.28**	**$471.92**	**4.1%**	**$457.74**	**$452.66**	**-1.1%**

Source: KEHP's claims and enrollment data aggregated by Truven

Overall, the total allowed costs incurred by members of KEHP increased 2.9% from 2011 to 2012 and are projected to decrease 2.3% from 2012 to 2013. KEHP's annual paid claims costs increased by 4.1% from 2011 to 2012 and decreased 2.4% from 2012 to 2013. Since average membership decreased negligibly from 2011 to 2012, the corresponding per member per month (PMPM) claims costs experienced very similar changes. However, the small decrease of 1.3% in membership for the first 6 months of 2012 and 2013 mitigated the reductions in total costs. Total allowed costs PMPM decreased 1.0% from 2012 to 2013 and the KEHP's portion of the total Medical and Rx claims decreased by 1.1% from 2012 to 2013.

Allowed cost includes the total cost of the service, both plan and employee cost share so the trend for allowed cost represents the true increase of the cost of the services. The plan paid trend is higher than the allowed cost trend from 2011 to 2012, indicating that the plan is carrying more of the extra cost burden than the employees.

Even though pharmacy claims tend to increase at a slightly lower rate than medical claims, pharmacy PMPM claim cost remained neutral from 2012 to 2013 while medical PMPM claims cost decreased slightly. Pharmacy claims continue to comprise roughly 24% of the total cost of KEHP.

Exhibit 11 contains KEHP's medical and pharmacy claim trends for 2010 to 2012 as well as the projected claim trends for 2013.

Exhibit 11 – Historical Claims Trends for KEHP

Historical trend	2010	2011	2012	2013*
Plan Paid PMPM - Medical	4.6%	1.6%	4.3%	-1.4%
Plan Paid PMPM - Rx	6.5%	-2.6%	3.4%	0.0%
Total Plan Paid PMPM	**5.0%**	**0.6%**	**4.1%**	**-1.1%**

Source: KEHP's claims and enrollment data aggregated by Truven
**Trend for 2013 calculated YTD using the first 6 months.*

Aon Hewitt used trend survey data to develop a trend expectation for 2014 of 8.5% for KEHP.

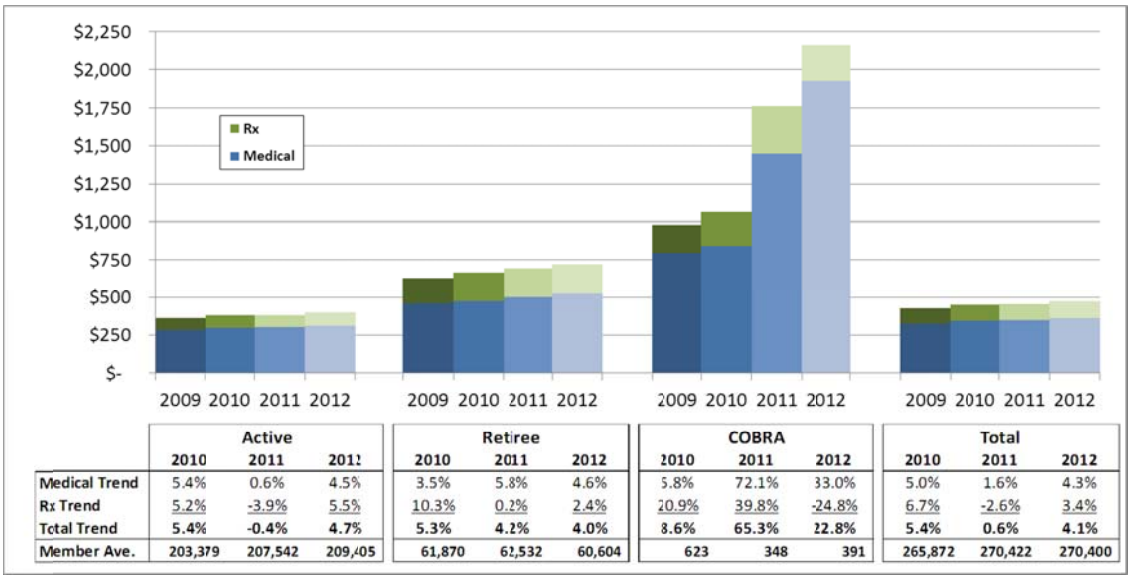
An important contributing factor to the decrease in both the medical and pharmacy trend in 2011 is the change in plan designs – while Standard PPO plan stays the same, all the other three plans increased the member cost sharing by increasing the deductible, out of pocket maximum and service copays. Furthermore, the employee contribution change affected the member selection for plan options - employees migrated from the most expensive plan (Optimum PPO) to three other plans, mostly to the cheapest plan (Standard PPO). Both the member cost sharing increase and member selection for plan option are reflected in the lower KEHP trend from 2010 to 2011. In addition, the lower pharmacy trend also results from the higher generic utilization and lower Rx scripts per member.

KEHP chose to retain grandfathered status in 2012. As PPACA regulations limit the extent to which benefit provisions and employee contributions can change for group health plans to maintain grandfathered status, KEHP only made slight plan design and employee contribution changes in 2012 and absorbed a bigger portion of the claims cost increases. For this reason, both pharmacy and medical trend increased in 2012.

Claims Payments by Employee Status

As noted in Exhibit 10, combined medical and pharmacy paid claims increased by 4.1% on a PMPM basis from 2011 to 2012. Exhibit 12 provides KEHP's PMPM costs and trends for both Medical and Pharmacy claims by member status (active employees, non-Medicare eligible retirees, and COBRA participants).

Exhibit 12 - Medical and Pharmacy Paid Claims per Member per Month (PMPM) by Member Status



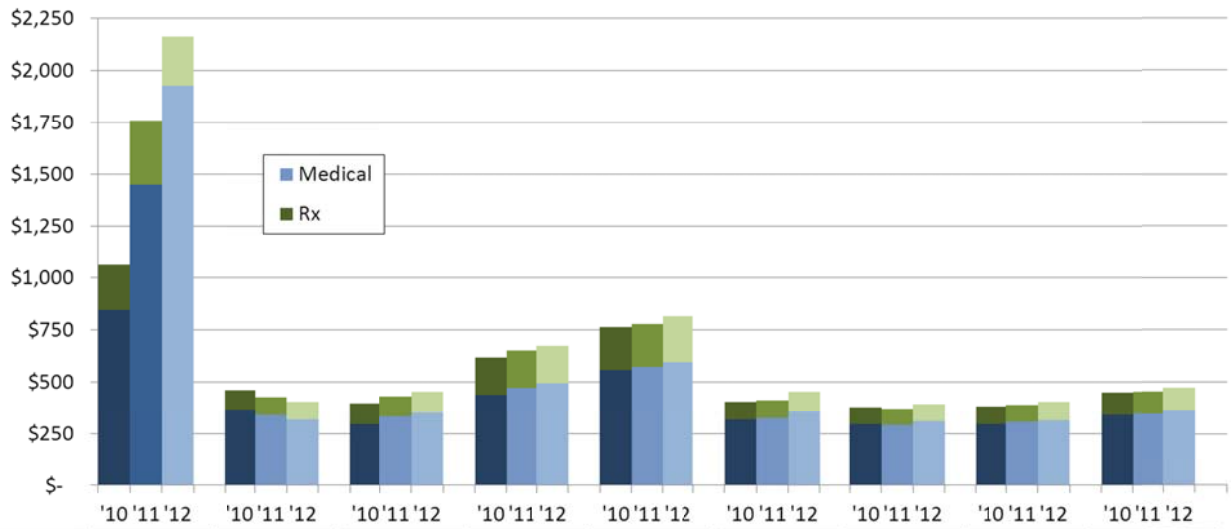
	Active			Retiree			COBRA			Total		
	2010	2011	2012	2010	2011	2012	2010	2011	2012	2010	2011	2012
Medical Trend	5.4%	0.6%	4.5%	3.5%	5.8%	4.6%	5.8%	72.1%	33.0%	5.0%	1.6%	4.3%
Rx Trend	5.2%	-3.9%	5.5%	10.3%	0.2%	2.4%	20.9%	39.8%	-24.8%	6.7%	-2.6%	3.4%
Total Trend	5.4%	-0.4%	4.7%	5.3%	4.2%	4.0%	8.6%	65.3%	22.8%	5.4%	0.6%	4.1%
Member Ave.	203,379	207,542	209,405	61,870	62,532	60,604	623	348	391	265,872	270,422	270,400

Source: KEHP's claims and enrollment data aggregated by Truven

Plan paid cost trends are largely impacted by plan design changes from year to year. The active group trend decreased in 2011 due to higher member cost sharing, whereas the retiree trends remained fairly stable over the past few years despite the high volatility in the pharmacy claim cost trends. The COBRA participants are, in general, more costly than members of other groups, as only those who know they need medical coverage are likely to continue coverage. This group shows more volatility over the last several years, especially in 2011, where there was a sharp increase in both medical and pharmacy claims. This large increase is likely due to catastrophic claims in the small group, and is not expected to be indicative of future trend.

Exhibit 13 further breaks out the medical and pharmacy costs for KEHP's groups, again on a PMPM basis.

Exhibit 13 – Medical and Rx Claims PMPM by Employee Group, 2010-2012



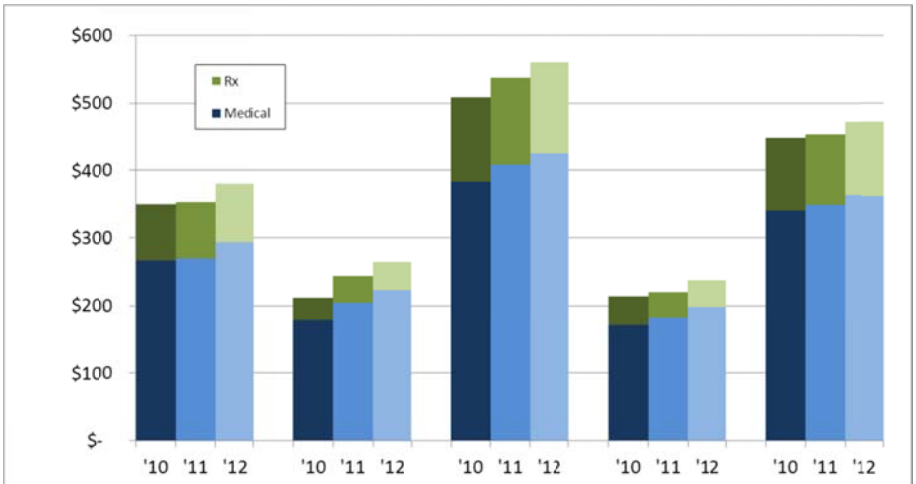
2012 Trends	COBRA	Health Dept	KCTCS	KERS	KTRS	Local Govt	School Boards	State Employees	Total
Medical	33.0%	-6.4%	5.1%	4.8%	3.9%	9.1%	5.6%	2.4%	4.3%
Rx	-24.8%	3.0%	4.5%	-0.5%	7.8%	11.9%	4.5%	7.5%	3.4%
Total	**22.8%**	**-4.5%**	**5.0%**	**3.4%**	**4.9%**	**9.7%**	**5.4%**	**3.5%**	**4.1%**

Source: KEHP's claims and enrollment data aggregated by Truven

As noted above, the COBRA members are by far the most expensive, followed by KTRS and KERS, the two groups of retirees. Aside from the COBRA and local government groups, most groups showed fairly modest cost increases in 2012, with some groups experiencing decreases in costs on a PMPM basis.

Exhibit 14 shows the medical and pharmacy costs for KEHP's four plans, also on a PMPM basis.

Exhibit 14 – Medical and Rx Claims PMPM by Plan, 2010-2012



2012 Trends	Capitol Choice	Maximum Choice	Optimum PPO	Standard PPO	Total
Medical	8.3%	8.7%	4.4%	8.5%	4.3%
Rx	6.0%	8.1%	4.2%	6.8%	3.4%
Total	**7.8%**	**8.6%**	**4.3%**	**8.2%**	**4.1%**

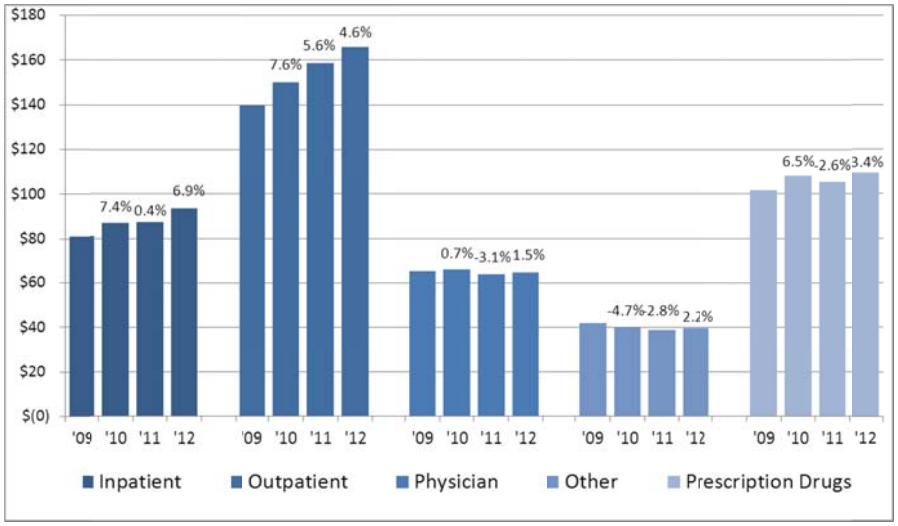
Source: KEHP's claims and enrollment data aggregated by Truven

The Optimum PPO is the most popular plan and the most costly plan to KEHP. Additionally, the Capitol Choice plan costs increased at a lower rate than most of the other plans.

Trends are influenced by employee migration between plans, with higher cost members migrating from the Optimum PPO to the Capitol and Maximum Choice plans, and lower cost members migrating to the Standard PPO. Selection plays a large role in these results.

Exhibit 15 shows the increase in cost, on a per member per month basis, for different service types.

Exhibit 15 – Medical and Rx Paid Costs PMPM by Service Type, 2009-2012



Source: KEHP's claims and enrollment data aggregated by Truven

Facility based costs continue to increase at a much higher rate than Physician claims.

Review of KEHP Cost & Utilization

Summary of Medical and Rx

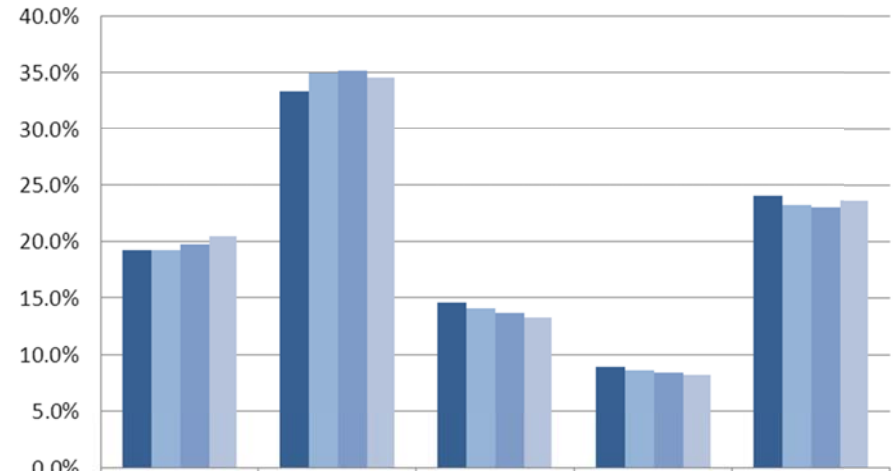
Key Findings

- KEHP's distribution of claims by service remains fairly consistent, with outpatient claims comprising the largest portion.
- The KEHP paid claim structure has remained stable in recent years. Approximately 23% of claimants account for about 82% of claims costs.
- Utilizations for inpatient, outpatient and professional services all decreased from 2011 to 2012. However, the average costs of service increased at a higher rate, resulting in an upward overall cost trends for all service types. Average cost for inpatient claims increased at the highest rate, making it the highest trend driver.
- The top ten Major Diagnostic Categories account for almost 80% of claim costs.

Distribution of Paid Claims by Service Type

Exhibit 16 shows the KEHP paid claims distribution by Service Type for 2010 to 2013.

Exhibit 16 - Paid Claims Distribution by Service Type and Year



	Inpatient	Outpatient	Physician	Other	Prescription Drugs
2010	19.3%	33.3%	14.6%	8.8%	24.0%
2011	19.3%	34.9%	14.1%	8.5%	23.2%
2012	19.8%	35.1%	13.7%	8.4%	23.1%
2013*	20.5%	34.5%	13.2%	8.2%	23.6%

Source: KEHP's claims data aggregated by Truven
**2013 figures include January through June 2013 data only*

KEHP's distribution of claims by Service Type (Inpatient, Outpatient, Physician, Prescription Drugs, and Other Claims) remains fairly consistent, with Outpatient claims comprising the largest portion (approx. 35%), and contributing the highest trend.

KEHP Medical Benefits Detailed Experience

Paid Claims by User-Type

The proportion of KEHP's patients and their costs, separated by User Type, is shown in Exhibit 17.

Exhibit 17 - Paid Claims by User Type

2010	$0 - $1,000	$1,000 - $5,000	$5,000 - $100,000	$100,000+
Patient %	40.0%	36.5%	23.1%	0.4%
Claim Amount %	3.0%	18.0%	65.4%	13.6%

2011	$0 - $1,000	$1,000 - $5,000	$5,000 - $100,000	$100,000+
Patient %	41.8%	35.3%	22.4%	0.5%
Claim Amount %	3.2%	17.5%	63.6%	15.7%

2012	$0 - $1,000	$1,000 - $5,000	$5,000 - $100,000	$100,000+
Patient %	42.1%	34.7%	22.7%	0.5%
Claim Amount %	2.7%	15.2%	63.9%	18.2%

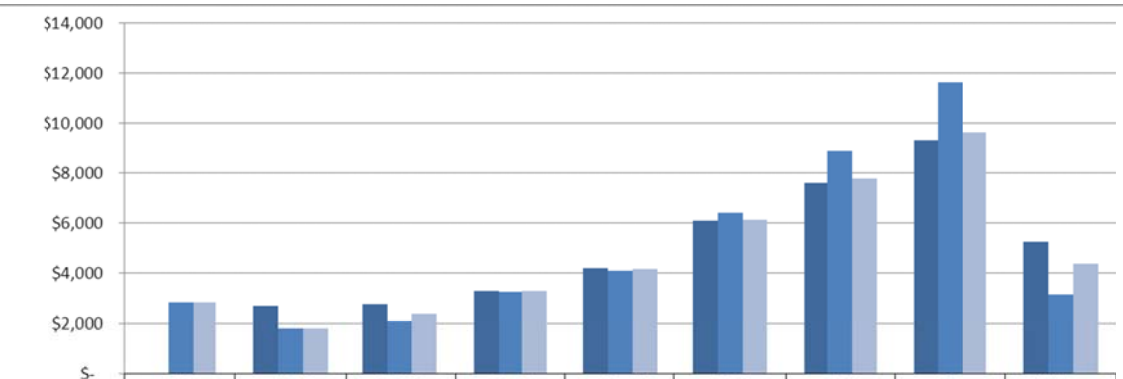
Source: KEHP's claims and enrollment data aggregated by Truven

The KEHP paid claims distribution in 2012 is very similar to the prior years. Roughly 40% of members had net paid claims of less than $1,000, whereas 23% of claimants consistently account for over 82% of claims costs.

Paid Claims Cost Detail by Age Band

Exhibit 18 shows KEHP's 2012 Medical Claims per member per year (PMPY) by age band.

Exhibit 18 – 2012 Employee and Dependent Medical Claims PMPY by Age Band



	<10	10-19	20-29	30-39	40-49	50-59	60-64	65+	All Ages
Employees	$-	$2,691	$2,741	$3,259	$4,179	$6,080	$7,576	$9,329	$5,252
Dependents	$2,807	$1,809	$2,067	$3,250	$4,082	$6,385	$8,893	$11,635	$3,119
Total	$2,807	$1,811	$2,368	$3,258	$4,159	$6,134	$7,758	$9,615	$4,356

2012 Member Counts									
Employees	-	83	13,953	26,623	34,220	48,344	29,830	3,836	156,888
Dependents	29,914	36,244	17,335	5,695	8,674	10,346	4,760	543	113,512
Total	29,914	36,327	31,288	32,318	42,894	58,690	34,590	4,379	270,399

Source: KEHP's claims and enrollment data aggregated by Truven

As expected, paid claims per member increases with age. Dependents under age 30 represent 73.6% of total dependents enrolled in the plan but only 52.4% of dependent costs. In comparison, dependents over 50 comprise merely 13.8% of the dependent population, but their costs represent 32.4% of the total dependent paid claims. Aging typically results in 1-2% higher cost per year of age. In the exhibit above, members over 65 are active employees (or dependents of active employees). The combination of the smaller size and higher demographic risk of this cohort leads to a greater likelihood of fluctuations in per capita costs.

Paid Claims Cost Details by Service Type

Exhibit 19 shows applicable utilization statistics for the Major Medical service types.

Exhibit 19 - Utilization by Service Type on an Allowed Charges Basis

Inpatient Hospital Claim Utilization Statistics	2010	2011	2012	2012 vs. 2011	Jan - Jun, 2012	Jan - Jun, 2013	2013 vs. 2012
Admits Per 1,000 Lives	86.1	80.3	77.1	-4.1%	77.2	73.7	-4.6%
Days Per 1,000 Lives	337.5	321.1	310.3	-3.4%	311.6	292.4	-6.2%
Average Length of Stay (Days)	3.9	4.0	4.0	0.7%	4.0	4.0	-1.7%
Average Cost per Admit	$14,747	$15,797	$17,502	10.8%	$17,205	$17,963	4.4%
Average Cost per Day	$3,762	$3,953	$4,348	10.0%	$4,264	$4,529	6.2%
Allowed Charges PMPM	$105.8	$105.8	$112.4	6.3%	$110.7	$110.3	-0.4%

Outpatient Hospital Claim Utilization Statistics	2010	2011	2012	2012 vs. 2011	Jan - Jun, 2012	Jan - Jun, 2013	2013 vs. 2012
Visit Per 1,000 Lives	1,862.7	1,876.3	1,876.4	0.0%	1,852.3	1,764.3	-4.8%
Services Per 1,000 Lives	10,389.2	10,427.8	9,438.2	-9.5%	10,235.7	10,532.0	2.9%
Services Per Visit	5.6	5.6	5.0	-9.5%	5.5	6.0	8.0%
Average Cost per Visit	$916	$986	$1,031	4.5%	$1,165	$1,202	3.2%
Average Cost per Service	$164	$177	$205	15.5%	$211	$201	-4.5%
Allowed Charges PMPM	$143.9	$155.4	$163.1	5.0%	$161.1	$158.4	-1.7%

Professional Service Claim Utilization Statistics	2010	2011	2012	2012 vs. 2011	Jan - Jun, 2012	Jan - Jun, 2013	2013 vs. 2012
Visit Per 1,000 Lives	8,643.8	8,378.6	8,258.2	-1.4%	8,184.5	7,936.1	-3.0%
Services Per 1,000 Lives	17,720.4	17,385.5	17,224.8	-0.9%	16,753.7	16,530.3	-1.3%
Services Per Visit	2.1	2.1	2.1	0.5%	2.0	2.1	1.8%
Average Cost per Visit	$109	$114	$115	1.0%	$128	$131	1.8%
Average Cost per Service	$53	$55	$55	0.5%	$63	$63	0.1%
Allowed Charges PMPM	$79.7	$79.9	$79.9	0.0%	$78.5	$77.5	-1.2%

Source: KEHP's claims and enrollment data aggregated by Truven

2012 utilization decreased for inpatient, outpatient, and professional services from 2011, but average PMPM costs increased at higher rates for all three service types. This resulted in a 6.3% increase for average inpatient PMPM charges, 5.0% increase for average outpatient PMPM charges and neutral cost trend for average professional PMPM charges.

Overall trend is driven by average cost per service increases and changes in utilization. However, utilization has decreased over the last couple of years, resulting in plan experience being better than anticipated.

Paid Claims Cost by Top Ten Major Diagnostic Categories

Total expenditure and number of patients covered for the top ten Major Diagnostic Categories (MDCs) in 2012 are shown in Exhibit 20. Note that Truven's categorization of "Health Status", included in this list is a "catch-all" category e.g., Preventive/Administrative Health Encounters, Signs/Symptoms/Others). Also note that many patients have multiple conditions falling within more than one MDC or clinical condition.

Exhibit 20 - Utilization by Major Diagnostic Categories

	Total Plan Cost				Patients			
Major Diagnostic Category	**2011**	**2012**	**Jan - Jun, 2012**	**Jan - Jun, 2013**	**2011**	**2012**	**Jan - Jun, 2012**	**Jan - Jun, 2013**
Musculoskeletal	$191,047,439	$198,862,815	$94,964,971	$94,365,364	106,410	106,084	74,336	69,532
Circulatory	$141,569,370	$144,500,761	$74,427,942	$67,389,122	76,423	74,285	50,938	47,274
Digestive	$110,728,181	$110,642,629	$53,691,916	$51,465,880	58,133	56,327	33,673	32,419
Health Status	$94,963,046	$106,443,625	$48,294,659	$49,557,728	179,790	183,100	107,598	107,672
Nervous	$57,376,359	$65,284,286	$31,676,477	$31,715,523	35,392	35,674	22,302	20,981
Kidney	$62,790,204	$63,767,891	$31,450,961	$27,992,874	35,257	34,994	20,743	19,033
Skin, Breast	$58,292,581	$62,712,251	$30,586,653	$28,583,721	93,066	92,987	57,956	53,658
Respiratory	$55,717,946	$56,527,096	$28,528,535	$27,010,301	58,522	57,381	34,496	32,918
Myeloproliferative Diseases	$56,152,731	$55,515,385	$26,689,153	$28,923,871	7,274	6,970	4,564	4,219
Ear, Nose, Mouth & Throat	$54,941,705	$55,259,011	$27,100,857	$24,809,813	138,569	134,716	93,233	92,794
Top Three as % of Total Spend	**39.3%**	**38.5%**	**39.0%**	**38.3%**				
Top Ten as % of Total Spend	**78.3%**	**78.1%**	**78.2%**	**77.6%**				

Source: KEHP's claims data aggregated by Truven

Nearly 80% of claim costs are for treatment of members whose diagnoses are contained in the top ten Major Diagnostic Categories (MDCs). The relatively high cost of Musculoskeletal, Circulatory, and Digestive MDCs, in particular, suggest that care management and managed pharmacy programs related to these diagnoses should continue to be encouraged. For example, targeted joint replacement, low back pain, heart disease, and reflux disease management programs or pharmaceutical step therapies, with high participation rates, can help manage these costs as well as improve the health of patients who have these diagnoses.

This distribution of claims by MDC is reflective of the average age of the covered population as well as indicative of a population with a significant prevalence of health risks and chronic conditions.

Exhibit 21 - Utilization by Chronic Conditions

Clinical Condition	2011 Plan Cost	2012 Plan Cost	2013 Plan Cost (Jan - Jun)
Cancer	$80,251,468	$79,610,101	$37,923,017
Chronic Back/Neck Pain	$47,772,197	$48,889,369	$23,794,549
Osteoarthritis	$48,810,541	$50,057,332	$26,038,154
Coronary Artery Disease	$40,055,904	$41,078,159	$17,283,319
Diabetes	$13,354,715	$13,884,970	$6,706,964
Hypertension	$10,954,469	$10,819,427	$5,582,927
Weight Management	$7,244,277	$8,127,839	$5,165,110
Heart Failure	$5,684,177	$4,322,979	$3,292,433
COPD	$4,436,007	$3,855,761	$1,529,444
Asthma	$3,570,546	$4,401,603	$1,785,584

Source: KEHP's claims data aggregated by Truven

Several Chronic Conditions, such as Chronic Back/Neck Pain, Coronary Heart Disease, and Osteoarthritis, each cost KEHP around $40 to $50 million in 2011 and 2012. For comparison, all types of cancer combined cost KEHP $80 million in 2011 and 2012. The costs associated with these ten chronic conditions represent approximately 23% of KEHP's medical costs. Members with these conditions should be targeted for disease management programs.

Exhibit 22 shows KEHP's medical costs separated by family status.

Exhibit 22 - Paid Claims by Member Type

Relationship	Total Plan Cost					
	2011	2012	2012 vs. 2011	Jan - Jun, 2012	Jan - Jun, 2013	2013 vs. 2012
Employees	$795,598,567	$823,963,586	3.6%	$401,545,651	$396,296,975	-1.3%
Spouse	$168,928,746	$172,973,293	2.4%	$84,510,839	$79,608,831	-5.8%
Child	$164,623,560	$181,019,032	10.0%	$86,046,396	$80,589,300	-6.3%
Total	**$1,129,150,874**	**$1,177,955,911**	**4.3%**	**$572,102,886**	**$556,495,107**	**-2.7%**

Relationship	Total Plan Cost PMPM					
	2011	2012	2012 vs. 2011	Jan - Jun, 2012	Jan - Jun, 2013	2013 vs. 2012
Employees	$416.68	$437.66	5.0%	$422.76	$427.12	1.0%
Spouse	$439.11	$459.80	4.7%	$445.08	$439.73	-1.2%
Child	$173.11	$183.60	6.1%	$175.37	$161.16	-8.1%
Total	**$347.96**	**$363.03**	**4.3%**	**$350.91**	**$345.88**	**-1.4%**

Source: KEHP's enrollment and claims data aggregated by Truven

From 2011 to 2012, KEHP's total medical costs for adults increased by a modest 3.6% for employees and 2.4% for spouses. Plan costs for children increased at a much higher rate, 10%, over the same time period. However, total plan costs are expected to decrease for each member type in 2013. On a PMPM basis, these trends are substantially different. PMPM costs increased moderately from 2011 to 2012: 5.0% for employees, 4.7% for spouses, and 6.1% for children from 2011 to 2012, indicating that the enrollment changes from 2011 to 2012 are mostly responsible for much of the total cost trend difference by member type. In 2013, the PMPM costs are projected to show more difference: 1.0% increase for employees, 1.2% decrease for spouses, and 8.1% decrease for children.

Exhibit 23 shows KEHP's medical costs separated by Active / Retiree Status.

Exhibit 23 - Paid Claims by Active / Retiree Status

Status	Total Plan Cost					
	2011	2012	2012 vs. 2011	Jan - Jun, 2012	Jan - Jun, 2013	2013 vs. 2012
Active Employees	$751,845,399	$795,543,477	5.8%	$384,632,459	$379,979,142	-1.2%
Retirees	$377,305,475	$382,412,434	1.4%	$187,470,427	$176,515,965	-5.8%
Total	**$1,129,150,874**	**$1,177,955,911**	**4.3%**	**$572,102,886**	**$556,495,107**	**-2.7%**

Status	Total Plan Cost PMPM					
	2011	2012	2012 vs. 2011	Jan - Jun, 2012	Jan - Jun, 2013	2013 vs. 2012
Active Employees	$301.38	$316.00	4.9%	$303.96	$299.19	-1.6%
Retirees	$502.82	$525.84	4.6%	$513.70	$520.83	1.4%
Total	**$347.96**	**$363.03**	**4.3%**	**$350.91**	**$345.88**	**-1.4%**

Source: KEHP's enrollment and claims data aggregated by Truven

From 2011 to 2012, active employees experienced a 5.8% increase in total medical claims and retirees experienced a 1.4% increase. On a PMPM basis, these both normalize to around 4.5%. The 2013 trend for actives is projected to be lower, at -1.6% on a PMPM basis, while the Retirees are projected to increase 1.4%.

KEHP Pharmacy Benefits Detailed Experience

Key Findings

- Pharmacy costs have increased modestly over the last several years, with trends significantly lower than industry norms. This is likely due, at least in part, to decreased utilization.
- Both the generic dispensing rate and mail order utilization have increased since 2008, helping to slow down the drug cost growth.
- Some of the top drugs utilized by KEHP are scheduled for patent expiration over the next several years, meaning a potential significant saving to KEHP for these drugs.

Pharmacy Cost Statistics

A summary of year over year trends for KEHP's total pharmacy claims experience is illustrated in Exhibit 24.

Exhibit 24 - Key Statistics - Aggregate Pharmacy Benefits Costs

	2009	2010	2011	2012	2012 vs. 2011	Jan - Jun, 2012	Jan - Jun, 2013	2013 vs. 2012
Total Eligible Members	259,196	265,876	270,422	270,400	0.0%	266,740	268,158	0.5%
Total Number of Scripts	5,216,242	5,369,274	5,229,310	4,993,394	-4.5%	2,510,652	2,393,960	-4.6%
Scripts Per Member	20.12	20.19	19.34	18.47	-4.5%	9.41	8.93	-5.2%
Total Plan Paid	$315,768,145	$344,959,438	$341,781,007	$353,321,327	3.4%	$174,168,748	$171,814,632	-1.4%
Total Member Paid	$61,036,109	$60,122,420	$76,840,003	$71,576,255	-6.9%	$38,435,298	$37,239,628	-3.1%
Total Allowed Cost	**$376,804,254**	**$405,081,858**	**$418,625,520**	**$424,897,045**	**1.5%**	**$212,603,936**	**$209,054,860**	**-1.7%**
Plan Paid PMPM	$101.52	$108.12	$105.32	$108.89	3.4%	$108.83	$106.79	-1.9%
Member Paid PMPM	$19.62	$18.84	$23.68	$22.06	-6.8%	$24.02	$23.15	-3.6%
Total Allowed Cost PMPM	**$121.15**	**$126.96**	**$129.00**	**$130.95**	**1.5%**	**$132.84**	**$129.93**	**-2.2%**

Source: KEHP's enrollment and claims data aggregated by Truven

The number of scripts per member has decreased 4.5% in 2012 and is projected to decrease for 2013 as well. The total allowed cost for prescription drugs increased 1.5% in 2012, though 2013 is projected to see a decrease of 1.7% from the first 6 months of 2012 to the first 6 of 2013.

The observed 2012 trend rate for KEHP's portion of the pharmacy cost in total is 3.4% compared to the overall 2012 trend on pharmacy allowed cost of 1.5%. The increase in employer cost share occurs because member copayments were held constant from 2011 to 2012, leaving the total cost increase to shift to the employer. The observed trend rate for KEHP's portion of the pharmacy cost for the first 6 months of 2013 is -1.9% (on a PMPM basis) versus the overall allowed cost trend of -2.2%.

Exhibit 25 shows key utilization and cost share statistics for KEHP's pharmacy claims.

Exhibit 25 - Key Pharmacy Cost Share Statistics

	2009	2010	2011	2012	2012 vs. 2011	Jan - Jun, 2012	Jan - Jun, 2013	2013 vs. 2012
Total Copayment per Claim	**$10.44**	**$9.83**	**$12.71**	**$12.21**	**-3.9%**	**$12.62**	**$12.52**	**-0.8%**
Retail Copayment per Claim	$10.08	$9.47	$12.34	$11.89	-3.7%	$12.27	$12.24	-0.3%
Mail Copayment per Claim	$24.56	$23.15	$25.75	$23.73	-7.8%	$24.60	$22.93	-6.8%
Total Member Cost Share	**16.2%**	**14.8%**	**18.4%**	**16.8%**	**-1.5%**	**18.1%**	**17.8%**	**-0.3%**
Retail Member Cost Share	16.5%	15.0%	18.7%	17.1%	-1.6%	18.4%	18.0%	-0.4%
Mail Member Cost Share	12.4%	12.9%	13.8%	12.9%	-1.0%	13.6%	14.0%	0.3%
Generic Utilization								
Generic Dispensing Rate	66.3%	69.7%	73.1%	75.9%	2.8%	75.1%	78.4%	3.3%
Generic Substitution Rate	92.7%	94.2%	94.1%	92.8%	-1.3%	93.3%	93.8%	0.5%
Mail Order Utilization	2.5%	2.6%	2.7%	2.7%	0.0%	2.7%	2.5%	-0.2%

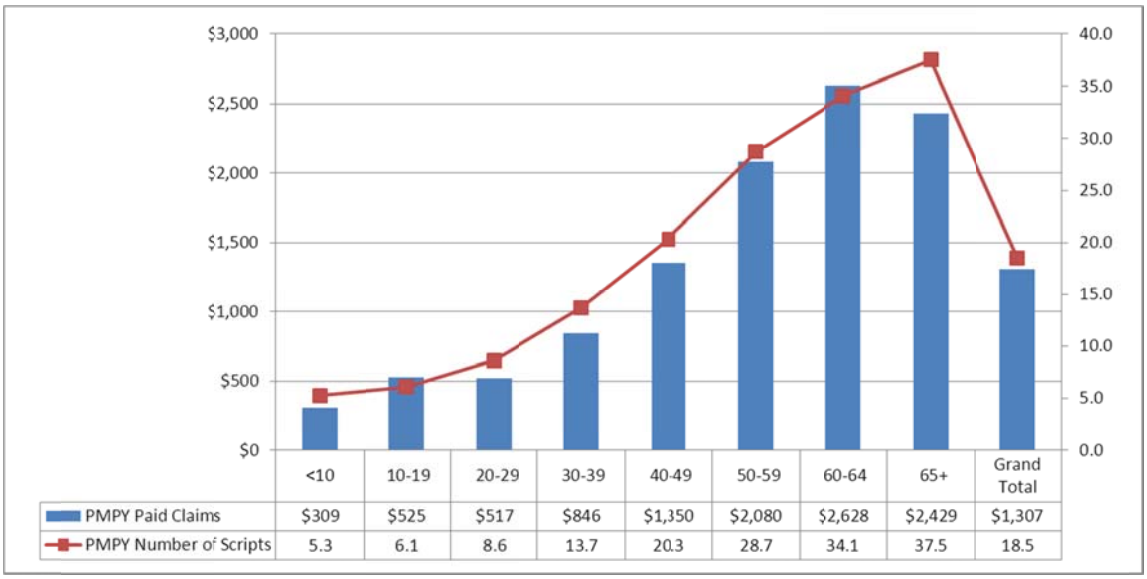
Source: KEHP's enrollment and claims data aggregated by Truven

The generic dispensing rate has continued to increase steadily from 59.9% in 2007 (not shown) to 75.9% in 2012 and 78.4% in 2013. Mail order utilization has remained fairly level over this same time period due to minimal incentives. Member cost share has remained fairly level before and after 2011, when plan design changes increased member co-pays.

Demographic Impact on Pharmacy Experience

Exhibit 26 illustrates the increase in medication usage with each increasing age band.

Exhibit 26 - 2011 Distribution of Pharmacy Claims and Number of Prescriptions, PMPY by Age Band

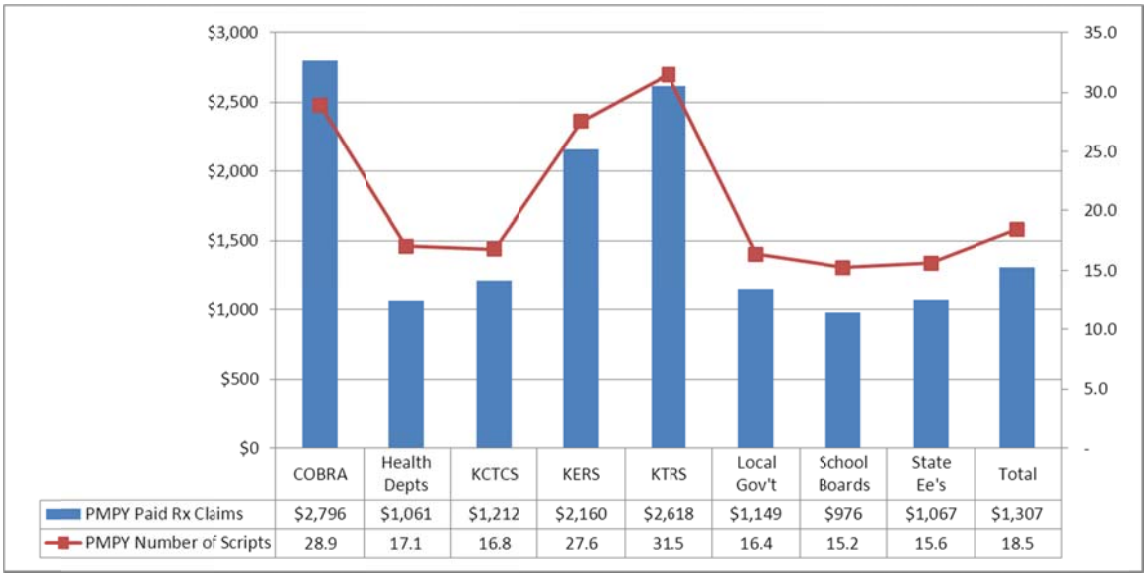


Source: KEHP's enrollment and claims data aggregated by Truven

Increase in utilization and cost with age is due to the natural progression of the membership's health status with age. The number of scripts, on a PMPY basis, increases throughout the age bands.

Exhibit 27 shows the pharmacy claim and script PMPMs by group.

Exhibit 27 - 2011 Distribution of Pharmacy Claims and Number of Prescriptions, PMPY by Group



Source: KEHP's enrollment and claims data aggregated by Truven

The highest user group, COBRA, continues to show high utilization as higher users of medical and pharmacy benefits are more likely to continue their coverage through COBRA. After COBRA, KERS and KTRS, the retiree groups, are the highest users of pharmacy benefits due to increased ages. The utilization for other groups are fairly level.

Prescription Drug Utilization and Disease States

Exhibit 28 shows the drugs that KEHP paid most for in 2012, along with their costs and number of scripts for 2009 through the first 6 months of 2013.

Exhibit 28 - Top 10 Drugs for KEHP

		Total Plan Cost					Number of Scripts				
Drug	2012 Rank	2009	2010	2011	2012	Jan - Jun, 2013	2009	2010	2011	2012	Jan - Jun, 2013
NEXIUM	1	$10,545,713	$10,915,333	$10,294,535	$10,553,716	$5,552,705	54,315	51,894	46,439	44,183	22,374
CRESTOR	2	$7,019,628	$9,041,563	$10,074,584	$10,259,712	$4,653,920	62,971	71,399	72,355	64,423	26,842
CYMBALTA	3	$5,066,659	$5,963,632	$6,724,693	$8,470,414	$4,617,271	31,867	33,108	34,895	36,270	17,563
HUMIRA	4	$5,127,691	$5,930,464	$6,935,556	$8,387,152	$4,791,436	2,345	2,566	2,646	2,778	1,394
ENBREL	5	$5,869,089	$6,576,469	$6,912,986	$7,490,921	$3,837,410	2,679	2,865	2,705	2,463	1,083
SINGULAIR	6	$6,835,600	$7,887,053	$8,450,919	$5,983,885	$38,893	62,951	64,432	60,576	37,170	307
COPAXONE	7	$3,455,620	$4,474,031	$5,306,220	$5,583,576	$2,552,338	1,106	1,213	1,127	937	358
ABILIFY	8	$2,944,940	$3,851,511	$4,701,817	$5,376,839	$2,651,718	6,498	7,760	8,441	8,438	3,735
JANUVIA	9	N/A	$2,745,169	$3,083,094	$3,580,794	$1,763,475	N/A	N/A	13,861	14,377	6,348
ATORVASTATIN CALCIUM	10	N/A	N/A	$244,401	$3,345,884	$1,136,401	N/A	N/A	1,942	38,767	26,030

Source: KEHP's enrollment and claims data aggregated by Truven

The top drugs utilized year over year correlate to MDC findings and further contribute to the potential for cost and health improvement through coordinated disease management and incentives, such as reduced copays for maintenance drugs prescribed to treat chronic conditions. In 2012 these ten drugs represented 19.5% of the KEHP total pharmacy costs.

Exhibit 29 shows utilization and cost statistics for the top indications that contribute to pharmacy costs in 2012.

Exhibit 29 - Top 10 Indications Contributing to Pharmacy Cost

Top 10 Indications for 2012 by Ingredient Cost							
Rank	Indication	Scripts	Patients	Ingredient Cost	Generic Fill Rate	Ing Cost PMPM	Ing Cost per patient
1	Diabetes	375,024	24,277	$ 42,325,365	46.4%	$ 13.02	$ 1,743.43
2	High Blood Cholesterol	479,380	50,935	$ 33,147,895	64.4%	$ 10.20	$ 650.79
3	High Blood Pressue / Heart Disease	872,983	73,468	$ 26,277,362	89.7%	$ 8.09	$ 357.67
4	Depression	411,353	51,449	$ 25,204,775	82.9%	$ 7.76	$ 489.90
5	Ulcer Disease	304,235	42,732	$ 23,433,692	75.2%	$ 7.21	$ 548.39
6	Asthma	176,292	36,375	$ 22,638,192	26.6%	$ 6.97	$ 622.36
7	Inflammatory Conditions	17,693	2,325	$ 21,368,335	19.9%	$ 6.58	$ 9,190.68
8	Multiple Sclerosis	4,175	433	$ 15,212,056	0.0%	$ 4.68	$ 35,131.77
9	Infections	422,928	168,481	$ 12,945,750	97.9%	$ 3.98	$ 76.84
10	Seizures	154,930	22,220	$ 12,834,265	88.2%	$ 3.95	$ 577.60
	Top Ten Total	**3,218,993**		**$ 235,387,687**		**$ 72.44**	

Source: Express Scripts Benchmark Report

Ingredient costs for these top indicators represent over $235 million in 2012. For comparison, KEHP's total allowed pharmacy costs were around $425 million in 2012. Diabetes is the top indicator, with $42 million in total ingredient costs and one of the highest ingredient costs per patient.

Pharmacy Benchmarks

Exhibit 30 compares some of the KEHP's pharmacy cost utilization statistics against public and private benchmarks provided by Express Scripts.

Exhibit 30 – Benchmarked Utilization Statistics

	KEHP			2012 Benchmarks	
	2011	2012	2012 vs. 2011	Express Scripts	State Govt.
Plan Cost PMPM	$ 105.32	$ 108.89	3.4%	$ 70.88	$ 96.14
Plan Cost per Script	$ 65.36	$ 70.76	8.3%	$ 55.55	$ 57.08
Number Scripts PMPM	1.61	1.54	-4.5%	1.28	1.68
Generic Fill Rate	73.1%	75.9%	2.8%	75.5%	76.5%
Member Cost %	18.4%	16.8%	-1.5%	16.1%	17.0%
Specialty Percent of Plan Cost	17.0%	18.3%	1.3%	21.2%	19.4%
Specialty Plan Cost PMPM	$ 17.52	$ 19.56	11.6%	$ 15.01	$ 18.69
Formulary Compliance Rate	95.8%	96.5%	0.7%	95.0%	95.3%

Source: KEHP's enrollment and claims data aggregated by Truven, Express Scripts Benchmark Report

KEHP's per member per month pharmacy costs are somewhat higher than the state government benchmark and substantially higher than the benchmark from Express Scripts' book of business. KEHP's generic fill rate and formulary compliance rate both improved from 2011 to 2012 and are comparable to ESI benchmark. In 2012, specialty drug cost as a percentage of total plan cost increased from 17.0% to 18.3%, due to higher specialty drug cost trend.

Several of KEHP's highly utilized drugs, including several of the top 10 listed in exhibit 28, are scheduled for patent expiration over the next several years, as shown in exhibit 31.

Exhibit 31 - Schedule of Top Prescription Drugs Losing Patent Protection

Year	Drug	Manufacturer	Use	KEHP Cost - 2013
2013	AcipHex	Ortho-McNeil	Acid Reflux	$ 1,283,614
	Cymbalta	Eli Lilly and Company	Depression	$ 8,470,414
	Lyrica	Pfizer	Epilepsy / Fibromyalgia	$ 2,077,480
	Niaspan	KOS Pharmaceuticals	Cholesterol Lowering	$ 1,659,776
	Oxycontin	Purdue Pharmaceuticals	Painkiller	$ 1,511,590
2014	Celebrex	Pfizer	Painkiller	$ 2,515,650
	Copaxone	Teva Neuroscience	Multiple Sclerosis	$ 5,583,576
	Evista	Eli Lilly and Company	Osteoporosis	$ 1,189,407
	Exforge	Novartis	Hypertension	$ 505,471
	Loestrin 24 Fe	Warner Chilcott	Oral Contraceptive	$ 749,244
	Nasonex	Merck	Allergy symptoms	$ 746,220
	Nexium	AstraZeneca	Acid Reflux	$ 10,553,716
	Restasis	Allergan	Dry eye disease	$ 1,258,668
	Spiriva	Pfizer	Pneumonia/Bronchitis	$ 1,696,691
	Trilipix	AbbVie	Cholesterol Lowering	$ 1,024,257
	Vivelle-Dot	Novartis	Menopause	$ 927,237
	Zetia	Merck	Cholesterol Lowering	$ 2,107,716
2015	Abilify	Otsuka	Antidepressant	$ 5,376,839
	Androgel	AbbVie	Endogenous testosterone deficiency	$ 2,729,624
	Gleevec	Novartis	chronic myelogenous leukemia	$ 2,326,989
	Lovaza	GlaxoSmithKline	high triglycerides	$ 2,767,322
	Patanol / Pataday	Alcon	allergic conjunctivitis	$ 514,846
	Prempro	Pfizer	menopause	$ 639,435
	Welchol	Daiichi Sankyo	hypercholesterolemia & diabetes	$ 629,161
2016	Benicar	Daiichi Sankyo	hypertension	$ 645,436
	Byetta	Amylin	Type 2 diabetes	$ 952,036
	Crestor	AstraZeneca	hypercholesterolemia	$ 10,259,712
	Focalin XR	Novartis	ADHD	$ 562,807
	Humira	AbbVie	TNF Inhibitor	$ 8,387,152
	Nuvigil	Teva	excessive sleepiness	$ 541,400
	Seroquel XR	AstraZeneca	depression	$ 981,812

Source: KEHP claims data aggregated by Truven

These highly utilized drugs in Exhibit 31 represent a significant portion of KEHP's total pharmacy. Together, these drugs account for over $81 million, or 23% of KEHP's total pharmacy cost.

However, it is important to note that, while these drugs represent a significant portion of KEHP's drug spend, they may not necessarily result in significant savings to the plan. Drugs coming off patent may have high cost generic alternatives or new, more expensive therapeutic equivalent brands.

Population Health Issues

Key Findings

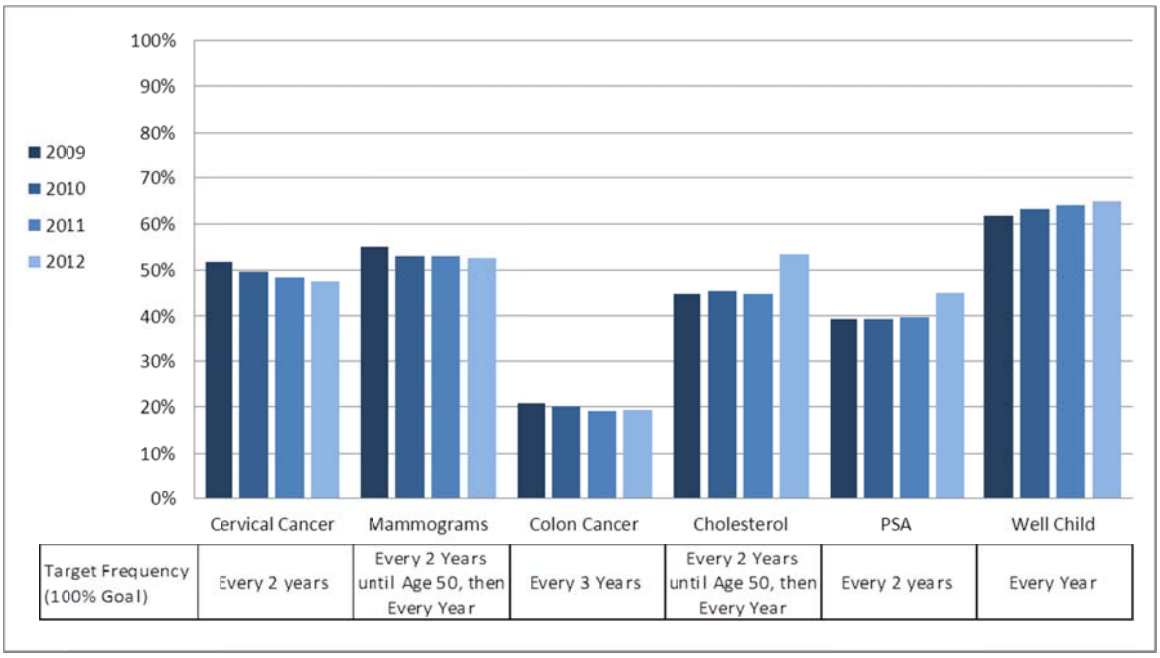
- Members of KEHP are not utilizing preventive care screenings as often as recommended, though there was a large increase in cholesterol and prostate cancer screenings in 2012.
- The Kaiser Family Foundation Survey, as with prior years, shows that Commonwealth of Kentucky residents, as a whole, have less healthy behaviors and outcomes than the United States as a whole, as well as other states in the South Region.

Preventive Care Screenings

"Healthy People 2010" and "Healthy People 2020" are sets of national health objectives for the U.S. to achieve by their respective target years - 2010 and 2020. Created by health experts, these objectives identify a wide range of public health priorities and specific, measurable objectives. These can be used to focus health improvement strategies at the state, community, or organizational level, in order to reach the ultimate goals of increasing the quality and years of healthy life and eliminating health disparities. For each of the preventive screenings, the desired target compliance rate is 100% for the respective target groups and screening frequencies per "Healthy People 2010" and "Healthy People 2020".

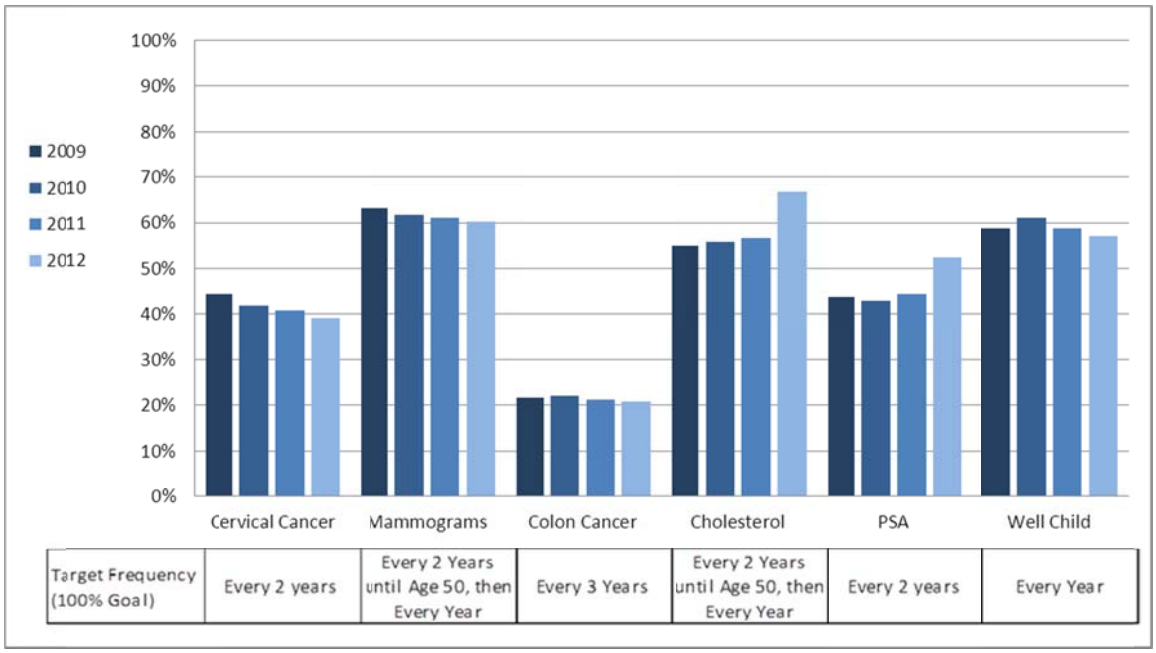
In Exhibits 32 and 33, the preventive care screening rates for KEHP members in 2009-2012 are shown for active members and for non-Medicare eligible retirees, respectively.

Exhibit 32 - Preventive Care Screening Utilization (Actives)



Source: KEHP's enrollment and claims data aggregated by Truven

Exhibit 33 - Preventive Care Screening Utilization (Early Retirees)



Source: KEHP's enrollment and claims data aggregated by Truven

From 2011 to 2012, both the active and Non-Medicare eligible retiree populations have seen minor decreases in mammogram, cervical cancer, and colon cancer screenings and sharp increases in Cholesterol and PSA screenings. KEHP's retiree population continues to achieve higher screening rates for all adult preventive measures, with the exception of cervical cancer screens, when compared with actives. Levels for both member groups are well under goals and expectations. Improvements in preventive care screenings are needed in all categories, but especially for colon cancer.

Disease Management and Care Management

ActiveHealth's disease management program was replaced by HumanaHealth Clinical Program in 2013.

Exhibit 34 shows the efforts of KEHP's clinical / case management programs.

Exhibit 34 – ICM Outreach Results (% of KEHP Population)

	2012, Jan - Jun	2013, Jan - Jun	% Difference
ER Visits Per 1000	193	168	-13%
Maternity Cases Managed	265	1,509	469%
Nurse Support	7,689	9,384	22%
Behavioral Health Utilization Per 1000	445	409	-8%

Source: HumanaHealth's Clinical Program Reports, 2013

Since moving from ActiveHealth's management program to Humana's clinical program, the number of managed maternity cases has risen from 265 in the first half of 2012 to 1,509 in the first half of 2013. For radiology and oncology cases, the disease management program is projected to produce around the same level of savings in 2013 as in 2012. However, savings for radiation therapy appears to be significantly higher in 2013 than in 2012 already.

Exhibit 35 shows the extent to which KEHP members have taken care of their health for 2012 and 2013. Note that only 6 months of data is available for 2013 and thus the "percentage of adults receiving their annual wellness exam" metric is artificially low.

Exhibit 35 – ICM Clinical Indicators

Cluster	Clinical Indicator	Measured Population	2012	2013, Jan - Jun
Overall Wellness	Percent of Adults receiving annual wellness exam	All KEHP members	34%	21%
	Percent of Adults with no gaps in Care		46%	49%
Vascular Conditions	Use of Beta-Blockers after heart attack	538	87%	87%
	LDL-Cholesterol Screening after a caridovascular event	3,435	78%	80%
Diabetes	HbA1c Testing Rate	17,622	79%	80%
	Nephropathy Screening Percent	16,396	75%	74%
	Lipid Test Percent	16,131	73%	73%
	Eye Exam Rate	7,673	36%	35%

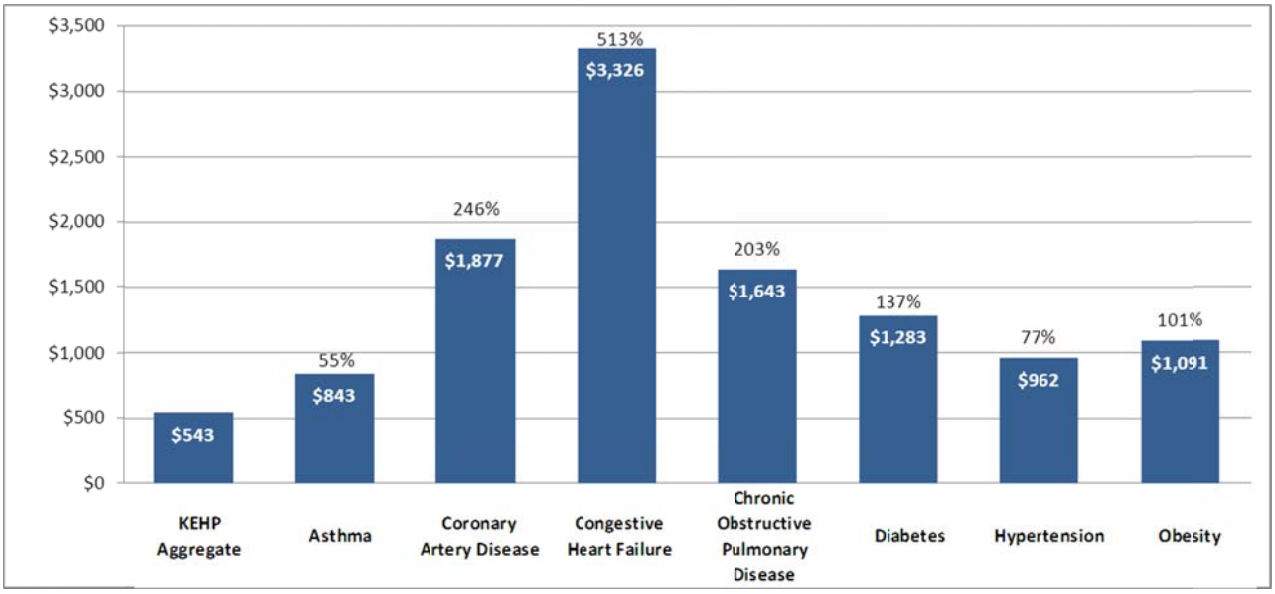
Source: KEHP's enrollment and claims data aggregated by Truven

2013 percentages are similar to those in 2012; 2013 shows fewer adults with gaps in care than in 2012 and increases in the percentage of members receiving a LDL-Cholesterol screening after a cardiovascular event. Of particular concern for both years is the very low percentage of KEHP members with diabetes who have received an eye exam.

Costs by Disease State

Exhibit 36 displays the difference in per member per month allowed charges (the cost to both the plan and member combined) between the average KEHP member and those with specified chronic conditions.

Exhibit 36 - 2012 Chronic Disease States PMPM versus KEHP Aggregate PMPM



Source: KEHP's enrollment and claims data aggregated by Truven

Members with Congestive Heart Failure, for example, are 513% more expensive than the average member. Given the average cost of members within each disease state, there is potential for significant savings through effective management of chronic diseases. Assisting members with accessing appropriate care, discussing concerns with their physicians, maintaining medication compliance, and gaining additional education through the disease management program will significantly improve member health and plan cost.

Population Health Statistics for the Commonwealth of Kentucky

The Kaiser Family Foundation has tabulated, state by state, the prevalence of certain behaviors and indicators that affect the health of individuals. These behaviors and indicators correlate closely to health status. Given that KEHP covers a significant portion of the total Commonwealth population, these behaviors and indicators are also evident in the plan population. A summary of these key statistics for Kentucky (KY), compared against other states in the South Region and the United States in total, is provided below in Exhibit 37 (statistics for which Kentucky is worse than both the South Region and the United States are marked in red).

Exhibit 37 – Comparison of Selected Population Health Statistics

Statistic	KY (Prior Survey)	KY (Current)	South Region	US Total
Life Expectancy at Birth	76.2	76.0	77.7	78.9
Percent of Adults Who are Overweight or Obese	67.5%	66.6%	65.1%	63.3%
Percent of Children (10-17) who are Overweight or Obese	37.1%	35.7%	33.6%	31.3%
Percent of Adults who Participate in Moderate or Vigorous Physical Activities	45.6%	46.9%	48.1%	51.4%
Percent of Adults Who Smoke	24.8%	29.0%	21.7%	20.1%
Percent of Smokers who Attempt to Quit Smoking	56.2%	53.8%	60.7%	59.6%
Percent of Adults Who Have Ever Been Told by a Doctor that They Have Diabetes	10.0%	10.8%	10.7%	9.5%
Adult Self-Reported Current Asthma Prevalence Percentage	10.4%	10.4%	7.9%	8.6%
Percent of Adults Reporting Poor Mental Health	36.7%	36.8%	34.8%	35.8%
Number of Cancer Deaths (per 100,000)	204	208	178	173
Number of Deaths Due to Diseases of the Heart (per 100,000)	210	210	188	180
Age-Adjusted Invasive Cancer Incidence Rate (per 100,000)	513	509	453	459

Source: Kaiser Family Foundation, www.statehealthfacts.org

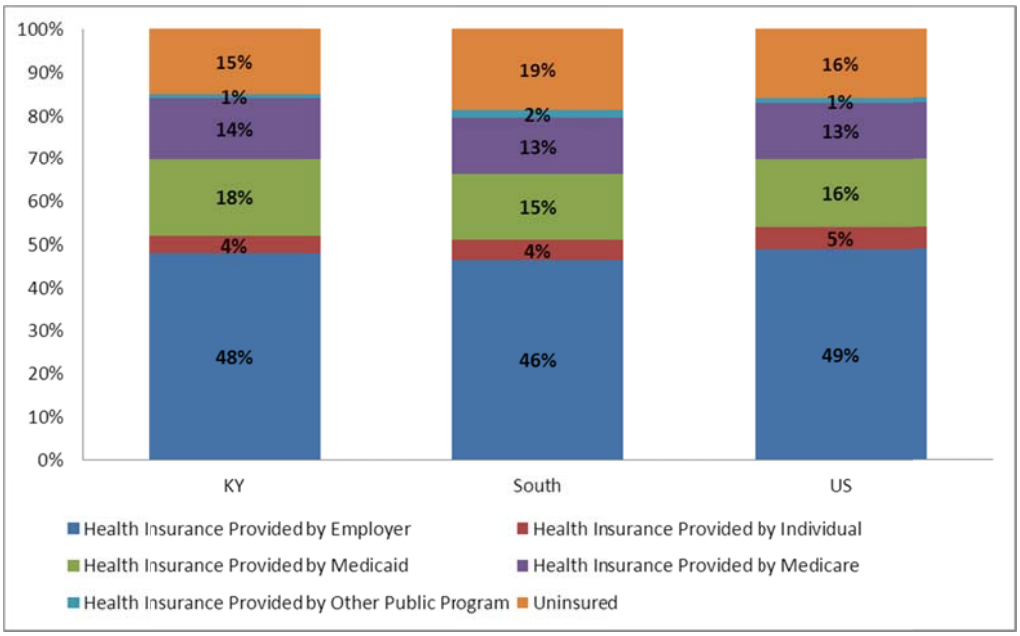
While some of Kentucky's statistics (diabetes and physical activity) are in line with the South Region's average, the population statistics suggest that Kentucky residents, on average, have a less healthy lifestyle than both the South Region and the United States as a whole and can expect both a higher prevalence of health issues and a lower life expectancy. Additionally, the percentage of adults who smoke and the percentage of smokers who have attempted quitting are both considerably worse this year than last year. However, some of the Kentucky statistics are better than the prior year, notably the percentage of adults who participate in physical activities.

Consistent with the health issues affecting KEHP members, the Commonwealth still lags behind national averages for metrics such as obesity, diabetes, and smoking. Progress towards reaching and exceeding the national averages will significantly impact the underlying cost of healthcare and demonstrate a significant opportunity and goal for the Commonwealth's population and for KEHP membership. KEHP is focusing on pushing forward with wellness initiatives in attempt to improve KEHP members' health statistics.

Health Insurance Coverage for the Commonwealth of Kentucky

In addition to the Health Risk Statistics Comparison, the Kaiser Family Foundation has aggregated data regarding the health insurance coverage of each state's residents. In Exhibit 38, Kentucky is again compared against the South Region as well as the United States as a whole.

Exhibit 38 – Source of Insurance Coverage Comparison



Source: Kaiser Family Foundation, www.statehealthfacts.org

In contrast to the disparity in their health risk statistics, the residents of Kentucky are insured in roughly the same proportions as the rest of the United States, with an uninsured rate lower than the National Average and significantly lower than the other Southern States. The percentage of Kentucky residents insured through Medicare and Medicaid are higher than both the South region and the US in total.

BENCHMARK RESULTS

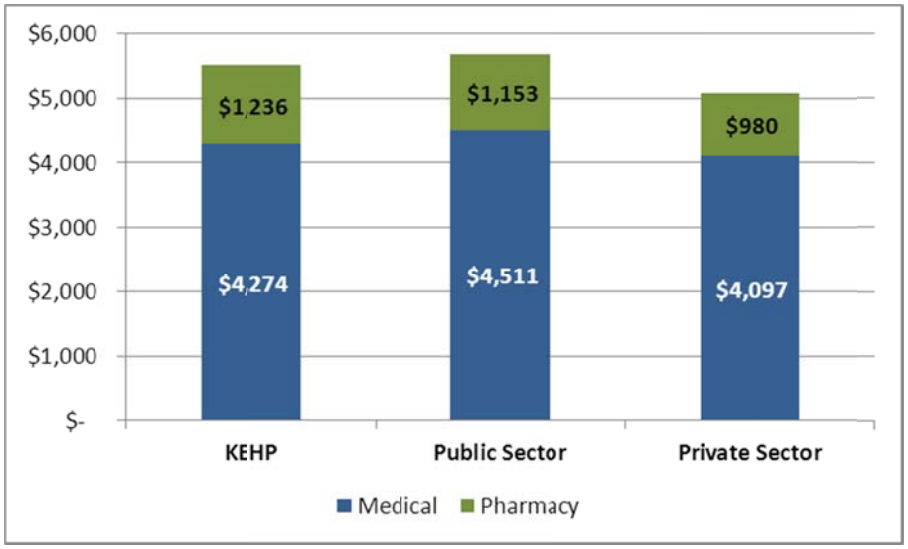
Key Findings

- KEHP's costs and prevalence of diseases are more similar to the public sector than the private sector.
- Admission rates for KEHP members are higher than both the private and public sector benchmarks. However, admission rates for KEHP members with chronic conditions are lower than both the benchmarks.

Total Allowed Costs

Truven has compiled several benchmarks comparing KEHP's 2012 allowed costs for active employee population against the active populations for other Truven clients, separated by public and private sectors. Due to changes in methodology made by Truven, this year's benchmark results may not be comparable to last year's results. Exhibit 39 shows the difference in total costs PMPY for both KEHP and the public and private sectors.

Exhibit 39 –2012 KEHP Active Population PMPY Allowed Costs vs. Public and Private Sector



Source: Truven Benchmark Report

For active employees in 2012, KEHP's total allowed per member per year cost was 2.7% lower than other clients in the public sector (5.3% lower for medical costs and 7.2% higher for pharmacy) and 8.5% higher than clients in the private sector (4.3% higher for medical costs and 26% higher for pharmacy).

Demographics

Exhibit 40 compares some key demographic statistics for the KEHP against the public and private sectors.

Exhibit 40 –2012 Key Demographic Statistics

	KEHP	Public Sector	Private Sector
Average Member Age	33.3	34.4	32.4
Member to Employee Ratio	1.8	1.9	2.2
Employee % male	41%	43%	49%
Risk Score	141.4	143.3	119.9

Source: Truven Benchmark Report

In general, KEHP's plans cover a younger population with smaller family size and more females than other Truven clients in the public sector. At younger ages, females have higher average claim costs than males, due to

maternity. KEHP's risk score is roughly equivalent to clients in the public sector and higher than other clients in the private sector.

Disease Prevalence in KEHP active population

Exhibit 41 compares the prevalence of several chronic diseases for the KEHP active population against other states and US population in general.

Exhibit 41 –2012 Disease Prevalence for Actives

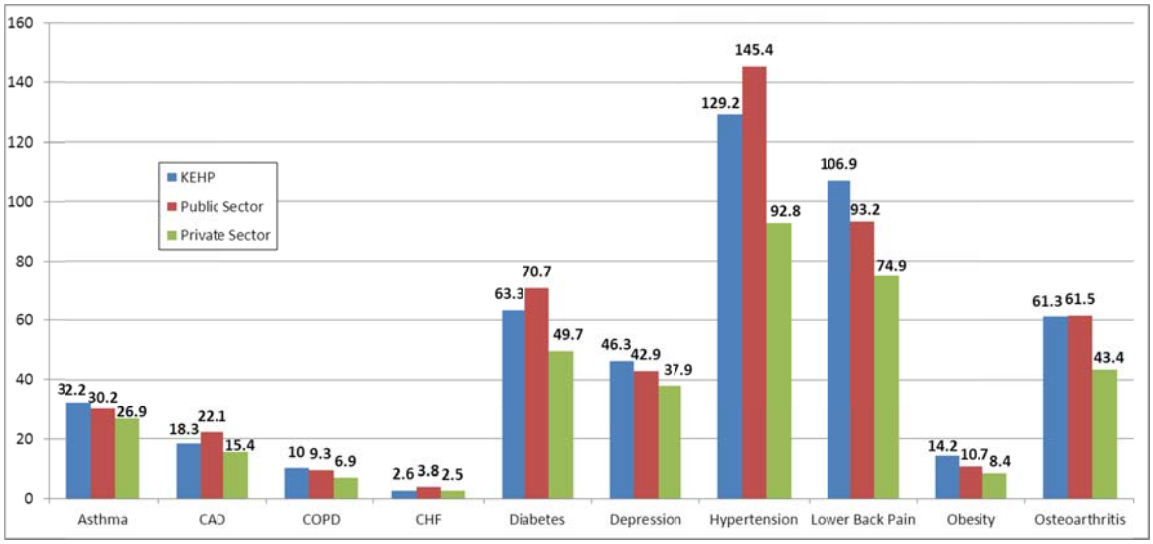
Disease Prevalance % of Patients	KEHP	Benchmark			
		State & Local Govt	Difference	US Total	Difference
Anxiety Disorder	3.9%	2.5%	1.4%	2.5%	1.4%
Asthma	2.8%	2.3%	0.5%	2.2%	0.6%
Bipolar Disorder	0.6%	0.7%	-0.1%	0.7%	-0.1%
Coronary Heart Disease	2.8%	2.2%	0.6%	1.8%	1.0%
CHF	0.4%	0.4%	0.0%	0.3%	0.1%
COPD	1.5%	0.9%	0.5%	0.9%	0.6%
Depression	5.6%	4.6%	1.0%	5.0%	0.6%
Diabetes	9.4%	8.6%	0.8%	6.8%	2.6%
HIV Infection	0.1%	0.1%	-0.1%	0.2%	-0.1%
Hypertension	19.5%	18.9%	0.6%	12.9%	6.6%
Osteoarthritis	9.2%	7.4%	1.9%	6.4%	2.9%
Rheumatoid Arthritis	0.7%	0.6%	0.1%	0.6%	0.1%

Source: Truven Benchmark Report

KEHP members have lower incidences of bipolar disorder and HIV infection than both the US and government benchmarks, but higher incidences of most other diseases, such as Hypertension and Osteoarthritis.

Exhibit 42 compares the prevalence of chronic conditions against private and public sector benchmarks.

Exhibit 42 –2012 Chronic Condition Prevalence per 1000 Members

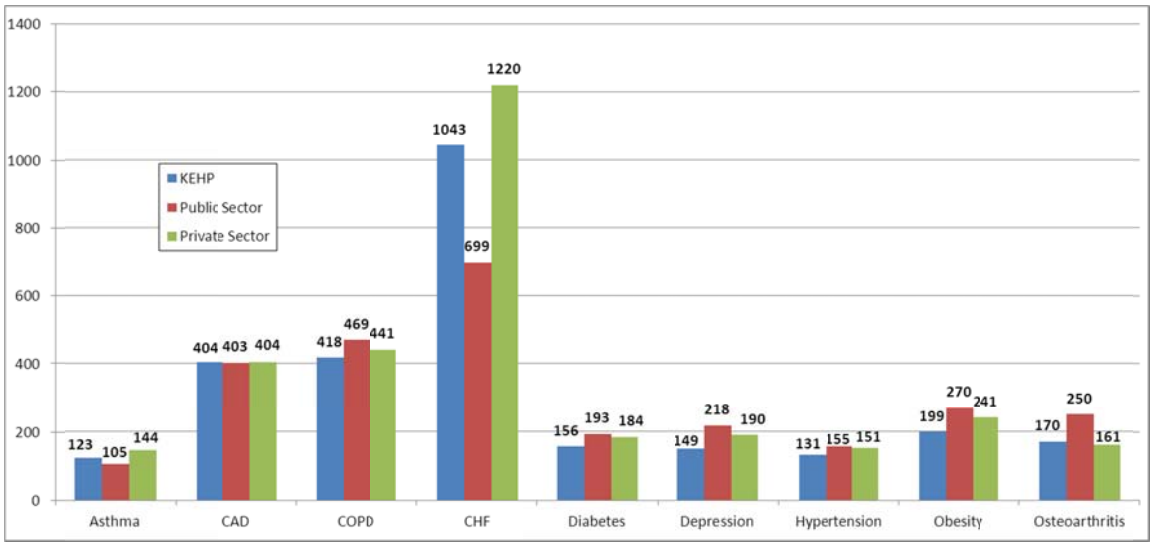


Source: Truven Benchmark Report

KEHP has higher prevalence figures than the private sector in every chronic category, but relatively comparable figures when compared to the public sector.

Exhibit 43 shows select admissions prevalence figures for KEHP against private and public sector benchmarks.

Exhibit 43 – 2012 Admissions per 1000 Members for Members with Chronic Conditions

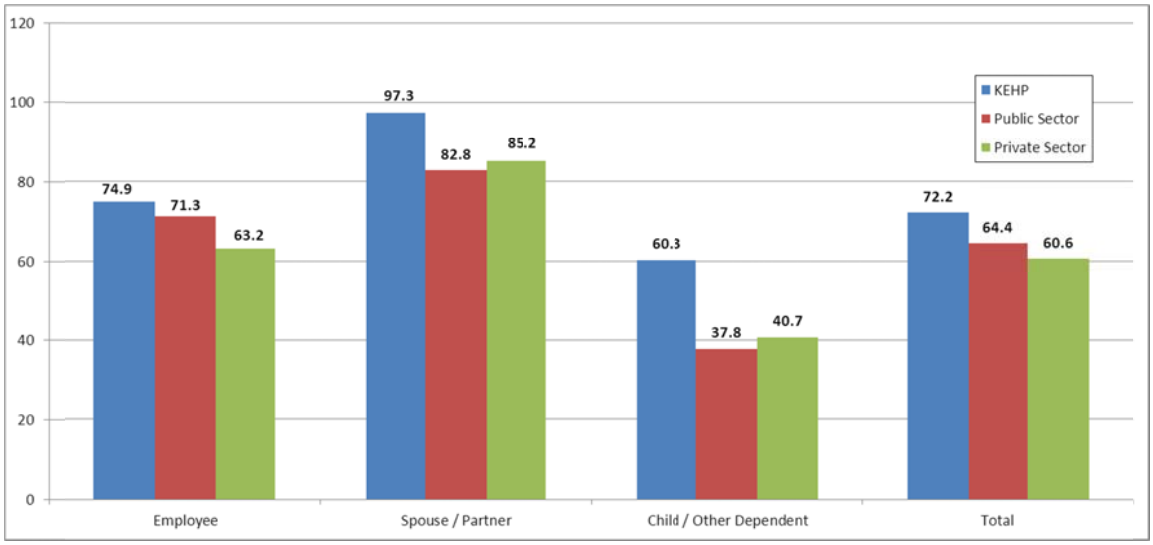


Source: Truven Benchmark Report

KEHP members with chronic conditions show similar, if not lower, admission rates than both private and public sectors.

Exhibit 44 compares the admissions of KEHP against those in the public and private sectors, split by relationship.

Exhibit 44 – 2012 Admissions per 1000 Members

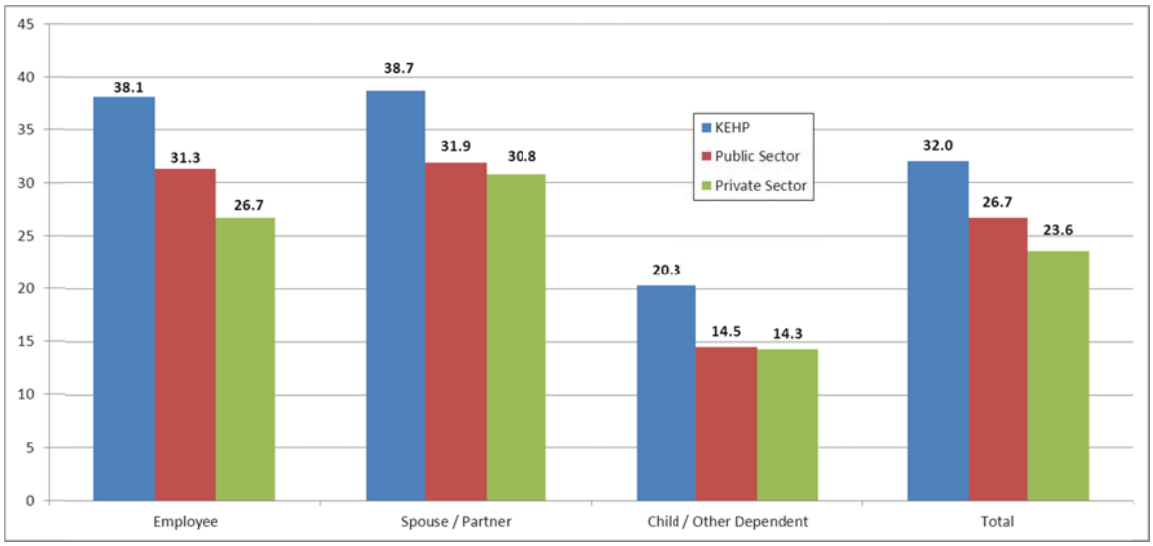


Source: Truven Benchmark Report

Despite the comparable admission rates for those with chronic conditions in exhibit 43, in total the KEHP population has considerable higher admission rates than both the public and private sector for each relationship.

Exhibit 45 compares the outpatient service rates of KEHP members against those in the public and private sectors, split by relationship.

Exhibit 45 – 2012 KEHP Outpatient Services per Member



Source: Truven Benchmark Report

The KEHP population has considerable higher outpatient services per member than both the public and private sector, for each relationship.

FEDERAL HEALTHCARE REFORM

The Patient Protection and Affordable Care Act (PPACA)

The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010, and the related Health Care and Education Reconciliation Act of 2010 (HCER), which modifies certain provisions of PPACA, was signed into law on March 30, 2010. These two statutes made sweeping changes to existing law governing employer-sponsored group health plans, individual health coverage, and governmental health programs. The provisions affect insured and self-insured employer health plans.

The provisions provided by these two statutes generally are added to the Public Health Service Act (PHSA) and are incorporated by reference into the Employee Retirement Income Security Act of 1974, as amended (ERISA). Certain changes are also made to the Internal Revenue Code of 1986, as amended (Code), and the Fair Labor Standards Act (FLSA). Since the law implicates a number of different statutes, various governmental agencies have authority to issue guidance. Much guidance has been released since the law went into effect, with much more still to come. The timeline for reform spans to 2020 with more than 60 major regulatory deadlines that have and continue to be addressed by the Federal government.

The Congressional Budget Office (CBO) originally estimated the cost of PPACA to be $938 billion. Savings and revenues were projected to provide $1.08 trillion, for a net reduction to the federal deficit of $143 billion. Savings and revenues were based on:

- Savings from Medicare Advantage cuts
- Savings from a reduction in the Medicare growth rate
- Savings from the CLASS program (a national Long Term Care program)
- Excise taxes on high cost insurance
- New Medicare taxes on high income individuals
- Penalty payments from Employers not providing coverage for employees
- Penalty payments from Individuals not maintaining minimum coverage for themselves and dependents
- A cap on annual contributions to flexible spending accounts
- Elimination of the Retiree Drug Subsidy tax exclusion
- Fees on insurance companies, pharmaceutical companies and medical devices companies
- Other net savings and net revenues

However, the CLASS program was repealed in October 2011. By law, implementation of this program was contingent on certification by the Secretary of Health and Human Services that the program was financially sound. The secretary, Kathleen Sebelius, reported to congress in October that the program, as designed, was not financially sound. Savings from this program were projected to have been $70 Billion.

Some Key Provisions of PPACA that Impact KEHP

Changes to Health Plans

PPACA creates unprecedented change in the US healthcare system. It impacts all stakeholders in healthcare, including employers, government, payers, providers and pharmaceutical companies. It will have a significant impact on employers, their health plans, and related administration for years to come. Some provisions were already effective, while some were deferred until 2014, and as late as 2018, with many provisions gradually phased-in. For KEHP, many provisions became effective January 1, 2011.

PPACA changes a number of requirements for group health plans and employers who sponsor or administer these plans:

- Plans must offer coverage for the children of covered individuals until age 26, and may opt to continue to do so through the end of the plan year during which they attain age 26.
- Plans may not place lifetime limits on the dollar value of coverage.
- Beginning in 2014, plans may not impose any annual limits on coverage; prior to 2014, only "reasonable" annual limits, as determined by the Secretary, may be imposed.
- Plans may not have waiting periods longer than 90 days.
- Plans must eliminate pre-existing condition exclusions, effective for children under 19 in 2011; effective for adults in 2014.
- Plans may not rescind coverage except in the case of fraud or intentional misrepresentation.
- Out-of-pocket limits may be no greater than current year's health savings account (HSA) out-of-pocket maximums ($6,350 individual, $12,700 family in 2014).
- Employer plans must have an HHS-approved binding external review process.
- Employers will be required to report the aggregate value of health benefits on employees' W-2 Forms beginning with the 2012 tax year.
- Changes to flexible spending accounts (FSAs):
    - The cost of over-the-counter drugs not prescribed by a doctor may not be reimbursed through a stand-alone health reimbursement account (HRA) or health FSA beginning January 1, 2011. KEHP is seeking legal options for stand-alone HRA.
    - Increased penalty for nonqualified HSA or Archer medical savings account (MSA) purchases or distributions increased from 10 to 20 percent, effective for distributions in 2011.
    - The maximum contribution to an FSA will be limited to $2,500 annually, beginning in 2013.
- Discrimination in insured group health plans based on the employee's salary is prohibited. IRS has delayed the application of this requirement until it issues further regulations.
- Self-insured plans are subject to comparative effectiveness fees and reinsurance fees.
- Plans are required to provide coverage for certain in-network preventive health services, including women’s preventive health services, at no cost sharing.
- Employers are required to provide Summary of Benefits and Coverage to participants in writing and free of charge by the first day of coverage, upon renewal or reissuance and upon request.
- Employers are required to provide notice to inform employees of coverage options in the exchange.
- Beginning in 2014, Plans are required to provide benefit coverage for certain routine patient costs for qualified individuals who participate in an approved clinical trial.
- Beginning in 2014, rewards for wellness programs must not exceed 30 percent of the total cost of coverage, except this percentage is increased to 50 percent to the extent that the wellness program is designed to prevent or reduce tobacco use.
- Beginning in 2015, employers are required to provide affordable Minimum Essential Coverage that meets minimum value.
- Beginning in 2015, employers are required to report health insurance information to government and participants.
- Beginning in 2018, a 40 percent excise tax will be imposed on the value of health insurance benefits exceeding a certain threshold.

Mandated Health Insurance Coverage

PPACA requires that most U.S. citizens and legal immigrants have health insurance starting in 2014. This individual mandate provision is enforced by a tax penalty based on income level. Insurance will be offered through state-based Exchanges to be available in 2014. Families with income up to 400% of the federal poverty

level may receive premium tax credits and cost-sharing subsidies for their coverage. PPACA also expands Medicaid eligibility to those with income up to 133% of the federal poverty level.

PPACA imposes penalties on group health plans that do not provide coverage for full-time employees, as well as on plans that have coverage that is inadequate or unaffordable for low-paid employees, beginning in 2014. A full-time employee is defined as an employee working at least 30 hours per week. The penalties vary based on whether or not the employer offers minimum essential coverage and, if so, the employee contribution towards the cost of the coverage compared to the employees' income.

- The penalty for employers who do not offer minimum essential coverage under an eligible employer-sponsored health plan, if at least one full-time employee is enrolled in a qualified health plan under an Exchange and receives a premium tax credit, is $2,000 times the number of full-time employees, excluding the first 30 full-time employees.
- The penalty for employers who do offer minimum essential health insurance coverage (at least 60% actuarial value), but where at least one full-time employee of the employer has enrolled in an Exchange and qualified for a premium tax credit (where employee income is less than 400% of the federal poverty level and the employee share of the premium exceeds 9.5% of income), is $3,000 for each such employee, but not more than $2,000 times the number of full-time employees.
- The penalty amounts will be indexed for inflation.

The Obama Administration announced on July 2, 2013 that the employer mandate will be delayed until 2015, thus giving employers an extra year to comply with the law's complicated hours-tracking and related reporting rules. On July 9, the Internal Revenue Service (IRS) followed up with a Notice (2013-45) spelling out the specifics of the delay.

The delay means that employers will have an additional year to offer health insurance coverage to their full-time employees before the IRS will assess penalties, known as the employer shared responsibility payment. Employers also will have an additional year to comply with the information reporting provisions that require employers to provide information to the IRS regarding the health insurance coverage offered to their full-time employees. That information will, in part, determine whether those employees are entitled to subsidized health insurance and whether employers are liable for an employer shared responsibility payment. It should be noted that the transition relief does not delay the effective date for other provisions of the Affordable Care Act, such as the requirement that individuals purchase health insurance or pay a penalty.

In light of the Individual Mandate, special consideration will need to be made regarding the benefit provided to employees that waive coverage in KEHP. Currently, these employees are provided $175 per month to cover healthcare expenses via a Health Reimbursement Account (HRA). This benefit does not satisfy the requirements for minimum essential coverage and is likely to result in assessment of one of the employer penalties listed above. Further, this "standalone" HRA does not satisfy the requirements for coverage needed for the employee to meet the Individual Mandate provisions in the law.

State Based Health Insurance Exchanges

Beginning in 2014, state-based Exchanges will be available to U.S. citizens and legal immigrants and employers with up to 100 employees to purchase qualified health insurance coverage. After 2017, states may permit larger employers to purchase coverage through their Exchanges. The Exchange must offer the following four categories of plans providing essential health benefits with out-of-pocket maximums equal to the HSA current law, as well as a catastrophic plan for individuals up to age 30:

- Bronze Plan (the standard for "minimum creditable coverage") covers 60% of the benefit costs
- Silver Plan covers 70% the benefit costs
- Gold Plan covers 80% of benefit costs
- Platinum Plan covers 90% of benefit costs

- Catastrophic Plan (for those up to age 30 or those who are exempt from the Individual mandate provisions of the law) provides catastrophic coverage only, based on current law HSA levels, except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is not available to employers.

The out-of-pocket limits are reduced for those with incomes up to 400% of the federal poverty level. Premiums in the exchange may not vary by more than 3 to 1 based on age.

Governor Steve Beshear issued an executive order to create a state-based health benefit exchange to best meet the needs of Kentuckians. Kynect is a program run by the Kentucky Office of the Health Benefit Exchange within the Cabinet for Health and Family Services. Kynect will provide simple, one-stop shopping for individuals and small businesses to purchase health insurance and receive payment assistance or tax credits.

The open enrollment for Kynect began on October 1, 2013, and runs through March 31, 2014, with coverage beginning as soon as January 2014. As of early November 2013, 40,572 members enrolled in new health coverage, including Medicaid and private insurance; 2,610 members enrolled in standalone dental plans; 33,561 members enrolled in Medicaid and 7,011 members enrolled in a qualified health plan.

Early Retiree Reinsurance Program (ERRP)

Congress appropriated $5 billion for a temporary program to reimburse retiree health plans for certain costs of benefits provided to pre-Medicare eligible retirees and their dependents. PPACA provided that the program be established by June 21, 2010, and end no later than January 1, 2014 (the effective date for the new state insurance exchanges), or when the $5 billion appropriation has been exhausted.

The objective of ERRP is to reduce the decline in the number of employers providing health coverage to early retirees, and to provide a bridge to Medicare for early retirees until the state-based exchanges are established.

ERRP provides reimbursement to participating employment-based plans for a portion of the cost of providing health coverage to early retirees and their eligible spouse or surviving spouse and dependents. PPACA provides that a participating employment-based plan that meets the requirements of the Act may submit claims for reimbursement based on the amount spent by the plan for the health benefits provided to an early retiree or the spouse, surviving spouse, or dependent of such retiree. The government will reimburse the plan for 80% of the portion of the costs attributable to the early retiree's claims that exceed $15,000 and are not greater than $90,000. Payments are not taxable to the plan sponsor.

The ERRP defines an "early retiree" as a plan participant who is age 55 and older who is enrolled for health benefits in a certified employment-based plan, who is not eligible for coverage under Medicare and is not an active employee of an employer maintaining or currently contributing to the plan, or of any employer that has made substantial contributions to fund such plan. Early retiree also includes the spouse, surviving spouse, and dependents of these individuals who are enrolled in the plan, regardless of their age or Medicare eligibility status.

The KEHP application was submitted on the first day that applications were being accepted and was in the first group of 2,000 such approved applications as reported by HHS on September 1, 2010. The regulations state that claims reimbursement requests are processed on a "first-come, first-served" basis in the order received from plan sponsors with accepted applications.

A plan sponsor may not use proceeds under ERRP as general revenue for the sponsor, but must use the proceeds:

- To reduce increases in the sponsor's health benefit premiums or health benefit costs,
- To reduce health benefit premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs, or any combination of these costs, for plan participants, or

- Any combination of these.

Plan sponsors who use proceeds from ERRP to reduce their own premiums or costs are required to maintain the level of effort in contributing to support their plans.

The regulations provide that the term "plan participants" for whom costs may be reduced includes all plan participants, including early retirees and active employees, retirees, and their spouses and dependents who participate in the plan. Under the regulations, the plan sponsor may determine how to use the reimbursement; for example, whether to use it to reduce costs immediately or for the next plan year.

As of January 19, 2012, ERRP has received requests for reimbursement that exceed the $5 billion in funding appropriated. Reimbursement requests which exceed the program's $5 billion will be held in the order of receipt, pending the availability of funds that may become available as a result of overpayment recoupment activities. CMS will continue to report the status of payments to plan sponsors periodically. The Commonwealth of Kentucky has received $95 million to date. At this point, $40 million in ERRP funds have been transferred to the KEHP trust fund. Actual ERRP funds needed will be determined by actual expenses incurred in 2013. Any remaining ERRP funds will be transferred to plan year 2014.

"Grandfathered" Health Plans

Under PPACA a group health plan that was in existence on March 23, 2010 and does not change plan designs or employee cost beyond certain limits identified in the regulations can be considered a "Grandfathered Health Plan". Grandfathered status permits the group health plan to be exempted from several of the PPACA requirements for as long as the plan remains grandfathered. KEHP, like most group health plans, has evaluated the advantages and disadvantages of continuing grandfathered status and concluded that grandfathered status will be maintained as long as this is a financially viable option. Because PPACA limits the amounts that a group health plan can change benefits provisions and employee contributions, most plan sponsors anticipate that they will lose grandfathered status in order to remain financially stable.

When grandfathered status is lost due to the changes mentioned above, the health plan will be required to comply with the following provisions of PPACA:

- Coverage of preventive benefits as defined by regulation with no participant cost sharing
- Implementation of the required external appeals process
- Reporting health plan information on plan costs, programs and outcomes to the federal government
- Non-discrimination requirements
- Coverage of adult children to age 26, even if they have other coverage available
- Coverage for individuals participating in approved clinical trials
- Other patient protections

KEHP maintained grandfathered status for 2013.

KEHP will address future PPACA challenges and opportunities according to the following timeline.

2013	2014	2018
• **Notice to Inform Employees of Coverage Options in Exchange** • **Limit of Health Care FSA Contributions to $2,500 (Indexed)** • **Elimination of Deduction for Expenses Allocable to Retiree Drug Subsidy (RDS)** • **Medicare Tax on High Income** • **Addition of women's preventive health requirements to No Cost Sharing and Coverage for Certain In-Network Preventive Health Services ****	• **Individual Shared Responsibility Payment** • **State Insurance Exchanges** • **Employer Responsibility to Provide Affordable Minimum Essential Coverage that meets MV*** *(DELAYED)*** • **Preexisting Conditions Exclusions Prohibited*** • **Annual Dollar Limits on EHB Prohibited*** • **Automatic Enrollment (*DELAYED)*** • **Limit of 90-Day Waiting Period for Coverage*** • **Employer Reporting of Health Insurance Information to Government and Participants *(DELAYED)*** • **Increased Cap on Rewards for Participation in Wellness Program**** • **OOP Maximum Limits and Rules**** • **Transitional reinsurance contributions** • **Coverage in approved clinical trials**** • **Provider non-discrimination**** • **Transparency reporting**(*DELAYED)*** • **More Taxes (Devices, Insurer, etc.)**	• **Excise Tax on High-Cost Coverage**

**Denotes group/insurance market reforms applicable to all group health plans.*
***Denotes group/insurance market reforms **not** applicable to grandfathered health plans.*
**** This requirement applies to Full-Time employees (e.g., 30 hours per week) and will require coverage that is affordable and satisfies a certain actuarial value to avoid the penalty. Guidance forthcoming.*

Some Key Considerations

On one level, PPACA does not represent radical change from the existing health system. PPACA still relies on employers, private health plans, and existing public programs to provide the fundamental foundation to health security for Americans. On another level, the rules and economics of that foundation have changed and require a "new look" at employers' benefits, rewards and health strategies. While PPACA reforms are mainly focused on regulation and expansion of coverage, employer-based plans still face the challenges associated with rising health care costs and deteriorating population health. After short term efforts to comply with immediate requirements, employers are recalibrating their longer term strategies based on a new set of underlying dynamics. What has been unthinkable in how employers approach benefits in the past will change in the very near future.

Going forward, employer costs are expected to rise 60% on a "stand still" basis with the following upward pressures:

- Demographics
- Obesity-related chronic illness—including children
- New therapies and technologies
- Cost shift from Medicare / Medicaid
- Industry fee pass-throughs
- New coverage provisions
- Individual mandate

These upward pressures may be mitigated with the following downward pressures:

- Plan design value
- Discretionary purchasing
- Uncompensated care
- Brand drug patent expirations
- Focused care management

- Investments in health

Employers will have to decide whether they want to be involved in aggressive health management or whether they want to provide subsidies to employees to receive coverage on an exchange. Down either path, employers have a persistent need to have a workforce that is healthy, present, and productive. This is imperative for all businesses.

Aggressive Health Management involves:

- Heavy emphasis on health risk improvement and cost management
- Sophisticated use of data analytics to drive design, program management, vendor accountability
- Migration from incentives to penalties and "requirement gates" to access better benefits
- Alignment with pay for performance business culture

Managed Defined Contribution involves:

- Subsidy fixed with company-driven increase
- Coverage via individual market (private or public Exchanges)
- Worksite health shifts to focus on return to work, absence reduction, productivity gains

Many health benefits strategies that employers are executing on today can be accelerated if properly integrated and synergized with broader system reforms. By understanding the broader context of health reform, employers can help to facilitate and ensure that all stakeholders are better aligned and integrated around the universal objective of improved health and better value.

All stakeholders will benefit over the long run if strategies and approaches are integrated, and transformational changes may finally be possible. Some examples are provided below:

- *Wellness* - Current employer efforts can be enhanced with the availability of more universal preventive care, increased incentives as well as the opportunity to integrate with community-wide efforts focused on improving health behaviors.
- *Consumerism* - As health information technology enables more connectivity in the delivery system and provider performance becomes measurable and transparent, real data can better define value in the system and drive better and more informed consumer engagement.
- *Value Based Design* - Over time, a commitment to study the comparative effectiveness of treatments will help to ensure more thoughtful designs and utilize behavioral economics to reward more effective care and discourage care with less value.
- *Integrated Health* - Traditional approaches to disease and case management may be restructured as new approaches to integrated health emerge in the form of Accountable Care Organizations and Patient-Centered Medical Homes.

Continued leadership by employers and plan sponsors will be critical to the long term success of sustainable health system reforms. Collaboration among providers, payors and employers will be key to achieving breakthroughs in health information technology, transparency in value, coordinated care processes and improved prevention and wellness efforts. Without this collaborative approach the critical health system transformation objectives of health reform may not be achievable.

BOARD RECOMMENDATIONS

For this year's report, Board members were surveyed and ranked the importance of their Guiding Principles. The Board recommends that the KEHP continue to follow the guiding principles stated below, presented in ranked order importance:

1. Provide uniform coverage across the Commonwealth
2. Encourage wellness and healthy lifestyles
3. Provide preventive care at little or no cost
4. Strive to hold down costs for family and dependent coverage, while balancing the management of the single subscriber's (planholder's) premium level as top priority
5. Improve chronic disease care
6. Educate members about plans that are more appropriate for their health needs
7. Provide members with quality PPO and consumer-driven options
8. Provide plan alternatives that are accessible for retirees

Based on the results of the prior year survey of Board members, the Board continues to support many of the recommendations made in the Twelfth Annual Report. These recommendations are detailed below along with a summary of progress made over the course of this year in furthering objectives.

- KEHP should continue to explore alternative methods for controlling and managing the cost of the plans and improving the health of members. A study of alternative approaches for health improvement (wellness initiatives), prevention of chronic conditions and other critical programs across the spectrum of members' health needs should be evaluated. Approaches that align incentives to encourage members' health behavior changes and providers' improved support for wellness should be evaluated. Resource requirements and potential outcomes of varying approaches should be considered.

  DEI implemented HumanaVitality (HV) on January 1, 2012 to provide a robust wellness program. The implementation of HumanaVitality was strategic with a goal in increasing personal health awareness for KEHP members.

  The HV program assists members to identify their health/lifestyle risks, set goals/identify activities for improving their risks and earn rewards for meeting goals and engaging in healthy behaviors. The program then provides a customized pathway for each member that will engage them to take action to improve their health, regardless of their risk level. The program is highly data-driven and provides sufficient incentives and options to encourage and continuously stimulate member engagement.

  Engagement in HumanaVitality continues to grow and KEHP expects that trend to continue in the future.

  DEI continues to evaluate data and information related to the plan's cost, members' use of services, and the clinical conditions prevalent in the population. Challenges and opportunities for improving both the cost to the plan and members and for improving members' health have been evaluated and implemented. Several strategic alternatives, including implementing approaches to improve and integrate disease and care management programs, strategies to increase the use of generic drugs and manage specialty drug use, and the continued expansion of wellness and prevention programs will continue to be evaluated and implemented as opportunities arise.

- KEHP should evaluate programs and options for improving the clinical and administrative quality of programs and services. This study should consider practical steps to evaluate and improve

administrative services including claims payment, customer service and others. It should consider programs to measure and improve quality of care currently available in the marketplace.

DEI changed disease management vendors effective January 1, 2013 moving from ActiveHealth Management to HumanaHealth. HumanaHealth is a fully integrated disease management platform. Program enhancements with implementation of HumanaHealth include behavioral health, onsite case management nurses, metabolic syndrome and diabetes pilot programs, maternity management and weight management.

In 2013, Aon Hewitt performed an operational audit of Humana as well as a full claim review including all Express Scripts claims paid during the 2012 plan year. Both audits revealed overall positive results but some changes and improvements have been made to improve the KEHP's operations and/or contractual arrangement with vendors.

- KEHP should develop a plan to improve communications directly to members and through Insurance Coordinators. The plan should consider different types of communications for different groups of members (internet communications, mailings, other) based on the best potential success with each group.

  DEI, with the assistance of the Personnel Cabinet, Center for Strategic Innovation, continues to focus on improved communications with KEHP members. This includes an extensive campaign (in conjunction with HumanaVitality) to promote the new wellness program and encourage engagement and participation. Communications have been e-mailed directly to members and continue to be provided through Insurance Coordinators. In 2013, the Personnel Cabinet and KEHP websites were completely revamped, and a focus on improved communications will continue. Moreover, KEHP implemented webinars and is currently considering social media options.

- Pursuant to KRS 18A.2254(3)(a), there are significant limitations on the use of any of the prior year trust fund surplus balances. Members of the Board noted that KRS 18A.2254(3)(a) has an effect on the level of plan reserves that should be maintained. Board members further discussed that adequate funds should continue to be budgeted by the General Assembly and adequate plan reserves should be maintained by the Trust to address annual healthcare inflation.

  The Board acknowledges that adequate reserves are necessary for all self-insured plans. It was requested by Board members that the actuary determine what adequate reserves are needed for self-funded plans similar to the Kentucky Employees' Health Plan bearing in mind the statutory limitations of using prior year surplus balances.

  DEI works with Aon Hewitt to develop a funding strategy that will ensure that KEHP obligations will be covered by revenue. The economic downturn has placed budget pressures on all states and benefit plans.

- KEHP should continue to study and evaluate the impact of any federal healthcare reform measures as the scope and detail of reform programs continue to develop and regulations and guidance emerge.

  DEI, working with Aon Hewitt, evaluated the impact of federal healthcare reform law and regulations as information became available. DEI will continue to evaluate the emerging impact of the law as regulations are finalized and market impact information becomes available.

- Increasing focus on wellness initiatives

  HumanaVitality was implemented January 1, 2012 as the KEHP's new comprehensive wellness initiative. Humana, HumanaVitality and DEI all have an increased commitment and focus on KEHP wellness programs and HumanaVitality. Due to the fact that KEHP members are in every city and county of the Commonwealth, a comprehensive and strategic approach to reaching membership is necessary. The Personnel Cabinet, Center for Strategic Innovation, DEI and HumanaVitality meet on a regular basis to

review progress, plan and strategize about KEHP wellness. HumanaVitality increased field staff when it became apparent that face-to-face engagement was very effective. Efforts are underway to engage leadership groups, the retirement systems, school districts by having onsite health assessment and screenings events to educate KEHP members about HumanaVitality.

In 2013, engagement in HumanaVitality continues to grow and KEHP expects that trend to continue in the future.

- Improving education of membership about plan options, mechanics of healthcare, and selecting the most appropriate plan option and medical services.

  DEI continues the use of the Benefits Analyzer tool to better educate KEHP members about the plan options and levels of coverage that may be ideal for their personal circumstances. DEI mails Benefits Analyzer letters each year before Open Enrollment process. KEHP Benefits Analyzer is a tool that helps KEHP members select the right health insurance plan based on their specific healthcare needs and finances. The Benefits Analyzer allows KEHP members to review their "real" past claims history and healthcare spending and run those claims through the health plan options offered. The analyzer will help KEHP members consider both "out-of-paycheck" costs and "out-of-pocket" healthcare costs in selecting the plan that might be the best choice for them.

- Continue to explore making the healthcare system, including cost, more transparent and easier to understand by membership.

  DEI continues efforts to better educate KEHP membership on consumer-driven health plans and of health care and pharmaceutical costs. To that end, DEI provides, though Express Scripts, Inc., each KEHP member a pharmacy benefits statement that includes all the member's prescriptions and the true cost of each medication.

APPENDIX

KEHP Program Changes & Plan Design Provisions by Year

Beginning in 1999, the KEHP 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 KEHP 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 KEHP program changed as follows:
  - Aetna was re-introduced as a healthcare option for the KEHP 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 KEHP 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 KEHP 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 KEHP 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 KEHP 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 KEHP 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 KEHP program members by fourteen counties.
  - Aetna was discontinued as an offering for KEHP 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 countries.
  - 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.

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 pre-certified 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 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 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 pre-certified 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)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
		$400 maximum benefit per year		$300 maximum benefit per year	
	Diagnostic Testing (per visit) - laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; 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 pre-certified 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	Co-pay 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 pre-certified 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

In 2003:

- Again, in response to requests from Legislators and members of the KEHP 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 KEHP 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, KEHP 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 KEHP employees and retirees to one state subsidy for health insurance,
    - required entities participating in the KEHP program to sign a contract with the Personnel Cabinet, and
    - Allowed KEHP 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).

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 pre-certified by Plan.	Covered same as Medicare benefit.	Covered same as Medicare benefit.
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $10 co-pay 50% co-insurance	 $20 co-pay 50% co-insurance
	Physical Therapy (per visit)–Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Occupational Therapy (per visit)–Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Cardiac Rehabilitation Therapy (per visit)–Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Speech Therapy (per visit)–Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Skilled Nursing Facility (per admission)–Limit 30 days per year.	$100 co-pay	$250 co-pay

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

2003 Public Employee Health Insurance Program Benefit Provisions (continued)

POS Plans				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	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 • 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 pre-certified 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 B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		Single: $250 Family: $500	Single: $500 Family: $1,000	Single: $500 Family: $1,000	Single: $1,000 Family: $2,000
Maximum out-of-pocket for Covered Expenses (including deductible)	Co-payments for office visits, hospital emergency room visits, urgent care center visits services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits.	Single: $1,250 Family: $2,500	Single: $2,500 Family: $5,000	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit)–visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
		$400 maximum benefit per year		$300 maximum benefit per year	
	Diagnostic Testing (per visit)–laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Emergency Services	Hospital Emergency Room–$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay plus 20% co-ins	$50 co-pay plus 40% co-ins	$50 co-pay plus 25% co-ins	$50 co-pay plus 50% co-ins
	Emergency Room Physician	20% co-ins	40% co-ins	25% co-ins	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins*	20% co-ins*	25% co-ins*	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed.	$10 co-pay Hospital in-patient co-ins also applies.*	40% co-ins*	25% co-ins* Hospital in-patient co-ins also applies.*	50% co-ins*
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary		$20 generic $30 brand $60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric–Only covered in conjunction with a disease, illness or injury.	50% co-ins*		Not covered	
	Chiropractor (per visit)–No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Home Health	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
		Limit 60 visits per year.		Limit 40 visits per year.	
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • 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 pre-certified 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 childcare, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	$25 co-pay (per visit)
	Ambulatory Hospital and Outpatient Surgery (per visit)–outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$500 co-pay (per visit)
	Diagnostic Testing (per visit)–laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$25 co-pay (per visit)
	Preventive Testing* – Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA.	50% co-insurance
	Immunizations*–All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults.	50% co-insurance
Emergency Services	Hospital Emergency Room (per visit)–Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$75 co-pay (per visit)
	Urgent Care Center (not hospital emergency room) (per visit)	$50 co-pay (per visit)
	Ambulance (per use)	$75 co-pay (per visit)
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval.	$25 co-pay (per visit) Hospital in-patient co-pay also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.	$25 generic $35 brand $50 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$50 generic $70 brand $100 non-formulary
Dental		Not covered
Vision		Not covered
Other Services	Audiometric	Not covered
	Chiropractor (per visit)–No referral is necessary. Limit of 15 visits per year. No more than one visit per day.	50% co-insurance Limit 15 visits per year.
	Durable Medical Equipment (DME) and Prosthetic Devices	50% coinsurance
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	50% coinsurance
	Home Health	Covered in full. Limit 20 visits per year.
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $25 co-pay (per visit) 50% co-insurance
	Hospice–Certain limits apply. Must be pre-certified 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.

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 KEHP program. This affected sixteen counties where Anthem offered PPO coverage to KEHP members in 2003
- Humana:
  - Discontinued offering HMO or POS options to KEHP 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 KEHP 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 KEHP 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 KRS participants to be eligible to participate in the KEHP program was increased from five years to ten years for individuals hired on or after July 1, 2003.

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	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 pre-certified by Plan.	Covered same as Medicare benefit.	Covered same as Medicare benefit.
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $10 co-pay 50% co-insurance	 $20 co-pay 50% co-insurance
	Physical Therapy (per visit)–Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Occupational Therapy (per visit)–Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Cardiac Rehabilitation Therapy (per visit)–Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Speech Therapy (per visit)–Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Skilled Nursing Facility (per admission)–Limit 30 days per year.	$100 co-pay	$250 co-pay

2004 Public Employee Health Insurance Program Benefit Provisions (continued)

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

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).

  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.

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%	
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 Preferred Brand Non-preferred Brand	$10 / $25 $20 / $50 $35 / $100	
Prescription drugs – Mail Order (90 day supply)	25%	
	Min / Max	
Generic Preferred Brand Non-preferred Brand	$20 / $50 $40 / $100 $70 / $200	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*
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 pre-certification 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%*
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 in-hospital care co-insurance applies*	40%*	$10 co-pay in-hospital care co-insurance applies*	30%*
Prescription drugs – Retail (30 day supply) Generic Preferred Brand Non-preferred Brand	 $10** $15** $30**	 40% 40% 40%	 $10** $15** $30**	 30% 30% 30%
Prescription drugs – Mail Order (90 day supply) Generic Preferred Brand Non-preferred Brand	 $20 $30 $60		 $20 $30 $60	
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 pre-certification 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.

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.

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%	
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	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*
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 pre-certification 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%*
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 in-hospital care co-insurance applies*	40%*	$10 co-pay in-hospital care co-insurance applies*	30%*
Prescription drugs – Retail (30 day supply) Generic Preferred Brand Non-preferred Brand	 $5** $15** $30**	 40% 40% 40%	 $5** $15** $30**	 30% 30% 30%
Prescription drugs – Mail Order (90 day supply) Generic Preferred Brand Non-preferred Brand	 $10 $30 $60		 $10 $30 $60	
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 pre-certification 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.

In 2007:

- The Commonwealth offered an additional 4th benefit plan option, Commonwealth Select. Commonwealth Select is a high-deductible PPO with an embedded Health Reimbursement Arrangement (HRA) funded by the employer, as follows:
  - Single coverage – $1,000 contributed to the HRA;
  - Couple coverage – $1,500 contributed to the HRA;
  - Parent-Plus coverage – $1,500 contributed to the HRA; and
  - Family coverage – $2,000 contributed to the HRA.
- Contracts with Humana (medical claims administration, flexible benefits, disease management, case management & utilization management, and HIPAA/COBRA administration) and Express Scripts, Inc. (pharmacy benefit administration) were maintained as in 2006. The current contracts expire June 30, 2008, and have eight (8) one-year renewal options.
- For the Essential, Enhanced, and Premier Plans, the benefits remained unchanged from the 2006 plan year.

2007 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Essential		Commonwealth Enhanced	
	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 - $750 Family - $1,500	Single - $1,500 Family - $3,000	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 - $3,500 Family - $7,000	Single - $7,000 Family - $14,000	Single - $1,250 Family - $2,500	Single - $2,500 Family - $5,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Not Applicable	
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	25%*	50%*	20%*	40%*
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).	25%*	50%*	$10 co-pay	40%*
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).	25%*	50%*	$10 co-pay	40%*
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%*	20%*	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%		$10 co-pay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$50 co-pay plus 25%*	$50 co-pay plus 50%*	$50 co-pay plus 20%	$50 co-pay plus 40%
Emergency room physician charges	25%*	50%*	20%	40%
Urgent care center treatment	25%*	50%*	$20 co-pay	40%*
Ambulance services	25%*	25%*	20%*	20%*
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.	25%*	50%*	$10 co-pay in-hospital care co-insurance applies*	40%*
Prescription drugs – Retail (30 day supply)	25% Min / Max			
Generic	$10 / $25		$5	40%
Preferred Brand	$30 / $50		$15**	40%
Non-preferred Brand	$35 / $100		$30**	40%
Prescription drugs – Mail Order (90 day supply)	25% Min / Max			
Generic	$20 / $50		$10	
Preferred Brand	$60 / $100		$30	
Non-preferred Brand	$70 / $200		$60	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*	$10 co-pay	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	25%*	50%*	$10 co-pay	40%*
▪ Respite care for children ages two through 21 ($500 maximum per month)	25%*	50%*	50%*	50%*
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*	20%*	40%*
Prosthetic devices	25%*	50%*	20%*	40%*
Home health – limited to 60 visits per year	25%*	50%*	20%*	40%*
Physical therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Occupational therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Speech therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*	20%*	40%*
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%*	20%*	40%*

*Subject to annual deductible

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

2007 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	Commonwealth Premier		Commonwealth Select	
	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 - $2,000 Family - $3,000	Single - $2,000 Family - $3,000
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - $1,000 Family - $2,000	Single - $2,000 Family - $4,000	Single - $3,000 Family - $4,500	Single - $4,000 Family - $6,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $1,000 Parent Plus - $1,500 Couple - $1,500 Family - $2,000	
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	10%*	30%*	10%*	40%*
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	30%*	10%*	40%*
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	30%*	10%*	40%*
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.	10%*	30%*	10%*	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	$10 co-pay per visit	30%*	Plan pays 100%	
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$50 co-pay plus 10%	$50 co-pay plus 30%*	10%*	40%*
Emergency room physician charges	10%	30%*	10%*	40%*
Urgent care center treatment	$20 co-pay	30%*	10%*	40%*
Ambulance services	10%*	10%*	10%*	10%*
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*	30%*	10%*	40%*
Prescription drugs – Retail (30 day supply) Generic Preferred Brand Non-preferred Brand	 $5** $15** $30**	 30% 30% 30%	 10% 10% 10%	 30% 30% 30%
Prescription drugs – Mail Order (90 day supply) Generic Preferred Brand Non-preferred Brand	 $10 $30 $60		 10% 10% 10%	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	$10 co-pay	30%*	10%*	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	$10 co-pay	30%*	10%*	40%*
▪ Respite care for children ages two through 21 ($500 maximum per month)	10%*	30%*	10%*	40%*
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	10%*	30%*	10%*	40%*
Prosthetic devices	10%*	30%*	10%*	40%*
Home health – limited to 60 visits per year	10%*	30%*	10%*	40%*
Physical therapy – limited to 30 visits per year	10%*	30%*	10%*	40%*
Occupational therapy – limited to 30 visits per year	10%*	30%*	10%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	10%*	30%*	10%*	40%*
Speech therapy – limited to 30 visits per year	10%*	30%*	10%*	40%*
Skilled nursing facility services – limited to 30 days per year	10%*	30%*	10%*	40%*
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	10%*	30%*	10%*	40%*

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

In 2008:

- The Commonwealth offered the same four benefit plans which were offered in 2007. The plans are:
  - Commonwealth Premier – a $250/$500 Deductible PPO plan;
  - Commonwealth Enhanced – a $250/$500 Deductible PPO plan;
  - Commonwealth Essential – a $750/$1,500 Deductible PPO plan;
  - Commonwealth Select – a $2,000/$3,000 Deductible consumer-driven plan with an embedded Health Reimbursement Account (HRA).
- The contracts with Humana (medical claims administration, flexible benefits, disease management, case management & utilization management, and HIPAA/COBRA administration) and Express Scripts, Inc. (pharmacy benefit administration) were renewed through December 31, 2009.
- $54,000,000 in surplus funds from the 2006 plan year was used to lower the overall increases in 2008 employer and employee contributions from 10.40% to 5.80%.
- The incentive for employees who don't smoke was continued, with a $15 per month incentive for employees with single (employee-only) coverage, and a $30 per month incentive for employees who cover their dependents.
- The Commonwealth's contribution for employees who waive coverage was maintained at $175 per month, the same amount as in 2007.

2008 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Essential		Commonwealth Enhanced	
	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 - $750 Family - $1,500	Single - $1,500 Family - $3,000	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 - $3,500 Family - $7,000	Single - $7,000 Family - $14,000	Single - $1,250 Family - $2,500	Single - $2,500 Family - $5,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Not Applicable	
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	25%*	50%*	20%*	40%*
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).	25%*	50%*	$10 co-pay	40%*
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).	25%*	50%*	$10 co-pay	40%*
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%*	20%*	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%		$10 co-pay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$50 co-pay plus 25%*	$50 co-pay plus 50%*	$50 co-pay plus 20%	$50 co-pay plus 40%
Emergency room physician charges	25%*	50%*	20%	40%
Urgent care center treatment	25%*	50%*	$20 co-pay	40%*
Ambulance services	25%*	25%*	20%*	20%*
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.	25%*	50%*	$10 co-pay in-hospital care co-insurance applies*	40%*
Prescription drugs – Retail (30 day supply)	25%			
	Min / Max			
Generic	$10 / $25		$5	40%
Preferred Brand	$20 / $50		$15**	40%
Non-preferred Brand	$35 / $100		$30**	40%
Prescription drugs – Mail Order (90 day supply)	25%			
	Min / Max			
Generic	$20 / $50		$10	
Preferred Brand	$40 / $100		$30	
Non-preferred Brand	$70 / $200		$60	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*	$10 co-pay	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	25%*	50%*	$10 co-pay	40%*
▪ Respite care for children ages two through 21 ($500 maximum per month)	25%*	50%*	50%*	50%*
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*	20%*	40%*
Prosthetic devices	25%*	50%*	20%*	40%*
Home health – limited to 60 visits per year	25%*	50%*	20%*	40%*
Physical therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Occupational therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Speech therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*	20%*	40%*
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%*	20%*	40%*

*Subject to annual deductible

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

2008 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	Commonwealth Premier		Commonwealth Select	
	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 - $2,000 Family - $3,000	Single - $2,000 Family - $3,000
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - $1,000 Family - $2,000	Single - $2,000 Family - $4,000	Single - $3,000 Family - $4,500	Single - $4,000 Family - $6,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $1,000 Parent Plus - $1,500 Couple - $1,500 Family - $2,000	
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	10%*	30%*	10%*	40%*
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	30%*	10%*	40%*
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	30%*	10%*	40%*
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.	10%*	30%*	10%*	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	$10 co-pay per visit	30%*	Plan pays 100%	
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$50 co-pay plus 10%	$50 co-pay plus 30%*	10%*	40%*
Emergency room physician charges	10%	30%*	10%*	40%*
Urgent care center treatment	$20 co-pay	30%*	10%*	40%*
Ambulance services	10%*	10%*	10%*	10%*
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*	30%*	10%*	40%*
Prescription drugs – Retail (30 day supply) Generic Preferred Brand Non-preferred Brand	 $5** $15** $30**	 30% 30% 30%	 10%* 10%* 10%*	 40%* 40%* 40%*
Prescription drugs – Mail Order (90 day supply) Generic Preferred Brand Non-preferred Brand	 $10 $30 $60		 10%* 10%* 10%*	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	$10 co-pay	30%*	10%*	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	$10 co-pay	30%*	10%*	40%*
▪ Respite care for children ages two through 21 ($500 maximum per month)	10%*	30%*	10%*	40%*
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	10%*	30%*	10%*	40%*
Prosthetic devices	10%*	30%*	10%*	40%*
Home health – limited to 60 visits per year	10%*	30%*	10%*	40%*
Physical therapy – limited to 30 visits per year	10%*	30%*	10%*	40%*
Occupational therapy – limited to 30 visits per year	10%*	30%*	10%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	10%*	30%*	10%*	40%*
Speech therapy – limited to 30 visits per year	10%*	30%*	10%*	40%*
Skilled nursing facility services – limited to 30 days per year	10%*	30%*	10%*	40%*
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	10%*	30%*	10%*	40%*

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

In 2009:

- The Commonwealth continued to offer four benefit plans; however, plans were re-designed and re-named.
  - Commonwealth Standard PPO – a $750/$1,500 Deductible PPO plan (formerly Commonwealth Essential, benefits remained the same);
  - Commonwealth Capitol Choice – a $500/$1,500 Deductible hybrid PPO plan with an up-front benefit allowance of $500 per member (new in 2009);
  - Commonwealth Optimum PPO – a $250/$500 Deductible PPO plan (new in 2009, combined the former Enhanced and Premier plans);
  - Commonwealth Maximum Choice – a $2,000/$3,000 Deductible consumer-driven plan with an embedded Health Reimbursement Account (HRA) (formerly Commonwealth Select, benefits remained the same).
- The Commonwealth's contribution for employees who waive coverage was maintained at $175 per month, the same amount as in 2008.

2009 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Standard PPO		Commonwealth Capitol Choice	
	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 - $750 Family - $1,500	Single - $1,500 Family - $3,000	Single - $500 Family - $1,500	Single - $1,000 Family - $3,000
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - $3,500 Family - $7,000	Single - $7,000 Family - $14,000	Single - $2,000 Family - $6,000	Single - $4,000 Family - $12,000
Up-Front Benefit Allowance	Not Applicable		$500/family member	Not Applicable
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Not Applicable	
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	25%*	50%*	$100 co-pay plus 0%*	40%*
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).	25%*	50%*	20%*	40%*
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).	25%*	50%*	20%*	40%*
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%*	$50 co-pay plus 0%*	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%		$15 co-pay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$50 co-pay plus 25%*	$50 co-pay plus 50%*	$100 co-pay plus 0%*	$100 co-pay plus 0%*
Emergency room physician charges	25%*	50%*	0%*	0%*
Urgent care center treatment	25%*	50%*	$50 co-pay	40%*
Ambulance services	25%*	25%*	20%*	20%*
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.	25%*	50%*	$15 co-pay in-hospital care co-insurance applies*	40%*
Prescription drugs – Retail (30 day supply)	25% Min / Max			
Generic Preferred Brand Non-preferred Brand	$10 / $25 $20 / $50 $35 / $100		$5 $20** $40**	
Prescription drugs – Mail Order (90 day supply)	25% Min / Max			
Generic Preferred Brand Non-preferred Brand	$20 / $50 $40 / $100 $70 / $200		$10 $40 $80	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*	$15 co-pay	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	25%*	50%*	20%*	40%*
▪ Respite care for children ages two through 21 ($500 maximum per month)	25%*	50%*	20%*	40%*
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*	20%*	40%*
Prosthetic devices	25%*	50%*	20%*	40%*
Home health – limited to 60 visits per year	25%*	50%*	20%*	40%*
Physical therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Occupational therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Speech therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*	20%*	40%*
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%*	20%*	40%*

*Subject to annual deductible

** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $15 preferred brand and $30 non-preferred brand.

2009 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	Commonwealth Optimum PPO		Commonwealth Maximum Choice	
	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 - $2,000 Family - $3,000	Single - $2,000 Family - $3,000
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - $1,125 Family - $2,250	Single - $2,250 Family - $4,500	Single - $3,000 Family - $4,500	Single - $4,000 Family - $6,000
Up-Front Benefit Allowance	Not Applicable		Not Applicable	
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $1,000 Parent Plus - $1,500 Couple - $1,500 Family - $2,000	
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	15%*	30%*	10%*	40%*
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	30%*	10%*	40%*
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	30%*	10%*	40%*
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.	15%	30%*	10%*	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	$10 co-pay per visit	30%*	Plan pays 100%	
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$50 co-pay plus 15%*	$50 co-pay plus 30%*	10%*	40%*
Emergency room physician charges	15%	30%*	10%*	40%*
Urgent care center treatment	$20 co-pay	30%*	10%*	40%*
Ambulance services	15%*	15%*	10%*	10%*
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*	30%*	10%*	40%*
Prescription drugs – Retail (30 day supply) Generic Preferred Brand Non-preferred Brand	 $5** $20** $40**	 30% 30% 30%	 10%* 10%* 10%*	 40%* 40%* 40%*
Prescription drugs – Mail Order (90 day supply) Generic Preferred Brand Non-preferred Brand	 $10 $40 $80		 10%* 10%* 10%*	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	$10 co-pay	30%*	10%*	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	$10 co-pay	30%*	10%*	40%*
▪ Respite care for children ages two through 21 ($500 maximum per month)	15%*	30%*	10%*	40%*
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	15%*	30%*	10%*	40%*
Prosthetic devices	15%*	30%*	10%*	40%*
Home health – limited to 60 visits per year	15%*	30%*	10%*	40%*
Physical therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Occupational therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Speech therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Skilled nursing facility services – limited to 30 days per year	15%*	30%*	10%*	40%*
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	15%*	30%*	10%*	40%*

*Subject to annual deductible
** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $15 preferred brand and $30 non-preferred brand.

In 2010:

- The Commonwealth offered the same four benefit plans which were offered in 2009 with slight changes to benefit designs. The plans are:
  - Commonwealth Standard PPO – a $500/$1,500 Deductible PPO plan (changed from $750/$1,500 in 2009);
  - Commonwealth Capitol Choice – a $500/$1,500 Deductible hybrid PPO plan with an up-front benefit allowance of $500 per member;
  - Commonwealth Optimum PPO – a $300/$600 Deductible PPO plan (changed from $250/$500 in 2009);
  - Commonwealth Maximum Choice – a $2,000/$3,000 Deductible consumer-driven plan with an embedded Health Reimbursement Account (HRA).
- The Commonwealth's contribution for employees who waive coverage was maintained at $175 per month, the same amount as in 2009.

2010 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Standard PPO		Commonwealth Capitol Choice	
	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 - $500 Family - $1,500	Single - $1,500 Family - $3,000	Single - $500 Family - $1,500	Single - $1,000 Family - $3,000
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - $3,500 Family - $7,000	Single - $7,000 Family - $14,000	Single - $2,000 Family - $6,000	Single - $4,000 Family - $12,000
Up-Front Benefit Allowance	Not Applicable		$500/family member	Not Applicable
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Not Applicable	
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	25%*	50%*	$100 co-pay plus 0%*	40%*
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).	25%*	50%*	20%*	40%*
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).	25%*	50%*	20%*	40%*
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%*	$50 co-pay plus 0%*	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%		$15 co-pay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$50 co-pay plus 25%*	$50 co-pay plus 50%*	$100 co-pay plus 0%*	$100 co-pay plus 0%*
Emergency room physician charges	25%*	50%*	0%*	0%*
Urgent care center treatment	25%*	50%*	$50 co-pay	40%*
Ambulance services	25%*	25%*	20%*	20%*
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.	25%*	50%*	$15 co-pay in-hospital care co-insurance applies*	40%*
Prescription drugs – Retail (30 day supply)	25% Min / Max			
Generic Preferred Brand Non-preferred Brand	$10 / $25 $20 / $50 $35 / $100		$5 $20** $40**	
Prescription drugs – Mail Order (90 day supply)	25% Min / Max			
Generic Preferred Brand Non-preferred Brand	$20 / $50 $40 / $100 $70 / $200		$10 $40 $80	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*	$15 co-pay	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	25%*	50%*	20%*	40%*
▪ Respite care for children ages two through 21 ($500 maximum per month)	25%*	50%*	20%*	40%*
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*	20%*	40%*
Prosthetic devices	25%*	50%*	20%*	40%*
Home health – limited to 60 visits per year	25%*	50%*	20%*	40%*
Physical therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Occupational therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Speech therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*	20%*	40%*
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%*	20%*	40%*

*Subject to annual deductible

** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $15 preferred brand and $30 non-preferred brand.

2010 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	Commonwealth Optimum PPO		Commonwealth Maximum Choice	
	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 - $300 Family - $600	Single - $600 Family - $1,200	Single - $2,000 Family - $3,000	Single - $2,000 Family - $3,000
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - $1,125 Family - $2,250	Single - $2,250 Family - $4,500	Single - $3,000 Family - $4,500	Single - $4,000 Family - $6,000
Up-Front Benefit Allowance	Not Applicable		Not Applicable	
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $1,000 Parent Plus - $1,500 Couple - $1,500 Family - $2,000	
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	15%*	30%*	10%*	40%*
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	30%*	10%*	40%*
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	30%*	10%*	40%*
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.	15%*	30%*	10%*	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	$10 co-pay per visit	30%*	Plan pays 100%	
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$75 co-pay plus 15%*	$75 co-pay plus 30%*	10%*	40%*
Emergency room physician charges	15%	30%*	10%*	40%*
Urgent care center treatment	$20 co-pay	30%*	10%*	40%*
Ambulance services	15%*	15%*	10%*	10%*
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*	30%*	10%*	40%*
Prescription drugs – Retail (30 day supply) Generic Preferred Brand Non-preferred Brand	 $5** $20** $40**	 30% 30% 30%	 10%* 10%* 10%*	 40%* 40%* 40%*
Prescription drugs – Mail Order (90 day supply) Generic Preferred Brand Non-preferred Brand	 $10 $40 $80		 10%* 10%* 10%*	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	$10 co-pay	30%*	10%*	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	$15 co-pay	30%*	10%*	40%*
▪ Respite care for children ages two through 21 ($500 maximum per month)	15%*	30%*	10%*	40%*
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	15%*	30%*	10%*	40%*
Prosthetic devices	15%*	30%*	10%*	40%*
Home health – limited to 60 visits per year	15%*	30%*	10%*	40%*
Physical therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Occupational therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Speech therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Skilled nursing facility services – limited to 30 days per year	15%*	30%*	10%*	40%*
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	15%*	30%*	10%*	40%*

*Subject to annual deductible
** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $15 preferred brand and $30 non-preferred brand.

In 2011:

- KEHP evaluated the advantages and disadvantages of continuing "grandfathered health plan" status under PPACA and determined grandfathered status would be maintained for 2011.
- As PPACA regulations limit the amounts that group health plans can change benefit provisions and employee contributions to maintain grandfathered status, only slight changes were made in 2011:
  - Most plan copayments were increased by the greater of $5 or 15%;
  - Most plan deductibles and out-of-pocket maximum amounts were increased 15% (however for the Standard PPO, deductibles and in-network out-of-pocket maximums were held constant; out-of-network out-of-pocket maximums were decreased);
  - Employee contributions were increased according to the limits allowed under PPACA while still maintaining grandfathered status (Optimum PPO, Maximum Choice, and Capitol Choice plans). Employee contributions for the Standard PPO plan were not increased.
- The Commonwealth offered the same four benefit plans which were offered in 2010 with slight changes to benefit designs, as noted above. The plans are:
  - Commonwealth Standard PPO – a $500/$1,500 Deductible PPO plan;
  - Commonwealth Capitol Choice – a $575/$1,725 Deductible hybrid PPO plan (changed from $500/$1,500 in 2010) with an up-front benefit allowance of $500 per member;
  - Commonwealth Optimum PPO – a $345/$690 Deductible PPO plan (changed from $300/$600 in 2010);
  - Commonwealth Maximum Choice – a $2,300/$3,455 Deductible consumer-driven plan (changed from $2.000/$3,000 in 2010) with an embedded Health Reimbursement Account (HRA).
- Coverage was offered to dependent children up to age 26, whom do not have other equivalent coverage available.
- The Commonwealth's contribution for employees who waive coverage was maintained at $175 per month, the same amount as in 2010.
- Legislation passed in 2010, and effective January 1, 2011, increased the amount of coverage that must be provided for autism spectrum disorders. HB 159 provides coverage for the diagnosis and treatment of autism spectrum disorders for individuals between the ages of 1 and 21, including coverage in the annual amount of $50,000 for individuals who are 1-6 years of age, and coverage in the monthly amount of $1,000 for individuals who are between the ages of 7 and 21.

2011 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Standard PPO		Commonwealth Capitol Choice	
	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 - $500 Family - $1,500	Single - $1,500 Family - $3,000	Single - $575 Family - $1,725	Single - $1,150 Family - $3,455
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - $3,500 Family - $7,000	Single - $5,000 Family - $9,500	Single - $2,300 Family - $6,900	Single - $3.800 Family - $9,400
Up-Front Benefit Allowance	Not Applicable		$500/family member	Not Applicable
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Not Applicable	
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	25%*	50%*	$115 co-pay plus 0%*	40%*
Doctor's Office Visits	25%	50%*	$20 co-pay - PCP $25 co-pay - Spec	40%*
Allergy Serums & injections	25%	50%*	$10 co-pay	40%*
Physician Care (Inpatient/Outpatient/Other)	25%*	50%*	20%*	40%*
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).	25%*	50%*	20%*	40%*
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%*	$55 co-pay plus 0%*	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%		$15 co-pay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$50 co-pay plus 25%*	$50 co-pay plus 50%*	$115 co-pay plus 0%*	$115 co-pay plus 0%*
Emergency room physician charges	25%*	50%*	0%*	0%*
Urgent care center treatment	25%*	50%*	$50 co-pay	40%*
Ambulance services	25%*	25%*	20%*	20%*
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.	25%*	50%*	$20 co-pay in-hospital care co-insurance applies*	40%*
Prescription drugs – Retail (30 day supply)	25%			
	Min / Max			
Generic Preferred Brand Non-preferred Brand	$10 / $25 $20 / $50 $35 / $100		$10 $25** $45**	
Prescription drugs – Mail Order (90 day supply)	25%			
	Min / Max			
Generic Preferred Brand Non-preferred Brand	$20 / $50 $40 / $100 $70 / $200		$15 $45 $90	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*	$20 co-pay	40%*
Autism Services Benefits payable based on services rendered	Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000		Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000	
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*	20%*	40%*
Prosthetic devices	25%*	50%*	20%*	40%*
Home health – limited to 60 visits per year	25%*	50%*	20%*	40%*
Physical therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Occupational therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Speech therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*	20%*	40%*
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%*	20%*	40%*

*Subject to annual deductible
** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $20 preferred brand and $35 non-preferred brand.

2011 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	Commonwealth Optimum PPO		Commonwealth Maximum Choice	
	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 - $345 Family - $690	Single - $690 Family - $1380	Single - $2,300 Family - $3,455	Single - $2,300 Family - $3,455
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - $1,295 Family - $2,590	Single - $2,590 Family - $5,185	Single - $3,455 Family - $5,185	Single - $4,600 Family - $6,900
Up-Front Benefit Allowance	Not Applicable		Not Applicable	
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $1,000 Parent Plus - $1,500 Couple - $1,500 Family - $2,000	
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	15%*	30%*	10%*	40%*
Doctor's Office Visits	$15 co-pay - PCP $20 co-pay - Specialist	30%*	10%*	40%*
Allergy Serums & injections	$15 co-pay	30%*	10%*	40%*
Physician Care (Inpatient/Outpatient/Other)	15%*	30%*	10%*	40%*
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).	$15 co-pay	30%*	10%*	40%*
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.	15%*	30%*	10%*	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	$10 co-pay per visit	30%*	Plan pays 100%	
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$85 co-pay plus 15%*	$85 co-pay plus 30%*	10%*	40%*
Emergency room physician charges	15%	30%*	10%*	40%*
Urgent care center treatment	$20 co-pay	30%*	10%*	40%*
Ambulance services	15%*	15%*	10%*	10%*
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.	$15 co-pay in-hospital care co-insurance applies*	30%*	10%*	40%*
Prescription drugs – Retail (30 day supply) Generic Preferred Brand Non-preferred Brand	 $10** $25** $45**	 30% 30% 30%	 10%* 10%* 10%*	 40%* 40%* 40%*
Prescription drugs – Mail Order (90 day supply) Generic Preferred Brand Non-preferred Brand	 $15 $45 $90		 10%* 10%* 10%*	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	$15 co-pay	30%*	10%*	40%*
Autism Services Benefits payable based on services rendered	Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000		Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000	
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	15%*	30%*	10%*	40%*
Prosthetic devices	15%*	30%*	10%*	40%*
Home health – limited to 60 visits per year	15%*	30%*	10%*	40%*
Physical therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Occupational therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Speech therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Skilled nursing facility services – limited to 30 days per year	15%*	30%*	10%*	40%*
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	15%*	30%*	10%*	40%*

*Subject to annual deductible
** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $20 preferred brand and $35 non-preferred brand.

In 2012:

- KEHP evaluated the advantages and disadvantages of continuing "grandfathered health plan" status under PPACA and determined grandfathered status would be maintained for 2012.
- As PPACA regulations limit the amounts that group health plans can change benefit provisions and employee contributions to maintain grandfathered status, only slight changes were made in 2012:
  - Most plan deductibles and out-of-pocket maximum amounts were increased slightly (except for Standard PPO);
  - Employee contributions were increased slightly according to the limits allowed under PPACA while still maintaining grandfathered status (Optimum PPO, Maximum Choice, and Capitol Choice plans). Employee contributions for the Standard PPO plan were not increased.
- The Commonwealth offered the same four benefit plans which were offered in 2011 with slight changes to benefit designs, as noted above. The plans are:
  - Commonwealth Standard PPO – a $500/$1,500 Deductible PPO plan;
  - Commonwealth Capitol Choice – a $600/$1,800 Deductible hybrid PPO plan (changed from $575/$1,725 in 2011) with an up-front benefit allowance of $500 per member;
  - Commonwealth Optimum PPO – a $355/$720 Deductible PPO plan (changed from $345/$690 in 2011);
  - Commonwealth Maximum Choice – a $2,325/$3,530 Deductible consumer-driven plan (changed from $2,300/$3,455 in 2011) with an embedded Health Reimbursement Account (HRA).
- Coverage was offered to dependent children up to age 26, whom do not have other equivalent coverage available.
- The Commonwealth's contribution for employees who waive coverage was maintained at $175 per month, the same amount as in 2011.
- Legislation passed in 2010, and effective January 1, 2011, increased the amount of coverage that must be provided for autism spectrum disorders. HB 159 provides coverage for the diagnosis and treatment of autism spectrum disorders for individuals between the ages of 1 and 21, including coverage in the annual amount of $50,000 for individuals who are 1-6 years of age, and coverage in the monthly amount of $1,000 for individuals who are between the ages of 7 and 21.

2012 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Standard PPO		Commonwealth Capitol Choice	
	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 - $500 Family - $1,500	Single - $1,500 Family - $3,000	Single - $600 Family - $1,800	Single - $1200 Family - $3,600
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - $3,500 Family - $7,000	Single - $5,000 Family - $9,500	Single - $2,400 Family - $7,000	Single - $4,000 Family - $9,650
Up-Front Benefit Allowance	Not Applicable		$500/family member	Not Applicable
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Not Applicable	
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	25%*	50%*	$115 co-pay plus 0%*	40%*
Doctor's Office Visits	25%*	50%*	$20 co-pay - PCP $25 co-pay - Spec	40%*
Allergy Serums & injections	25%*	50%*	$15 co-pay	40%*
Physician Care (Inpatient/Outpatient/Other)	25%*	50%*	20%*	40%*
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).	25%*	50%*	20%*	40%*
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.	25%*	50%*	$55 co-pay*	40%*
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 an ambulatory center.	25%*	50%*	$55 co-pay	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%		$15 co-pay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$50 co-pay plus 25%*	$50 co-pay plus 50%*	$115 co-pay plus 0%*	$115 co-pay plus 0%*
Emergency room physician charges	25%*	50%*	0%*	0%*
Urgent care center treatment	25%*	50%*	$50 co-pay	40%*
Ambulance services	25%*	25%*	20%*	20%*
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.	25%*	50%*	$20 co-pay in-hospital care co-insurance applies*	40%*
Prescription drugs – Retail (30 day supply)	25% Min / Max Generic: $10 / $25 Preferred Brand: $20 / $50 Non-preferred Brand: $35 / $100		$10 $25** $45**	
Prescription drugs – Mail Order (90 day supply)	25% Min / Max Generic: $20 / $50 Preferred Brand: $40 / $100 Non-preferred Brand: $70 / $200		$15 $45 $90	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*	$20 co-pay	40%*
Autism Services Benefits payable based on services rendered	Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000		Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000	
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*	20%*	40%*
Prosthetic devices	25%*	50%*	20%*	40%*
Home health – limited to 60 visits per year	25%*	50%*	20%*	40%*
Physical therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Occupational therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Speech therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*	20%*	40%*
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%*	20%*	40%*

*Subject to annual deductible
** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $20 preferred brand and $35 non-preferred brand.

2012 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	Commonwealth Optimum PPO		Commonwealth Maximum Choice	
	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 - $355 Family - $720	Single - $720 Family - $1,430	Single - $2,325 Family - $3,530	Single - $2,400 Family - $3,600
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - $1,350 Family - $2,700	Single - $2,700 Family - $5,350	Single - $3,550 Family - $5,280	Single - $4,700 Family - $7,000
Up-Front Benefit Allowance	Not Applicable		Not Applicable	
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $1,000 Parent Plus - $1,500 Couple - $1,500 Family - $2,000	
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	15%*	30%*	10%*	40%*
Doctor's Office Visits	$15 co-pay - PCP $20 co-pay - Specialist	30%*	10%*	40%*
Allergy Serums & injections	$10 co-pay	30%*	10%*	40%*
Physician Care (Inpatient/Outpatient/Other)	15%*	30%*	10%*	40%*
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).	$15 co-pay	30%*	10%*	40%*
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.	15%*	30%*	10%*	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	$10 co-pay per visit	30%*	Plan pays 100%	
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$85 co-pay plus 15%*	$75 co-pay plus 30%*	10%*	40%*
Emergency room physician charges	15%	30%*	10%*	40%*
Urgent care center treatment	$20 co-pay	30%*	10%*	40%*
Ambulance services	15%*	15%*	10%*	10%*
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.	$15 co-pay in-hospital care co-insurance applies*	30%*	10%*	40%*
Prescription drugs – Retail (30 day supply) Generic Preferred Brand Non-preferred Brand	 $10** $25** $45**	 30% 30% 30%	 10%* 10%* 10%*	 40%* 40%* 40%*
Prescription drugs – Mail Order (90 day supply) Generic Preferred Brand Non-preferred Brand	 $15 $45 $90		 10%* 10%* 10%*	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	$15 co-pay	30%*	10%*	40%*
Autism Services Benefits payable based on services rendered	Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000		Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000	
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	15%*	30%*	10%*	40%*
Prosthetic devices	15%*	30%*	10%*	40%*
Home health – limited to 60 visits per year	15%*	30%*	10%*	40%*
Physical therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Occupational therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Speech therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Skilled nursing facility services – limited to 30 days per year	15%*	30%*	10%*	40%*
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	15%*	30%*	10%*	40%*

*Subject to annual deductible
** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $20 preferred brand and $35 non-preferred brand.

In 2013:

- KEHP has chosen to retain their grandfathered status.
- As PPACA regulations limit the amounts that group health plans can change benefit provisions and employee contributions to maintain grandfathered status, only slight changes were made in 2013:
  - Most plan deductibles and out-of-pocket maximum amounts were increased slightly
  - Employee contributions were increased slightly according to the limits allowed under PPACA while still maintaining grandfathered status (Optimum PPO, Maximum Choice, and Capitol Choice plans). Employee contributions for the Standard PPO plan single tier was not increased.
  - There were also small increases to Optimum and Capitol Choice plan co-payments
- The Commonwealth offered the same four benefit plans which were offered in 2012 with slight changes to benefit designs, as noted above. The plans are:
  - Commonwealth Standard PPO – a $600/$1,800 Deductible PPO plan (changed from $500/$1,500 in 2012);
  - Commonwealth Capitol Choice – a $615/$1,850 Deductible hybrid PPO plan (changed from $600/$1,800 in 2012) with an up-front benefit allowance of $500 per member;
  - Commonwealth Optimum PPO – a $370/$740 Deductible PPO plan (changed from $355/$720 in 2012);
  - Commonwealth Maximum Choice – a $2,450/$3,650 Deductible consumer-driven plan (changed from $2,325/$3,530 in 2012) with an embedded Health Reimbursement Account (HRA).
- The Commonwealth's contribution for employees who waive coverage was maintained at $175 per month, the same amount as in 2012.

2013 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Standard PPO		Commonwealth Capitol Choice	
	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 - $600 Family - $1,800	Single - $1,200 Family - $3,000	Single - $615 Family - $1,850	Single - $1,230 Family - $3,700
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - $3,000 Family - $6,000	Single - $6,000 Family - $9,000	Single - $2,470 Family - $7,400	Single - $4,900 Family - $9,000
Up-Front Benefit Allowance	Not Applicable		$500/family member	Not Applicable
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Not Applicable	
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	25%*	50%*	$122 co-pay plus 0%*	40%*
Doctor's Office Visits	25%*	50%*	$21 co-pay - PCP $26 co-pay - Spec	40%*
Allergy Serums & injections	25%*	50%*	$11 co-pay	40%*
Physician Care (Inpatient/Outpatient/Other)	25%*	50%*	20%*	40%*
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).	25%*	50%*	Office co-pay plus 20%*	40%*
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.	25%*	50%*	$61 co-pay*	40%*
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 an ambulatory center.	25%*	50%*	$61 co-pay	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%		$16 co-pay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$50 co-pay plus 25%*	$50 co-pay plus 50%*	$122 co-pay plus 0%*	$122 co-pay plus 0%*
Emergency room physician charges	25%*	50%*	0%*	0%*
Urgent care center treatment	25%*	50%*	$60 co-pay	40%*
Ambulance services	25%*	25%*	20%*	20%*
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.	25%*	50%*	$21 co-pay in-hospital care co-insurance applies*	40%*
Prescription drugs – Retail (30 day supply)	25% Min / Max	Not Covered		
Generic	$10 / $25		$11	
Preferred Brand	$20 / $50		$26**	
Non-preferred Brand	$35 / $100		$48**	
Prescription drugs – Mail Order (90 day supply)	25% Min / Max	Not Covered		Not Covered
Generic	$20 / $50		$16	
Preferred Brand	$40 / $100		$46	
Non-preferred Brand	$70 / $200		$95	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*	$21 co-pay	40%*
Autism Services Benefits payable based on services rendered	Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000		Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000	
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*	20%*	40%*
Prosthetic devices	25%*	50%*	20%*	40%*
Home health – limited to 60 visits per year	25%*	50%*	20%*	40%*
Physical therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Occupational therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Speech therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*	20%*	40%*
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%*	20%*	40%*

*Subject to annual deductible
** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $21 preferred brand and $37 non-preferred brand.

2013 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	Commonwealth Optimum PPO		Commonwealth Maximum Choice	
	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 - $370 Family - $740	Single - $740 Family - $1,480	Single - $2,450 Family - $3,650	Single - $2,450 Family - $3,700
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - $1,390 Family - $2,780	Single - $2,780 Family - $5,550	Single - $3,700 Family - $5,400	Single - $4,945 Family - $7,400
Up-Front Benefit Allowance	Not Applicable		Not Applicable	
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $1,000 Parent Plus - $1,500 Couple - $1,500 Family - $2,000	
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	15%*	30%*	10%*	40%*
Doctor's Office Visits	$16 co-pay - PCP $21 co-pay - Specialist	30%*	10%*	40%*
Allergy Serums & injections	$16 co-pay	30%*	10%*	40%*
Physician Care (Inpatient/Outpatient/Other)	15%*	30%*	10%*	40%*
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).	Office co-pay	30%*	10%*	40%*
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.	15%*	30%*	10%*	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	$11 co-pay per visit	30%*	Plan pays 100%	Not Covered
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$92 co-pay plus 15%*	$92 co-pay plus 30%*	10%*	40%*
Emergency room physician charges	15%	30%*	10%*	40%*
Urgent care center treatment	$21 co-pay	30%*	10%*	40%*
Ambulance services	15%*	15%*	10%*	10%*
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.	$16 co-pay in-hospital care co-insurance applies*	30%*	10%*	40%*
Prescription drugs – Retail (30 day supply) Generic Preferred Brand Non-preferred Brand	 $11** $26** $48**	 30% 30% 30%	 10%* 10%* 10%*	 40%* 40%* 40%*
Prescription drugs – Mail Order (90 day supply) Generic Preferred Brand Non-preferred Brand	 $16 $46 $95	Not Covered	 10%* 10%* 10%*	Not Covered
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	$21 co-pay	30%*	10%*	40%*
Autism Services Benefits payable based on services rendered	Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000		Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000	
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	15%*	30%*	10%*	40%*
Prosthetic devices	15%*	30%*	10%*	40%*
Home health – limited to 60 visits per year	15%*	30%*	10%*	40%*
Physical therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Occupational therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Speech therapy – limited to 30 visits per year	15%*	30%*	10%*	40%*
Skilled nursing facility services – limited to 30 days per year	15%*	30%*	10%*	40%*
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	15%*	30%*	10%*	40%*

*Subject to annual deductible
** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $20 preferred brand and $35 non-preferred brand.

In 2014:

- KEHP will offer four new plan options – two LivingWell health plan options and two Standard health plan options, which will result in a loss of grandfathered status in 2014.
- If the member chooses one of the KEHP LivingWell plans, they are making a LivingWell Promise and agree to:
  - Complete online HumanaVitality® Health Assessment between January 1, 2014–May 1, 2014
  - Keep contact information (i.e., mailing address, phone number, and email) current in KHRIS or, if a retiree, keep contact information current with their retirement system
- The plan design highlights for the new plan options are:
  - LivingWell CDHP - a $1,250/$2,500 Deductible consumer-driven plan with 85% coinsurance and $500/$1,000 embedded Health Reimbursement Account (HRA);
  - LivingWell PPO - a $500/$1,000 Deductible PPO plan with 80% coinsurance;
  - Standard PPO - a $750/$1,500 Deductible PPO plan with 70% coinsurance;
  - Standard CHDP - a $1,750/$3,500 Deductible consumer-driven plan with 70% coinsurance and $250/$500 embedded Health Reimbursement Account (HRA);
- The Commonwealth's contribution for employees who waive coverage was maintained at $175 per month, the same amount as in 2013.

2014 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Standard PPO		Standard CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit co-pay, preventive care services, outpatient diagnostic testing, prescription drugs, chiropractic services and hospital emergency room services)	Single - $750 Family - $1,500	Single - $1,500 Family - $3,000	Single - $1,750 Family - $3,500	Single - $3,000 Family - $6,000
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - $3,000 Family - $7,000	Single - $7,000 Family - $10,000	Single - $3,500 Family - $7,000	Single - $7,000 Family - $10,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $250 Family - $500	
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	30%*	50%*	30%*	50%*
Doctor's Office Visits	30%*	50%*	30%*	50%*
Allergy Serums & injections	30%*	50%*	30%*	50%*
Physician Care (Inpatient/Outpatient/Other)	30%*	50%*	30%*	50%*
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).	30%*	50%*	30%*	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.	30%*	50%*	30%*	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 an ambulatory center.	30%*	50%*	30%*	50%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%	50%*	Plan pays 100%	50%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$150 co-pay plus 30%* (co-pay waived if admitted)		30%*	
Emergency room physician charges	30%*		30%*	
Urgent care center treatment	30%*		30%*	
Ambulance services	30%*		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.	30%*	50%*	30%*	50%*
Prescription drugs – Retail (30 day supply)	30%	Not Covered	30%*	50%*
	Min / Max			
Generic	$10 / $25			
Preferred Brand	$20 / $50			
Non-preferred Brand	$60 / $100			
Prescription drugs – Mail Order (90 day supply)	30%	Not Covered	30%*	Not Covered
	Min / Max			
Generic	$20 / $50			
Preferred Brand	$40 / $100			
Non-preferred Brand	$120 / $200			
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	30%*	50%*	30%*	50%*
Autism Services Benefits payable based on services rendered	Treated the same as any other health condition.		Treated the same as any other health condition.	
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	30%*	50%*	30%*	50%*
Prosthetic devices	30%*	50%*	30%*	50%*
Home health – limited to 60 visits per year	30%*	50%*	30%*	50%*
Physical therapy – limited to 30 visits per year	30%*	50%*	30%*	50%*
Occupational therapy – limited to 30 visits per year	30%*	50%*	30%*	50%*
Cardiac rehabilitation therapy – limited to 30 visits per year	30%*	50%*	30%*	50%*
Speech therapy – limited to 30 visits per year	30%*	50%*	30%*	50%*
Skilled nursing facility services – limited to 30 days per year	30%*	50%*	30%*	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	30%*	50%*	30%*	50%*

*Subject to annual deductible

2014 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	LivingWell PPO		LivingWell CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit co-pay, preventive care services, outpatient diagnostic testing, prescription drugs, chiropractic services and hospital emergency room services)	Single - $500 Family - $1,000	Single - $1,000 Family - $2,000	Single - $1,250 Family - $2,500	Single - $2,500 Family - $5,000
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - $2,500 Family - $5,000	Single - $5,000 Family - $10,000	Single - $2,500 Family - $5,000	Single - $5,000 Family - $10,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $500 Family - $1,000	
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%*	15%*	40%*
Doctor's Office Visits	$25 co-pay - PCP $45 co-pay - Specialist	40%*	15%*	40%*
Allergy Serums & injections	$25 co-pay	40%*	15%*	40%*
Physician Care (Inpatient/Outpatient/Other)	20%*	40%*	15%*	40%*
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).	Office co-pay	40%*	15%*	40%*
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%*	15%*	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%	40%*	Plan pays 100%	40%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$150 co-pay plus 20%* (co-pay waived if admitted)		15%*	
Emergency room physician charges	20%*		15%*	
Urgent care center treatment	$50 co-pay		15%*	
Ambulance services	20%*		15%*	
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.	$25 co-pay Delivery charge: 20%*	40%*	15%*	40%*
Prescription drugs – Retail (30 day supply) Generic Preferred Brand Non-preferred Brand	 $10 $35** $55**	Not Covered	 15%* 15%* 15%*	 40%* 40%* 40%*
Prescription drugs – Mail Order (90 day supply) Generic Preferred Brand Non-preferred Brand	 $20 $70 $110	Not Covered	 15%* 15%* 15%*	Not Covered
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	$25 co-pay	30%*	15%*	40%*
Autism Services Benefits payable based on services rendered	Treated the same as any other health condition.		Treated the same as any other health condition.	
Hospice care – subject to pre-certification 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%*	15%*	40%*
Prosthetic devices	20%*	40%*	15%*	40%*
Home health – limited to 60 visits per year	20%*	40%*	15%*	40%*
Physical therapy – limited to 30 visits per year	20%*	40%*	15%*	40%*
Occupational therapy – limited to 30 visits per year	20%*	40%*	15%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	20%*	40%*	15%*	40%*
Speech therapy – limited to 30 visits per year	20%*	40%*	15%*	40%*
Skilled nursing facility services – limited to 30 days per year	20%*	40%*	15%*	40%*
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%*	15%*	40%*

*Subject to annual deductible
** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $30 preferred brand and $44 non-preferred brand.

Contribution Rates

The following are monthly employee contribution rates split by plan, year, and smoker status:

	Non-Tobacco User Rates			
2010	**Standard PPO**	**Maximum Choice**	**Capitol Choice**	**Optimum PPO**
Single	$ -	$ -	$ 5.00	$ 27.50
Parent	$ 8.28	$ 108.86	$ 144.02	$ 176.52
Couple	$ 282.18	$ 334.66	$ 444.12	$ 469.52
Family	$ 288.44	$ 398.32	$ 525.84	$ 561.16
Cross Reference	$ -	$ 9.66	$ 12.88	$ 28.34

	Tobacco User Rates			
2010	**Standard PPO**	**Maximum Choice**	**Capitol Choice**	**Optimum PPO**
Single	$ 24.00	$ 24.00	$ 29.00	$ 51.50
Parent	$ 56.28	$ 156.86	$ 192.02	$ 224.52
Couple	$ 330.18	$ 382.66	$ 492.12	$ 517.52
Family	$ 336.44	$ 446.32	$ 573.84	$ 609.16
Cross Reference	$ 24.00	$ 33.66	$ 36.88	$ 52.34

2011	**Standard PPO**	**Maximum Choice**	**Capitol Choice**	**Optimum PPO**
Single	$ -	$ 29.98	$ 36.54	$ 61.52
Parent	$ 8.28	$ 118.66	$ 156.98	$ 192.40
Couple	$ 282.18	$ 364.78	$ 483.98	$ 511.78
Family	$ 288.44	$ 434.16	$ 573.16	$ 611.66
Cross Reference	$ -	$ 44.34	$ 51.74	$ 68.40

2011	**Standard PPO**	**Maximum Choice**	**Capitol Choice**	**Optimum PPO**
Single	$ 25.50	$ 55.52	$ 61.82	$ 86.64
Parent	$ 60.60	$ 170.98	$ 209.30	$ 244.72
Couple	$ 334.50	$ 417.10	$ 536.40	$ 564.10
Family	$ 340.76	$ 486.48	$ 625.48	$ 663.98
Cross Reference	$ 24.72	$ 68.98	$ 76.50	$ 93.12

2012	**Standard PPO**	**Maximum Choice**	**Capitol Choice**	**Optimum PPO**
Single	$ -	$ 30.74	$ 37.24	$ 62.74
Parent	$ 8.28	$ 120.60	$ 160.00	$ 195.60
Couple	$ 282.18	$ 371.10	$ 493.00	$ 520.60
Family	$ 288.44	$ 442.00	$ 584.00	$ 622.50
Cross Reference	$ -	$ 45.22	$ 52.74	$ 69.74

2012	**Standard PPO**	**Maximum Choice**	**Capitol Choice**	**Optimum PPO**
Single	$ 25.50	$ 56.62	$ 63.06	$ 88.36
Parent	$ 60.60	$ 174.40	$ 213.48	$ 249.60
Couple	$ 334.50	$ 425.44	$ 547.12	$ 575.38
Family	$ 340.76	$ 496.20	$ 638.00	$ 677.25
Cross Reference	$ 24.72	$ 70.36	$ 78.02	$ 94.98

2013	**Standard PPO**	**Maximum Choice**	**Capitol Choice**	**Optimum PPO**
Single	$ -	$ 30.88	$ 37.28	$ 62.76
Parent	$ 20.00	$ 140.00	$ 179.00	$ 220.00
Couple	$ 298.00	$ 396.00	$ 518.00	$ 546.00
Family	$ 310.00	$ 470.00	$ 610.00	$ 650.00
Cross Reference	$ 5.00	$ 45.24	$ 52.76	$ 69.80

2013	**Standard PPO**	**Maximum Choice**	**Capitol Choice**	**Optimum PPO**
Single	$ 25.50	$ 56.76	$ 63.10	$ 88.36
Parent	$ 72.32	$ 193.80	$ 232.48	$ 274.00
Couple	$ 350.32	$ 450.34	$ 572.12	$ 600.78
Family	$ 362.32	$ 524.20	$ 664.00	$ 704.76
Cross Reference	$ 29.72	$ 70.38	$ 78.04	$ 95.04

2014	**Standard CDHP**	**Standard PPO**	**LivingWell PPO**	**LivingWell CDHP**
Single	$ 12.98	$ 47.98	$ 79.98	$ 47.98
Parent	$ 72.98	$ 122.98	$ 227.98	$ 122.98
Couple	$ 262.98	$ 287.98	$ 512.98	$ 287.98
Family	$ 312.98	$ 337.98	$ 642.98	$ 337.98
Cross Reference	$ 32.98	$ 77.98	$ 152.98	$ 77.98

2014	**Standard CDHP**	**Standard PPO**	**LivingWell PPO**	**LivingWell CDHP**
Single	$ 52.98	$ 87.98	$ 119.98	$ 87.98
Parent	$ 152.98	$ 202.98	$ 307.98	$ 202.98
Couple	$ 342.98	$ 367.98	$ 592.98	$ 367.98
Family	$ 392.98	$ 417.98	$ 722.98	$ 417.98
Cross Reference	$ 72.98	$ 117.98	$ 192.98	$ 117.98

Legislative Mandates

The following legislative mandates enacted by the Kentucky General Assemblies may affect the Public Employee Health Insurance Program. This is intended for context and historical purposes only. The Public Employee Health Insurance Program is subject to the Kentucky Insurance Code (Chapter KRS 304.17 and 17A) to the extent that code sections are specifically enumerated as such in the either the Insurance Code or Chapter KRS 18A.

History of Legislation Enacted by the 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.
2002	HB 163	Expands Kentucky Group Health Insurance Board to include: ▪ 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	▪ 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.

History of Legislation Enacted by the General Assemblies that Impacts the Public Employee Health Insurance Program		
Year Enacted	**Bill**	**Key Provisions**
2002	HB 846	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.
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.

History of Legislation Enacted by the General Assemblies that Impacts the Public Employee Health Insurance Program		
Year Enacted	**Bill**	**Key Provisions**
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 KRS from a minimum of 5 years to 10 years to be eligible to participate in the Commonwealth's retiree health insurance program.
2004	HB 1	Legislation that changed the Public Employee Health Insurance Program from fully funded to self funded. Requires that group healthcare coverage contain three health plans named Commonwealth Essential, Commonwealth Enhanced and Commonwealth Premier. Permits married couples who are both eligible to participate in the state health insurance plan to be covered under one family health benefit plan and to apply each employer contribution for the single premium of the plan they select toward family coverage, not to exceed the total premium. Requires the state contribute $234 per month to the employee's flexible spending account for those who waive health insurance coverage. Allows employees to carry forward to the succeeding plan year, any unused funds remaining in a flexible spending account at the end of the plan year to the extent permissible by the Internal Revenue Code in effect on the date the plan year ends.
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 Public Employee Health Insurance Program to be in compliance with certain specifically enumerated 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.

History of Legislation Enacted by the General Assemblies that Impacts the Public Employee Health Insurance Program		
Year Enacted	**Bill**	**Key Provisions**
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 Public Employee Health Insurance Program 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.
2007	SB22	Create a new section of KRS Chapter 18A to require the Personnel Cabinet, Department for Employee Insurance, to offer TRICARE supplement insurance to eligible TRICARE insurance beneficiaries; require the Commonwealth to pay for individual TRICARE supplement insurance; permit an employee eligible for TRICARE to choose between the Commonwealth sponsored TRICARE supplemental insurance or other coverage offered through the public employee health insurance program; permit the secretary of the Personnel Cabinet to promulgate administrative regulations. Note this legislation is pre-empted by Federal law which prohibits employers from offering incentives to employees if they elect coverage under a Federally-sponsored program.
2008	HB 321	Provides the General Assembly with the authority to review trust fund expenditures and authorize spending for trust fund receipts. Outlines quarterly report content, formulary review changes, deadlines and other administrative regulations regarding the trust.
2008	HB 406	Requires agencies to coordinate the timing of employer payments to Public Employee Health Insurance Program in such a manner as to provide the agencies the flexibility to lapse $7 million in General Fund moneys in each fiscal year.

History of Legislation Enacted by the General Assemblies that Impacts the Public Employee Health Insurance Program		
Year Enacted	**Bill**	**Key Provisions**
2009	HB 143	Allows the Governor to direct a one-time transfer of up to $50 million from the Public Employee Health Insurance Trust Fund's surplus to the General Fund. Outlines the conditions under which the transfer is authorized.
2010	HB 159	Requires coverage for the diagnosis and treatment of autism spectrum disorders for individuals ages 1 to 21, limited to an annual maximum of $50,000 for individuals ages 1 through 6, and limited to a $1,000 monthly maximum for individuals ages 7 through 21.
2010	HB 1	Report of the Group Health Insurance Board: Notwithstanding KRS 18A.226(5)(b) and (c), the report of the Kentucky Group Health Insurance Board shall be submitted to the Governor, the Legislative Research Commission, and the Chief Justice of the Supreme Court by December 15th of each calendar year.
2011	HB 229	Amend KRS 78.530 to allow agencies that are established by a merger or interlocal agreement consisting of agencies who participated in the County Employees Retirement System (CERS) on or before April 9, 2002, to be exempt from the requirement of signing a contract for employee health insurance with the Personnel Cabinet as a condition of participation in CERS; apply the amendments to KRS 78.530 to existing agencies established before the effective date of the Act.
2012	HB 265	State Group Health Insurance Plan - Plan Year Closure: Notwithstanding KRS 18A.2254, plan years 2006, 2007, 2008, and 2009 shall be considered closed as of December 31, 2011, and all balances from those plan years shall be transferred to Plan Year 2010. All other income and expenses attributable to the closed plan years shall be deposited in or charged to the Plan Year 2010 account after that date. Notwithstanding KRS 18A.2254, no transfer of funds from Plan Year 2010 is authorized.

General Kentucky Insurance Code Legislative Mandates

The Department of Insurance provided the summary in Exhibit LVII of 29 mandated health insurance benefits that currently exist in Kentucky's statutes. These mandates are generally not applicable to the Public Employee Health Insurance Program. This is intended for context and historical purposes only. The Public Employee Health Insurance Program is subject to the Kentucky Insurance Code (Chapter KRS 304.17 and 17A) to the extent that code sections are specifically enumerated in the either the Insurance Code or Chapter KRS 18A.

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.
Dependent Eligibility	KRS 304.17A-256. All group health benefit plans which provide dependent benefits shall offer the master policyholder the following two (2) options to purchase coverage for an unmarried dependent child: (a) Coverage until age nineteen (19) and coverage to unmarried children from nineteen (19) to twenty-five (25) years of age who are full-time students enrolled in and attending an accredited educational institution and who are primarily dependent on the policyholder for maintenance and support; and (b) Coverage until age twenty-five (25).
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.

Kentucky Mandated Health Insurance Benefits	
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.
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.

Kentucky Mandated Health Insurance Benefits	
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.)
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.
Colorectal Cancer Detection	KY Act, Chapter 107 provides that all health benefit plans provide for colorectal cancer examinations and laboratory tests, specified in current American Cancer Society guidelines.
Health benefit plan wellness programs.	SB 114 (2011) creates a new section of Subtitle 17A of KRS Chapter 304 to authorize health benefit plans to offer incentives or rewards to members who participate in a voluntary wellness or health improvement program; the authorized incentives and rewards shall not be deemed a violation of the rebate prohibition contained in KRS 304.12-090 and 304.12.010; if a health plan member is unable to participate in a wellness or health improvement programs due to a medical condition, verification may be required; and, an insurer shall not be prohibited from offering incentives or rewards to members participating in a wellness or health improvement program if otherwise allowed by state or federal.

Source: Kentucky Department of Insurance

Glossary

Accountable Care Organization (ACO): A provider organization that accepts responsibility for meeting the health needs of a specific population, including the cost and quality of care and effectiveness of services. ACO members share in the savings that result from their cooperation and coordination.

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.

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.

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 or retiree 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.

Employee: References to "Employees" includes Active Employees, non-Medicare-eligible retirees, and COBRA participants. When meant to reflect only those employees still actively at work, the term "Active Employees" will be used.

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.

Grandfathered Plan: An insured or self-insured group health plan offered by an employer that was in existence on March 23, 2010, the date on which the PPACA was enacted.

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.

Health Reimbursement Arrangement (HRA): IRS-sanctioned arrangements that allow an employer, as agreed to in the HRA plan document, to reimburse for medical expenses paid by participating employees. HRAs reimburse only those items (co-pays, coinsurance, deductibles and services) agreed to by the employer which are not covered by the company's selected standard insurance plan (any health insurance plan, not only high-deductible plans). These arrangements are described in IRS Section 105.

Health Savings Account (HAS): Owned by individuals enrolled in a high deductible health plan (HDHP), as a tax-advantaged means to pay for qualified medical expenses. Funds roll over and accumulate from year to year if they are not spent.

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 healthcare 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.

Patient Protection and Affordable Care Act (PPACA): A product of the health reform agenda, signed into law on Tuesday, March 23, 2010 by President Obama. The PPACA was then amended by the Healthcare and Education Reconciliation Act in many ways. The law includes numerous provisions to be phased in over several years, including eligibility of coverage, health insurance exchanges, expanding Medicaid eligibility, and medical loss ratio regulations.

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

PEPM (Per Employee Per Month): A measure of costs as expressed as total costs divided by total number of employees.

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.

Pre-existing Condition: A medical condition developed prior to an individual obtaining insurance, which may result in the limitation in the contract on coverage or benefits.

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 healthcare 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 and KRS 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 healthcare coverage through his/her employer for a plan year. Often the employee obtains healthcare coverage through another means, typically a spouse's employer or an individual.

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