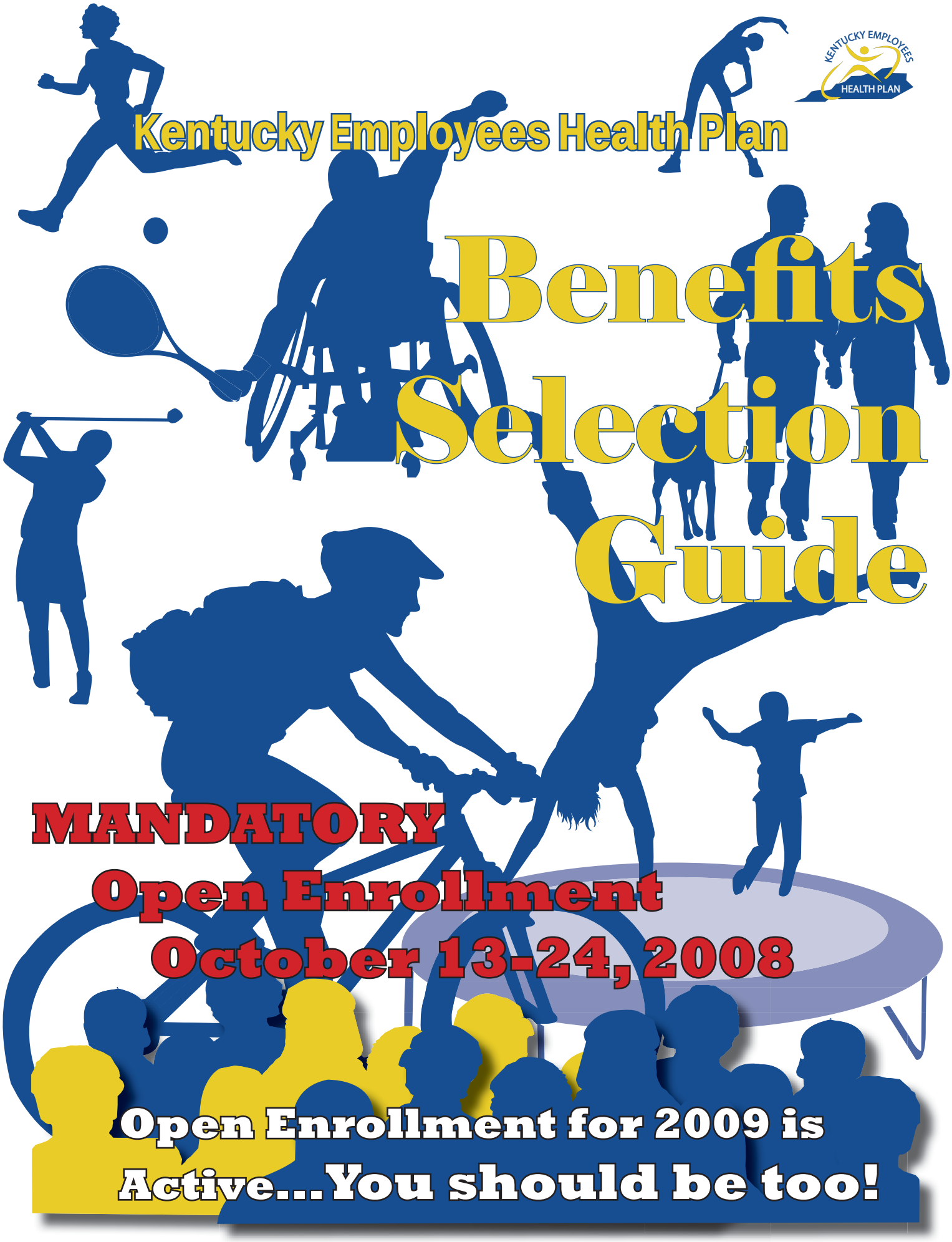

Kentucky Employees Health Plan
KENTUCKY EMPLOYEES
HEALTH PLAN
Benefits
Selection
Guide
MANDATORY
Open Enrollment
October 13-24, 2008
Open Enrollment for 2009 is
Active...You should be too!

Table of Contents

DON'T FORGET:

Open Enrollment WILL BE HELD OCTOBER 13 – 24, 2008.

If you are a benefits eligible employee, you must enroll on-line or complete a paper application.

Enrolling on-line requires both an I.D. # and password.

An I.D. # and password will be mailed to your home address shortly before Open Enrollment. Please keep these important numbers in a safe place so that you do not lose them.

If you misplace your I.D. # or password, you may call KEHP ID # **Hotline** 1-866-302-5632 outside Frankfort or 564-3116 in Frankfort.

(Telephone service at these numbers is only valid between October 13 and October 24, 2008.)

If you are a retiree, your retirement system will assist with your enrollment.

This booklet contains brief highlights of some of the major features of the benefit plans offered by KEHP. Every effort has been made to ensure the accuracy of these highlights. However, the plans are actually governed by plan documents and applicable legal requirements. If there is a conflict between the descriptions in this booklet and the plan documents or applicable legislation, the documents and/or legislation will take precedence over this Benefits Selection Guide.

For more information about benefit plans, consult the 2009 Plan Year KEHP Handbook at http://kehp.ky.gov.

The Commonwealth of Kentucky does not discriminate on the basis of race, color, religion, sex, national origin, sexual orientation, gender identity, ancestry, age, disability, or veteran status in employment or the provision of services. This booklet is available in alternate format upon request.

Dear KEHP Member:

Welcome to the 2009 Kentucky Employees Health Plan (KEHP). KEHP is a non-profit, self-funded governmental health plan operated by the Department of Employee Insurance in the Personnel Cabinet. The Kentucky Group Health Insurance Board (KGHIB) is an advisory body which assists in making decisions about KEHP. KGHIB members work hard to ensure your interests are represented in the operation of the program.

This Benefits Selection Guide is designed to give you an overview of KEHP and to provide information to assist you in enrolling in KEHP for the 2009 Plan Year. It is intended to supplement the much larger KEHP Handbook which is customarily published at this time of year. For more detailed information regarding your benefits, please consult the 2009 Plan Year KEHP Handbook by visiting KEHP's website at http://kehp.ky.gov.

2009 promises to be a busy and exciting year. I would like to draw your attention to three events which will occur during the next several months: Mandatory Open Enrollment; December Premium Holiday; and Virgin HealthMiles.

- Open Enrollment for the 2009 Plan Year is a mandatory, active enrollment. EVERYONE MUST ENROLL — NO EXCEPTIONS! Open Enrollment for the 2009 Plan Year will run from October 13 – 24, 2008. During this two week period, well over 100,000 KEHP members will be enrolling on-line. I encourage you to enroll early to avoid a last minute "log jam" which could jeopardize your ability to enroll.
- KEHP will have a PREMIUM HOLIDAY in December 2008! Employee contributions will no longer be collected a month in advance. Beginning in January 2009, the contributions will be collected for the current month of coverage. So those who currently pay for coverage each month will get a break this December. For some families, this will be a savings of over $500!
- To help make 2009 a happy, healthy year, KEHP is pleased to bring you Virgin HealthMiles, an award-winning, internet-based wellness program. Information about the Virgin HealthMiles program may be found on the back cover and inside back cover of this Benefits Selection Guide. I encourage all KEHP members to join me on a journey to wellness through Virgin HealthMiles!

My staff and I are dedicated to providing high-quality customer service. We look forward to working with you during the upcoming Open Enrollment and throughout the 2009 Plan Year.

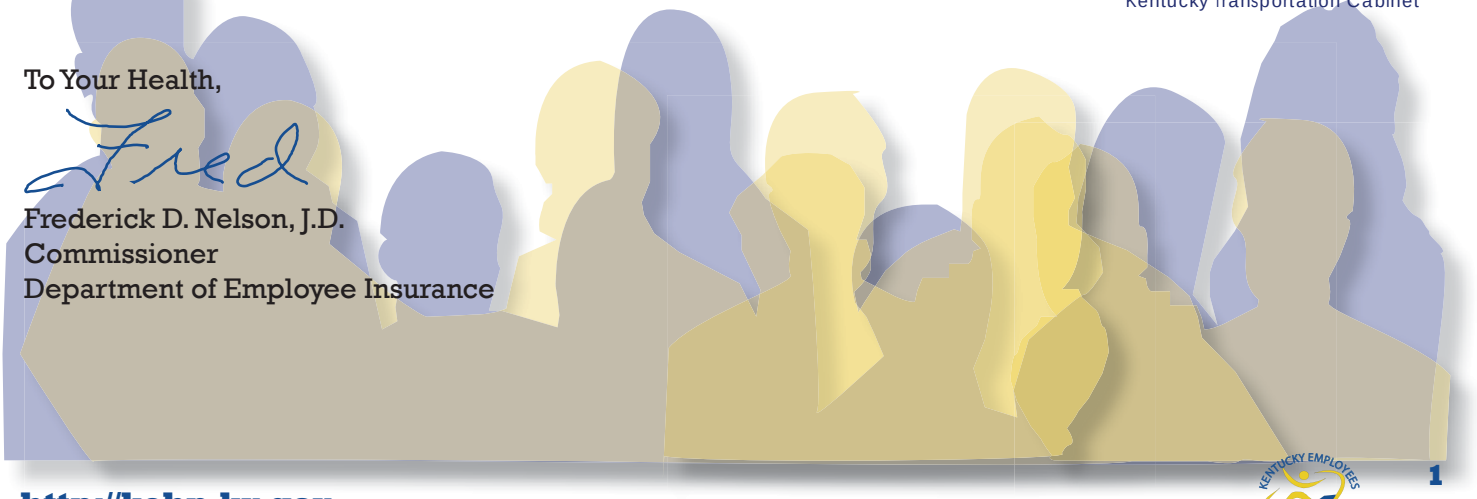
To Your Health,

Fred

Frederick D. Nelson, J.D.
Commissioner
Department of Employee Insurance

Commonwealth of Kentucky
Personnel Cabinet
Department of Employee Insurance
2nd Floor, State Office Building
501 High Street
Frankfort, Kentucky 40601

Website: http://kehp.ky.gov



New for 2009

1. Mandatory, Active Enrollment

Open Enrollment for the 2009 Plan Year will be a mandatory, active enrollment. This means YOU MUST ENROLL either on-line or by paper application — NO EXCEPTIONS! We encourage you to enroll on-line; however, retirees must complete a paper application.

Everyone must enroll during Open Enrollment.

None of your current benefits will automatically "roll over" to the 2009 Plan Year. If you do not enroll for the 2009 Plan Year, you will be deemed by default to have waived all benefits; and you will not receive any contribution to a Health Reimbursement Account (HRA).

2. Premium Holiday

No one likes to pre-pay for anything and that includes health insurance. That's why KEHP will have a PREMIUM HOLIDAY for health insurance in December 2008! Employee contributions will no longer be collected a month in advance. Beginning in January 2009, the contributions will be collected for the current month of coverage. So those who currently pay for coverage each month will get a break this December. For some families, this will be a savings of over $500! The absence of December deductions will not interrupt plan coverage for December.

The extra money in many employees' December paychecks will be welcome during a time when all families are feeling the squeeze of a tough economy. In many cases, the extra money realized during this premium holiday will exceed the total cost of any premium increases experienced during the 2009 Plan Year.

3. Virgin HealthMiles

You never knew getting healthy could be so much fun! You move, you track, you measure. Virgin motivates, Virgin encourages, Virgin rewards! For the 2009 Plan Year, KEHP is pleased to introduce HealthMiles from Virgin Life Care — an award-winning, internet-based wellness program specially-customized for KEHP members.

With Virgin HealthMiles, you can earn cash and gift cards for being physically active, tracking results, and reaching goals. Movements, distance, and calories are recorded on a GoZone pedometer, then uploaded via a USB port to your LifeZone website. As you earn HealthMiles for physical activity, you can progress through five different reward levels. The higher the level you achieve, the more entries you will receive in a monthly healthcash challenge held exclusively for KEHP members. Each monthly challenge will include significant monetary incentives.

KEHP members who sign up for Virgin HealthMiles will also be eligible for rebates on purchases from nationally-known, internet retailers, plus participation in an optional "buy-up" program with additional cash rewards. Of course, the real reward will come in the form of increased vigor and vitality as you build a new you!

The program starts January 1, 2009.

4. In-home Urgent Care

Shorter wait, convenient hours, lower cost.
Carena's modern-day, physician house-call service was initiated in 2008 for KEHP members in the Greater Louisville area. Now, the Carena pilot project is being expanded. Effective immediately, Carena is also available to KEHP members who live in Franklin County.

In-home urgent care can save you time and money. Carena is an option for non-emergency conditions when your doctor is unavailable, and it is inconvenient to go to an urgent care center. To help decide what level of care you need, call the HumanaFirst® Nurse Advice Line— Humana's 24-hour, toll-free information line — at 1-800-622-9529. If the nurse's assessment indicates your health issue is urgent, and your doctor is unavailable, you may be referred for In-home Urgent Care through Carena. If a referral is made, a board-certified physician will be on the way to your home soon!

5. Extended Coverage for Dependents to Age 25

In 2009, enrollees will be able to cover unmarried dependent children up to the end of the month in which the dependent turns 25 years old.

As a result, some enrollee contributions for this extended dependent coverage may be paid on a post-tax basis. Enrollees interested in this option should refer to pages 22 through 23 of this guide for more information.

6. Smoking Status Change

Effective January 1, 2009, you may request a change in your smoking status outside of Open Enrollment. You will be required to provide certification (such as completion of a smoking cessation program, etc.) with the required form. The change to your smoking status will be limited to the smoker contributions. This change does not create a qualifying event to allow other changes to your plan. The change will be limited to the effective date with no retroactive premiums.

Benefit Fairs

The dates, times, and locations for statewide Benefit Fairs are listed below. Just choose the Benefit Fair nearest you. Representatives from the Department of Employee Insurance (DEI), Humana, and Express Scripts will be available at each Benefit Fair to answer any questions you may have.

October 2
Franklin County
8:00 a.m. – 6:00 p.m.
Frankfort Convention Center
405 Mero Street
Frankfort, KY 40601

October 2
Boyle County
2:00 p.m. – 6:00 p.m.
Inter-County Energy
Cooperative
1009 Hustonville Road
Danville, KY 40422

October 6
Hardin County
2:00 p.m. – 6:00 p.m.
Central Hardin High School
3040 Leitchfield Road
Cecilia, KY 42724

October 6
McCracken County
2:00 p.m. – 6:00 p.m.
Western KY Comm.
& Tech. College
Crounse Hall Atrium
4810 Alben Barkley Drive
Paducah, KY 42001

October 7
Daviess County
2:00 p.m. – 6:00 p.m.
Daviess County Public
Schools Learning Center
1700 Parrish Plaza Drive
Owensboro, KY 42301

October 7
Jefferson County
8:00 a.m. – 6:00 p.m.
Kentucky Fair &
Exposition Center
West Hall Meeting
Rooms 1 & 2
Louisville, KY 40233

October 8
Christian County
2:00 p.m. – 6:00 p.m.
Christian County
Board of Education
Board Room
200 Glass Avenue
Hopkinsville, KY 42240

October 8
Whitley County
2:00 p.m. – 6:00 p.m.
Whitley County Board
of Education
300 Main Street
Williamsburg, KY 40769

October 9
Pike County
2:00 p.m. – 6:00 p.m.
Pike Central High School
Conference Room
100 Winners Circle
Pikeville, KY 41502

October 9
Pulaski County
2:00 p.m. – 6:00 p.m.
The Center for Rural
Development
2292 South Highway 27
Somerset, KY 42501

October 13
Kenton County
2:00 p.m. – 6:00 p.m.
Northern KY Area
Development District
22 Spiral Drive
Florence, KY 41022

October 13
Madison County
2:00 p.m. – 6:00 p.m.
Madison Central High School
705 North Second Street
Richmond, KY 40475

October 14
Boyd County
2:00 p.m. – 6:00 p.m.
Boyd County Middle
School Theater
1226 Summit Road
Ashland, KY 41112

October 14
Calloway County
2:00 p.m. – 6:00 p.m.
Calloway County
Board of Education
Board Meeting Room
2110 College Farm Road
Murray, KY 42071

October 15
Fayette County
4:00 p.m. – 8:00 p.m.
Dunbar High School
Cafeteria
1600 Man-O-War Boulevard
Lexington, KY 40513

October 15
Hopkins County
2:00 p.m. – 6:00 p.m.
Madisonville North Hopkins
High School Library
4515 Hanson Road
Madisonville, KY 42431

October 16
Rowan County
2:00 p.m. – 6:00 p.m.
Rowan County Board
of Education
Central Office Board Room
121 East 2nd Street
Morehead, KY 40351

October 16
Warren County
2:00 p.m. – 6:00 p.m.
Greenwood High
School Library
5065 Scottsville Road
Bowling Green, KY 42104

When to Enroll

Open Enrollment is October 13 through October 24, 2008.

Employees enrolling on-line are encouraged to enroll early during this two week period to avoid a last-minute "log jam."

How to Enroll

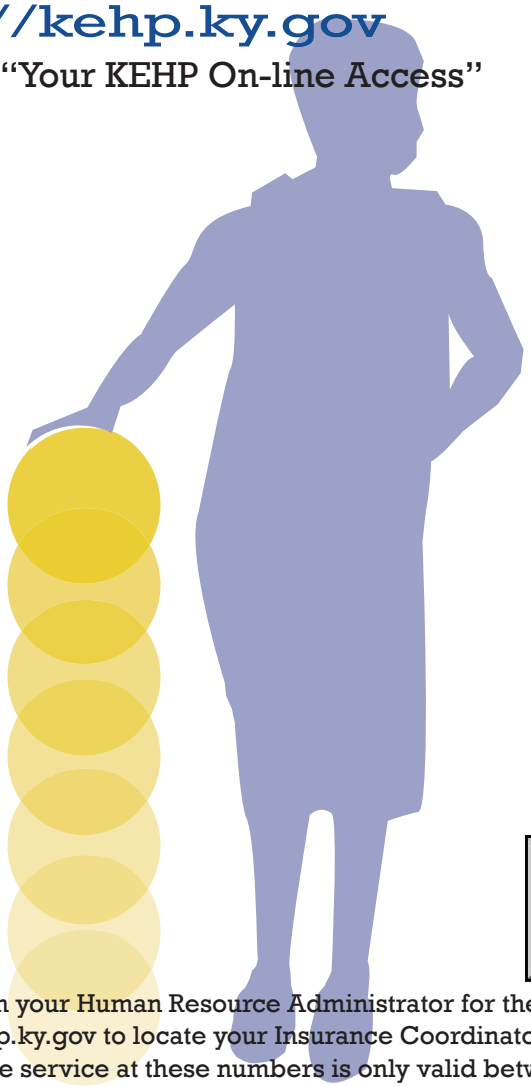
- Active employees must enroll on-line at http://kehp.ky.gov.
- Retirees will receive a paper application from their retirement system.

Where to Enroll

On-line at:

http://kehp.ky.gov

Click on "Your KEHP On-line Access" link.



Who to Call

For local, personalized help, contact your

Insurance Coordinator*

For assistance with employee ID # and password, contact the

Commonwealth Office of Technology

Outside Frankfort: 1-866-302-5632 **

In Frankfort: 564-3116 **

For computer or technical assistance, contact the

Commonwealth Office of Technology

Outside Frankfort: 1-866-746-1613**

In Frankfort: 564-4708**

For information about your current benefits or 2009 Open Enrollment, contact

Humana Customer Service & Open Enrollment Hotline

1-877-KYSPIRIT (1-877-597-7474)

For other information relating to Open Enrollment, contact the

Member Services Branch of the Department of Employee Insurance (DEI)

Outside Frankfort: 1-888-581-8834

In Frankfort: 502-564-6534

Hours for Open Enrollment Assistance

Monday - Friday 8 a.m. to 8 p.m. EST

Saturday and Sunday 8 a.m. to Noon EST

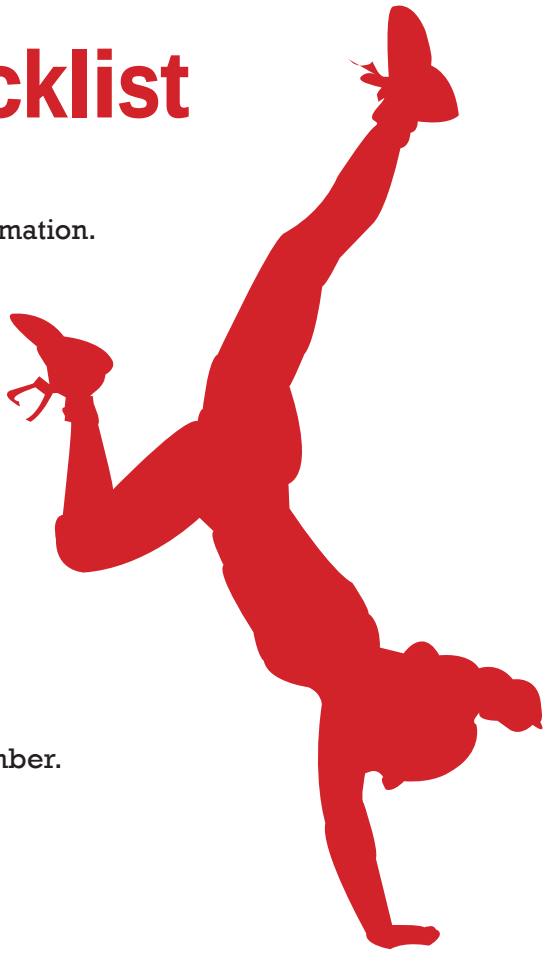
The DEI phone message will prompt you to choose from one of the following five options:

Option 1	Option 2	Option 3	Option 4	Option 5
User ID & Password Reset	Benefit Questions	Web Enrollment & Eligibility	Computer Assistance	Department of Employee Insurance

* Check with your Human Resource Administrator for the Insurance Coordinator's phone number or go to http://kehp.ky.gov to locate your Insurance Coordinator's name and number.

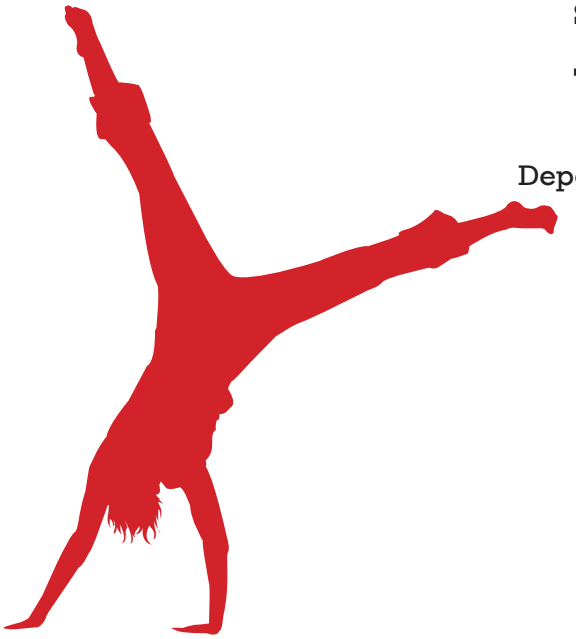
** Telephone service at these numbers is only valid between October 13 and October 24, 2008.

Handy Checklist



- [ ] 1. I completed and verified all personal information.
- [ ] 2. I included my email address.
- [ ] 3. I identified smoker or non-smoker.
- [ ] 4. I selected a plan or waived coverage.
- [ ] 5. I listed all dependents (if applicable).
- [ ] 6. I reviewed my selections for accuracy.
- [ ] 7. I received an enrollment confirmation number.
- [ ] 8. I printed the confirmation page.

To Help You Remember in 2009



Healthcare Flexible Spending Account (FSA)

My contribution amount $ _____

Spouse amount $ _____

Total FSA contribution for 2009 $ _____

Dependent Care Flexible Spending Account (FSA)

My contribution amount $ _____

Spouse amount $ _____

Confirmation number _____

My ID number _____

My password _____

Enrollment

Before Open Enrollment, your employee ID # and password will be mailed to your home. If you have not received your employee ID # and password before the Open Enrollment period, contact your Insurance Coordinator or the Commonwealth Office of Technology at 1-866-302-5632 (outside Frankfort)or 564-3116 (inside Frankfort).

On-line

Advantages of enrolling on-line

Fast

- You can finish enrollment in minutes!

Easy

- A series of questions will walk you through each step.

Flexible

- You can change your selections anytime during Open Enrollment.

Private and Secure

- Your employee ID # and personal password allow you access to the enrollment site. We are committed to protecting the privacy of your personal information.

Instant Confirmation

Once you complete the enrollment process, you will see a confirmation number screen. PRINT THIS PAGE as proof of your enrollment or write down the number. Enter an email address and receive a confirmation message.

You should immediately review the confirmation you receive. If it does not contain a confirmation number, you must re-enroll prior to the end of Open Enrollment.

Print or write down your enrollment confirmation number for your records.

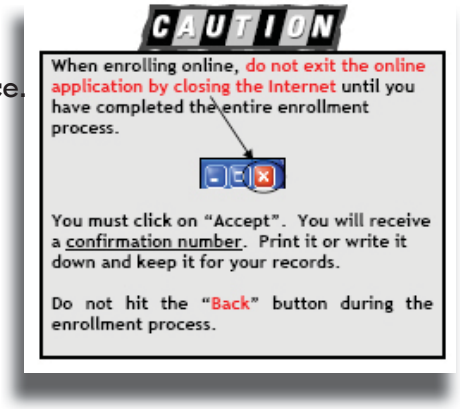
DID YOU KNOW . . .

All KEHP benefit plans offer unlimited lifetime maximums.

Tips

Go to http://kehp.ky.gov to enroll online. Click on "Your KEHP On-line Access" link. You will find a tutorial at http://kehp.ky.gov.

You will need your employee ID # and your password, which you should have received in a letter from the Department of Employee Insurance.



Before you begin:

Num Lock should be ON

Caps Lock should be OFF

The first three (3) letters of the employee ID are capitalized.

The first two (2) letters of the password are capitalized.

After three (3) unsuccessful attempts, you will be locked out and will need to contact your Insurance Coordinator or the Commonwealth Office of Technology for a new password.

Paper

Most participants will be able to enroll on-line, but there are a few exceptions. You will have to complete a paper Enrollment Application and submit it to your Insurance Coordinator if you are:

- A retiree;
- Paying by cross-reference with a retiree;
- A new employee who has not yet enrolled for 2008; or
- Switching the "primary" planholder on a cross-reference payment option.

Reason for Application

At the top of the application you will see several reasons why an application should be completed. EVERYONE should mark **Open Enrollment.**

If you are already a member in a cross-reference payment option, and you would like to end it, you and your spouse will need to complete separate paper applications and submit them to your Insurance Coordinators. Your coordinators will need to mail these applications to DEI.

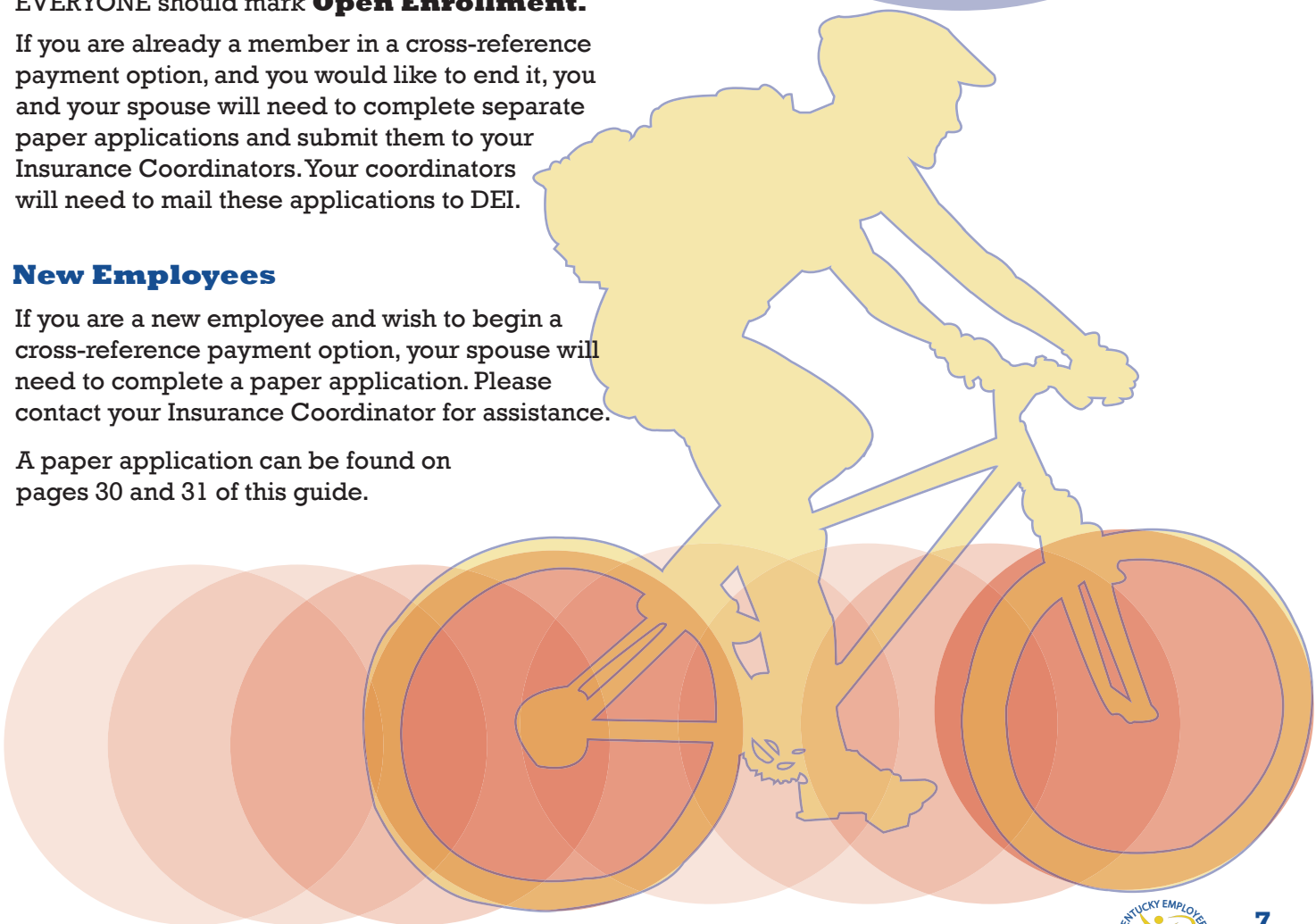
New Employees

If you are a new employee and wish to begin a cross-reference payment option, your spouse will need to complete a paper application. Please contact your Insurance Coordinator for assistance.

A paper application can be found on pages 30 and 31 of this guide.

PLEASE NOTE:

KEHP plans to conduct a Dependent Eligibility Audit during the 2009 Plan Year. The purpose of the audit is to verify that each dependent listed on your plan is actually eligible for coverage. You should review the dependent eligibility section of the 2009 Plan Year KEHP Handbook to determine if your dependents are eligible for the KEHP plan; if not, you should remove them during Open Enrollment. Covering ineligible dependents may be considered insurance fraud.



2009 Employee Contributions

Monthly Non-Smoker Rates

Benefit Plan	Employer Contribution		Employee Contribution*		Total Premium
Commonwealth Maximum Choice					
Single	$527.92	+	$0.00	=	$ 527.92
Parent Plus	681.28	+	103.18	=	784.46
Couple	773.40	+	317.22	=	1,090.62
Family	863.48	+	379.44	=	1,242.92
Family Cross-Reference**	612.30	+	9.16	=	621.46
Commonwealth Optimum PPO					
Single	$541.20	+	$25.00	=	$ 566.20
Parent Plus	654.14	+	167.32	=	821.46
Couple	820.06	+	445.04	=	1,265.10
Family	875.40	+	531.92	=	1,407.32
Family Cross-Reference**	676.80	+	26.86	=	703.66
Commonwealth Capitol Choice					
Single	$545.08	+	$0.00	=	$ 545.08
Parent Plus	692.24	+	134.14	=	826.38
Couple	828.78	+	420.96	=	1,249.74
Family	885.08	+	498.44	=	1,383.52
Family Cross-Reference**	679.56	+	12.20	=	691.76
Commonwealth Standard PPO					
Single	$446.24	+	$0.00	=	$ 446.24
Parent Plus	625.28	+	64.72	=	690.00
Couple	739.10	+	305.38	=	1,044.48
Family	785.44	+	376.72	=	1,162.16
Family Cross-Reference**	581.08	+	0.00	=	581.08

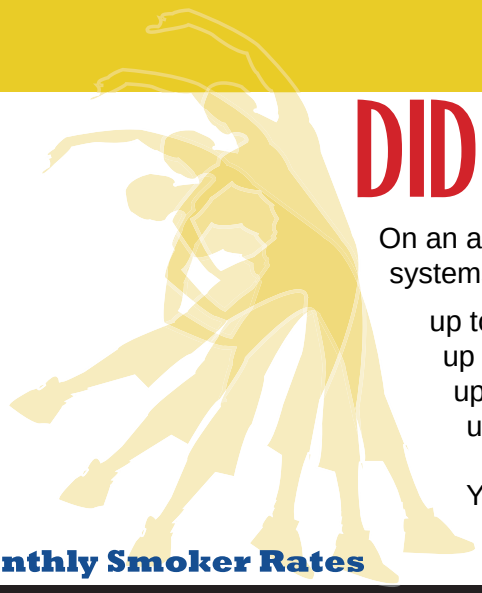
* All employee contributions are per employee.

** For additional information about the family cross-reference payment option, please consult the 2009 Plan Year KEHP Handbook at http://kehp.ky.gov.

Note: If either employee in a Family Cross-Reference plan is a smoker, each employee is subject to the Monthly Smoker Rates.

DID YOU KNOW !!!

On average, the employer groups and retirement systems which participate in KEHP pay 85% of the cost of employee health benefits.



DID YOU KNOW . . .

On an annual basis, the employer groups and retirement systems which participate in KEHP contribute:

up to $6,541 for each “Single” plan;
up to $8,307 for each “Parent Plus” plan;
up to $9,945 for each “Couple” plan;
up to $10,620 for each “Family” plan.

Your KEHP health insurance is a valuable benefit!

Monthly Smoker Rates

Benefit Plan	Employer Contribution		Employee Contribution*		Total Premium
Commonwealth Maximum Choice					
Single	$ 506.92	+	$21.00	=	$ 527.92
Parent Plus	639.28	+	145.18	=	784.46
Couple	731.40	+	359.22	=	1,090.62
Family	821.48	+	421.44	=	1,242.92
Family Cross-Reference**	591.30	+	30.16	=	621.46
Commonwealth Optimum PPO					
Single	$ 520.20	+	$ 46.00	=	$ 566.20
Parent Plus	612.14	+	209.32	=	821.46
Couple	778.06	+	487.04	=	1,265.10
Family	833.40	+	573.92	=	1,407.32
Family Cross-Reference**	655.80	+	47.86	=	703.66
Commonwealth Capitol Choice					
Single	$ 524.08	+	$ 21.00	=	$ 545.08
Parent Plus	650.24	+	176.14	=	826.38
Couple	786.78	+	462.96	=	1,249.74
Family	843.08	+	540.44	=	1,383.52
Family Cross-Reference**	658.56	+	33.20	=	691.76
Commonwealth Standard PPO					
Single	$ 425.24	+	$21.00	=	446.24
Parent Plus	583.28	+	106.72	=	690.00
Couple	697.10	+	347.38	=	1,044.48
Family	743.44	+	418.72	=	1,162.16
Family Cross-Reference**	560.08	+	21.00	=	581.08

* All employee contributions are per employee.

** For additional information about the family cross-reference payment option, please consult the 2009 Plan Year KEHP Handbook at http://kehp.ky.gov.

Note: If either employee in a Family Cross-Reference plan is a smoker, each employee is subject to the Monthly Smoker Rates.

Health Plan Choices

Who Is Eligible?

Regular full-time employees (and dependents) of the following agencies who contribute to one of the state-sponsored retirement systems, or who are otherwise defined in KRS 18A.225, are eligible to participate:

- State Agencies
- Boards of Education
- Health Departments
- Members of quasi-governmental agencies who pay into a state-sponsored retirement system and have elected to participate in the Kentucky Employees Health Plan (KEHP)
- School Board members participate on a post-tax basis only. Board members are responsible for the payment of the total premiums per KRS 160.280(4).
- Retirees
- COBRA qualified beneficiaries

Eligible employees who choose to waive KEHP medical coverage will receive a $175 per month contribution towards a Health Reimbursement Account (HRA).

What Are My Plan Choices?

Different individuals have different health care needs. For this reason, KEHP will offer four different health plan choices during the 2009 Plan Year. Three of the four KEHP plans feature a $0 employee contribution for single coverage. While you are free to choose where to receive your care, all four plans offer an opportunity to save money by utilizing an extensive network of preferred providers. None of the four plans require referrals.

All four plans feature 100% coverage for most or all preventive services. All four plans also feature low, annual out-of-pocket maximums and unlimited lifetime maximums. With health care inflation and the ever-increasing cost of new lifesaving therapies causing more and more individuals to exceed benefit "caps" in other programs, KEHP's unlimited lifetime maximums ensure your health insurance benefits will not run out. Regardless of which KEHP plan you choose, you will have a comfortable safety net in the event of a chronic or catastrophic condition.

How Do I Choose a Plan?

There are several factors to consider when choosing a health benefit plan. To begin with, you should consider how much money will be deducted from your paycheck(s) on a monthly and annual basis to pay for the plan. These periodic employee contributions are sometimes referred to as your "out-of-paycheck" costs.

You should also consider how much additional money you will have to pay in the event you receive medical care. These expenses are sometimes referred to as your "out-of-pocket" costs. To determine your out-of-pocket costs, you need to estimate the dollar amount(s) of all medical and pharmacy expenses you expect to incur during the 2009 Plan Year.

A Brief Overview of the 2009 KEHP Benefit Plans Is Presented Below:

Commonwealth Maximum Choice

Commonwealth Maximum Choice is a modern health insurance plan known as a "consumer-driven" health plan. Commonwealth Maximum Choice is a good choice for people at both ends of the health care spectrum: those who are healthy and have few, if any, medical and pharmacy expenses; and those who have chronic or other significant medical conditions with above-average expenses.

According to our actuaries, Commonwealth Maximum Choice has the richest benefits of any KEHP plan. At the same time, it has the second lowest employee contributions in the program. Employees who choose Commonwealth Maximum Choice will enjoy substantial "out-of-paycheck" savings throughout the Plan Year.

Besides its low employee contribution, Commonwealth Maximum Choice comes with a KEHP-funded pool of money known as a Health Reimbursement Account (HRA). HRA funds can be used for a variety of qualified medical, dental, vision, and other expenses. Non-medical covered expenses do not count toward your deductible or out-of-pocket maximum.

Commonwealth Maximum Choice is "consumer-driven" because it lets you decide whether to use your HRA funds and what to use them for. In the event you continue to pick health

benefit plans with HRAs, any and all HRA funds not used during the current year will be "rolled over" for use in future years.

HRA amounts in Commonwealth Maximum Choice start at $1,000 for single coverage; increase to $1,500 for parent plus and couple coverage; and increase even more to $2,000 for family coverage.

In many cases, the combined effect of the "out-of-paycheck" savings and HRA funds associated with Commonwealth Maximum Choice will largely or completely offset the deductibles associated with the plan; and once you satisfy your deductible, Commonwealth Maximum Choice will pay up to 90% of most in-network expenses until you reach your annual, maximum out-of-pocket limit!

PLEASE NOTE:

Commonwealth Maximum Choice replaces the Commonwealth Select plan. Participants in the 2008 Select plan who pick Commonwealth Maximum Choice for 2009 will "roll over" any unused 2008 HRA funds into the HRA attached to Commonwealth Maximum Choice.

Due to the nature of the HRA accompanying Commonwealth Maximum Choice, retirees are NOT ELIGIBLE to participate in Commonwealth Maximum Choice.

Commonwealth Optimum PPO

Commonwealth Optimum PPO is a traditional Preferred Provider Organization (PPO) plan. Commonwealth Optimum PPO is a good choice if you are willing to have larger paycheck deductions in exchange for lower out-of-pocket costs. As with all KEHP plans, you pay less when you use in-network providers. The plan also provides coverage when you use out-of-network providers, but in most cases you will pay more.

Commonwealth Optimum PPO offers the peace of mind of knowing that you have fixed, predictable co-pays for physician office visits, prescription medications, and various other services.

Commonwealth Capitol Choice

Commonwealth Capitol Choice is a unique, hybrid health plan which combines features of a modern, consumer-driven health plan with features of a traditional PPO plan. Commonwealth Capitol Choice is "consumer-driven" because it offers a special $500 per family member "benefit allowance" that provides 100% coverage (subject to co-pays) for many in-network services before you start paying towards your deductible. The $500 per family member benefit allowance should not be viewed as a spending account: it is different from an HRA in the sense that it cannot be used for non-medical or out-of-network services, and it does not "roll over" from year-to-year.

Commonwealth Capitol Choice is "PPO-like" because it offers traditional features of a PPO plan such as predictable office visit and pharmacy co-pays. Another extremely valuable feature of Commonwealth Capitol Choice is the $100 per admission hospital co-pay. After payment of the $100 per admission co-pay and a $500 annual deductible, you pay nothing for additional hospital facility charges.

Commonwealth Capitol Choice should work especially well for people with annual medical expenses below $500, and people looking for a plan with excellent inpatient hospital facility benefits.

Commonwealth Standard PPO

Commonwealth Standard PPO is a value-based, traditional PPO plan. Although it features higher deductibles, higher member co-insurance percentages, and higher annual out-of-pocket maximums than Commonwealth Optimum PPO, it offers lower premiums.

Commonwealth Standard PPO is a good choice for people who are mainly interested in a good, basic plan to provide catastrophic coverage and those who want dependent coverage at a lower price.

Selecting a Plan

Scenario 1:
Commonwealth Maximum Choice

John is a 24-year-old, unmarried transportation worker. He only occasionally goes to the doctor. In selecting a health plan, he is mainly interested in a low premium and coverage for his infrequent doctor visits. John needs single coverage.

In reviewing his options, John notices three of the four plans offered by KEHP do not require any employee contribution for single coverage. John ultimately settles on Commonwealth Maximum Choice. Although it has a higher deductible, single coverage comes with a $1,000 Health Reimbursement Account (HRA) funded by the health plan. The HRA funds can be used for qualified medical, dental, vision, and other types of expenses. Non-medical covered expenses do not count toward your deductible or out-of-pocket maximum.

John estimates his annual medical and pharmacy expenses will cost only $400. He concludes the $1,000 in HRA funds will easily cover those expenses and will also enable him to purchase a $300 pair of glasses. If John chooses an HRA plan again next year, any unused HRA funds will "roll over" to the next year.

Scenario 2:
Commonwealth Capitol Choice

Mary is a 57-year-old, retired school teacher. Her husband recently had a heart attack and ended up with inpatient hospital facility charges of over $40,000. Mary is relieved to learn every KEHP plan has unlimited lifetime benefits. Mary is interested in a plan with good hospital benefits. Mary needs couple coverage.

After reviewing her options, Mary learns retirees are not eligible for Commonwealth Maximum Choice. Mary instead focuses on Commonwealth Capitol Choice. The very first thing Mary notices about Commonwealth Capitol Choice is the $500 per person, up-front "benefit allowance." The benefit allowance provides up to $500 per person, per year in "first dollar coverage" after co-pays for many types of in-network expenses excluding prescription drugs.

Mary is also attracted to the generous inpatient hospital facility benefit. The total, out-of-pocket inpatient facility cost is only $600 — a $100 per admission, inpatient hospital co-pay plus a $500 per person deductible. After payment of the co-pay and deductible, Commonwealth Capitol Choice pays 100% of eligible expenses for that admission.

Scenario 3:
Commonwealth Optimum PPO

Angela is a 38-year-old, divorced, school principal with 2 young children. Each year, the children require numerous visits to the pediatrician. Last year, Angela had a PPO plan with a $10 physician office visit co-pay. Her plan also had set pharmacy co-pays. Angela needs parent plus coverage.

After reviewing her options, Angela chooses Commonwealth Optimum PPO. Although the employee contribution for that plan is somewhat higher than the employee contributions for other plans, Angela likes the fact that Commonwealth Optimum PPO enables her to know beforehand how much each doctor visit and each medicine will cost. In the event of a catastrophic injury, Commonwealth Optimum PPO also has a lower annual, out-of-pocket maximum than other plans.

Scenario 4:
Commonwealth Maximum Choice

Sam is a 41-year-old, accountant for a local government. He has a wife and 4 kids. As an accountant, Sam knows that his "out-of-paycheck" costs may be just as important as his "out-of-pocket" costs. In other words, Sam knows that the annual cost savings associated with a lower employee contribution may offset some or all of a higher deductible. Sam needs family coverage.

After reviewing his options, Sam focuses on Commonwealth Optimum PPO and Commonwealth Maximum Choice. At first, the $3,000 family deductible for Commonwealth Maximum Choice seems high – especially when compared to the $500 family deductible for Commonwealth Optimum PPO. However, Sam quickly realizes the annual employee contribution for family coverage under Commonwealth Maximum Choice is $1,830 less than the annual employee contribution for family coverage under Commonwealth Optimum PPO.

Sam further realizes if he chooses Commonwealth Maximum Choice plan, his family will receive $2,000 in HRA funds. The $1,830 in premium savings plus the $2,000 in HRA money will give Sam $3,830 — more than enough to cover the $3,000 family deductible. Once the family deductible has been satisfied, Sam will have to pay only 10% of any additional costs until the annual, family, out-of-pocket maximum has been met. For this reason, Sam chooses Commonwealth Maximum Choice.

Scenario 5:
Commonwealth Standard PPO

Susie is a 19-year-old food service worker. She and her husband are healthy with very few medical issues or costs. They typically go to the doctor only once a year

for their preventive exams. They very rarely have prescriptions or other medical needs. Susie needs couple coverage.

As Susie reviews her take-home pay and her budget, she realizes the lowest premium is the most important to her.

Susie selects Commonwealth Standard PPO plan. Although it has a relatively high deductible and annual out-of-pocket maximum, it also has the lowest employee contribution of any coverage offered by KEHP.

Scenario 6:
Cross Reference

Curtis is a 53-year-old, retired social worker who participates in KEHP through his retirement system. His wife, Jennie, is a 46-year-old school secretary who participates in KEHP through her school system. They have a teenage son. Curtis and Jennie need family coverage. Since each is insured through an organization which participates in KEHP, they qualify for the "cross-reference" payment option.

Curtis and Jennie have different thoughts about the type of plan they should choose. Curtis wants a consumer-directed plan which allows the insured to manage a pool of money to cover medical costs. Jennie wants a PPO-type plan.

Curtis and Jennie agree on Commonwealth Capitol Choice because it combines features of a consumer-directed plan with features of a PPO-type plan. Curtis likes the "first dollar coverage" after co-pays provided by the $500 per person, up-front, benefit allowance, while Jennie likes the fixed doctor office visit and pharmacy co-pays. They both like the low employee contributions associated with the cross-reference payment option!

Prescription Benefits

Express Scripts

Prescription coverage is administered by the Pharmacy Benefit Administrator Express Scripts, Inc. The amount you pay will depend on whether the drug prescribed is a generic equivalent, brand-preferred drug, or brand non-preferred.

Generic Requirement

If a generic drug is available, Kentucky Law requires the pharmacy to dispense the generic drug. Generic drugs are therapeutically equivalent to brand name drugs whose patents have expired. If you request the brand name drug, you will pay the brand name co-pay/co-insurance plus the difference in the total cost of the generic and total cost of the brand name.

Formulary Information

You may view the list of formulary drugs at http://kehp.ky.gov.

Mail Order

The mail order drug benefit provides a ninety (90) day supply of maintenance drugs for a two-month co-pay or co-insurance. Express Scripts utilizes First Data Bank to determine which drugs are considered maintenance drugs. First Data Bank makes this determination based on the drug company's recommended dosage and the Food and Drug Administration.

To qualify for the mail order benefit, the drug must be listed on Express Script's maintenance drug list and you must have filled at least one thirty (30) day supply or one ninety (90) day supply within the last 180 days. If you fill a ninety (90) day supply, and for any reason do not refill within 180 days, you will be required to again have one thirty (30) day fill prior to receiving another supply at the reduced co-pay or co-insurance.

The mail order benefit is available two ways:

- Through Express Scripts mail order program, which delivers your prescription straight to your door; or
- At participating retail pharmacies by simply going to the retail pharmacy to pick up your prescription. For a listing of the local retail pharmacies participating in the mail order program, refer to the KEHP website or contact Express Scripts.

PLEASE NOTE:

90-day supplies of maintenance drugs may be purchased at participating local retail pharmacies.

For additional information about prior authorization, step therapy, quantity level limits, inherited metabolic diseases, CuraScript Specialty Pharmacy, and other pharmacy issues, please consult the 2009 Plan Year KEHP Handbook at http://kehp.ky.gov.

2009 Benefits Grid

Benefit Plan	Commonwealth Maximum Choice		Commonwealth Optimum PPO		Commonwealth Capitol Choice		Commonwealth Standard PPO	
	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Up-Front Benefit Allowance	Not Applicable	Not Applicable	Not Applicable	Not Applicable	$500 per Family Member (In-Network Only)	Not Applicable	Not Applicable	Not Applicable
Health Reimbursement Account (HRA)	Health Reimbursement Account: Single $1,000 Parent Plus $1,500 Couple $1,500 Family $2,000 Cross Ref. $2,000 (In - and Out-of-Network Combined)		Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Annual Deductible	Single $2,000 Family $3,000	Single $2,000 Family $3,000	Single $250 Family $500	Single $500 Family $1,000	Single $500 Family $1,500	Single $1,000 Family $3,000	Single $750 Family $1,500	Single $1,500 Family $3,000
Co-insurance	Plan pays 90% You pay 10%	Plan pays 60% You pay 40%	Plan pays 85% You pay 15%	Plan pays 70% You pay 30%	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%	Plan pays 75% You pay 25%	Plan pays 50% You pay 50%
Annual Out-of-Pocket Maximum	Single $3,000 Family $4,500	Single $4,000 Family $6,000	Single $1,125 Family $2,250	Single $2,250 Family $4,500	Single $2,000 Family $6,000	Single $4,000 Family $12,000	Single $3,500 Family $7,000	Single $7,000 Family $14,000
	All covered expenses apply to the out-of-pocket maximum.		Excludes prescription drug co-pays and all other co-pays		Excludes prescription drug co-pays and all other co-pays		Excludes prescription drug expenses and emergency room co-pays	

* Applies to out-of-pocket maximum ** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $15 2nd tier and $30 3rd tier.

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2009 Benefits Grid

Benefit Plan	Commonwealth Maximum Choice		Commonwealth Optimum PPO		Commonwealth Capitol Choice		Commonwealth Standard PPO	
	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network
	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Hospital Services								
Inpatient Hospital (Semi-Private Room)	Deductible then 10%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	$100 co-pay per admission plus Deductible then 0%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Outpatient Surgery	Deductible then 10%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	$50 co-pay plus Deductible then 0%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Outpatient Diagnostic X-ray and Lab	Deductible then 10%*	Deductible then 40%*	$10 per provider/ member/site	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Pre-admission Testing	Deductible then 10%*	Deductible then 40%*	$10 co-pay	Deductible then 30%*	Pay 0%	Pay 0%	Deductible then 25%*	Deductible then 50%*
Emergency Room	Deductible then 10%*	Deductible then 40%*	$50 co-pay plus 15%*	$50 co-pay then deductible plus 30%*	$100 co-pay plus Deductible then 0%	$100 co-pay plus Deductible then 0%	$50 co-pay then deductible and 25%*	$50 co-pay then deductible and 50%*
			Co-pay waived if admitted		Co-pay waived if admitted		Co-pay waived if admitted	
E.R. Physician	Deductible then 10%*	Deductible then 40%*	15%*	Deductible then 30%*	Deductible then 0%*	Deductible then 0%*	Deductible then 25%*	Deductible then 50%*
Other Facility Services								
Free Standing Surgical Facility	Deductible then 10%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	$50 co-pay plus 0%	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Urgent Care Facility	Deductible then 10%*	Deductible then 40%*	$20 co-pay	Deductible then 30%*	$50 co-pay plus 0%	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Physician Services								
Qualified Practitioner (Office Visits)	Deductible then 10%*	Deductible then 40%*	$10 co-pay	Deductible then 30%*	$15 co-pay plus 0%	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Qualified Practitioner (Other than Office Visits)	Deductible then 10%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Injections (Other than Routine)	Deductible then 10%*	Deductible then 40%*	$10 co-pay	Deductible then 30%*	$5 co-pay plus 0%	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Diagnognostic X-ray and Lab								
Office Setting (Same Site / Same Day as Office Visit)	Deductible then 10%*	Deductible then 40%*	Office visit co-pay then 0%	Deductible then 30%*	Office visit co-pay then 0%	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Independent Lab & X-ray	Deductible then 10%*	Deductible then 40%*	Office visit co-pay then 0%	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Outpatient Hospital X-ray	Deductible then 10%*	Deductible then 40%*	$10 co-pay	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
E.R. Setting	Deductible then 10%*	Deductible then 40%*	Deductible then 15%* after ER co-pay	Deductible then 30%* after ER co-pay	Deductible then 0%* after ER co-pay	Deductible then 40%*	Deductible then 25%* after ER co-pay	Deductible then 50%* after ER co-pay
Anesthesia and Surgery Services								
Office / Clinic Setting	Deductible then 10%*	Deductible then 40%*	Office visit co-pay then 0%	Deductible then 30%*	Office visit co-pay then 0%	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*

* Applies to out-of-pocket maximum ** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $15 2nd tier and $30 3rd tier.
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2009 Benefits Grid

Benefit Plan	Commonwealth Maximum Choice		Commonwealth Optimum PPO		Commonwealth Capitol Choice		Commonwealth Standard PPO	
	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network
	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Inpatient or outpatient setting	Deductible then 10%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Routine Child Care Ages 0-18								
Exam and Immunizations	Pay 0%	Not Covered	$10 co-pay	Deductible then 30%*	$15 co-pay then 0%	Deductible then 40%*	Pay 0%	Pay 0%
Lab and X-ray (Same Site / Same Day as Office Visit)	Pay 0%	Not Covered	Pay 0%	Deductible then 30%*	Pay 0%	Deductible then 40%*	Pay 0%	Pay 0%
Routine Adult Care Ages 18 and older								
Exam and testing	Pay 0%	Not Covered	$10 co-pay	Deductible then 30%*	$15 co-pay then 0%	Deductible then 40%*	Pay 0%	Pay 0%
	Sometimes during the course of a screening procedure (routine wellness or preventive care), abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider. This may result in a possible difference in your co-pay and/or co-insurance.							
Lab and X-ray (Same Site / Same Day as Office Visit)	Pay 0%	Not Covered	Pay 0%	Deductible then 30%*	Pay 0%	Deductible then 40%*	Pay 0%	Pay 0%
Inpatient Newborn Benefits								
Well newborn	Deductible then 10%*	Deductible then 40%*	15% co-insurance*	30% co-insurance*	Pay 0%	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Sick Newborn	Deductible then 10%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Pay 0%	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Maternity Care								
Prenatal Care, Labor, Delivery, Postpartum Care, and One Ultrasound per Pregnancy (Additional Ultrasounds Subject to Prior Plan Approval)	Deductible then 10%*	Deductible then 40%*	$10 co-pay (limited to office visit in which pregnancy is diagnosed). Delivery charge subject to Deductible then 15%*	Deductible then 30%*	$15 co-pay (limited to office visit in which pregnancy is diagnosed.) Delivery charge subject to $100 co-pay per admission plus Deductible then 0%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Chemotherapy and Radiation Therapy								
Office / Clinic Setting	Deductible then 10%*	Deductible then 40%*	$10 co-pay	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Outpatient Hospital Setting	Deductible then 10%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Miscellaneous Benefits								
Autism Service	$500 monthly maximum		$500 montly maximum		$500 monthly maximum		$500 montly maximum	
Rehabilitative and Therapeutic Care	Deductible then 10%*	Deductible then 40%*	$10 co-pay	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
	Therapy services for autism are payable under the specific therapy benefit first and once those limits are exhausted, services are covered under the autism benefit							
Respite Care Children Ages 2 - 21	Deductible then 10%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Ambulance Services	Deductible then 10%*	Deductible then 10%*	Deductible then 15%*	Deductible then 15%*	Deductible then 20%*	Deductible then 20%*	Deductible then 25%*	Deductible then 25%*

* Applies to out-of-pocket maximum ** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $15 2nd tier and $30 3rd tier.
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2009 Benefits Grid

Benefit Plan	Commonwealth Maximum Choice		Commonwealth Optimum PPO		Commonwealth Capitol Choice		Commonwealth Standard PPO	
	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network
	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Skilled Nursing Facility	Deductible then 10%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
	Maximum of thirty (30) days per calendar year		Maximum of thirty (30) days per calendar year		Maximum of thirty (30) days per calendar year		Maximum of thirty (30) days per calendar year	
Home Health Care	Deductible then 10%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
	Maximum of sixty (60) visits per calendar year		Maximum of sixty (60) visits per calendar year		Maximum of sixty (60) visits per calendar year		Maximum of sixty (60) visits per calendar year	
Hospice Care	Same as Medicare		Same as Medicare		Same as Medicare		Same as Medicare	
Physical Therapy	Deductible then 10%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
	Maximum of thirty (30) days per calendar year		Maximum of thirty (30) visits per calendar year		Maximum of thirty (30) days per calendar year		Maximum of thirty (30) days per calendar year	
Occupational Therapy	Deductible then 10%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
	Maximum of thirty (30) days per calendar year		Maximum of thirty (30) visits per calendar year		Maximum of thirty (30) days per calendar year		Maximum of thirty (30) days per calendar year	
Speech Therapy	Deductible then 10%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
	Maximum of thirty (30) days per calendar year		Maximum of thirty (30) visits per calendar year		Maximum of thirty (30) days per calendar year		Maximum of thirty (30) days per calendar year	
Cardiac Rehab. Therapy (Phase I and II)	Deductible then 10%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
	Maximum of thirty (30) days per calendar year		Maximum of thirty (30) visits per calendar year		Maximum of thirty (30) days per calendar year		Maximum of thirty (30) days per calendar year	
Rehab. Centers	Deductible then 10%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Hearing Aids (Covered Persons Under 18 Years of age)	Deductible then 10%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
	One (1) hearing aid per ear every 3 years, up to a maximum benefit of $1,400 per ear		One (1) hearing aid per ear every 3 years, up to a maximum benefit of $1,400 per ear		One (1) hearing aid per ear every 3 years, up to a maximum benefit of $1,400 per ear		One (1) hearing aid per ear every 3 years, up to a maximum benefit of $1,400 per ear	
Chiropractor, Exam, Therapy, Manipulations	Deductible then 10%*	Deductible then 40%*	$10 co-pay	Deductible then 30%*	$15 co-pay plus 0%	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
	Maximum of 26 visits per calendar year, no more than 1 visit per day		Maximum of 26 visits per calendar year, no more than 1 visit per day		Maximum of 26 visits per calendar year, no more than 1 visit per day		Maximum of 26 visits per calendar year, no more than 1 visit per day	
Durable Medical Equip. (Rental up to purchase price)	Deductible then 10%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 20%*	Deductible then 40%*	Deductible then 25%*	Deductible then 50%*
Prescription Drugs								
Retail Pharmacy Thirty (30) Day Supply								
							25%	
							Min	Max
1st Tier	Deductible then 10%*	Deductible then 40%*	$5	30%	$5		$10	$25
2nd Tier	Deductible then 10%*	Deductible then 40%*	$20**	30%	$20**		$20	$50
3rd Tier	Deductible then 10%*	Deductible then 40%*	$40**	30%	$40**		$35	$100
Mail Order Ninety (90) Day Supply								
							25%	
							Min	Max
1st Tier	Deductible then 10%*		$10		$10		$20	$50
2nd Tier	Deductible then 10%*		$40		$40		$40	$100
3rd Tier	Deductible then 10%*		$80		$80		$70	$200

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Benefits Estimator

This Benefits Estimator gives EXAMPLES of low, moderate, and high levels of annual health care expenses. The examples are all based on situations which could really occur. For instance, the example of "low annual expenses" in the "Single Coverage" table (below) is based on a situation involving a single individual who seldom needs medical or pharmacy services. The example assumes an individual who utilizes the following medical and pharmacy services in a year: 1 preventive primary care office visit ($106); 1 non-preventive primary care office visit ($106); miscellaneous laboratory charges ($400); and 2 "Tier 1" (generic) prescription medications ($104) — all for a total allowable amount of $716.

Within each EXAMPLE of low, moderate or high annual expenses, the Benefits Estimator demonstrates how much money a person might actually have to pay in annual "out-of-pocket" costs under each of the four KEHP benefit plans. The Benefits Estimator also demonstrates the annual "out-of-paycheck" costs associated with each plan. The out-of-pocket and out-of-paycheck costs are then combined to determine the "Total Member Cost" under each plan. Comparing the Total Member Costs associated with the various plans may be helpful in determining the best plan for you!

Using the Benefits Estimator is as Easy as 123

1 Find the table for the type of coverage you need (Single, Couple, Parent Plus, Family, or Cross-Reference).

2 Choose the column which most closely approximates a "best estimate" of your total annual medical + pharmacy expenses (Low, Moderate, or High).

3 In the column you have chosen, observe the "Total Member Cost" for each plan (Maximum Choice, Optimum PPO, Capitol Choice, or Standard PPO); the plan with the lowest "Total Member Cost" may represent the best value for your chosen level of health care expenses.

Single COVERAGE	Low Annual Expenses ($716)	Moderate Annual Expenses ($4,909)	High Annual Expenses ($22,746)
MAXIMUM CHOICE			
Out-of-Paycheck Cost:	$ 0	$ 0	$ 0
Out-of-Pocket Cost:	0	1,240	2,000
Total Member Cost:	$ 0	$ 1,240	$ 2,000
OPTIMUM PPO			
Out-of-Paycheck Cost:	$ 300	$ 300	$ 300
Out-of-Pocket Cost:	30	930	2,380
Total Member Cost:	$ 330	$ 1,230	$ 2,680
CAPITOL CHOICE			
Out-of-Paycheck Cost:	$ 0	$ 0	$ 0
Out-of-Pocket Cost:	40	1,560	3,810
Total Member Cost:	$ 40	$ 1,560	$ 3,810
STANDARD PPO:			
Out-of-Paycheck Cost:	$ 0	$ 0	$ 0
Out-of-Pocket Cost:	560	2,290	6,000
Total Member Cost:	$ 560	$ 2,290	$ 6,000

Couple COVERAGE	Low Annual Expenses ($1,432)	Moderate Annual Expenses ($9,818)	High Annual Expenses ($45,492)
MAXIMUM CHOICE			
Out-of-Paycheck Cost:	$ 3,807	$ 3,807	$ 3,807
Out-of-Pocket Cost:	0	2,080	3,000
Total Member Cost:	$3, 807	$ 5,887	$ 6,807
OPTIMUM PPO			
Out-of-Paycheck Cost:	$ 5,340	$ 5,340	$ 5,340
Out-of-Pocket Cost:	60	1,850	4,750
Total Member Cost:	$ 5,400	$ 7,190	$ 10,090
CAPITOL CHOICE			
Out-of-Paycheck Cost:	$ 5,052	$ 5,052	$ 5,052
Out-of-Pocket Cost:	80	2,730	7,210
Total Member Cost:	$ 5,132	$ 7,782	$12,262
STANDARD PPO:			
Out-of-Paycheck Cost:	$ 3,665	$ 3,665	$ 3,665
Out-of-Pocket Cost:	1,110	4,580	12,000
Total Member Cost:	$ 4,775	$ 8,245	$ 15,665

Parent Plus COVERAGE	Low Annual Expenses ($2,194)	Moderate Annual Expenses ($16,848)	High Annual Expenses ($114,429)
MAXIMUM CHOICE			
Out-of-Paycheck Cost:	$ 1,238	$ 1,238	$ 1,238
Out-of-Pocket Cost:	0	1,650	2,500
Total Member Cost:	$1,238	$ 2,888	$ 3,738
OPTIMUM PPO			
Out-of-Paycheck Cost:	$ 2,008	$ 2,008	$ 2,008
Out-of-Pocket Cost:	710	1,930	3,570
Total Member Cost:	$ 2,718	$ 3,938	$ 5,578
CAPITOL CHOICE			
Out-of-Paycheck Cost:	$ 1,610	$ 1,610	1,610
Out-of-Pocket Cost:	610	3,710	8,670
Total Member Cost:	$ 2,220	$ 5,320	$ 10,280
STANDARD PPO:			
Out-of-Paycheck Cost:	$ 777	$ 777	$ 777
Out-of-Pocket Cost:	1,600	4,530	9,400
Total Member Cost:	$ 2,377	$ 5,307	$10,177

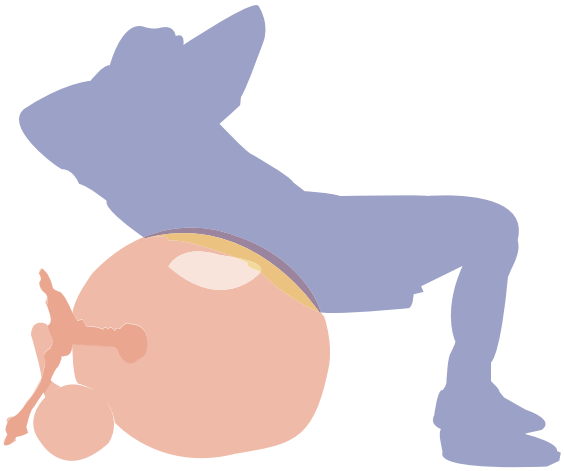
Cross Reference PAYMENT OPTION	Low Annual Expenses ($2,194)	Moderate Annual Expenses ($16,848)	High Annual Expenses ($114,428)
MAXIMUM CHOICE			
Out-of-Paycheck Cost:	$ 220	$ 220	$ 220
Out-of-Pocket Cost:	0	1,650	2,500
Total Member Cost:	$ 220	$ 1,870	$ 2,720
OPTIMUM PPO			
Out-of-Paycheck Cost:	$ 645	$ 645	$ 645
Out-of-Pocket Cost:	710	1,930	3,570
Total Member Cost:	$ 1,355	$ 2,575	$ 4,215
CAPITOL CHOICE			
Out-of-Paycheck Cost:	$ 293	$ 293	$ 293
Out-of-Pocket Cost:	610	3,710	8,670
Total Member Cost:	$ 903	$ 4,003	$ 8,963
STANDARD PPO:			
Out-of-Paycheck Cost:	$ 0	$ 0	$ 0
Out-of-Pocket Cost:	1,600	4,530	9,400
Total Member Cost:	$ 1,600	$ 4,530	$ 9,400

Family COVERAGE	Low Annual Expenses ($2,194)	Moderate Annual Expenses ($16,848)	High Annual Expenses ($114,428)
MAXIMUM CHOICE			
Out-of-Paycheck Cost:	$ 4,553	$ 4,553	$ 4,553
Out-of-Pocket Cost:	0	1,650	2,500
Total Member Cost:	$ 4,553	$ 6,203	$ 7,053
OPTIMUM PPO			
Out-of-Paycheck Cost:	$ 6,383	$ 6,383	$ 6,383
Out-of-Pocket Cost:	710	1,930	3,570
Total Member Cost:	$ 7,093	$ 8,313	$ 9,953
CAPITOL CHOICE			
Out-of-Paycheck Cost:	$ 5,981	$ 5,981	$ 5,981
Out-of-Pocket Cost:	610	3,710	8,670
Total Member Cost:	$ 6,591	$ 9,691	$ 14,651
STANDARD PPO:			
Out-of-Paycheck Cost:	$ 4,521	$ 4,521	$ 4,521
Out-of-Pocket Cost:	1,600	4,530	9,400
Total Member Cost:	$ 6,121	$ 9,051	$ 13,921

DID YOU KNOW . . .

28% of all KEHP members have total medical and pharmacy expenses of less than $500 per year.

40% of all KEHP members have total medical and pharmacy expenses of less than $1,000 per year.



Out-of-Paycheck Cost = Annual non-smoker employee premium contribution

Out-of-Pocket Cost = Annual estimated out-of-pocket cost for medical + pharmacy expenses

Total Member Cost = Out-of-paycheck cost + out-of-pocket cost

PLEASE NOTE:
Out-of-pocket costs shown in tables are estimates only; actual out-of-pocket costs may differ based on providers selected, services provided, and order in which claims for services are presented. Estimates of out-of-pocket costs have been rounded to the nearest $10.

Estimates of out-of-pocket costs for Commonwealth Maximum Choice plan include application of HRA funds associated with that plan.

Out-of-paycheck costs for cross-reference coverage have been doubled so as to include annual employee contributions for both participating employees.

http://kehp.ky.gov.

Q: I am retired; may I enroll in Commonwealth Maximum Choice during Open Enrollment?

A: No. This plan is only available for active employees.

Q: If I choose Commonwealth Maximum Choice for 2009 and have funds remaining at the end of the year, but choose another plan in 2010, will I retain the remaining funds in the HRA?

A: No. If you switch plans, any remaining HRA funds will be forfeited as of the termination date.

Q: Am I eligible to elect the family cross-reference payment option?

A: To be eligible to elect the cross-reference payment option, each of the following requirements must be met:

- The members must be eligible employees or retirees of a group participating in KEHP;
- The members must be legally married (husband and wife) with at least one dependent; and
- The members must elect the same benefit plan.

Q: If I drop my dependent during Open Enrollment, will they be eligible for COBRA?

A: Dependents dropped during Open Enrollment are not eligible for COBRA, unless the removal is in anticipation of a Qualifying Event. (Make sure your Insurance Coordinator knows that the change is related to a Qualifying Event instead of an Open Enrollment change.)

Q: If I elect coverage during Open Enrollment and my spouse has Open Enrollment at a later date, may I make changes to my plan?

A: Yes. We will require documentation from the spouse's employer on company letterhead identifying the Open Enrollment deadline, effective dates, and persons who are being added to or dropped from the spouse's policy.

Q: I am an active employee and my spouse will be turning 65 and eligible for Medicare. Do I have to drop him/her from my plan?

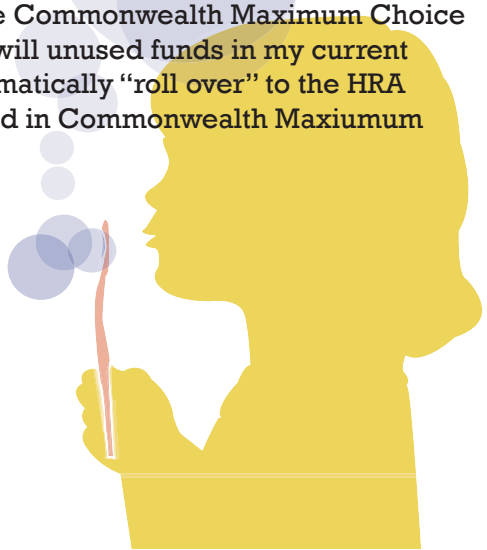
A: No. As long as you are actively working, you can keep your spouse on your plan even after he/she turns 65 and becomes Medicare eligible. However, your KEHP will be the primary insurance on your spouse and Medicare will be secondary.

Q: If I elect coverage during Open Enrollment and after the Plan Year starts I become eligible for insurance under my spouse, may I drop coverage here and receive the HRA contribution?

A: If you gain group health insurance coverage, that is a Qualifying Event which will enable you to drop coverage here; however, you will not receive the HRA contribution if the Plan Year has already started.

Q: I currently have the Commonwealth Select plan - the plan with a Health Reimbursement Account (HRA) embedded in the benefits. If I choose Commonwealth Maximum Choice for 2009, will unused funds in my current HRA automatically "roll over" to the HRA embedded in Commonwealth Maxiumum Choice?

A: Yes.



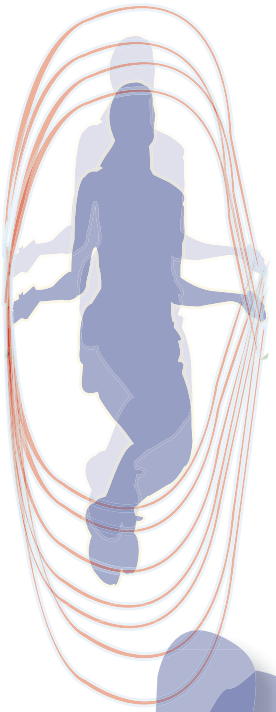
Your Choices
Your Health
Your Health Plan

The choices you make each day affect your health and well-being, but they also affect the efficiency of your health plan.

The Kentucky Employees Health Plan (KEHP) has developed new plans for you to choose from this year that will accommodate the various needs you may have, but the reality is your health is up to you.

- **Choosing healthy snacks and eating the right foods is important.**
- **Making sure you drink enough water is essential.**
- **Trying to include more physical activity into your regular routine is important: take the stairs, park further away, walk the dog, investigate a new sport.**

Let's all get off the sidelines, Kentucky, and take charge of our own health and wellness. You can do it, and KEHP is committed to helping.



Dependent Eligibility

The following dependents are eligible for participation under the Kentucky Employees Health Plan (KEHP):

1) An employee's spouse under an existing legal marriage; and
2) A planholder's unmarried dependent child.

Age Limits	Eligibility Qualifier 1	Eligibility Qualifier 2	Tax Treatment
0 up to 19th Birthday	Must meet KEHP dependent definition and Q.C. definition (does not require full-time student status)	Must meet KEHP dependent definition and Q.R. definition.	Pre-tax
19 to end of 23rd year	Must meet KEHP dependent definition and Q.C. definition. (requires full-time student status)	Must meet KEHP dependent definition and Q.R. definition.	Pre-tax
Up to 25th birthday	Cannot meet Q.C. definition due to age.	Must meet KEHP dependent definition and Q.R. definition.	Post-tax, but may be eligible for Pre-tax

Under a new option for 2009, KEHP planholders will be able to cover their unmarried dependent children up to the end of the month in which the dependent turns 25. Choosing this new option for your unmarried dependent child(ren) may subject your employee contributions to different tax treatment.

Dependent Child Eligibility

Pursuant to KRS 304.17A-256, KEHP rules for Unmarried Dependent Children.
(For purposes of Health Plan eligibility):

1) Unmarried;
2) Has a specific, family-type relationship to the planholder (a child of the planholder, stepchild, adopted\placed child, foster child or grandchild);
3) Planholder is primarily responsible for dependents maintenance and support; and
4) Is under age 25.

NOTE:
A dependent must meet KEHP's elibility rules before a planholder may add the dependent to the Plan. Upon reaching age 25, the dependent child will become ineligible and be terminated as a dependent at the end of the month in which the birthday occurs.

NOTE:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. This includes adding a dependent to the Plan who does not meet the KEHP eligibility rules.

Section 125 Cafeteria Plan and Working Families Tax Relief Act (WFTRA) of 2004

In the Working Families Tax Relief Act (WFTRA) of 2004 (I.R.C. § 152), Congress changed the way the Internal Revenue Service treats children under the tax code. This change may affect planholders if they pay their health insurance premiums pre-tax through KEHP's Section 125 cafeteria plan. The WFTRA of 2004 developed a new definition for "qualified child" and "qualified relative." An employee will NOT be able to pay dependent premiums on a pre-tax basis if the employee's/planholder's dependent(s) CANNOT MEET ONE of these definitions (qualifying child or qualifying relative).

Pursuant to I.R.C. § 152, the definitions are as follows:

1. A *"qualifying child"* (QC) of an employee under Code § 152, there are four tests—the relationship, residency, age, and limited self-support tests.

A "qualifying child" (QC) is a child who is unmarried and:

- Has a specific, family-type relationship to the member taxpayer (a child of the employee, ...etc.)
- Resides with the member in his/her household for more than half of the tax year (with certain exceptions such as "temporary absences" if a full-time student).
- Is under age 19 and not a full-time student (or under age 24 if a full-time student) as of the end of the calendar year in which the member's taxable year begins. A "student" means an individual who, during each of five calendar months during the calendar year in which the employee's taxable year begins, is a full-time student at an educational organization;
- There is no age requirement if a child is permanently and totally disabled;
- Individual must not provide more than half of his or her own support for the calendar year in which the taxable year of the employee begins.

2. In order to be a *"qualifying relative"* (QR) of an employee under Code § 152(d), there are three tests—the relationship, support, and not anyone's qualifying child tests.

A "qualifying relative" (QR) is a child or other individual who:

For additional information, consult the 2009 Plan Year KEHP Handbook at

- Has a specific, family-type relationship to the member taxpayer (a child of the employee,...etc) and is someone who resides with the employee in his/her household for the member's taxable year.
- A person cannot be a "qualifying relative" of the member if at any time during the taxable year the relationship between the member and the person violates federal, state, or local law;
- Receives over half of his/her own support from the member-taxpayer. (Support includes food, shelter, clothing, medical and dental care, education, and the like.)
- Is not anyone's (including the member's) "qualifying child." (See definition above.)

NOTE:

An individual generally will not be a dependent under Code § 152 if he or she is a dependent of a Code § 152 dependent, a married dependent filing a joint tax return, or a citizen or national of a country other than the United States.

Tax Consequences

Paying dependent premiums on a pre-tax basis for an individual who does not meet the definition of "qualifying child" or "qualifying relative" may be in violation of federal tax law. However, if a dependent child fails to meet the requirements of an I.R.C. § 152 "qualifying child" or "qualifying relative" he or she may be eligible to be covered as a dependent on a post-tax basis pursuant to KEHP plan eligibility defined by KRS 304.17A-256. If you are electing to cover a dependent on a post-tax basis then you must acknowledge the post-tax status.

Other Eligibility Limitations

1) Employees, retirees, and COBRA participants may only be covered under one (1) state-sponsored plan.
2) Dependents may only be covered under one (1) state-sponsored plan. In the case of a child from divorced parents, the parent with custody shall have first option to cover the dependent child, unless both employees/planholders agree otherwise in writing.

For complete eligibility and dependent eligibility information please see:

2009 Plan Year Kentucky Employees Health Plan Handbook at http://kehp.ky.gov.

What is the Family Cross-Reference Payment Option?

The family cross-reference payment option is a legislatively mandated payment option made only available for two (2) eligible employees who are: legally married and have at least one (1) eligible dependent. When choosing this option, the dual planholders are required to elect the same benefit plan, complete all other required information when enrolling, and have both planholders authorize or sign the enrollment application.

How does loss of employment and divorce affect the Cross-Reference Payment Option?

A family cross-reference payment option is a legislatively mandated payment option for two (2) eligible employees. Thus, the family cross-reference payment option in fact has two (2) planholders.

If either planholder loses employment for any reason (voluntary or involuntary), the family cross-reference payment option terminates since eligibility to participate in the family cross-reference payment option has ceased. Only eligible employees may be planholders under KEHP. Additionally, upon loss of employment, that former planholder has lost planholder eligibility status and can only be covered as a dependent on that existing plan. As a result, the remaining planholder's coverage level will drop to Parent-Plus coverage (from family cross-reference) reflecting the loss of planholder status of the former planholder. The remaining planholder will be required to pay Parent-Plus contribution for the same plan option he/she has. Should the remaining planholder wish to elect dependent coverage for that former planholder, he or she may make that election for dependent coverage within 35 days of that loss of planholder status.

The remaining planholder will NOT be responsible for the full, regular family contribution unless that former planholder is added back to the plan as a dependent. This creates a traditional Family plan.

A family cross-reference payment option requires that the two (2) eligible employees be legally married to participate and receive the financial benefit. A divorce automatically terminates eligibility to participate in the family cross reference payment option. Each planholder has an affirmative obligation to notify the Department of Employee Insurance that eligibility to participate has ceased. A failure to notify the Department of Employee Insurance may result in penalties ranging from responsibility for premium arrearages to charges of insurance fraud.

Waiving Health Insurance

Under KEHP, if you waive health insurance coverage, your employer will contribute $175 per month, up to $2,100 per year, to an HRA provided you are an active employee. Employees hired with an effective date later than January 1 will receive $175 for each month in which they are eligible for health insurance. For example, if you are hired on March 1, you would be eligible for the employer contribution beginning May 1 and would receive $175 for eight months.

What is an HRA?

A Health Reimbursement Account (HRA) is a federally qualified expense account where KEHP sets aside funds to reimburse you for qualified medical expenses.

Who is eligible?

Refer to the 2009 Plan Year KEHP Handbook for details.

DID YOU KNOW . . .

On average, KEHP members will likely pay around 19% of the overall cost of pharmacy benefits in 2009. This is the same percentage members paid at the beginning of 2006.

DID YOU KNOW . . .

97% of all medical services received by KEHP members are obtained from "in-network" providers.

Who is NOT eligible?

- If you (or your spouse) have a Health Savings Account (HSA), you are NOT allowed to have an HRA. If you have an HSA and elect our HRA, you will be in violation of federal tax law.
- If you are a member of an agency who chose not to participate in the KEHP HRA.
- If you are a retiree who has gone back to work and elects coverage under the retirement system.

What happens to any unused funds at the end of the year?

Any balance rolls over to the next calendar year if you continue to waive coverage and elect the HRA. This is also true if you continue to select the Commonwealth Maximum Choice plan.

Flexible Spending Accounts (FSA's)

What is an FSA?

There are two types of Flexible Spending Accounts (FSA's) offered under the Kentucky Employees Health Plan: Healthcare FSA and Dependent Care FSA. Both are pre-tax money you set aside, through payroll deductions, to use for certain eligible expenses.

What are the benefits of an FSA?

An FSA allows you to set aside money at a pre-tax basis to pay for eligible expenses. This results in your paying less in income and Social Security taxes.

Who is eligible to participate in an FSA?

- Employees of state agencies or school boards are eligible for participation in the Flexible Spending Account Program.
- Employees of local health departments and certain quasi-governmental agencies must contact their Insurance Coordinators for participating details.

Who is NOT eligible?

- If you (or your spouse) have a Health Savings Account (HSA)
- Retirees
- Non-participating agencies

Does the unused balance roll over?

No, any unused balance does not roll over to the next calendar year.

Healthcare FSA

- Can be used for certain expenses not reimbursed by your medical plan.
- You may use the funds to pay toward out-of-pocket prescription costs and eligible medical expenses such as doctor visits, x-rays, and lab tests; and some services not covered by your health insurance plan. Eligible expenses may be found at http://kehp.ky.gov.
- The maximum contribution per year is $5,000.

How am I reimbursed from the Healthcare FSA account?

- Use your Humana*Access*® Visa Debit card to pay for your service and funds are automatically deducted from your account. You may use the Humana*Access*® Visa Debit card wherever Visa debit cards are accepted; or
- Submit a claim. Pay for your eligible expenses up front and then fax to the number on the claim form or mail the completed form with the documentation to:

  Humana Spending
  Account Administration
  P O Box 14167
  Lexington, KY 40512-4167

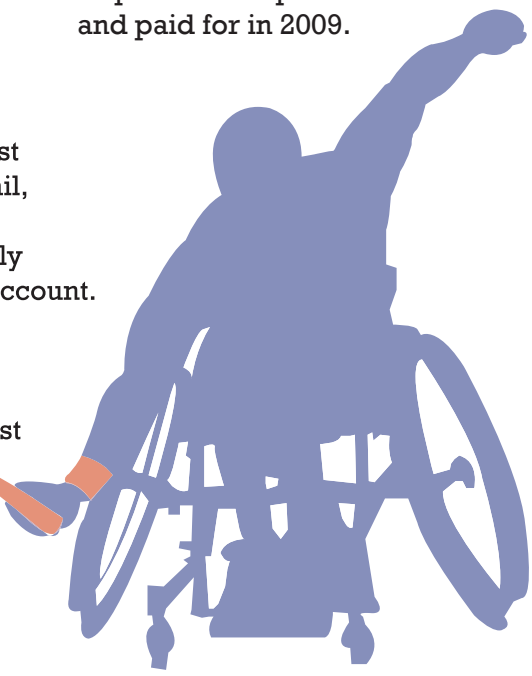
Humana will process the request and send you a check in the mail, or you can request that your reimbursement be electronically deposited into your checking account. You can download an HRA/ FSA claim form from Humana at http://kehp.ky.gov or call 1-800-604-6228 to request that a form be mailed to you.

Dependent Care FSA

- You may use the funds to pay for certain dependent care expenses such as day care, after school child care programs, and summer day camps.
- The maximum contribution depends on your tax filing status as listed on the Enrollment Application.
- When considering a Dependent Care FSA remember there is also a dependent care tax credit provided by federal law. In some cases, this tax credit may be a better choice than the Dependent Care FSA. You cannot take the tax credit for any amounts reimbursed by the Dependent Care FSA.

How long do I have to submit all of my claims?

You have until March 31, 2010, to submit reimbursement requests for expenses incurred and paid for in 2009.



Retiree Information

The Enrollment Application in this booklet is for active employees ONLY.

Retirees will receive an application from their retirement system.

Retirees should **NOT** complete the application included in this booklet. Commonwealth Maximum Choice will NOT be available for retirees.

Retirees should contact their respective retirement systems for rates and/or contribution amounts.

If I am retired, who do I contact regarding health insurance questions?

Most of your questions can be answered in the 2009 Plan Year KEHP Handbook and your retirement systems' materials, which you will receive from your retirement system. Retirees should contact their respective retirement systems for rates and/or contribution amounts. Health benefits questions should be directed to Humana or DEI at the numbers listed on page four (4) of this guide.

KTRS Retirees

If you have returned to work, you may choose one of the following scenarios:

ONE - Under Age 65 Retirees
Any KTRS retiree under the age of 65 who is re-employed in ANY position that makes them eligible for insurance coverage through the Kentucky Employees Health Plan, MUST terminate health insurance coverage through KTRS. (Board Action September 2000)

TWO - Waiver of Retirement
All KTRS retirees (regardless of age) who return to work and waive their monthly annuity must waive medical insurance coverage with KTRS. (KRS 161.605)

THREE - Retirees (any age) re-employed in a KTRS covered position and eligible for active employee health insurance, MUST terminate health insurance coverage through KTRS. (KRS 161.605)

FOUR - Age 65 and older (KTRS) retirees re-employed in non-KTRS covered positions will be able to remain on the KTRS Medicare Eligible Health Plan (MEHP) if the active coverage is not as good as the KTRS MEHP coverage. (October 18, 2005 Retiree Memo)

These retirees will not be allowed a retirement and an active employer contribution toward coverage and cannot flex employer contributions if KTRS coverage is selected. (KRS 18A.225(12).)

KRS Retirees

Age 65 and Older Retirees Who Have Returned to Work with an Employer Who Participates in KEHP.

You must complete a paper Enrollment Application with your active employer. Note the following information regarding funding and eligibility:

a. If you are receiving KRS funds toward a secondary coverage to Medicare plan and choose to continue your coverage through your retirement system, you must complete an application to waive insurance coverage through your employer.

b. If you are not receiving KRS funds toward a secondary coverage to Medicare plan, you are eligible to enroll for coverage and receive state funding through your employer. However, you must also complete a waiver application through your retirement system.

(KRS Medicare eligible plans do not meet Medicare's definition to be called a Medicare Supplement plan.)

Who To Call...!

- Kentucky Retirement Systems
  (800) 928-4646, menu option 2 or
  (502) 696-8800, menu option 2
  www.kyret.com
- Kentucky Teachers' Retirement System
  (800) 618-1687 or (502) 848-8500
  www.ktrs.ky.gov
- KCTCS Retirement
  (859) 256-3100
- Judicial Retirement Plan or Legislators Retirement Plan (502) 564-5310

Mid-Year Changes Due to Health Insurance Qualifying Events

Your benefits are provided through a Federally-regulated, Section 125 Cafeteria Plan which enables you to pay your health insurance premiums with pre-tax dollars. In exchange for this tax benefit, Federal regulations prohibit changing your Open Enrollment choices unless and until you experience a Qualifying Event. In the absence of a Qualifying Event, your choices during Open Enrollment are irrevocable and will remain in effect for the entire Plan Year.

If you experience a Qualifying Event such as a change in status, you may be able to make certain changes to your coverage for you, your spouse, and/or your dependents. All such changes must be requested within a limited time period after the occurrence of the Qualifying Event and must be consistent with the Qualifying Event. The requested change cannot be effective before the Qualifying Event date.

Depending on the nature of the Qualifying Event, you must submit a specific type of change form (Application / Dependent Add Form / Dependent Drop Form) to your Insurance Coordinator. The form must be signed and dated within the requisite time period after the Qualifying Event. KEHP typically requires submission of supporting documentation with the change form; however, do not delay submission of your change form if you are having difficulty acquiring supporting documentation.

If you do not sign and date the required change form in a timely fashion, you will not be permitted to revise your coverage until the next Open Enrollment period. Examples of Qualifying Events and the types of supporting documentation you may be required to submit are briefly summarized in the table below.

There are some restrictions on the types of changes you may make due to the Qualifying Event rules. For example, if you participate in a Flexible Spending Account (FSA) or a Health Reimbursement Account (HRA), changes in status may not entitle you to change the amount you contribute to that account. By the same token, changes in a participating provider network do not constitute a Qualifying Event.

The subject of Qualifying Events is a complicated one. This Benefits Selection Guide presents only a brief summary of some of the rules relating to mid-year changes due to Qualifying Events. For additional information about Qualifying Events, contact the Insurance Coordinator in your organization or retirement system; or consult the 2009 Plan Year KEHP Handbook at http://kehp.ky.gov.

Qualifying Events Which Allow You to ADD Individuals to Your Coverage	Supporting Documentation	Time Limit for Signing & Dating Change Form	Effective Date of Coverage
Marriage	Copy of Marriage License.	35 calendar days after date of marriage.	1st day of 1st month after signature date of change form.
Birth of a Child [1]	Copy of hospital birth certificate.	60 calendar days after date of birth.	Date of birth.
Adoption of a Child	Copy of adoption or placement for adoption documentation. (required document)	60 calendar days after earlier of date the child is placed for adoption or date of adoption.	Earlier of date of placement for adoption or date of adoption.
Legal Guardianship, Administrative Order, or Court Order	Copy of court order dated and filed with Court. (required document)	35 calendar days after issuance of Court Order.	1st day of 1st month after signature date.
Loss of Other Health Insurance Coverage	Certificate of coverage or letter from other employer listing covered individuals and date coverage ended. (required document)	35 calendar days after loss of other health insurance coverage.	1st day of 1st month after signature date.
Qualifying Events Which Allow You to DROP Individuals from Your Coverage	**Supporting Documentation**	**Time Limit for Signing & Dating Change Form**	**Effective Date of Termination of Coverage**
Loss of spouse/dependent status due to divorce / annulment	Copy of decree of divorce, or annulment.	35 calendar days after date of divorce/ annulment decree.	Last day of the month of divorce or annulment.
Loss of dependent status for other reasons	Copy of documents showing when and why dependent became ineligible.	35 calendar days after loss of dependent status.	Last day of the month in which the dependent becomes ineligible.
Death	Copy of death certificate.	35 calendar days after date of death	Date of death.
Gain of Other Group Health Insurance Coverage	Letter from other insurance company or employer, or copy of insurance card, listing individual(s) covered and effective date of coverage. (required document)	35 calendar days after gain of other group insurance coverage.	Last day of the month after signature date.
Entitlement to Medicare/Medicaid by You, Your Spouse, or Your Dependent Child	Copy of Medicare/Medicaid original eligibility letter. (required document)	35 calendar days after date of entitlement to Medicare/Medicaid.	Last day of the month after signature date.

[1] Kentucky law requires that newborn care must be covered for thirty-one (31) calendar days on the mother's policy after the date of birth, regardless of enrollment. However, to cover a newborn beyond thirty-one (31) calendar days, a Dependent Add Form must be completed, signed, dated and submitted to your Insurance Coordinator within sixty (60) calendar days from the date of birth (when adding the newborn only). If you are adding the newborn, plus other dependents, the time limit for enrollment is 35 calendar days.

Note: Ineligible dependents must be dropped upon ceasing to satisfy eligibility requirements regardless of signature date.

You Can Find It On the Web

If you ever need to find a form, brochure, or handbook relating to your KEHP insurance benefits, you can find it on the KEHP website at **http://kehp.ky.gov.**

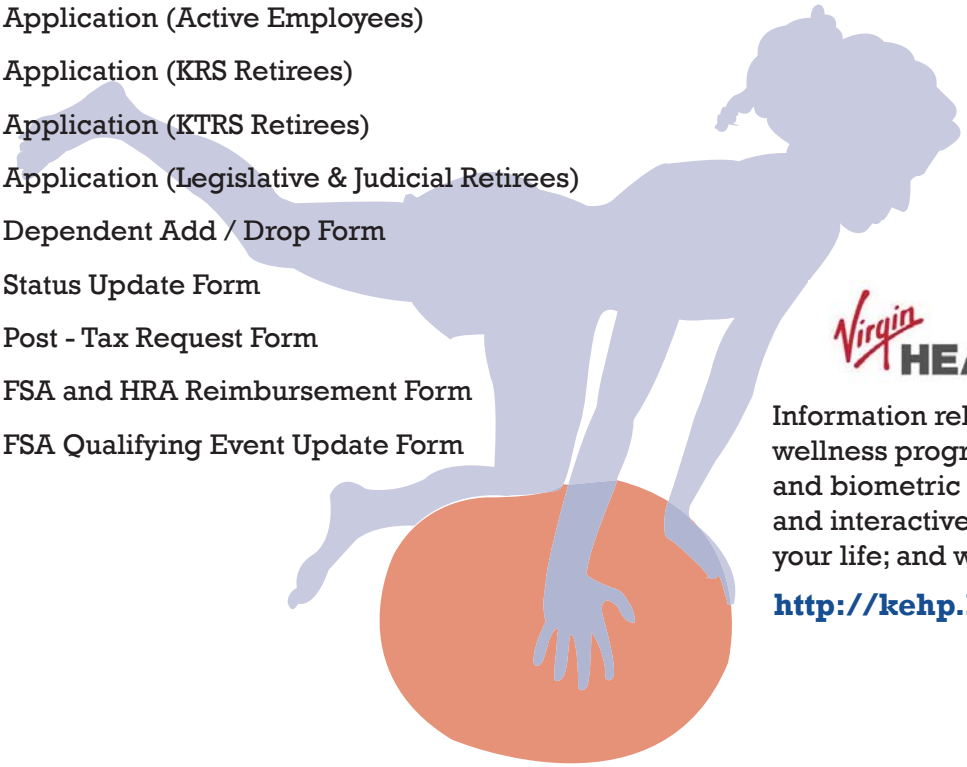
Documents available on the website include:

2009 Guide Books, Manuals, etc.

- 2009 Plan Year KEHP Handbook
- KEHP Benefits Selection Guide
- KEHP Administration Manual
- My FSA Guide: How to Get More from Your Flexible Spending Account
- My HRA with Medical Plan Guide: How to Get More from Your Health Reimbursement Account
- My Waiver / HRA Guide: How to Get More from Your Health Reimbursement Account
- Use of Humana*Access* Card for OTC Products
- FSA/HRA Sample Allowable Expenses
- Humana*Access* Quick Reference Chart
- Health Spending Account Secondary Payor Network
- 2009 Summary Plan Descriptions (Available January 1, 2009)

2009 Forms

- Application (Active Employees)
- Application (KRS Retirees)
- Application (KTRS Retirees)
- Application (Legislative & Judicial Retirees)
- Dependent Add / Drop Form
- Status Update Form
- Post - Tax Request Form
- FSA and HRA Reimbursement Form
- FSA Qualifying Event Update Form



Our partners have websites too! In addition to the information on the KEHP website, each of our partners provides a secure website where you can find a wide variety of information relating to medical benefits, pharmacy benefits, wellness activities, and a whole lot more. Topics of interest include:

HUMANA. *Guidance* when you need it most **Third Party Administrator**

Information relating to ID cards; medical claims; participating providers; Healthcare FSAs; Dependent Care FSAs; Health Reimbursement Accounts; Humana*Access* Visa Debit Card; Summary Plan Descriptions; disease management; wellness; Humana Health Assessment; health coaching; etc. Go to:

www.myhumana.com

EXPRESS SCRIPTS® **Pharmacy Benefits Manager**

Information relating to prescription drug formulary; participating pharmacies; prescription drug claims; step therapy; prior authorization; specialty pharmacy; mail order prescription program; etc. Go to:

www.express-scripts.com

Virgin HEALTHMILES **Wellness Program**

Information relating to the Virgin HealthMiles wellness program; track your physical activity and biometric readings; engage in personal and interactive walking challenges; improve your life; and win cash rewards. Go to:

http://kehp.ky.gov

Legal Notices

The Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a Federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This federal law requires insurers offering individual health insurance coverage, as well as all group health plans, which provide medical and surgical benefits with respect to a mastectomy, to provide in a case of an insured who is receiving benefits in connection with a mastectomy.

This notice describes how your protected health information may be used and disclosed, and how you can get access to this information.

Please read it carefully.

This notice describes the obligations of the Department of Employee Insurance (DEI) and your legal rights regarding your Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, this Notice describes how your PHI may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. The Kentucky Employees Health Plan (KEHP) is a self-funded governmental plan and, therefore, we are required to provide this Notice of Privacy Practice to you pursuant to HIPAA. DEI is the plan sponsor.

The HIPAA Privacy Rule protects only PHI. Generally, PHI is individually identifiable health information, including demographics information, collected from you or created or received by a health care provide, health care clearing house, or your employer on behalf of a group health plan that relates to:
1) Your past, present, or future physical or mental health or condition;
2) The provisions or health care to you;
3) Past, present, or future payment for provisions of health care to you.

DEI does not maintain information regarding your specific medical condition but does maintain PHI related to demographic information and other information that is necessary for determining eligibility and enrollment in KEHP. If you have any questions about this Notice or about our Privacy Practices, please visit http://personnel.ky.gov/benefits/dei/hipaa.htm or contact Department of Employee Insurance, Attn: HIPAA Privacy Officer, 501 High Street, 2nd Floor, Frankfort, Kentucky 40601. The effective date of this Notice is January 1, 2009.

DEI Responsibilities

We are required by law to:
1) Maintain the privacy of your PHI;
2) Provide you certain rights with respect to your PHI;
3) Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI;
4) Follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of Notice and to make new provisions regarding your PHI that we maintain, or as required by law.

How DEI May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your PHI under certain circumstance without your permission. The following categories represent the different ways that we may use or disclose your protected health information:

1) For Treatment;
2) For Payment;
3) For Health Care Operations;
4) To Business Associates;
5) As Required by Law;
6) To Avert a Serious Threat to Health or Safety;
7) To Plan Sponsors.

Required Disclosures

DEI is required to disclose your PHI to you (as a participant) and for Government audits.

Other Disclosures

Other disclosures may be made to your personal representatives, spouses and other family members and with written authorization.

Special Situations

In addition to the above, the following categories represent other possible ways we may use and disclose your PHI:
1) Organ tissue donation;
2) Military and veterans;
3) Workers' Compensation;
4) Public health risk;
5) Health oversight activities;
6) Lawsuits and disputes;
7) Law enforcement;
8) Coroners, medical examiners, and intelligence activities;
9) Inmates;
10) Research.

Participant Rights

A participant has the following rights with respect to their PHI:

1) Right to inspect and copy;
2) Right to amend;
3) Right to an accounting of disclosures;
4) Right to request restrictions;
5) Right to request confidential communications;
6) Right to a paper copy of this Notice.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with DEI or with the Office of Civil Rights of the United States Department of Health and Human Services.

To file a complaint with DEI please visit http://personnel.ky.gov/benefits/dei/hippa.htm.

All complaints must be in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Right or with DEI.

Pre-existing Conditions

Kentucky Employees Health Plans (KEHP) restrict coverage for medical conditions present before an individual's enrollment – known as a pre-existing condition exclusion can only apply to medical conditions for which medical advice, diagnosis, care of treatment was recommended or received within the six months before your enrollment date. Your enrollment date is the first day of your coverage under the plan. In addition, a pre-existing condition cannot last more than 12 months after your enrollment date. KEHP plans impose a pre-existing condition exclusion, and the length of the exclusion will be reduced by the amount of your prior creditable coverage. Pre-existing condition exclusion does not apply to certain conditions.

Special Enrollment

To qualify for special enrollment, an individual must be otherwise eligible for coverage under the plan. If you have other health coverage and lose that coverage, you may be able to enroll in a KEHP health plan. For example, if you waive coverage under a KEHP plan because you are covered under your spouse's plan and you later lose that coverage, you may request to enroll in a KEHP plan within 35 days of losing the other coverage. Additional special enrollments are triggered by marriage, birth, adoption, or placement for adoption.

All special enrollments require proof of the special enrollment event. This form must be submitted to DEI within 35 days of the qualifying event.

COBRA Notice

The Consolidated Omnibus Budget Reconciliation Act of 1986, or COBRA, provides that all employers who sponsor group health plans must permit covered individuals, who lose coverage under that plan as a result of certain enumerated events, to elect to continue their coverage under the plan for a prescribed period of time on a self-pay basis. Individuals who are entitled to COBRA continuation coverage are known as Qualified Beneficiaries. Under federal law, you must have 60 days after the date of the COBRA qualifying event or the date you lose benefits due to a COBRA qualifying event to decide whether you want to elect COBRA continuation coverage under the Plan. If you have questions regarding your COBRA rights, contact your agency's Insurance Coordinator or the Department for Employee Insurance, Member Services Branch.

Please see the 2009 Plan Year KEHP Handbook and the 2009 KEHP Summary Plan Descriptions for complete COBRA information available online at http://kehp.ky.gov.

Creditable Coverage

You may add up any creditable coverage you have, but if at any time you went for 63 days or more without coverage, you may not count the coverage prior to this break. If you do not receive a certificate for past creditable coverage, call your carrier for the time you had the creditable coverage to request the certificate.

Notice of Creditable Coverage

Important Notice from the Kentucky Employees Health Plan About Your Prescription Drug Coverage and Medicare. This notice has information about your current prescription drug coverage with Kentucky Employees Health Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

Please see the 2009 Plan Year KEHP Handbook and the 2009 KEHP Summary Plan Descriptions for additional information available online at http://kehp.ky.gov.

Notice to Enrollees Concerning Tobacco

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with certain requirements. However, the law also permits state and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. A group health plan may not discriminate in enrollment rules or in the amount of premiums or contributions it requires an individual to pay based on certain health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. The sole differentiation among enrollees in the Commonwealth's Plan relates to the incentive, through a greater employer contribution, offered to enrollees that refrain from the use of tobacco products. No other health-related factors are used to distinguish enrollees.

Please see the 2009 Plan Year KEHP Handbook and the 2009 KEHP Summary Plan Descriptions for additional information available online at http://kehp.ky.gov.

Do Not Staple!

OPEN ENROLLMENT/NEW HIRE APPLICATION VALID FOR USE FROM 10/1/2008 – 12/31/2008

KENTUCKY EMPLOYEES HEALTH PLAN

PY 2009

ENROLLMENT APPLICATION

FOR ACTIVE EMPLOYEES

INSURANCE COORDINATOR SECTION **REQUIRED**

__/__/0__ Coverage Effective Date

_____ Company Number

Reason for Application:

☐ < New Employee ☐ < Open Enrollment ☐ < New Group ☐ < FSA Only

☐ < QE* ☐ < Previously Waived* ☐ < Other*

* If you previously waived, or marked "Other" or "QE" above, enter the Qualifying Event Date AND a description of the Qualifying Event: _____ Date _____ Qualifying Event Description

SECTION I: DEMOGRAPHIC INFORMATION → Please PRINT

___-___-____ Social Security Number

__/__/____ Date of Birth (MM/DD/YYYY)

Smoking Status *(Required)*

Have you smoked in the last 2 months? ☐ < Yes ☐ < No

_____ NAME (First, MI, Last)

_____ Mailing Address

Gender

☐ < Male

☐ < Female

Marital Status

☐ < Married

☐ < Single

_____ City, State, Zip Code

_____ County of Residence

_____ Country / Mail Code, if not USA

_____ Planholder's HOME Phone Number

_____ Planholder's WORK Phone Number

_____ Planholder's Email Address (prefer Work Email Address)

_____ Hire Date

_____ Employer Name

_____ Work County

SECTION II: PLAN SELECTION → *If you wish to waive (i.e. decline) coverage, skip to Section V below*

1. Option (Check only one)

☐ < Commonwealth Standard PPO

☐ < Commonwealth Capitol Choice

☐ < Commonwealth Optimum PPO

☐ < Commonwealth Maximum Choice

2. Level of Coverage

☐ < Single

☐ < Parent Plus

☐ < Couple

☐ < Family

3. Cross-Reference Payment Option
(Available for Family Coverage Only)

☐ < Yes

If Yes, you must complete Sections III and IV

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION → *If you selected Single coverage, skip to Section VI*

Social Security Number	Name (First, MI, Last)	Gender (Circle one)	Date of Birth (MM/DD/YYYY)	Relationship Code
		M F		
		M F		
		M F		
		M F		
		M F		

Relationship Codes: SP = Spouse, CH = Child, DD = Disabled Dependent, CO = Court-Ordered Dependent

SECTION IV: CROSS-REFERENCE INFORMATION → *Complete ONLY if you checked Yes in Section II, box 3*

Your Spouse's Company Number: ***(Required)***	Has your spouse smoked in the last 2 months? ***(Required)***	Is your spouse a Hazardous Duty Retiree?	Your spouse's Hire Date or Retirement Date:
_____	☐ <Yes ☐ <No	☐ <Yes ☐ <No	_____

SECTION V: WAIVER → *Complete this section only if you did not select coverage in Section II*

Do you wish to waive (i.e. decline) your coverage and have the employer contribution of $175 per month deposited into a Health Reimbursement Account (HRA), ***if eligible***? *(If not eligible, you will be set up as a **Waiver with no HRA**).* ☐ < Yes

PY **2009**

Planholder's SSN

SECTION VI: FLEXIBLE SPENDING ACCOUNTS (FSA) → Enrollment in an FSA is OPTIONAL

If you are an employee of a health department or certain quasi agencies, this section does not apply to you. You must contact your Insurance Coordinator regarding your employer's FSA enrollment process.

Healthcare FSA → All amounts must be divisible by two and be listed for a full calendar year.
The **maximum** allowable yearly contribution is $5,000

Planholder	**Spouse** → If paying by cross-reference and spouse's FSA program is administered by the KEHP
Total Employee Contribution for Calendar Year 1/1-12/31 _____	Total Spouse Contribution for Calendar Year 1/1-12/31 _____

Dependent Care FSA → All amounts must be divisible by two.
The **maximum** allowable yearly contribution (per family) based on tax filing status

Tax Filing Status:

☐ < Married, filing separately (max = $2,500) ☐ < Married, filing jointly (max = $5,000) ☐ < Single, head of household (max = $5,000)

Planholder	**Spouse** → If paying by cross-reference and spouse's FSA program is administered by the KEHP
Total Employee Contribution for Calendar Year 1/1-12/31 _____	Total Spouse Contribution for Calendar Year 1/1-12/31 _____

HumanaAccess℠ VISA® Card
Upon enrolling in an HRA or a **healthcare** FSA you will Receive the HumanaAccess- Visa® card at no cost to you.

SECTION VII: AUTHORIZATION AND CERTIFICATION

* I understand that my signature on this application creates a legal and binding contract between myself, the Department for Employee Insurance and the TPA.
* **I understand that if my spouse and I elect the cross-reference payment option, we are dual plan holders and our level of coverage (Family) will automatically drop to a parent plus coverage level upon termination of employment by either spouse/planholder. The cross-reference payment option ceases upon termination of employment by either spouse/planholder.**
* I understand that each dependent I am enrolling meets the eligibility requirements of a dependent as set forth in the plan document and in the KEHP handbook.
* I understand that all benefits for my eligible dependents and me will be provided in accordance with the plan document.
* I agree to abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
* I understand that the elections indicated on this application may not be changed or canceled during the plan year, with the exception of certain Qualifying Events.
* I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected.
* **I elect to have the employee contribution for health coverage deducted on a pre-tax basis unless I sign a Post-Tax Form or otherwise acknowledge post-tax treatment for my dependents. For Pre-tax treatment, dependent coverage must meet eligibility requirements of section 152.**
* I understand that enrollment in an FSA is optional and that by completing Section VI of this application, I am enrolling in an FSA, if eligible to participate.
* Regarding my FSA, I understand that any dependents for which I claim reimbursement are Section 152 dependents as defined by the Internal Revenue Code.
* Regarding my FSA, I further understand that any unused amount remaining in my spending account at the end of the plan year cannot be carried forward to the next year due to the Commonwealth's Cafeteria Plan Document.
* I understand that I have a 90-day run-out period (until March 31) for reimbursement of eligible FSA expenses incurred during my period of coverage.
* I understand that the misrepresentation of any information on this application with the intent to defraud is a fraudulent insurance act, which is a crime, and any material misrepresentation or omission may be used to reduce or deny a claim or to terminate my coverage.
* I understand that this plan has a tobacco incentive for members that do not use tobacco and that this plan offers tobacco cessation programs.
* I have fully read the materials provided to me. My signature below certifies that the statements on this form are true and complete to the best of my knowledge.

_____ _____
Employee Signature Date

_____ _____
Spouse Signature – ***REQUIRED*** **if electing the cross-reference payment option** Date

.....

I understand that any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the KEHP. My signature below certifies that all signatures and signature dates affixed to this contract are correct to the best of my knowledge.

_____ _____
Employee's Insurance Coordinator Signature Date

_____ _____
Spouse's Insurance Coordinator Signature – ***REQUIRED*** **if electing the cross-reference pmt. option** Date

*My*Humana

Register now at www.humana.com and find your personalized health and benefits information in one place.

As a Humana member, you have a password-protected, personal home page on www.humana.com called MyHumana. With MyHumana, you can get answers to questions about your health plan at your convenience, 24 hours a day. You can find health information, from wellness tips to heart-healthy recipes, with just a few mouse clicks.

Some of the things you can do on MyHumana:

- Look up participating doctors, hospitals, and other medical facilities
- Review your health plan benefits
- See if a claim has been paid and how much of the cost you're responsible for, if any
- Use financial tools to see how much you're spending on health care
- Use health resources to find out about medical procedures, tests, treatments, and conditions
- Get discounts on multi-vitamins, eye exams, contact lens, eye glasses, gym memberships, Weight Watchers, and even a massage.

While you are exploring MyHumana, take your Health Assessment and sign up for your own personal health coach.

Why take the Humana Health Assessment?

- Discover your health risk for developing disease
- Receive action steps to reduce your risk
- Become more aware of your health status (Are you in bad, good, fair, or excellent health?) You might be surprised!
- Compare your score to your peers on-line

Humana offers you special professional wellness support: your very own Health Coach.

Get a healthier start by signing up for your very own Health Coach!

- Lose Weight
- Quit smoking
- Eat Healthier
- Reduce your back pain
- Relax!!!

Here's your chance to work one-on-one with a professional to develop your own wellness plan. Specially trained, phone-based "Health Coaches" are available to you free through your KEHP health plan. Your coach will help you develop an action plan designed just for you based on the information you provide.

Enrollment is easy, and it's free! Don't wait - sign up for MyHumana and begin feeling healthier today.

For instructions on how to sign up for the HHA and Health Coaching, go to http://kehp.ky.gov.

DID YOU KNOW . . .

Each KEHP plan costs the same regardless of where a KEHP member lives.

IT'S YOUR JOURNEY TO WELLNESS.

LET'S MAKE IT A FUN ONE!

It's all in the getting there, and Virgin is going to put some spring in your step along the way. It starts with adding a little more activity into your day. Wear a pedometer, wear comfy shoes … and before you know it you won't even remember what being *in*active felt like.

And did we mention the motivation to keep moving? **Cash!** With the HealthMiles program, you are entered into monthly healthcash challenges for your chance to win big, **plus** we offer you three healthcash rewards packages to choose from for extra motivation (cash!) throughout the year.

WHAT YOU GET WITH THE HEALTHMILES PROGRAM

For only $1.50 per month, you get a digital pedometer and a great program to track your activity, fun promotions, motivation… and the chance to win some major cash prizes!

THE GOZONE PEDOMETER
Wear it daily to capture your steps. It's a great reminder to stay active, and all you do to keep track of your activity is plug in into your computer. No need to self-enter your steps; this little gadget does it all for you.

THE LIFEZONE WEBSITE
See those steps and lots more on your personal, secure website. Watch your healthmiles add up (we call the points you earn 'healthmiles'), spend your healthcash, monitor your progress, all in one easy place.

CHALLENGES, PROMOTIONS, AND LOTS MORE
Challenge your pals to a little healthy competition with our fun, easy-to-use tools. Earn extra healthmiles in our activity promotions, read up on all the latest health & fitness news… and lots more!

NOW, ABOUT THAT CASH...

With HealthMiles, you have the chance to win big bucks each month in our healthcash challenges!

141 lucky winners every month! And the healthcash you win is yours to spend on gift cards to national retailers like Target and Best Buy or can come to you as a personal check for the full dollar amount.

- **1** $1,000 healthcash winner
- **40** $250 healthcash winners
- **100** $100 healthcash winners

Here's how you earn entries into the healthcash challenges:

YOUR ACTIVITY:
For each day you take & upload over 7,000 steps on your pedometer, you earn 1 entry

OTHER PROGRAMS:
For completion of other wellness initiatives*, you earn 5 entries

REWARDS PACKAGES:
If you purchase one of our rewards packages, the entries you earn will increase two, three, or four times. See details below!

HEALTHMILES REWARDS PACKAGES

To increase your chances in the healthcash challenge (and for even more motivation to stay active throughout the year), you may purchase one of our three rewards packages. Lady luck may not be on your side every month, so this way, you're sure to earn some healthcash by being active, uploading your pedometer, monitoring your progress, and other fun promotions.

Sign up for the program in January, 2009

For more information about the HealthMiles program, visit **HTTP://KEHP.KY.GOV**

up to:

$500 HEALTHCASH
$12.99 / month – purchasing this package quadruples your entries in the healthcash challenge

$300 HEALTHCASH
$9.99 / month – purchasing this package triples your entries in the healthcash challenge

$150 HEALTHCASH
$6.99 / month – purchasing this package doubles your entries in the healthcash challenge

Virgin HEALTHMILES

KENTUCKY EMPLOYEES HEALTH PLAN

*stay tuned for details about other wellness initiatives and programs

WHO SAYS GETTING ACTIVE & FIT CAN'T BE FUN AND REWARDING?

Coming January, 2009!

Virgin HealthMiles is going to help put some spring in your step and cash in your pocket. Get active with the program that rewards you for making healthy decisions.

Walk, stroll, jog, pedal… just move, and the HealthMiles program does the rest. Your pedometer tracks your activity and reminds you to stay active, your personal website displays your progress, your rewards keep you going. Sign up for a program where getting active means getting great stuff. Coming in January, 2009.

EACH MONTH YOU HAVE THE CHANCE TO EARN MORE CASH PRIZES!

The more active you are, the more chances you have to win. Each month, one lucky winner gets $1,000!

plus:
40 $250 healthcash winners each month
100 $100 healthcash winners each month

For more detail about the HealthMiles program,
see inside back cover of this Benefits Selection Guide or visit
http://kehp.ky.gov

Virgin HEALTHMILES

KENTUCKY EMPLOYEES HEALTH PLAN