Kentucky Employees' Health Plan

Eighteenth Annual Report of the Kentucky Group Health Insurance Board

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

December 14, 2018

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EXECUTIVE SUMMARY

This Eighteenth Annual Report of the Kentucky Group Health Insurance Board (KGHIB), prepared for the Governor, General Assembly, and Chief Justice of the Supreme Court of the Commonwealth of Kentucky, provides an overview of the 2017 Kentucky Employees' Health Plan (KEHP) cost and service usage, as well as a look at changes in plan performance from prior years. The report also includes a look at the first six months of plan experience in 2018, historical information on plan designs, legislative mandates, and commentary on the KGHIB's focus in a post-federal health care reform world.

Highlights of KEHP Experience in 2017

KEHP 2017 health care costs increased from 2016. The increase in 2017 is close to national market trend levels.

- In 2017, KEHP offered two Preferred Provider Organization (PPO) options and two Consumer-Driven Health Plan (CDHP) options.
  - PPOs are a more traditional health plan with medical and pharmacy copays, while CDHPs offer lower premiums with more member control in managing health care expenses.
- In 2017, approximately 58% of members enrolled in one of the two CDHPs.
- In 2017, the health plan paid nearly $1.39 billion in total medical and pharmacy claims. This is 4.5% higher than the plan paid cost in 2016.
- When adjusted for changes in enrollment, the per member per month (PMPM) cost to the plan increased 4.1% from 2016 to 2017; this is a 2.0% increase in medical claims PMPM and 9.8% increase in pharmacy claims PMPM.

The KEHP employer pays a greater percentage of the total premium cost for employees and members in employee plus dependent(s) tiers than national averages.

- The average monthly subsidy (or portion of the total premium paid by the employer) for each employee's health insurance coverage has increased, on average, from $784 per month in 2016 to $788 in 2017, a 0.5%increase over 2016. The employee's portion of the total premium increased from $145 in 2016 to $146 in 2017, which represents a 1.1% increase.
- Compared to national averages, KEHP employers pay a greater percentage of the total premium.

KEHP membership increased slightly from the previous year, while the number of employees waiving coverage under KEHP decreased slightly.

- Membership in KEHP increased 0.4% from 2016 to 2017.
- The number of employees who elect to waive coverage decreased from 22,667 in 2016 to 22,613 in 2017, which represents a 0.2% decrease.

KEHP continues to spend the largest portion of its total claims cost for hospital outpatient care but prescription drug has been growing at a higher pace over the last several years.

- KEHP's claims distribution across outpatient hospital, physician, other medical, and pharmacy goods and services remained relatively consistent from 2016 to 2017 except for a small increase in prescription drugs and a small decrease in outpatient hospital.
- On a PMPM basis, KEHP's outpatient claims, the largest component of cost, decreased at a rate of 0.4%. Inpatient claims increased 5.0%, physician claims remained flat, and pharmacy costs increased 9.8%.

Clinical conditions related to heart disease, musculoskeletal, and health status continue to be prevalent in KEHP's population.

- A significant portion of plan cost has been attributable to largely the same clinical conditions since 2004.
- Members with these three clinical conditions are responsible for 38.7% of the plan's 2017 medical claims cost.
- Given that KEHP provides coverage to a significant percentage of the people of Kentucky (approximately 7%), these conditions reflect the health challenges of the Commonwealth as a whole.

Pharmacy benefit costs increased from 2016. The increase is below national market trend levels for pharmacy.

- On a PMPM basis, allowed prescription drug charges, defined as total discounted charges less charges for noncovered drugs, increased by 8.0% from 2016 to 2017.
- Pharmacy utilization increased from 17.4 scripts per member in 2016 to 17.5 scripts per member in 2017, which represents a 0.7% increase.

Benchmark Results

IBM Watson, KEHP's data warehouse consultant, benchmarked several statistics for the plan. IBM Watson compared KEHP's 2017 plan performance against employer plan performance of other IBM Watson clients in the public sector and private sector. The data shows that the KEHP total allowed cost on a per member per year (PMPY) basis is 1.9% lower than that of other clients in the public sector and 3.3% higher than that of clients in the private sector. As a comparison from last year's report, KEHP total allowed cost on a PMPY basis was 6.8% higher than other clients in the public sector.

In general, KEHP's plans cover a slightly older population with smaller family size than other IBM Watson clients in the public sector. KEHP members have higher risk scores than members in both the public and private sectors for all age groups. Fifty-five percent of KEHP members are either healthy or stable; but the percentage of members at risk, struggling, and in crisis is higher than both the public and private sectors. KEHP members with chronic conditions had higher admission rates than both the public and private sectors' members for the majority of conditions. KEHP members have higher prescription drug and outpatient utilization rates than IBM Watson clients in the public sector and private sector. However, KEHP has a slightly higher generic drug prescription rate and a similar generic efficiency rate compared to both the private and public sectors.

Affordable Care Act

Health care reform was signed into law in March 2010. The first wave of employer-based compliance has passed with many changes having been executed in 2011. Since then, the focus has been on reporting compliance and operational issues such as providing Summary of Benefits and Coverage to participants, defining W-2 reporting of the value of health coverage for members, providing notices of options in the exchange, and reporting health coverage information to the IRS and to participants. However, there are many rules and guidance still outstanding on these provisions that are required to move forward.

The Affordable Care Act (ACA) requires employers, plans, and health insurance issuers to report health coverage information to the IRS and to participants annually. ACA reporting became mandatory for responsible entities starting in 2015. The first forms were provided in early 2016 reflecting the 2015 calendar year. The forms that must be filed and distributed depend on whether the employer is an applicable large employer (ALE) and the type

of coverage provided. Employers filing 250 or more of a particular form are required to file with the IRS electronically.

The high-cost plan excise tax (a/k/a "Cadillac" tax), originally scheduled to become effective for tax years beginning in 2018, was postponed and the new Act changes the tax effective year to 2022. Further, the Consolidated Appropriations Act amends the Internal Revenue Code making the tax deductible to payers. Finally, the Act calls for a demographic study to be commissioned to study the appropriateness of using the Federal Health Benefits Plan as a benchmark for the age and gender adjustment of the applicable dollar limit for the excise tax.

Under the ACA's individual mandate, a taxpayer must be covered by a health plan that provides at least "minimum essential coverage" or be subject to a tax for failure to maintain such coverage. Most forms of health insurance coverage (e.g., employer group health plans, individual health insurance policies, and government health plans) qualify as minimum essential coverage. The tax is imposed for any month that an individual does not have minimum essential coverage, unless the individual qualifies for an exemption. With the enactment of the Tax Cut and Jobs Act of 2017, the amount of the individual mandate's penalty was reduced to zero, effectively repealing it. This provision is effective beginning after December 31, 2018, making individuals potentially liable for individual mandate penalties for years prior to 2019.

Board Recommendations

For this year's report, Board members were surveyed and voted on the desired outcome and recommendations. The Board's strategic initiatives are ranked from the highest priority:

- Provide state-of-the-art benefits while maintaining reasonable employer and employee premiums.
- Offer competitive health insurance benefits that meet the needs of a diverse workforce.
- Improve employee health and wellbeing.
- Provide members with the tools and benefits to be able to manage chronic disease conditions.
- Increase member engagement in the variety of free to low-cost health and wellness programs available.
- Continue to educate and drive members to the highest quality, safe, effective, and cost-effective care based on the patient's health care needs.
- Help employees understand the tools and resources available to them; as well as initiatives of the KEHP.

Based on the results of the recent survey of Board members, the Board considers the following to be the most significant challenges and obstacles:

- Understand and navigate the increasing complexity of the health care delivery system.
- Offer affordable coverage for plan participants.
- Low employee engagement in programs desired to help members manage their health.
- Administer and implement future health care strategies.
- Deliver a benefit selection and enrollment experience that is easy-to-use by multiple employer groups.

INTRODUCTION

In accordance with the provisions of Kentucky Retirement System (KRS) 18A.226(5)(b) enacted by the 2000 General Assembly as a part of Senate Bill 288, this document comprises the Eighteenth Annual Report from the Kentucky Group Health Insurance Board (KGHIB or the Board) to the Governor, the General Assembly, and the Chief Justice of the Supreme Court. The report contains information on the status of the Public Employee Health Insurance (PEHI) program, commonly referred to as KEHP.

The report includes:

- A review of the 2017 KEHP experience.
- A look at plan experience for the first six months of 2018.
- A perspective on sustainability in a post-reform world.

The appendix to this report contains:

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

Research was jointly conducted by the Department of Employee Insurance (DEI) and Aon to prepare this report. The report has been reviewed by the Board and modified to incorporate a full and accurate representation of the Board's findings and recommendations.

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

2017 KEHP Experience

This section of the Annual Report provides a summary of cost and usage trends experienced by KEHP in 2017. The 2016–2018 information is based on self-insured KEHP claims reported by the plan administrators. The claims and enrollment data were compiled by the IBM Watson database, KEHP's data warehouse. Any data prior to 2016 was taken directly from the Seventeenth Annual Report.

A Note About 2018 Claims Experience

At the time that this report was written, incurred 2018 claims data was available through June 2018, with three months of runout (paid through September 2018).

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

KENTUCKY EMPLOYEES' HEALTH PLAN EXPERIENCE

Summary of KEHP Program Costs

Key Findings

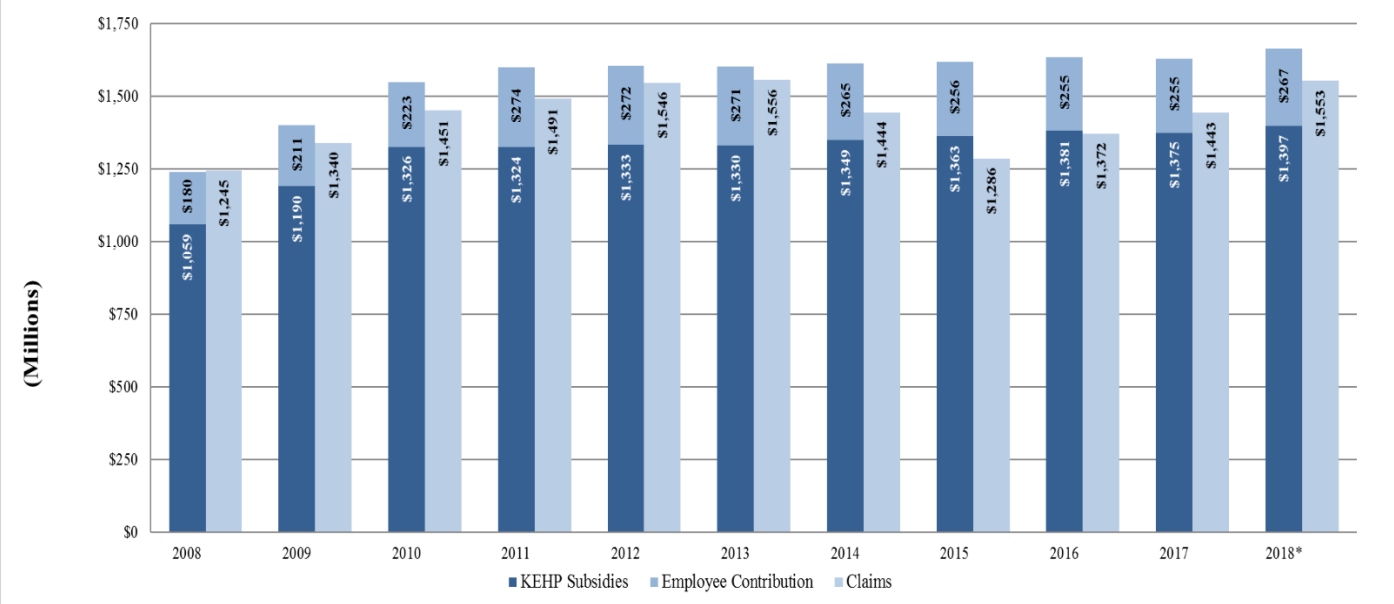
- Prior to 2014, KEHP claims and expenses had been close to the budgeted costs.
- Starting from 2014, KEHP generated a large surplus due to savings from benefit design changes, migrations to the CDHPs, and lower member utilization. This surplus continued into 2015 which was attributable to improved network pricing from the new vendors.
- KEHP subsidy levels have moved closer to and exceeded the benchmark norms for both employee and dependent coverage from 2008 to 2017.

Summary of Total Costs

KEHP's total incurred claims, KEHP's subsidy (the amount paid by the plan, excluding the amount paid by the participant), and employee contributions are shown in Exhibit 1. (The total incurred claims paid by KEHP's self-funded program are identified as "Claims.") Administrative fees are not included in these figures. For 2018, only the first six months of incurred data was available at the time of the writing of this report.

Exhibit 1 identifies the total subsidy amounts KEHP paid in 2008 through 2017, as well as the first six months of 2018 for all members of KEHP, the total annual employee contributions and the aggregate claims costs incurred. The figures included in this exhibit represent millions of dollars.

Exhibit 1: Aggregate KEHP Paid Claim Costs vs. KEHP Subsidies and Employee Contribution ($Millions)



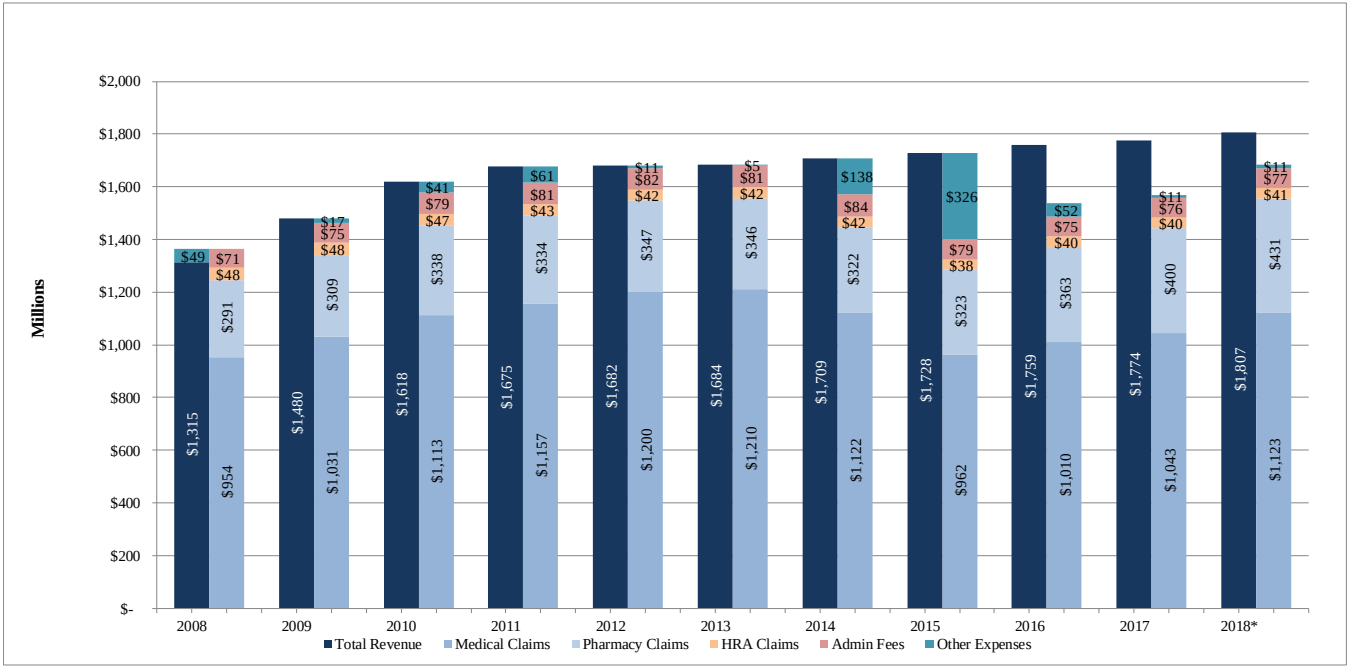
Source: *Seventeenth Annual Report, KEHP's claims data aggregated by IBM Watson, Aon Projections of Trust Balances*
**2018 claims are based on Aon's projections for KEHP.*

Since KEHP changed the funding from fully insured to self-insured in 2006, only once have claim costs exceeded the total employee plus employer contributions (premiums), in 2008. A look at the first six months of available data for 2018 shows this trend continuing.

Year-by-Year Trust Fund Balances

Exhibit 2 shows the KEHP plan year balances from 2008 to 2018, using Aon's projections incorporating the Trust Fund Report as of September 2018.

Exhibit 2: Plan Year Balances as of September 30, 2018



Source: *KEHP Trust Cash Transactions from September 2018, Aon Projections*
**2018 figures reflect estimates based on six months of 2018 claims experience.*

Apart from 2008, KEHP has had modest surpluses each year from 2008 on. Note that in 2008 the category "Other Expenses" was negative, as this field includes balance transfers between years.

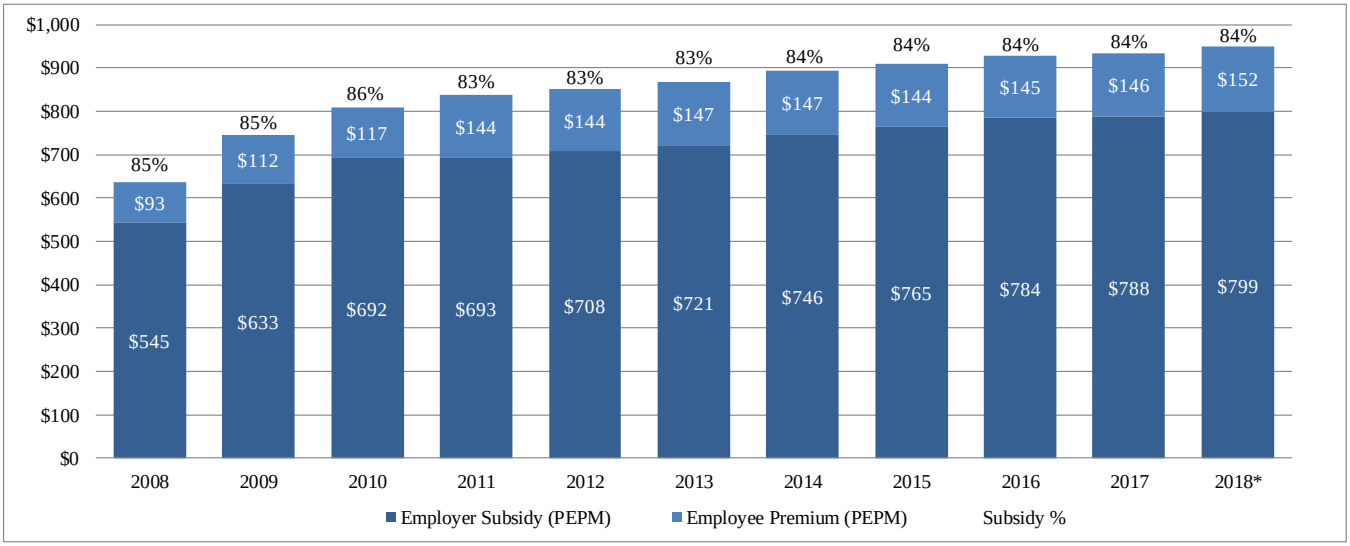
Starting from 2014, KEHP generated a large surplus due to savings from benefit design changes, migrations to the CDHPs, lower member utilization, and improved network pricing from the new vendors.

Per House Bill 510 and House Bill 303, $63.5 million and $500 million have been withdrawn from plan years 2012-2017 to transfer from the Public Employee Health Insurance Trust Fund to the General Fund. These transfers are included in the other expenses category of these plan years.

Historical Per Employee KEHP Subsidies

KEHP's per employee per month (PEPM) subsidy, employee PEPM premium, and KEHP's subsidy percentage (percentage of total contributions from KEHP) from 2008 through 2018 are illustrated in Exhibit 3.

Exhibit 3: Historical KEHP (PEPM) Health Benefit Subsidy Paid for Those Electing Coverage



Source: *Seventeenth Annual Report and KEHP's claims and enrollment data aggregated by IBM Watson*
**2018 figures reflect estimates based on six months of 2018 claims experience.*

The KEHP average monthly subsidy toward the cost of an employee's health insurance coverage has risen from $545 per month in 2008 to $788 in 2017 and is projected to increase to $799 per month for 2018. Above each year's bar is the percentage of KEHP's subsidy. In 2011, the members began to pay a slightly larger percentage of the total premiums, with the KEHP subsidy dropping from 86% in 2010 to approximately 83% to 84% afterwards. Employee premiums remained relatively flat since then with KEHP having absorbed most of the premium increase.

KEHP Subsidy Benchmarks

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

Exhibit 4: KEHP Subsidies Compared to Government Sector Benchmarks

	2014		2015		2016		2017		2018*	
	Kaiser	**KEHP**	**Kaiser**	**KEHP**	**Kaiser**	**KEHP**	**Kaiser**	**KEHP**	**Kaiser**	**KEHP**
Employee Only	87.0%	90.3%	88.0%	90.6%	89.0%	90.9%	86.0%	90.8%	84.0%	90.4%
Employee + Dependents	76.0%	77.3%	75.0%	78.2%	77.0%	78.6%	74.0%	78.8%	76.0%	78.7%
Overall	**81.2%**	**83.6%**	**81.3%**	**84.2%**	**82.7%**	**84.4%**	**79.6%**	**84.3%**	**79.6%**	**84.0%**

Source: *KEHP's claims data aggregated by IBM Watson, and benchmarks from Kaiser Family Foundation Employer Health Benefits surveys*
**Prior to 2017, Kaiser survey has breakout by industry sector, beginning from 2017 the survey only provides nonprofit large firm subsidy ratio.*

In 2018, KEHP is projected to cover 84.0% of total costs (90.4% for single coverage and 78.7% blended for the employee + dependent coverage tiers). The KEHP subsidy for enrollees with single coverage has consistently been higher compared to the benchmarks. The subsidy for those with dependent coverage has moved from being lower than the benchmark in historical years to being above the benchmark since 2014. For example, KEHP's subsidy was 6.4 percentage points higher than the national average for single coverage and 2.7 percentage points higher than the national average for employee plus dependent coverage in 2018.

Enrollment/Demographics Analysis

Key Findings

- The number of covered employees dropped slightly in 2017, while membership increased slightly.
- The number of children covered by the plan has grown since 2015.
- The number of employees who have waived coverage under KEHP has remained steady since 2014.

Key Statistics

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

Exhibit 5: Population Demographics—Key Statistics

	KEHP Membership (Actives, Non-Medicare Eligible Retirees and COBRA Participants)						
	2015	**2016**	**2017**	**2017 vs. 2016**	**Jan - Jun, 2017**	**Jan - Jun, 2018**	**2018 vs. 2017**
Total Enrollment:							
Employees	148,477	146,711	145,350	-0.9%	146,067	145,540	-0.4%
Members	261,938	262,032	263,061	0.4%	263,343	266,023	1.0%
Average Age:							
Employees	48.4	48.4	48.4	0.0%	48.4	48.4	-0.1%
Members	37.1	37.0	36.8	-0.5%	36.9	36.7	-0.4%
Demographic Splits:							
Employee Percentage Male	34.0%	33.9%	33.8%	-0.1%	33.8%	33.8%	0.1%
Member to Employee Ratio	1.76	1.79	1.81	2.4%	1.80	1.83	1.4%
% of Covered Members Who Are:							
Adult Male	25.5%	25.5%	25.5%	0.0%	25.5%	25.5%	0.0%
Adult Female	43.1%	42.7%	42.3%	-0.4%	42.5%	42.0%	-0.4%
Children	31.4%	31.8%	32.2%	0.4%	32.0%	32.4%	0.4%

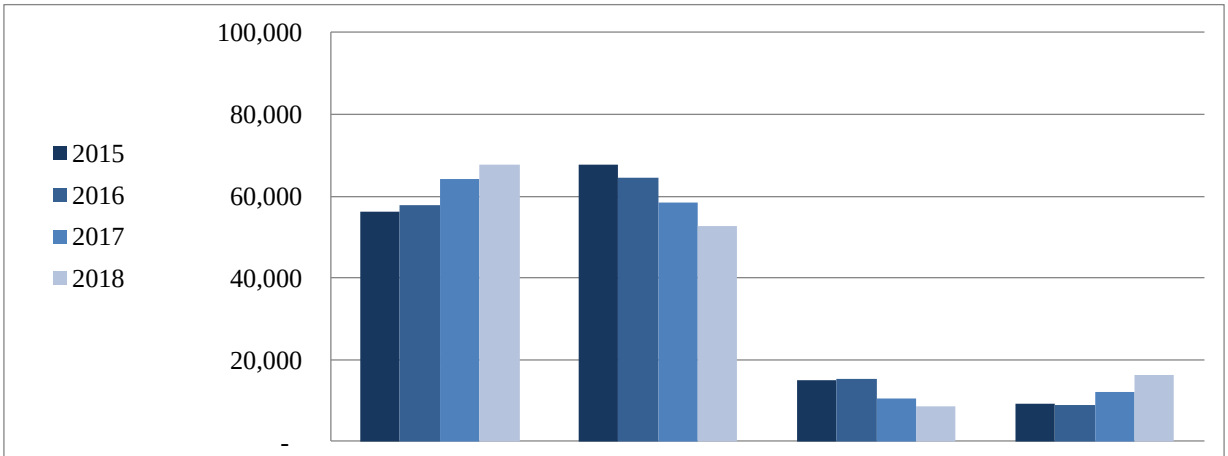
Source: *KEHP's enrollment data aggregated by IBM Watson*

Total enrollment for KEHP's plans increased 0.4% from 2016 to 2017 and the first six months of 2018 show continued increase of 1.0% over the prior year. The average member to employee ratio continues to increase slightly from 1.79 in 2016 to 1.81 in 2017. The first six months of 2018 show another slight increase, to 1.83. As a result, the percentage of children covered by the plan has increased since 2015.

Enrollment by Plan

Exhibit 6 shows KEHP enrollment by plan option from 2014 through the first six months of 2018.

Exhibit 6: Employee Enrollment by Plan 2015–2018



2017	LivingWell CDHP	LivingWell PPO	Standard CDHP	Standard PPO
Employees Average Age	46.5	51.3	43.2	49.2
Members % Male	43.5%	39.0%	44.3%	45.7%
Member to EE ratio	2.13	1.59	1.45	1.46

Source: *KEHP's enrollment aggregated by IBM Watson*
**2018 figures include January through June 2018 data only.*

In 2015, 84% of employees enrolled in the LivingWell plans, and the enrollment increased to 84.5% in 2018. The LivingWell PPO plan is perceived to be the richest plan, as it offers the lowest deductible and cost-sharing provisions even though it requires the highest monthly employee premiums. In reality, the LivingWell CDHP provides the highest level of benefits. Members started to understand the value of the LivingWell CDHP resulting in an enrollment increase from 38% in 2015 to 47% in 2018.

Exhibit 7 shows the plan compositions by tier.

Exhibit 7a: Employee Enrollment by Coverage Tier and Plan, 2017

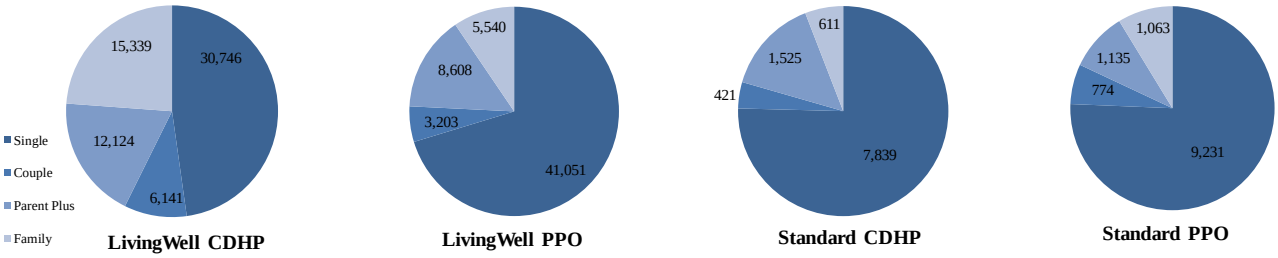
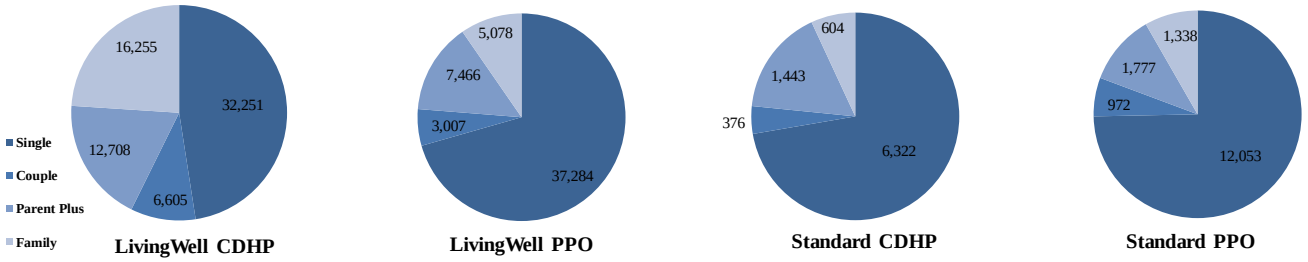


Exhibit 7b: Employee Enrollment by Coverage Tier and Plan, January–June 2018



Source: *KEHP's enrollment data aggregated by IBM Watson*

In 2017 and 2018, families comprise a larger portion of the LivingWell CHDP enrollment than on average, and the same pattern exists for singles in the Standard CDHP. Beginning in 2017, singles in the Standard PPO have a larger portion of enrollment.

Group Composition

Exhibit 8 shows some key statistics for KEHP's groups for 2016 to 2018.

Exhibit 8: Key Statistics by Group

	Number of Employees					2017 Key Statistics			2018 Key Statistics*		
Group	**2016**	**2017**	**2018 (6 Months)**	**2018 % of Total**	**2018 vs. 2017**	**Employee Ave. Age**	**Member to EE ratio**	**Members % Male**	**Employee Ave. Age**	**Member to EE ratio**	**Members % Male**
Actives	**108,981**	**108,161**	**108,374**	**74.5%**	**0.2%**	**45.0**	**1.95**	**42.6%**	**44.9**	**1.97**	**42.8%**
School Boards	71,384	71,440	72,120	49.6%	1.0%	45.0	2.01	40.5%	45.0	2.03	40.8%
State Employees	29,190	28,638	28,089	19.3%	-1.9%	44.3	1.83	47.6%	44.2	1.83	47.8%
Quasi/Local Govt	3,227	3,050	3,038	2.1%	-0.4%	45.4	1.80	46.8%	45.5	1.81	46.7%
KCTCS	3,296	3,165	3,182	2.2%	0.5%	48.3	1.86	44.8%	48.2	1.93	45.3%
Health Departments	1,883	1,868	1,946	1.3%	4.2%	46.4	1.86	33.7%	46.1	1.87	33.9%
Retirees	**37,516**	**36,924**	**36,874**	**25.3%**	**-0.1%**	**58.4**	**1.40**	**40.5%**	**58.4**	**1.41**	**40.3%**
KERS	25,515	25,605	26,114	17.9%	2.0%	57.8	1.41	43.6%	57.8	1.42	43.6%
TRS	12,001	11,319	10,760	7.4%	-4.9%	59.7	1.38	33.5%	59.6	1.40	33.0%
COBRA	109	131	152	0.1%	15.8%	50.2	1.88	41.6%	50.5	1.85	41.0%
Unknown	106	134	140	0.1%	4.5%	60.6	1.29	35.8%	60.7	1.31	35.4%
Total	**146,711**	**145,350**	**145,540**	**100.0%**	**0.1%**	**48.4**	**1.81**	**42.0%**	**48.4**	**1.83**	**42.2%**

Source: *KEHP's enrollment data aggregated by IBM Watson*
**2018 figures include January through June 2018 data only.*

The participating groups' composition changed very little over the last several years, with small increases in the average member to employee ratio for the active population. The retiree population decreased slightly in the past few years, largely from the TRS group.

Historical Number of Eligible Individuals Who Waive Enrollment in KEHP

KEHP provides a monthly waiver deposit into an HRA for eligible employees who waive KEHP coverage. These accounts are intended to pay for eligible out-of-pocket health care expenses. In 2006, the monthly deposit was $234 for the months January through June, and then decreased to $200 for the remainder of 2006; in 2007, the amount decreased to $175 per month, where it has remained through 2018. In 2013, KEHP introduced a dental/vision only waiver HRA that covers only dental and visions costs.

Exhibit 9 shows the annual waiver participation from 2014 through 2018.

Exhibit 9: 2014 Through 2018 Monthly Coverage Waiver Participation

	2014	2015	2016	2017	2018
Average # Employees	**22,197**	**22,543**	**22,667**	**22,612**	**22,473**
% Change	N/A	1.6%	0.5%	-0.2%	-0.6%
HRA Waiver Contributions	$46,543,245	$47,248,810	$47,516,224	$47,274,599	$47,193,767
HRA Waiver Claims	-$42,426,114	-$37,784,776	-$40,086,525	-$40,361,246	-$41,056,966
HRA Waiver Claims PEPM	-$159.28	-$139.68	-$147.37	-$148.74	-$152.24
% Change	N/A	-12.3%	5.5%	0.9%	2.4%

Source: *KEHP Trust Fund Summaries, 2018 contributions and claims are projected*

Considering the $175 per month has remained constant since 2007, the value of the waiver incentive continues to decline as inflation erodes the incentive purchasing price. The average number of people waiving coverage has remained steady since 2014. Starting from 2015, employees who are eligible to waive KEHP health insurance coverage and choose a waiver HRA may do so only if the employee has other group health plan coverage that provides minimum value and the employee attests or declares, in writing that the employee has such other coverage. If the employee does not attest or declare and waives coverage, the employee is only eligible for the dental/vision only HRA. The waiver claims decreased in 2015 since this requirement was put in place and has increased since 2016.

Medical & Pharmacy Trends

Key Findings

- Allowed cost trends were substantially lower than industry averages in 2015 but have reverted to national levels.
- Overall, on a PMPM basis, 2017 cost increased 4.1% mainly driven by a higher pharmacy trend of 9.8%.
- Overall, on a PMPM basis, 2018 cost increased due to unit cost inflation as member utilization has been relatively stable since 2017.

Medical and Pharmacy Claims Cost Increases

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

Exhibit 10: 2014–2018 Claims Experience

	2014	2015	2016	2017	2017 vs. 2016	Jan - Jun, 2017	Jan - Jun, 2018	2018 vs. 2017
Allowed Cost - Medical	$1,286,546,423	$1,104,576,487	$1,160,263,710	$1,194,786,335	3.0%	$566,988,892	$602,720,912	6.3%
Allowed Cost - Rx	$397,459,618	$383,874,554	$416,630,223	$451,851,371	8.5%	$221,040,662	$234,624,103	6.1%
Total Allowed Cost	**$1,684,006,041**	**$1,488,451,041**	**$1,576,893,933**	**$1,646,637,706**	**4.4%**	**$788,029,554**	**$837,345,015**	**6.3%**
Plan Paid - Medical	$1,077,768,368	$912,889,238	$956,550,829	$979,417,150	2.4%	$437,447,738	$468,014,625	7.0%
Plan Paid - Rx	$324,305,143	$323,322,903	$362,291,199	$399,516,260	10.3%	$190,393,724	$201,509,141	5.8%
Total Plan Paid	**$1,402,073,511**	**$1,236,212,141**	**$1,318,842,028**	**$1,378,933,411**	**4.6%**	**$627,841,462**	**$669,523,766**	**6.6%**
Covered Members	**263,456**	**261,938**	**262,032**	**263,061**	**0.4%**	**263,343**	**266,023**	**1.0%**
Allowed Cost PMPM - Medical	$406.95	$351.41	$369.00	$378.49	2.6%	$358.84	$377.61	5.2%
Allowed Cost PMPM - Rx	$125.72	$122.13	$132.50	$143.14	8.0%	$139.89	$146.99	5.1%
Total Allowed Cost PMPM	**$532.67**	**$473.54**	**$501.49**	**$521.63**	**4.0%**	**$498.73**	**$524.61**	**5.2%**
Plan Paid PMPM - Medical	$340.91	$290.43	$304.21	$310.26	2.0%	$276.86	$293.22	5.9%
Plan Paid PMPM - Rx	$102.58	$102.86	$115.22	$126.56	9.8%	$120.50	$126.25	4.8%
Total Plan Paid PMPM	**$443.49**	**$393.29**	**$419.43**	**$436.82**	**4.1%**	**$397.35**	**$419.46**	**5.6%**

Source: *KEHP's claims and enrollment data aggregated by IBM Watson*

Overall, the total allowed costs incurred by members of KEHP increased 4.4% from 2016 to 2017 and increased by 6.3% from 2017 to 2018. KEHP's annual paid claims costs increased 4.6% from 2016 to 2017 and increased 6.6% from 2017 to 2018. Since average membership increased minimally from 2016 to 2017, the corresponding PMPM allowed claims costs experienced a 4.0% increase from 2016 to 2017. Total allowed PMPM costs increased 5.2% from 2017 to 2018 and the KEHP's portion of the total medical and Rx claims increased by 5.6% from 2017 to 2018.

Allowed cost includes the total cost of the service, both plan and employee cost share. The allowed cost trend represents the true cost of service increase. When the plan paid trend is higher than allowed cost trend, it indicates the plan absorbed a larger portion of claims cost increase than the employees and vice versa.

The increase in allowed and plan paid costs in 2017 and 2018 is driven by an increase in unit cost inflation and a slight uptick in member utilization.

Exhibit 11 contains KEHP's medical and pharmacy claim trends for 2015 to 2017 as well as the projected claim trends for 2018.

Exhibit 11: Historical Claims Trends for KEHP

Historical Trend	2015	2016	2017	2018*
Plan Paid PMPM - Medical	-14.8%	4.7%	2.0%	5.9%
Plan Paid PMPM - Rx	0.3%	12.0%	9.8%	4.8%
Total Plan Paid PMPM	**-11.3%**	**6.6%**	**4.1%**	**5.6%**

Source: *KEHP's claims and enrollment data aggregated by IBM Watson*
**Trend for 2018 calculated YTD using the first six months.*

Aon used national trend survey data to develop a trend expectation of 8.5% for 2018 for KEHP.

KEHP changed medical and pharmacy vendors in 2015. Overall plan cost decreased 11.3% from 2014 to 2015, driven by better network pricing and lower member utilization.

KEHP made minimal changes in 2016. Overall plan cost increased 6.6% from 2015 to 2016, driven by increased unit cost and a slight uptick in member utilization.

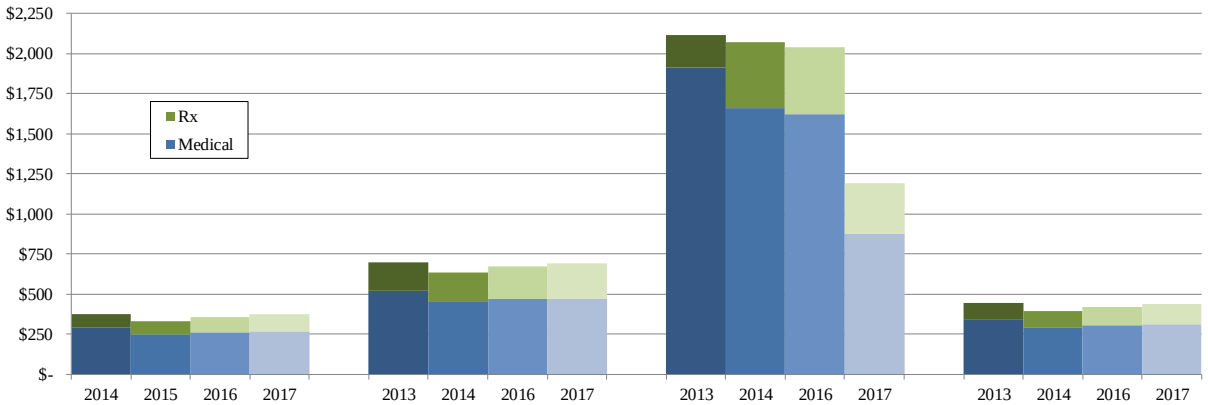
There were no vendor changes or major plan design changes in 2017. KEHP trends are approaching industry averages. Overall plan cost increased 4.1% from 2016 to 2017, driven by increase in member utilization and unit cost inflation primarily for prescription drugs.

In 2018, KEHP adopted the advanced control formulary and implemented an additional dispense as written requirement. Overall plan costs have increased 5.6% for the first 6 months of 2017 to 2018, driven mainly by increase in unit cost inflation for medical and prescription drugs.

Claims Payments by Employee Status

As noted in Exhibit 10, combined medical and pharmacy paid claims increased by 4.1% on a PMPM basis from 2016 to 2017. Exhibit 12 provides KEHP's PMPM costs and trends for both medical and pharmacy claims by member status (active employees, non-Medicare eligible retirees, and COBRA participants).

Exhibit 12: Medical and Pharmacy Paid Claims PMPM by Member Status



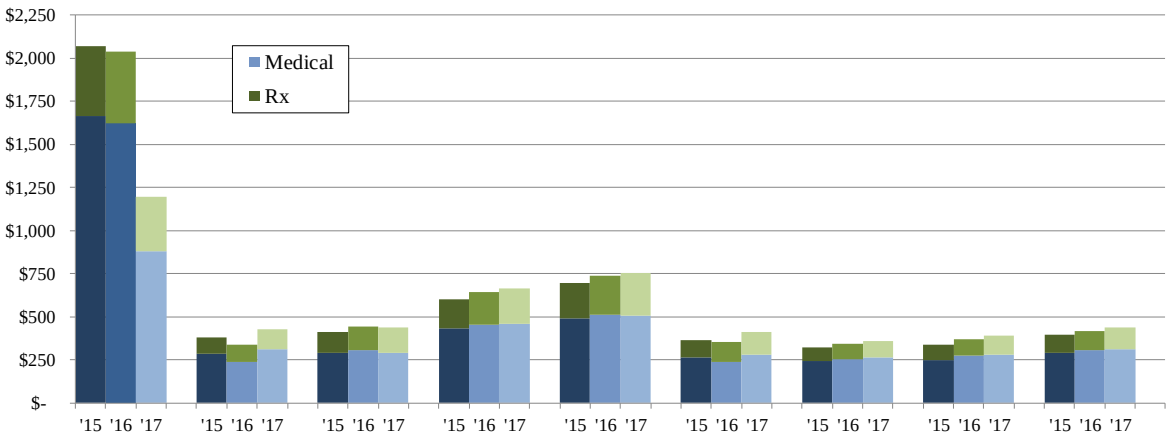
	Active			Retiree			COBRA			Total		
	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017
Medical Trend	-15.3%	5.3%	3.3%	-13.0%	4.6%	0.2%	-13.0%	-2.6%	-45.8%	-14.8%	4.7%	2.0%
Rx Trend	0.0%	13.3%	10.9%	0.8%	11.1%	8.8%	100.9%	2.9%	-24.5%	0.3%	12.0%	9.8%
Total Trend	**-12.0%**	**7.2%**	**5.3%**	**-9.5%**	**6.5%**	**2.8%**	**-2.1%**	**-1.6%**	**-41.4%**	**-11.3%**	**6.6%**	**4.1%**
Member Ave.	208,142	209,397	210,922	53,639	52,437	51,892	158	198	246	261,938	262,032	263,061

Source: *KEHP's claims and enrollment data aggregated by IBM Watson*

Plan paid cost trends are not only impacted by allowed cost trend but also impacted by plan design changes from year to year. The active and retiree populations are driving the overall trends in 2017. The COBRA participants are, in general, costlier than the members in the other groups, as only those who know they need medical coverage are likely to continue coverage. This group shows more volatility over the last several years, especially in 2015, where there were sharp increases in Rx claims. However, in 2016 the trends observed are less volatile. The large fluctuation in trends is likely due to catastrophic claims in the small group and is not expected to be indicative of future trend.

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

Exhibit 13: Medical and Rx Claims PMPM by Employee Group, 2015–2017



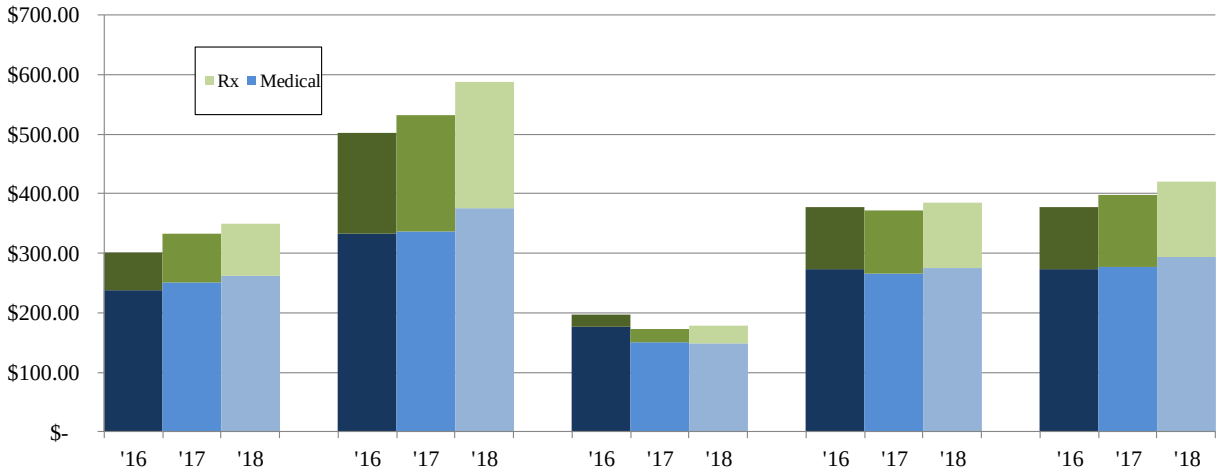
2017 Trends	COBRA	Health Dept	KCTCS	KERS	TRS	Local Govt	School Boards	State Employees	Total
Medical	-45.8%	30.3%	-5.6%	1.0%	-0.8%	17.7%	2.7%	3.2%	2.0%
Rx	-24.5%	17.6%	7.4%	7.8%	11.2%	16.2%	11.0%	10.9%	9.8%
Total	**-41.4%**	**26.6%**	**-1.6%**	**3.0%**	**2.8%**	**17.2%**	**4.8%**	**5.3%**	**4.1%**

Source: *KEHP's claims and enrollment data aggregated by IBM Watson*

A majority of the groups observed cost increases in 2017, with the largest cost increase for Health Department, on a PMPM basis. The largest cost reduction observed was for COBRA, which observed a 41.4% cost reduction, on a PMPM basis.

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

Exhibit 14: Medical and Rx Claims PMPM by Plan, January–June 2017 to January–June 2018



2018/2017 Trends	LivingWell CDHP	LivingWell PPO	Standard CDHP	Standard PPO	Total
Medical	4.4%	11.3%	-1.2%	3.4%	5.9%
Rx	6.8%	8.9%	34.7%	3.7%	4.8%
Total	**5.0%**	**10.5%**	**3.2%**	**3.5%**	**5.6%**

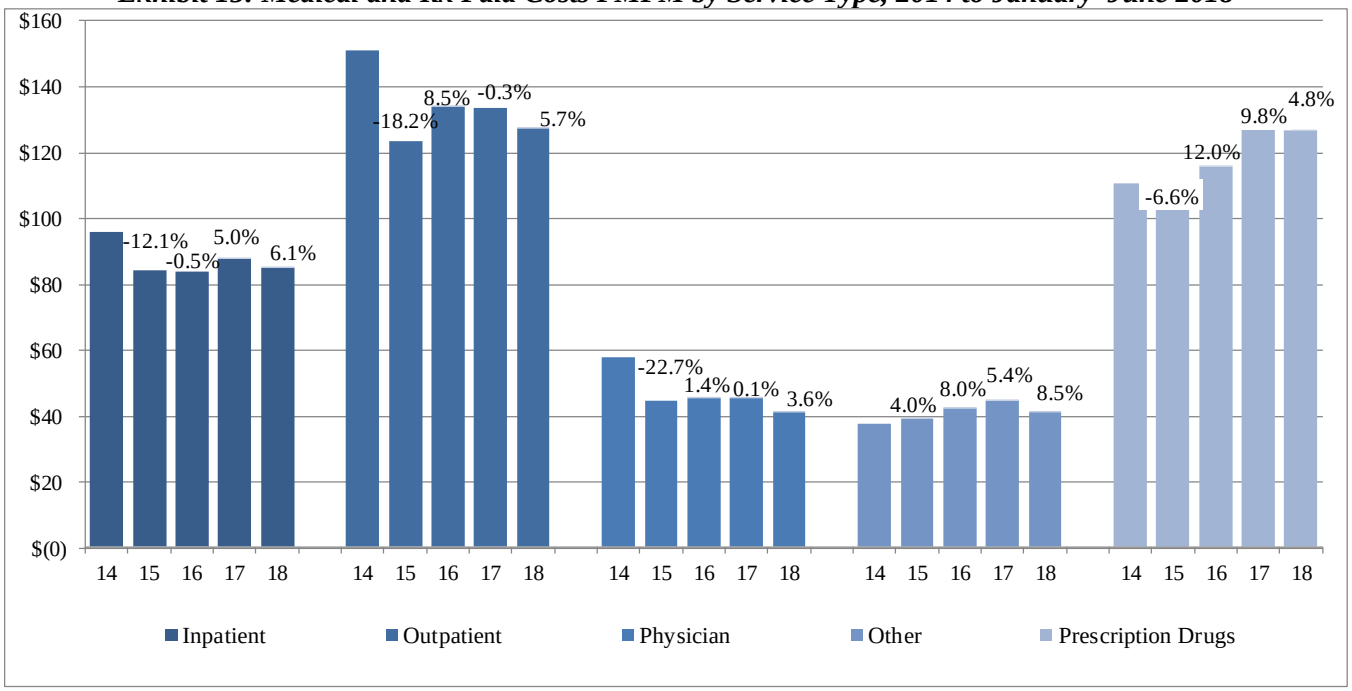
Source: *KEHP's claims and enrollment data aggregated by IBM Watson*

The LivingWell PPO is the most costly plan to KEHP and has the largest pre-65 retiree population. The LivingWell PPO is the only plan that experienced a double-digit trend from 2017 to 2018.

Trends are influenced by employee migration between plans. With more members migrating from the PPO plans to the CDHPs, the remaining members in the PPO may be higher cost and more risk averse.

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

Exhibit 15: Medical and Rx Paid Costs PMPM by Service Type, 2014 to January–June 2018



Source: *KEHP's claims and enrollment data aggregated by IBM Watson*

2018 data includes Jan-Jun 2018 compared to Jan – Jun 2017

In 2017, plan paid costs on PMPM basis increased in all service categories except for outpatient services. The prescription drug category has a 9.8% increase, followed by other services with an 5.4% increase, inpatient with an 5.0% increase, and physician services with a 0.1% increase, while the outpatient services has a 0.3% decrease. The increases align with national market trend.

PMPM costs increased in all service categories in the first half of 2018.

Review of KEHP Cost & Utilization

Summary of Medical and Pharmacy

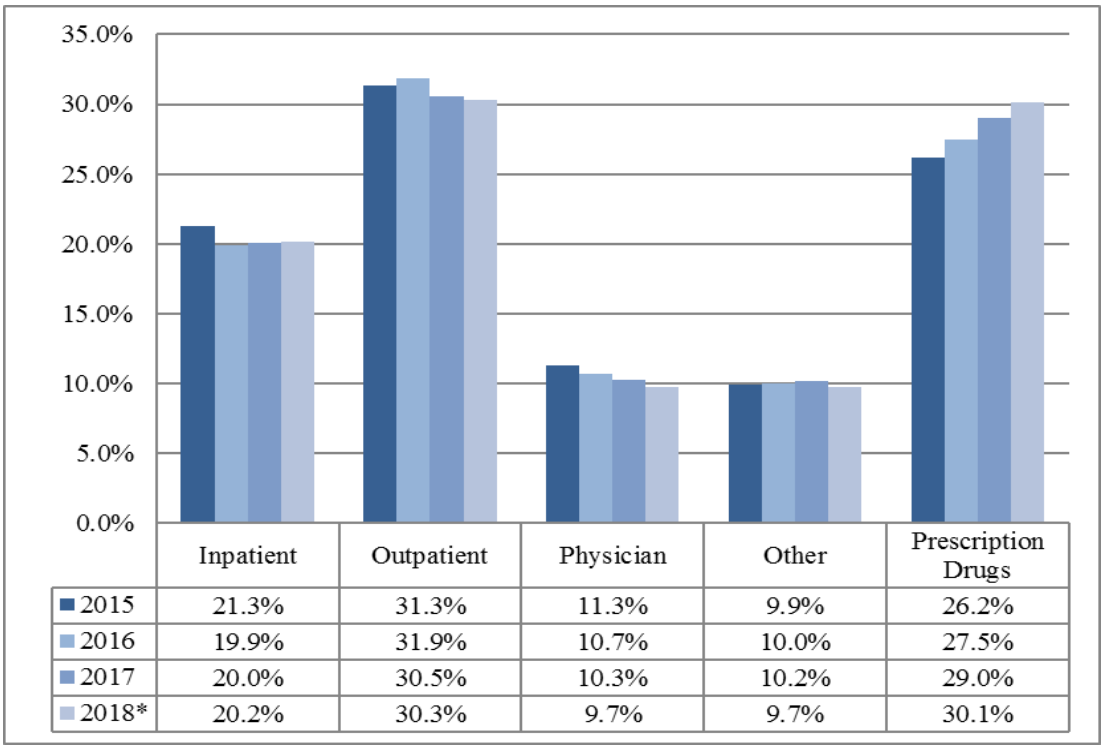
Key Findings

- Inpatient, outpatient, physician and other claims as a portion of total claims started to decrease slightly since 2015. Drug spend increased faster than overall health spend in the past few years. Pharmacy cost as a percentage of total allowed cost increased from 26.2% in 2015 to 30.1% in 2018.
- The KEHP paid claim structure has remained relatively stable in recent years. Approximately 18% of claimants account for about 85% of claims costs.
- Except for the utilization decrease for inpatient and outpatient services in 2017, both utilization and unit costs increased for all service types, which resulted in 0-5% increases in PMPM allowed charges in 2017. The same pattern continues in 2018 for all service types which resulted in 0-11% increases in PMPM allowed charges.
- The top ten Major Diagnostic Categories account for almost 80% of claim costs.

Distribution of Paid Claims by Service Type

Exhibit 16 shows the KEHP paid claims distribution by service type for 2015 to 2018.

Exhibit 16: Paid Claims Distribution by Service Type and Year



	Inpatient	Outpatient	Physician	Other	Prescription Drugs
2015	21.3%	31.3%	11.3%	9.9%	26.2%
2016	19.9%	31.9%	10.7%	10.0%	27.5%
2017	20.0%	30.5%	10.3%	10.2%	29.0%
2018*	20.2%	30.3%	9.7%	9.7%	30.1%

Source: *KEHP's claims data aggregated by IBM Watson*
**2018 figures include January through June 2018 data only.*

Prescription claims comprise the largest portion (30.1%) of the total claims. Starting from 2015, inpatient, outpatient, and physician claims as a portion of total claims started to decrease slightly. Drug claims increased faster than overall health spending in the past few years. As a result, pharmacy cost as a percentage of total allowed cost increased from 26.2% in 2015 to 30.1% in 2018.

KEHP Medical Benefits Detailed Experience

Paid Claims by User Type

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

Exhibit 17: Paid Claims by User Type

2015	$0 - $1,000	$1,000 - $5,000	$5,000 - $100,000	$100,000+
Patient %	56.2%	26.4%	16.9%	0.5%
Claim Amount %	3.2%	13.5%	62.3%	20.9%

2016	$0 - $1,000	$1,000 - $5,000	$5,000 - $100,000	$100,000+
Patient %	56.0%	25.9%	17.6%	0.6%
Claim Amount %	3.0%	12.5%	62.5%	22.0%

2017	$0 - $1,000	$1,000 - $5,000	$5,000 - $100,000	$100,000+
Patient %	55.8%	25.8%	17.8%	0.6%
Claim Amount %	3.1%	12.0%	62.7%	22.3%

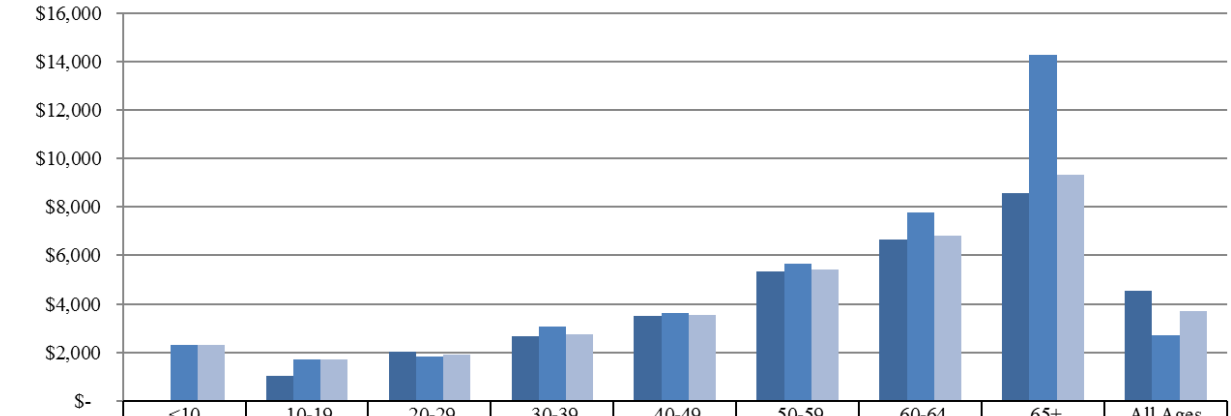
Source: *KEHP's claims and enrollment data aggregated by IBM Watson*

The KEHP paid claims distribution in 2017 indicated 55.8% members had net paid claims of less than $1,000, whereas 18.4% of claimants account for over 85% of claims costs, compared to 18.2% in 2016, which indicates the portion of high claimants remained relatively stable in 2017.

Paid Claims Cost Detail by Age Band

Exhibit 18 shows KEHP's 2017 medical claims PMPY by age band.

Exhibit 18: 2017 Employee and Dependent Medical Claims PMPY by Age Band



	<10	10-19	20-29	30-39	40-49	50-59	60-64	65+	All Ages
Employees	$-	$1,042	$2,047	$2,667	$3,517	$5,357	$6,653	$8,585	$4,534
Dependents	$2,291	$1,696	$1,829	$3,059	$3,645	$5,678	$7,766	$14,293	$2,721
Total	$2,290	$1,694	$1,912	$2,752	$3,547	$5,416	$6,802	$9,320	$3,723

2017 Member Counts									
Employees	-	101	12,125	25,320	32,853	43,125	27,541	4,284	145,349
Dependents	28,723	37,927	19,657	7,019	9,832	9,675	4,245	633	117,712
Total	28,723	38,028	31,782	32,339	42,686	52,800	31,785	4,917	263,061

Source: *KEHP's claims and enrollment data aggregated by* IBM Watson

As expected, paid claims per member increases with age. Dependents under age 30 represent 73.3% of total dependents enrolled in the plan but only 51.8% of dependent costs. In comparison, dependents over 50 comprise merely 12.4% of the dependent population, but their costs represent 30.3% of the total dependent paid claims. Aging typically results in 1%–2% higher cost per year of age. In the exhibit on the prior page, members over 65 are active employees (or dependents of active employees). The combination of the smaller size and higher demographic risk of this cohort leads to a greater likelihood of fluctuations in per capita costs.

Paid Claims Cost Details by Service Type

Exhibit 19 shows applicable utilization statistics for the major medical service types.

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

Inpatient Hospital Claim Utilization Statistics	2015	2016	2017	2017 vs. 2016	Jan - Jun, 2017	Jan - Jun, 2018	2018 vs. 2017
Admits Per 1,000 Lives	64.5	61.4	60.5	-1.5%	59.0	58.2	-1.4%
Days Per 1,000 Lives	284.1	270.2	266.8	-1.2%	257.3	246.6	-4.2%
Average Length of Stay (Days)	4.4	4.4	4.4	0.2%	4.4	4.2	-2.8%
Average Cost per Admit	$18,823	$20,098	$21,138	5.2%	$19,615	$21,186	8.0%
Average Cost per Day	$4,271	$4,568	$4,792	4.9%	$4,501	$5,000	11.1%
Allowed Charges PMPM	$101.1	$102.8	$106.5	3.6%	$96.5	$102.8	6.5%

Outpatient Hospital Claim Utilization Statistics	2015	2016	2017	2017 vs. 2016	Jan - Jun, 2017	Jan - Jun, 2018	2018 vs. 2017
Visit Per 1,000 Lives	1,129.8	1,168.9	1,224.1	4.7%	1,170.5	1,200.3	2.5%
Services Per 1,000 Lives	7,515.6	7,852.0	7,817.9	-0.4%	7,626.5	7,724.1	1.3%
Services Per Visit	6.7	6.7	6.4	-4.9%	6.5	6.4	-1.2%
Average Cost per Visit	$1,450	$1,506	$1,449	-3.8%	$1,468	$1,500	2.2%
Average Cost per Service	$217	$225	$229	1.7%	$225	$233	3.5%
Allowed Charges PMPM	$135.8	$147.1	$149.0	1.3%	$143.2	$150.0	4.8%

Professional Service Claim Utilization Statistics	2015	2016	2017	2017 vs. 2016	Jan - Jun, 2017	Jan - Jun, 2018	2018 vs. 2017
Visit Per 1,000 Lives	7,462.6	7,693.1	7,893.6	2.6%	7,764.8	7,852.1	1.1%
Services Per 1,000 Lives	15,414.7	15,673.7	16,182.4	3.2%	15,812.2	16,098.3	1.8%
Services Per Visit	2.1	2.0	2.1	0.6%	2.0	2.1	0.7%
Average Cost per Visit	$116	$117	$120	1.9%	$118	$123	4.2%
Average Cost per Service	$56	$58	$58	1.3%	$58	$60	3.5%
Allowed Charges PMPM	$72.1	$75.3	$78.7	4.6%	$76.2	$80.4	5.4%

Source: *KEHP's claims and enrollment data aggregated by IBM Watson*

Overall trend is driven by average cost per service increases and changes in utilization. The 2017 utilization increased for outpatient visits and professional services, and costs per service and admits increased for all service types. This resulted in a 3.6% increase for average inpatient PMPM charges, 1.3% increase for average outpatient PMPM charges, and 4.6% increase for average professional PMPM charges. Similar patterns continue in 2018 for outpatient and professional services, which resulted in a 4.8% increase for average outpatient PMPM charges and 5.4% increase for average professional PMPM charges. Inpatient charges observed a 6.5% increase for average PMPM charges, driven by an increase in cost per admit while the number of admits decreased.

Paid Claims Cost by Top 10 Major Diagnostic Categories

Total expenditure and number of patients covered for the top 10 major diagnostic categories (MDCs) in 2017 are shown in Exhibit 20. Note that IBM Watson's categorization of "Health Status," included in this list is a "catch-all" category (e.g., preventive/administrative health encounters, signs/symptoms/others). Also, note that many patients have multiple conditions falling within more than one MDC or clinical condition. The top 10 MDCs has been consistent for many years while the ranking has changed slightly.

Exhibit 20: Utilization by MDC

	Total Plan Cost				Patients			
Major Diagnostic Category	**2016**	**2017**	**Jan - Jun, 2017**	**Jan - Jun, 2018**	**2016**	**2017**	**Jan - Jun, 2017**	**Jan - Jun, 2018**
Musculoskeletal	$176,197,688	$175,840,454	$75,350,282	$81,173,868	94,113	94,483	64,681	65,299
Circulatory	$113,837,264	$114,531,247	$55,103,766	$55,085,020	67,160	66,944	45,047	45,236
Health Status	$86,477,366	$91,182,324	$41,242,397	$44,060,338	181,981	187,129	113,340	125,492
Digestive	$86,682,268	$91,174,205	$40,901,223	$42,571,746	52,384	52,380	31,150	31,578
Nervous	$55,576,721	$61,583,619	$26,713,572	$29,931,745	31,050	31,543	19,737	20,166
Myeloproliferative Diseases	$49,379,899	$47,445,247	$22,065,684	$27,405,769	6,197	6,310	3,909	4,090
Skin, Breast	$47,364,894	$45,099,281	$19,777,797	$20,877,481	84,254	85,435	51,523	50,820
Respiratory	$45,544,182	$42,757,089	$20,768,085	$20,109,534	53,847	58,221	37,093	37,917
Kidney	$39,750,466	$42,233,263	$18,443,181	$19,467,732	33,689	34,660	20,426	20,707
Ear, Nose, Mouth & Throat	$38,131,031	$41,179,354	$17,408,814	$16,930,896	129,259	133,498	92,848	89,921
Top Three as % of Total Spend	**39.4%**	**39.0%**	**39.2%**	**38.5%**				
Top Ten as % of Total Spend	**77.3%**	**76.9%**	**77.2%**	**76.4%**				

Source: *KEHP's claims data aggregated by IBM Watson*

Approximately 77% of claim costs are for treatment of members whose diagnoses are contained in the top 10 MDCs. This percent has remained consistent and is not improving despite investment for treating chronic conditions. The relatively high cost of musculoskeletal, circulatory, and digestive MDCs, in particular, suggests that care management and managed pharmacy programs related to these diagnoses should continue to be encouraged. For example, targeted joint replacement, low back pain, heart disease, and reflux disease management programs or pharmaceutical step therapies, with high participation rates, can help manage these costs as well as improve the health of patients who have these diagnoses.

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

Exhibit 21: Utilization by Chronic Conditions

Clinical Condition	**2016 Plan Cost**	**2017 Plan Cost**	**2017 Plan Cost (Jan - Jun)**	**2018 Plan Cost (Jan - Jun)**
Cancer	$64,869,069	$65,784,256	$31,454,909	$35,449,271
Chronic Back/Neck Pain	$44,295,912	$45,401,592	$18,552,746	$19,930,270
Osteoarthritis	$44,437,175	$44,295,318	$18,216,284	$21,288,866
Coronary Artery Disease	$29,916,053	$33,492,311	$16,663,537	$16,917,949
Diabetes	$14,398,124	$14,192,477	$6,137,873	$7,089,291
Weight Management	$8,395,148	$10,611,802	$3,877,591	$4,688,515
Hypertension	$8,220,140	$10,096,723	$3,999,013	$5,322,494
COPD	$2,597,445	$3,579,212	$2,044,899	$1,234,905
Asthma	$2,060,736	$2,236,990	$898,728	$1,320,478
Heart Failure	$4,084,142	$1,745,885	$891,719	$1,193,887

Source: *KEHP's claims data aggregated by IBM Watson*

Several chronic conditions, such as chronic back/neck pain, coronary heart disease, and osteoarthritis each cost KEHP around $30 to $50 million in 2016 and 2017. For comparison, all types of cancer combined cost KEHP over $60 million in 2016 and 2017. The costs associated with these 10 chronic conditions represent approximately 23.6% of KEHP's medical costs.

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

Exhibit 22: Paid Claims by Member Type

Relationship	Medical Plan Cost					
	2016	2017	2017 vs. 2016	Jan - Jun 2017	Jan - Jun 2018	2018 vs. 2017
Employees	$647,954,209	$659,081,067	1.7%	$295,431,337	$308,839,203	4.5%
Spouse	$149,336,896	$156,763,942	5.0%	$69,019,135	$77,755,995	12.7%
Child	$159,259,724	$163,572,141	2.7%	$72,997,266	$81,419,427	11.5%
Total	**$956,550,829**	**$979,417,150**	**2.4%**	**$437,447,738**	**$468,014,625**	**7.0%**

Relationship	Medical Plan Cost PMPM					
	2016	2017	2017 vs. 2016	Jan - Jun 2017	Jan - Jun 2018	2018 vs. 2017
Employees	$368.04	$377.87	2.7%	$337.10	$353.67	4.9%
Spouse	$389.30	$394.79	1.4%	$348.28	$378.55	8.7%
Child	$159.22	$161.08	1.2%	$144.41	$157.33	8.9%
Total	**$304.21**	**$310.26**	**2.0%**	**$276.86**	**$293.22**	**5.9%**

Source: *KEHP's enrollment and claims data aggregated by IBM Watson*

From 2016 to 2017, KEHP's total medical cost increased 1.7%, 5.0%, and 2.7% for employees, spouses, and children, respectively. In 2018, the total plan costs are expected to increase for all tiers. On a PMPM basis, total plan cost increased 2.7%, 1.4%, and 1.2% for employees, spouses, and children, respectively. In 2018, the PMPM costs increased by 4.9%, 8.7% , 8.9% for employees, spouses and children, respectively.

Exhibit 23 shows KEHP's medical costs separated by active/retiree status.

Exhibit 23: Paid Claims by Active/Retiree Status

Status	Medical Plan Cost					
	2016	2017	2017 vs. 2016	Jan - Jun 2017	Jan - Jun 2018	2018 vs. 2017
Active Employees	$659,495,991	$684,831,762	3.8%	$306,277,798	$326,755,188	6.7%
Retirees	$297,054,838	$294,585,389	-0.8%	$131,169,940	$141,259,437	7.7%
Total	**$956,550,829**	**$979,417,150**	**2.4%**	**$437,447,738**	**$468,014,625**	**7.0%**

Status	Medical Plan Cost PMPM					
	2016	2017	2017 vs. 2016	Jan - Jun 2017	Jan - Jun 2018	2018 vs. 2017
Active Employees	$262.21	$270.25	3.1%	$240.60	$254.79	5.9%
Retirees	$472.08	$473.07	0.2%	$427.16	$450.34	5.4%
Total	**$304.21**	**$310.26**	**2.0%**	**$276.86**	**$293.22**	**5.9%**

Source: *KEHP's enrollment and claims data aggregated by IBM Watson*

From 2016 to 2017, active employees experienced a 3.8% increase in total medical claims and retirees experienced a 0.8% decrease. On a PMPM basis, active employees experienced a 3.1% increase and retirees experienced a 0.2% increase. The 2018 PMPM trend for active employees is 5.9% and 5.4% for retirees.

KEHP Pharmacy Benefits Detailed Experience

Key Findings

- Total allowed pharmacy PMPM cost increased by 8.0% in 2017 and 5.1% in the first six months of 2018. The main drivers of pharmacy cost increase were significant price inflation for generic, brand, and specialty drugs; a declining number of patent expirations on blockbuster drugs; and a continued pipeline of new specialty drugs.
- The reduced copayment and coinsurance paid by diabetic members starting in 2016 resulted in higher prescription utilization and reduced member out-of-pocket costs, leaving KEHP to absorb most of the cost increases since 2016 and forward.
- Generic dispensing rate has increased since 2008, helping to slow down the drug cost growth.

Pharmacy Cost Statistics

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

Exhibit 24: Key Statistics—Aggregate Pharmacy Benefits Costs

	2014	2015	2016	2017	2017 vs. 2016	Jan - Jun, 2017	Jan - Jun, 2018	2018 vs. 2017
Total Eligible Members	263,456	261,938	262,032	263,061	0.4%	263,343	266,023	1.0%
Total Number of Scripts	4,553,940	4,455,571	4,553,836	4,604,411	1.1%	2,282,902	2,255,590	-1.2%
Scripts Per Member	17.29	17.01	17.38	17.50	0.7%	8.67	8.48	-2.2%
Total Plan Paid	$324,305,143	$323,322,903	$362,291,199	$399,516,260	10.3%	$190,393,724	$201,509,141	5.8%
Total Member Paid	$72,677,325	$60,007,483	$53,733,203	$51,770,547	-3.7%	$30,364,039	$32,213,497	6.1%
Total Allowed Cost	**$397,459,618**	**$383,874,554**	**$416,630,223**	**$451,851,371**	**8.5%**	**$221,040,662**	**$234,624,103**	**6.1%**
Plan Paid PMPM	$102.58	$102.86	$115.22	$126.56	9.8%	$120.50	$126.25	4.8%
Member Paid PMPM	$22.99	$19.09	$17.09	$16.40	-4.0%	$19.22	$20.18	5.0%
Total Allowed Cost PMPM	**$125.72**	**$122.13**	**$132.50**	**$143.14**	**8.0%**	**$139.89**	**$146.99**	**5.1%**

Source: *KEHP's enrollment and claims data aggregated by IBM Watson*

The number of scripts per member has increased 0.7% in 2017 and is projected to decrease 2.2% for 2018. The total allowed cost for prescription drugs increased 8.5% in 2017, and 2018 is projected to see an increase of 6.1% from the first six months of 2017 to the first six months of 2018. The observed 2017 trend rate for KEHP's portion of the pharmacy cost on a PMPM basis is 9.8% compared to total allowed cost trend of 8.0%. The observed trend rate for KEHP's portion of the pharmacy cost for the first six months of 2018 is 4.8% (on a PMPM basis) with the total allowed cost trend of 5.1%. Effective 1/1/2016, KEHP diabetic members pay a reduced copayment and coinsurance, with no deductibles, for most of their maintenance diabetic prescriptions and supplies. This resulted in higher prescription utilization and reduced member out-of-pocket costs. A number of factors are driving the high pharmacy trends, including significant price inflation for generic, brand, and specialty drugs; a declining number of patent expirations on blockbuster drugs; and a continued pipeline of new specialty drugs.

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

Exhibit 25: Key Pharmacy Cost Share Statistics

	2014	2015	2016	2017	2017 vs. 2016	Jan - Jun, 2017	Jan - Jun, 2018	2018 vs. 2017
Member Cost per Claim	**$16.30**	**$13.67**	**$12.02**	**$11.52**	**-4.2%**	**$13.82**	**$14.43**	**4.4%**
Retail Member Cost per Claim	$15.79	$13.45	$11.87	$11.42	-3.8%	$11.52	$11.44	-0.7%
Mail Member Cost per Claim	$35.16	$26.05	$20.35	$17.16	-15.7%	$19.71	$15.14	-23.2%
Specialty Member Cost per Claim						$141.43	$188.59	33.3%
Total Member Cost Share	**18.3%**	**15.7%**	**12.9%**	**11.5%**	**-1.4%**	**13.8%**	**13.8%**	**0.0%**
Retail Member Cost Share	18.8%	15.6%	12.9%	11.5%	-1.5%	19.6%	19.5%	-0.1%
Mail Member Cost Share	12.7%	16.1%	12.5%	11.3%	-1.2%	13.5%	13.5%	0.0%
Specialty Member Cost per Claim						5.3%	6.9%	1.6%
Generic Utilization								
Generic Dispensing Rate	81.4%	84.1%	85.0%	85.5%	0.5%	86.3%	86.0%	-0.3%
Generic Substitution Rate	93.8%	94.9%	95.9%	96.3%	0.4%	96.9%	97.3%	0.4%
Mail Order Utilization	2.6%	1.7%	1.8%	1.7%	0.0%	1.8%	1.8%	0.0%

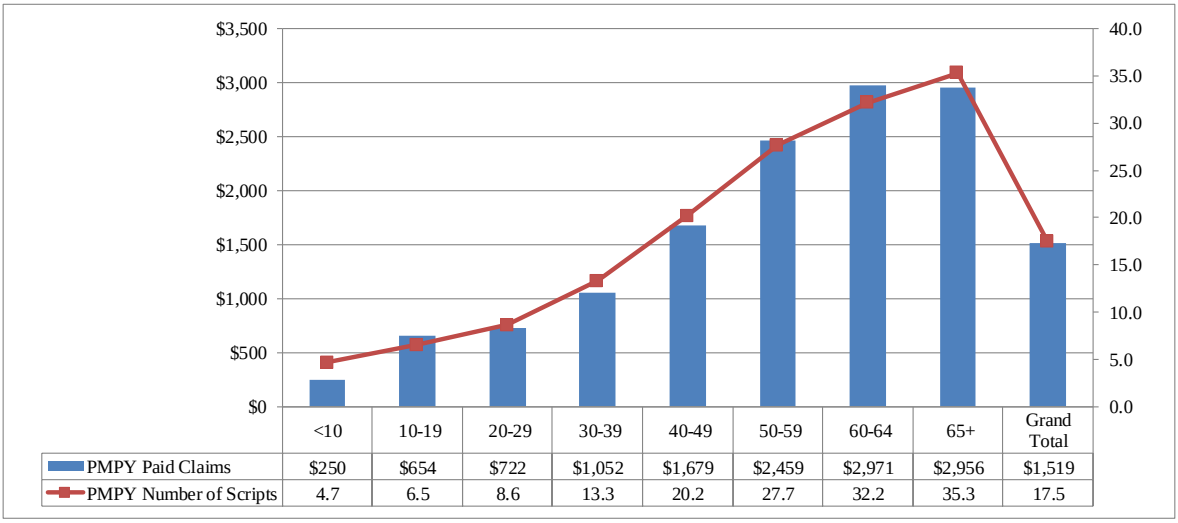
Source: *KEHP's enrollment and claims data aggregated by IBM Watson*

The generic dispensing rate has continued to increase steadily from 59.9% in 2007 (not shown) to 85.5% in 2017 and 86.0% through first six months of 2018. Mail order utilization has remained fairly level through 2014. Mail order utilization decreased by 0.9% in 2015 after the pharmacy vendor change and then stayed stable through 2018. Member cost share shows a modest increase in 2014 when plan design changes increased member cost share. The reduced copayment and coinsurance paid by diabetic members starting in 2016 resulted in higher prescription utilization and reduced member out-of-pocket costs. There were no other changes to member copayments from 2014 to 2018, leaving KEHP to absorb most of the cost increases.

Demographic Impact on Pharmacy Experience

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

Exhibit 26: 2017 Distribution of Pharmacy Claims and Number of Prescriptions, PMPY by Age Band



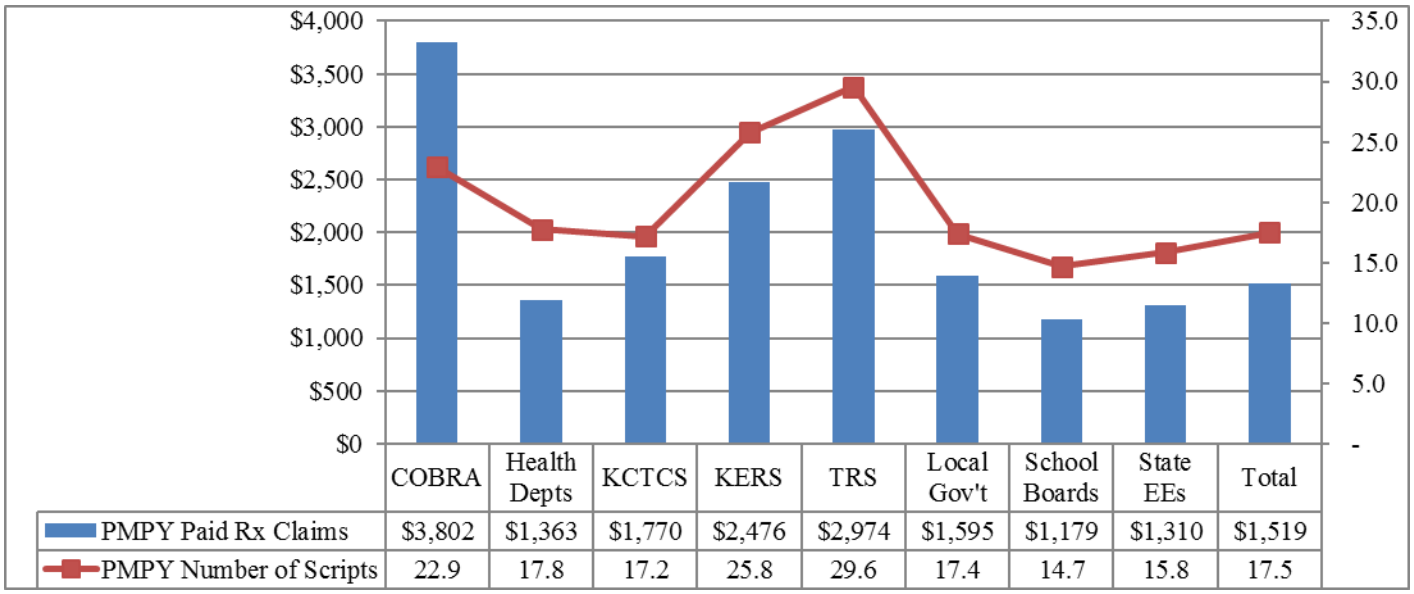
	<10	10-19	20-29	30-39	40-49	50-59	60-64	65+	Grand Total
PMPY Paid Claims	$250	$654	$722	$1,052	$1,679	$2,459	$2,971	$2,956	$1,519
PMPY Number of Scripts	4.7	6.5	8.6	13.3	20.2	27.7	32.2	35.3	17.5

Source: *KEHP's enrollment and claims data aggregated by IBM Watson*

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

Exhibit 27 shows pharmacy claims and number of scripts PMPMs, compiled by group.

Exhibit 27: 2017 Distribution of Pharmacy Claims and Number of Prescriptions, PMPY by Group



Source: *KEHP's enrollment and claims data aggregated by IBM Watson*

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

Prescription Drug Utilization and Disease States

Exhibit 28 shows the drugs that KEHP paid most for in 2017, along with their costs and number of scripts for 2014 through the first six months of 2018.

Exhibit 28: Top 10 Drugs for KEHP

Drug	2017 Rank	2016 Rank	Total Plan Cost					Number of Scripts				
			2014	2015	2016	2017	Jan - Jun 2018	2014	2015	2016	2017	Jan - Jun 2018
HUMIRA	1	1	$11,821,985	$15,058,077	$22,188,371	$28,837,226	$16,134,675	3,028	2,796	3,431	3,983	2,223
ENBREL	2	2	$9,204,171	$11,383,174	$13,962,392	$13,739,847	$6,999,115	2,504	2,307	2,333	1,971	939
STELARA	3	9	$3,381,031	$4,696,392	$5,179,552	$7,580,761	$5,427,286	274	394	420	542	349
NOVOLOG FLEXPEN	4	3	$116,828	$4,857,011	$6,254,116	$7,167,014	$3,556,416	191	7,097	7,740	8,341	4,131
JANUVIA	5	4	$3,626,340	$4,647,228	$6,072,060	$6,945,198	$3,876,478	11,583	12,840	14,179	15,013	7,322
VICTOZA	6	7	N/A	$3,168,218	$5,414,070	$6,700,526	$3,724,852	N/A	5,091	7,350	8,179	4,379
NOVOLOG	7	5	N/A	$4,436,835	$5,708,118	$6,506,841	$3,326,609	N/A	6,452	6,760	7,043	3,417
GILENYA	8	8	N/A	$4,297,637	$5,311,600	$6,142,401	$3,071,330	N/A	461	426	431	216
TECFIDERA	9	11	NA	NA	$5,061,757	$5,555,004	$2,819,641	NA	NA	583	568	270
FARXIGA	10	16	NA	NA	$3,374,721	$5,366,565	$4,434,800	NA	NA	8,109	11,254	8,007

Source: *KEHP's enrollment and claims data aggregated by IBM Watson*

In 2017, the top 10 drugs represented 23.7% of the KEHP total pharmacy costs. The top drugs utilized year over year are highly correlated to MDC categories and further support the need for health improvement through coordinated disease management programs and incentives, such as reduced copays for maintenance drugs prescribed to treat chronic conditions. KEHP implemented reduced member cost share for diabetic prescriptions and supplies beginning in 2016. Effective 1/1/2019, KEHP will expand the program into asthma and COPD

disease categories. Also, KEHP implemented the Preventive Therapy Drug Benefit that allows members with CDHPs to bypass their deductible and only pay the co-insurance when they fill their prescription.

Exhibit 29 shows utilization and cost statistics for the top therapeutic classes that contribute to pharmacy costs in January 2018 to June 2018.

Exhibit 29: Top 10 Therapeutic Classes Contributing to Pharmacy Cost

Top 10 Therapeutic Classes for January - June 2018 by Plan Cost								
2018 Rank	2017 Rank	Therapeutic Class	Scripts	Patients		Gross Costs	Generic Fill Rate	Gross Cost PMPM
1	1	Antidiabetics	123,791	21,286	$	41,922,341	54.1%	$26.18
2	2	Analgesics - Anti-Inflammatory	74,493	33,573	$	34,728,070	92.3%	$21.69
3	4	Dermatologicals	46,213	27,638	$	16,572,263	89.6%	$10.35
4	3	Psychotherapeutic And Neurological Agents	5,968	2,302	$	14,710,167	35.8%	$9.19
5	5	Antiasthmatic And Bronchodilator Agents	84,527	27,764	$	10,897,759	58.0%	$6.81
6	7	ADHD/Anti-Narcolepsy Obesity/Anorexiants	40,504	10,217	$	8,966,787	64.7%	$5.60
7	8	Antineoplastics	9,030	2,715	$	8,606,958	93.4%	$5.38
8	9	Antivirals	29,712	22,229	$	7,478,408	95.1%	$4.67
9	12	Anticonvulsants	65,386	16,564	$	6,126,929	89.3%	$3.83
10	14	Gastrointestinal Agents - Misc	8,452	3,141	$	5,414,826	45.1%	$3.38
		Top Ten Total	**488,076**		**$**	**155,424,508**	**72.4%**	**$97.06**

Source: *CVS/Caremark Prescription Benefit Review January 2018–June 2018*

Plan costs for these top indicators represent about $155 million in the first six months of 2018. KEHP's total allowed pharmacy costs were around $235 million for the same period; therefore, 66% of pharmacy costs are due to the top ten indicators. Diabetes is the top indicator, with nearly $42 million in total ingredient costs and one of the highest plan costs per patient.

Pharmacy Benchmarks

Exhibit 30 compares some of KEHP's pharmacy cost utilization statistics against public benchmarks provided by CVS/Caremark.

Exhibit 30: Benchmarked Utilization Statistics

	KEHP				State Govt.
	2016	2017	Jan - Jun, 2017	Jan - Jun, 2018	Jan - Jun, 2018
Member Cost %	12.9%	11.5%	13.8%	13.8%	9.9%
Generic Fill Rate	85.0%	85.5%	86.3%	86.0%	87.1%
Generic Substitution Rate	95.9%	96.3%	96.9%	97.3%	98.9%
Mail Subscription Rate	1.8%	1.7%	1.8%	1.8%	5.8%
Specialty Percent of Allowed Cost	35.7%	40.2%	40.0%	45.1%	39.2%
Specialty Plan Allowed Cost PMPM	$47.25	$57.57	$56.03	$66.30	$58.65

Source: *KEHP's enrollment and claims data aggregated by IBM Watson, CVS/caremark Prescription Benefit Review January 2018–June 2018*

KEHP's member cost share is 3.9% higher than the CVS/Caremark benchmark. KEHP's generic fill rate and mail subscription rate are lower than the benchmark. However, the specialty percent of total allowed cost and specialty plan allowed cost are much higher than the benchmark.

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

Exhibit 31: Schedule of Top Prescription Drugs Losing Patent Protection

Year	Drug	Manufacturer	Use	KEHP Cost - 2017
2018	Restasis	Allergan	Eye Drugs	$ 1,524,099
	Nuvaring	Organon	Contraceptives	$ 1,009,873
	TREXIMET	GlaxoSmithKline	Migraine Headaches	$ 914,569
	Cialis	Lilly	Circulatory Disorders	$ 833,903
	Welchol	Daiichi Sankyo	High Blood Cholesterol	$ 817,767
	Solodyn	Medicis	Infections	$ 565,799
	EpiPen Auto-Injector	Mylan	Misc Conditions	$ 522,047
	Uceris	Santarus	Inflammatory Conditions	$ 487,456
	Adcirca	Lilly	Pulmonary Hypertension	$ 345,356
	Zortress	Novartis	Cancer	$ 330,574
	Makena	KV Pharm	Hormonal Supplementation	$ 314,776
	Letairis	Gilead	Pulmonary Hypertension	$ 296,262
	Tracleer	Actelion	Pulmonary Hypertension	$ 241,287
	Canasa	Allergan	Inflammatory Conditions	$ 222,814
2019	Lyrica	Pfizer	Pain And Inflammation	$ 3,433,680
	Latuda	Sunovion	Mental/Neuro Disorders	$ 1,285,927
	Forteo	Lilly	Osteoporosis	$ 1,093,822
	ProAir HFA	Teva	Asthma	$ 832,999
	Ranexa	CV Therapeutics	Heart Disease	$ 822,345
	Firazyr	Shire	Hereditary Angioedema	$ 737,403
	Vesicare	Astellas	Urinary Disorders	$ 391,803
2020	Revlimid	Celgene	Cancer	$ 2,444,200
	Dexilant	Takeda	Heartburn/Ulcer Disease	$ 2,213,405
	Xyrem	Jazz	Sleep Disorders	$ 1,527,037
	Dulera	Merck	Asthma	$ 1,365,448
	Absorica	Ranbaxy	Acne	$ 1,132,822
	Chantix	Pfizer	Smoking Cessation	$ 945,167
	Ampyra	Acorda	Multiple Sclerosis	$ 786,299
	Kuvan	Biomarin	Endocrine Disorders	$ 649,460
	Uloric	Takeda	Gout	$ 562,207
	CiproDex	Alcon	Eye Infections	$ 316,380
	Saphris Black Cherry	Organogenesis Inc.	Mental/Neuro Disorders	$ 266,352
	Taytulla	Allergan	Contraceptives	$ 240,311
	Epiduo Forte	Astellas	Acne	$ 228,365
2021	Gilenya	Novartis	Multiple Sclerosis	$ 6,142,401
	Tecfidera	Biogen Idec	Multiple Sclerosis	$ 5,555,004
	Bystolic	Forest	High Blood Pressure/Heart Disease	$ 1,403,991
	Truvada	Gilead	Hiv	$ 1,096,575
	Atripla	Gilead	Hiv	$ 718,749
	Suprep Bowel Prep K	Boehringer Ingelheim	Constipation	$ 347,631
	Amitiza	Sucampo	Gi Disorders	$ 326,646
	CAYSTON	Gilead	Cystic Fibrosis	$ 212,542
2022	Afinitor	Novartis	Cancer	$ 950,549
	Vimpat	UCB Pharma	Seizures	$ 920,245
	Apriso	Salix	Gi Disorders	$ 475,827

Source: *KEHP clams data aggregated by IBM Watson*

These highly utilized drugs in Exhibit 31 represent a significant portion of KEHP's total pharmacy. Together, these drugs account for nearly $48 million, or 12.0%, of KEHP's total pharmacy cost.

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

Population Health Issues

Key Findings

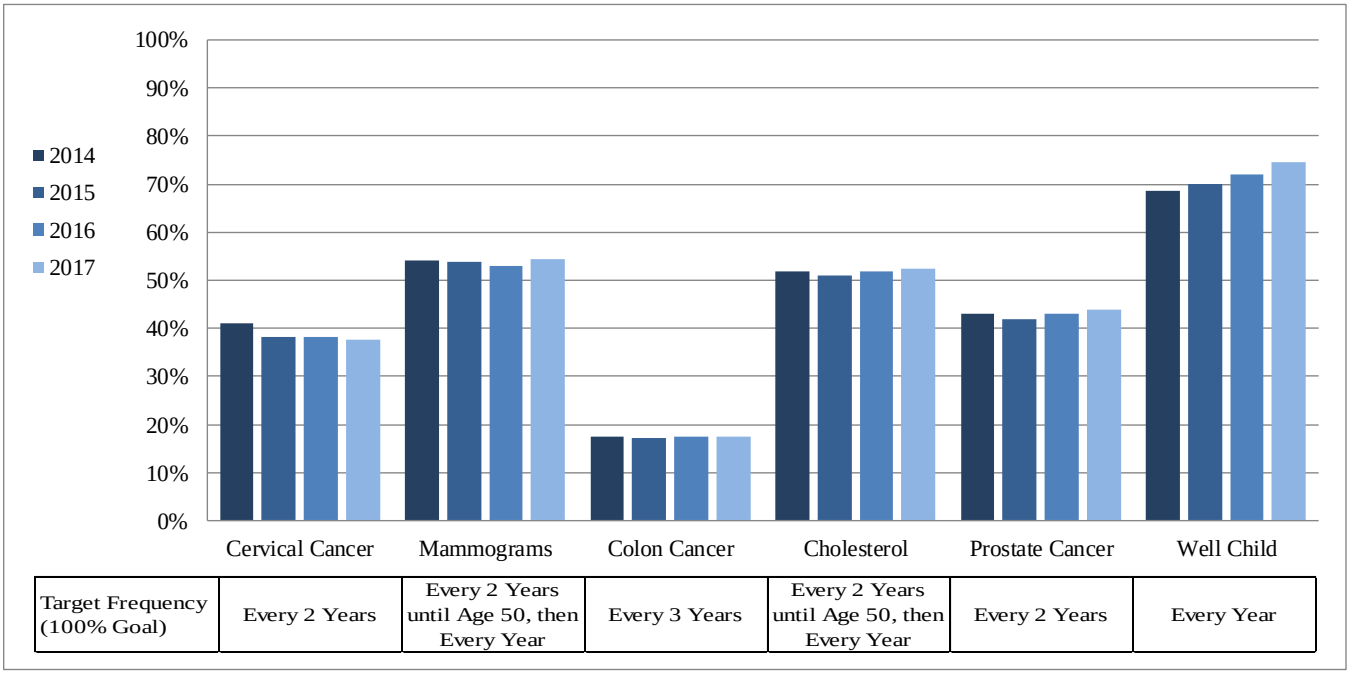
- Members of KEHP are not utilizing preventive care screenings as often as recommended. There were no major changes in preventive screening rates between 2016 and 2017 except for a slight increase in well child visits, prostate screenings, and mammograms for both active and retiree populations.
- The Kaiser Family Foundation Survey, as with prior years, shows that Commonwealth of Kentucky residents, as a whole, have less healthy behaviors and outcomes than the U.S. as a whole, as well as other states in the South Region.

Preventive Care Screenings

Health experts created objectives publicized in "Healthy People 2010" and "Healthy People 2020" to identify a wide range of public health priorities and specific, measurable objectives. These can be used for health improvement strategies at the state, community, or organizational level in order to reach the ultimate goals of increasing the quality and years of healthy life and eliminating health disparities. For each of the preventive screenings, the desired target compliance rate is 100% for the respective target groups and screening frequencies.

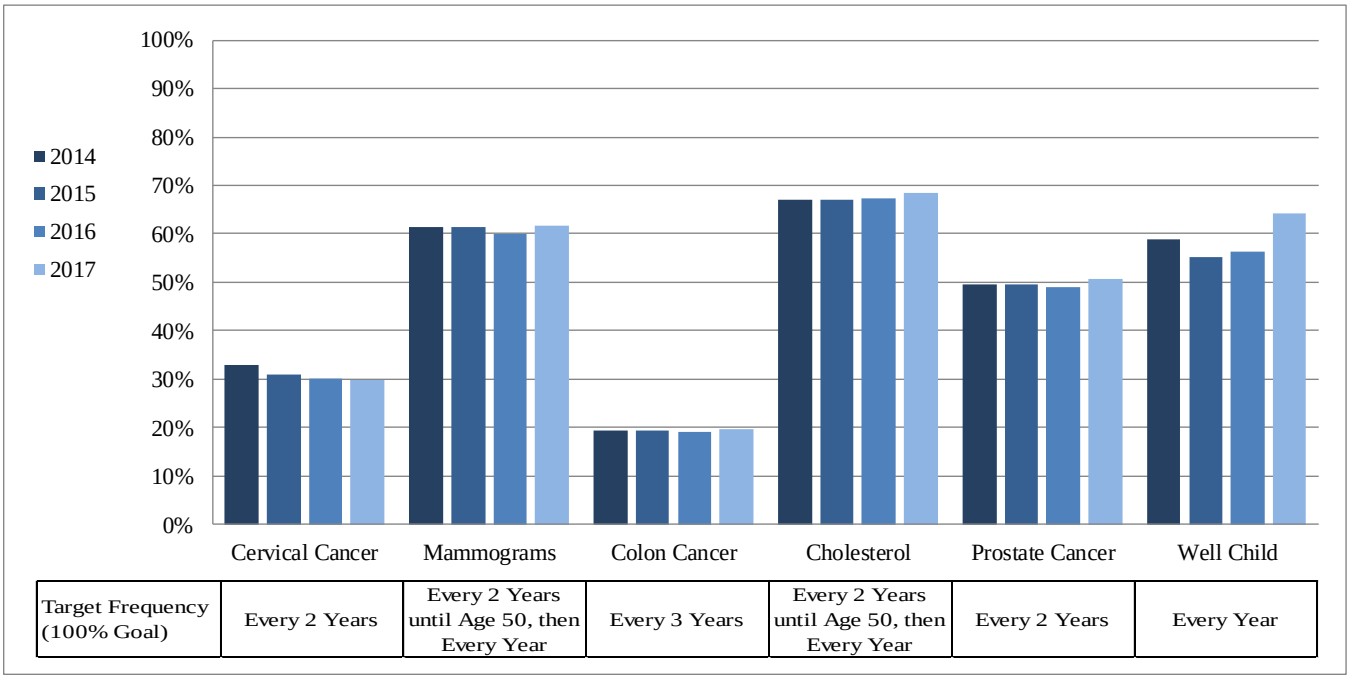
Exhibits 32 and 33 show the preventive care screening rates for KEHP members from 2014–2017 by active and non-Medicare eligible retiree status, separately.

Exhibit 32: Preventive Care Screening Utilization (Actives)



Source: *KEHP's enrollment and claims data aggregated by IBM Watson*

Exhibit 33: Preventive Care Screening Utilization (Early Retirees)



Source: *KEHP's enrollment and claims data aggregated by IBM Watson*

There were no major changes in preventive screening rates between 2016 and 2017 except for an increase in well child visits, prostate screenings, and mammograms for both active and retiree populations. KEHP's retiree population continues to achieve higher screening rates for all adult preventive measures, with the exception of cervical cancer screens, when compared with actives. Levels for both member groups are well under goals and expectations. Improvements in preventive care screenings are needed in all categories, especially colon cancer.

Disease Management and Care Management

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

Exhibit 34: Outreach Results

	2016			2017			Jan 2018 - June 2018		
Anthem	Referral	Engagement	Engagement Rate	Referral	Engagement	Engagement Rate	Referral	Engagement	Engagement Rate
Diabetes Prevention Program	549	397	72%	345	356	103%	174	171	98%

Source: *Anthem's Diabetes Program Reports, 2016–2017 and the first 6 months of 2018*

	2016			2017			July 2017 - Jun, 2018		
Anthem	Referral	Engagement	Engagement Rate	Referral	Engagement	Engagement Rate	Referral	Engagement	Engagement Rate
Case Management	77,374	13,734	18%	69,109	12,435	18%	83,537	13,459	16%

Source: *Anthem's Case Management Program Reports, 2016–2017 and the last rolling 12 months through June 2018*

The number of engaged members in the Diabetes Prevention Program (DPP) has stayed relatively consistent in 2016 and 2017, while the number of referrals has decreased. The DPP was introduced in 2015 with the change in the medical carrier. As a result, the engagement is expected to be the highest initially as members are newly identified and decrease or level off in following years given the population is relatively stable. The number of referrals and those engaged in the Diabetes Prevention Program appear to be consistent during the first six months of 2018. The case management engagement rate remained steady from 2016 to 2017 at 18% but decreased slightly to 16% through June 2018.

Exhibit 35 shows the extent to which KEHP members have taken care of their health in 2016 and 2017.

Exhibit 35: ICM Clinical Indicators

Cluster	Clinical Indicator	Measured Population	2016	2017	Jan - Jun, 2018
Overall Wellness	Percent of Adults with no gaps in Care	All KEHP Members	39%	44%	45%
Vascular Conditions	Use of Beta-Blockers after heart attack	238	84%	85%	82%
	LDL-Cholesterol Screening after a caridovascular event*	3,562	78%	69%	N/A
Diabetes	HbA1c Testing Rate	19,694	81%	81%	81%
	Lipid Test Percent*	14,245	74%	86%	N/A
	Eye Exam Rate	9,243	33%	38%	38%

Source: *KEHP's enrollment and claims data aggregated by IBM Watson*

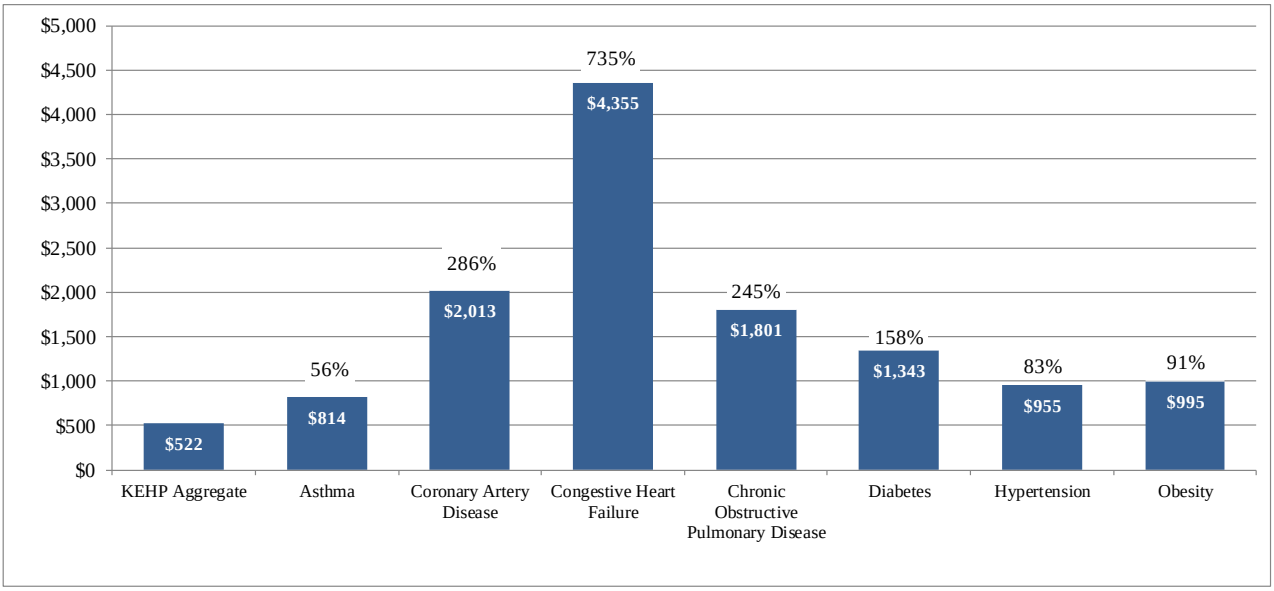
**Measurements are only available for a full year of experience*

Several indicators improved in 2017 and 2018 such as percent of adults with no gaps in care, lipid test percent and eye exam rate. However, an ongoing concern is the low percentage of KEHP members with diabetes who have received an eye exam.

Costs by Disease State

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

Exhibit 36: 2017 Chronic Disease States PMPM vs. KEHP Aggregate PMPM



Source: *KEHP's enrollment and claims data aggregated by IBM Watson*

Members with congestive heart failure, for example, are 735% more expensive than the average member. Given the average cost of members within each disease state, there is potential for significant savings through effective management of chronic diseases. Assisting members with accessing appropriate care, discussing concerns with

their physicians, maintaining medication compliance, and gaining additional education through the disease management program will significantly improve member health and plan cost.

Population Health Statistics for the Commonwealth of Kentucky

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

Exhibit 37: Comparison of Selected Population Health Statistics

Statistic	KY (Prior Survey)	KY (Current)	South Region	US Total
Life Expectancy at Birth	76.0	76.0	77.7	78.9
Percent of Adults Who are Overweight or Obese	67%	68%	67%	65%
Percent of Children (10-17) who are Overweight or Obese	36%	34%	34%	31%
Percent of Adults who Participate in any Physical Activities	68%	66%	70%	73%
Percent of Adults Who Smoke	26%	25%	18%	16%
Percent of Smokers who Attempt to Quit Smoking	53%	57%	61%	59%
Percent of Adults Who Have Ever Been Told by a Doctor that They Have Diabetes	13%	13%	12%	11%
Adult Self-Reported Current Asthma Prevalence Percentage	12%	11%	9%	9%
Percent of Adults Reporting Poor Mental Health	36%	38%	34%	36%
Number of Cancer Deaths (per 100,000)	199	194	161	156
Number of Deaths Due to Diseases of the Heart (per 100,000)	198	203	175	166
Age-Adjusted Invasive Cancer Incidence Rate (per 100,000)	512	514	432	437

Source: *Kaiser Family Foundation, www.statehealthfacts.org*

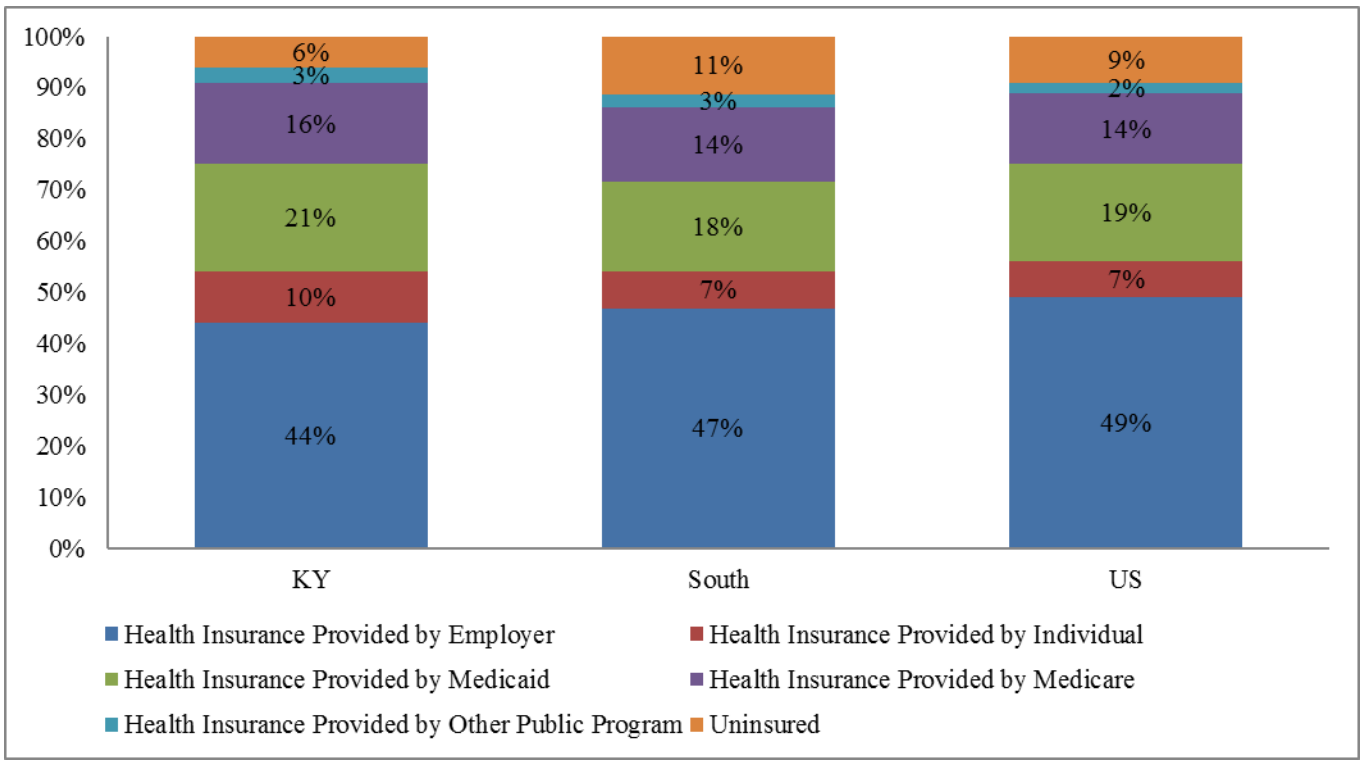
The population statistics suggest that Kentucky residents, on average, have a less healthy lifestyle than both the South Region and the U.S. as a whole and can expect both a higher prevalence of health issues and a lower life expectancy. However, some of the statistics have improved since the prior survey: the percent of children who are overweight or obese, the percentage of adults who smoke, the percentage of smokers who attempt to quit smoking, adult self-reported current asthma prevalence percentage, and number of cancer deaths and the percentage of adults self-reported asthma are better this year than last year.

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

Health Insurance Coverage for the Commonwealth of Kentucky

In addition to the health risk statistics comparison, the Kaiser Family Foundation has aggregated data regarding the health insurance coverage of each state's residents. In Exhibit 38, Kentucky is again compared against the South Region as well as the U.S. as a whole.

Exhibit 38: Source of Insurance Coverage Comparison



Source: *Kaiser Family Foundation, www.statehealthfacts.org*

In contrast to the disparity in their health risk statistics, the residents of Kentucky are insured in roughly the same proportions as the rest of the U.S., with an uninsured rate that's lower than both the national average and the other southern states. The percentage of Kentucky residents insured through Medicare and Medicaid are higher than both the South Region and the U.S. in total.

BENCHMARK RESULTS

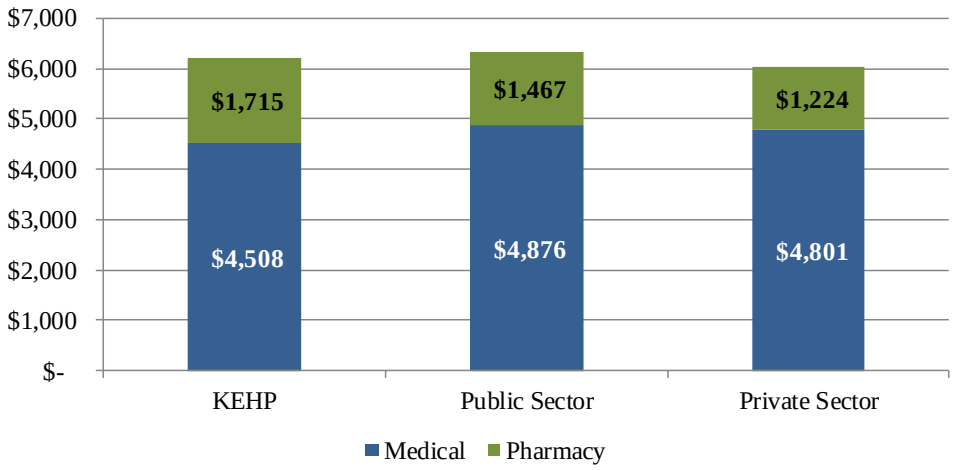
Key Findings

- KEHP members have higher incidences in all major disease categories than the U.S. benchmarks and the state and local government benchmarks.
- KEHP has higher prevalence figures than both public sector and private sector in all chronic conditions.
- Admission rates for KEHP members with chronic conditions are higher than both the private and public sector benchmarks.

Total Allowed Costs

IBM Watson benchmarked several statistics for KEHP. IBM Watson compared KEHP's 2017 plan performance against employer plan performance of other IBM Watson clients in the public sector and private sector. Exhibit 39 shows the difference in total costs PMPY for both KEHP and the public and private sectors.

Exhibit 39: 2017 KEHP Active & Early Retiree Population PMPY Allowed Costs vs. Public and Private Sector



Source: *IBM Watson Benchmark Report*

KEHP's total allowed PMPY cost was 1.9% lower than other clients in the public sector (7.5% lower for medical costs and 16.9% higher for pharmacy) and 3.3% higher than clients in the private sector (6.1% lower for medical costs and 40.1% higher for pharmacy).

Demographics

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

Exhibit 40: 2017 Key Demographic Statistics

	KEHP	Public Sector	Private Sector
Average Member Age	36.8	35.7	33.5
Member to Employee Ratio	1.8	2.0	2.2
Employee % male	42%	44%	49%
Risk Score	193	117	99

Source: *IBM Watson Benchmark Report*

In general, KEHP's plans cover an older population with smaller family size than other IBM Watson clients in the public sector. KEHP's risk score is substantially higher than clients in the public sector and higher than other clients in the private sector. Additionally, KEHP risk score increased from 181 in 2016 to 193 in 2017.

Disease Prevalence in KEHP Active Population

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

Exhibit 41: 2017 Disease Prevalence for Actives

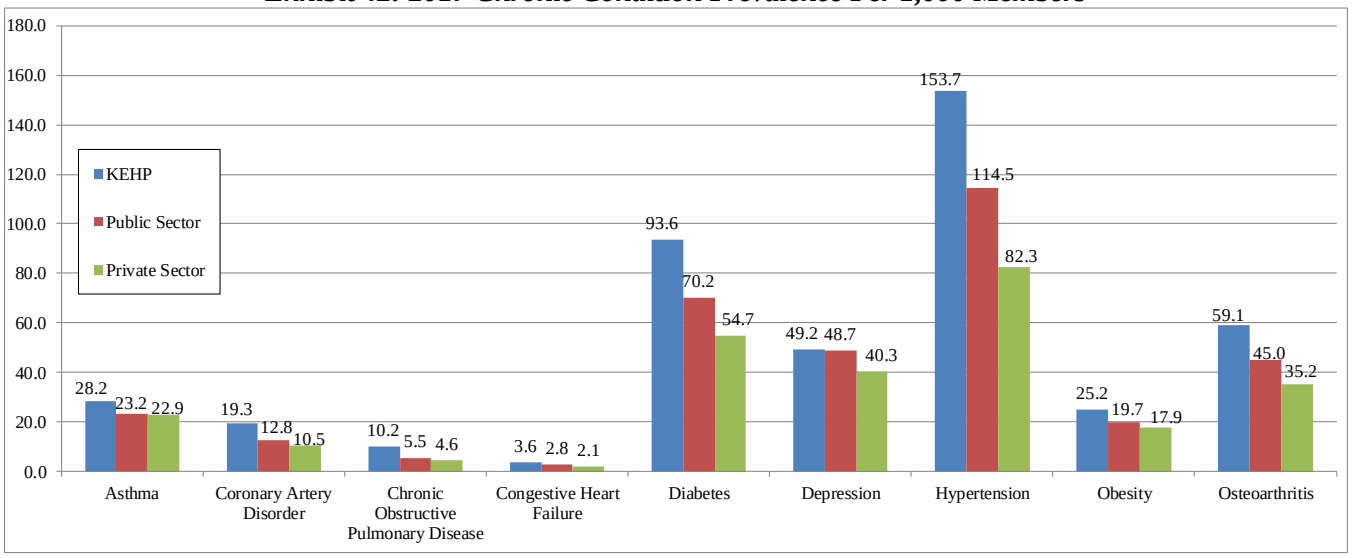
Disease Prevalence % of Patients	KEHP	Benchmark			
		State & Local Govt	Difference	Private	Difference
Asthma	2.6%	2.0%	0.5%	1.9%	0.7%
Coronary Artery Disorder	2.3%	1.6%	0.6%	1.4%	0.9%
Chronic Obstructive Pulmonary Disease	1.2%	0.7%	0.5%	0.6%	0.6%
Congestive Heart Failure	0.4%	0.4%	0.1%	0.3%	0.2%
Diabetes	11.4%	8.8%	2.7%	7.1%	4.4%
Depression	5.5%	5.4%	0.1%	4.5%	1.0%
Hypertension	19.0%	14.4%	4.6%	10.8%	8.2%
Low Back Disorder	12.7%	10.1%	2.6%	8.6%	4.1%
Obesity	2.5%	2.0%	0.6%	1.8%	0.8%
Osteoarthrits	7.3%	5.7%	1.6%	4.6%	2.7%

Source: *IBM Watson Benchmark Report*

KEHP members have higher incidences in all major disease categories than the U.S. benchmarks and state and local government benchmarks.

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

Exhibit 42: 2017 Chronic Condition Prevalence Per 1,000 Members

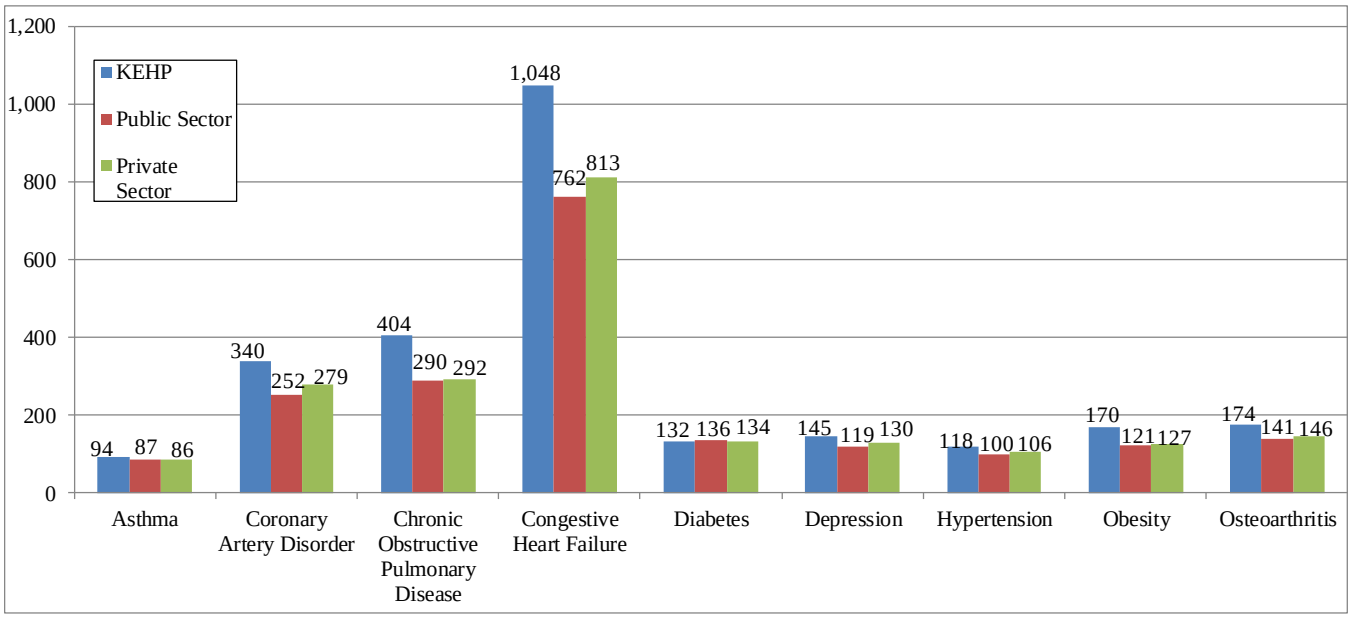


Source: *IBM Watson Benchmark Report*

KEHP has higher prevalence figures than both public sector and private sector in all chronic conditions.

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

Exhibit 43: 2017 Admissions Per 1,000 Members for Members With Chronic Conditions

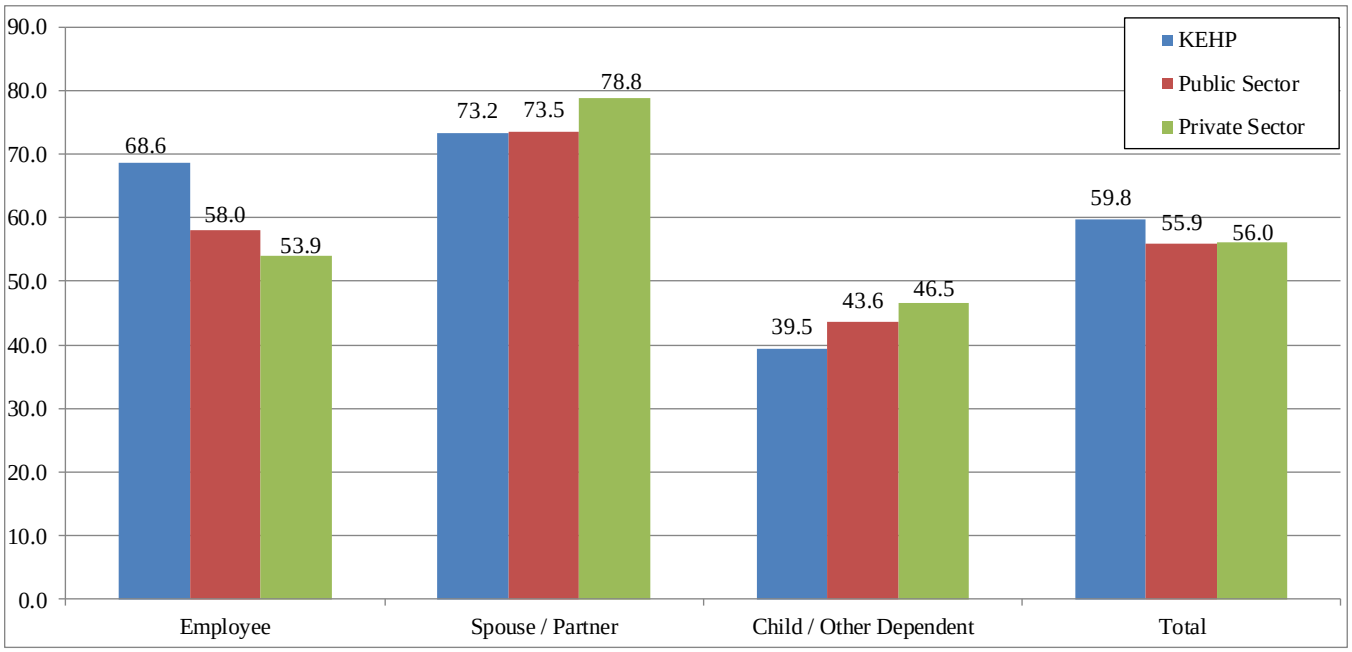


Source: *IBM Watson Benchmark Report*

KEHP members with chronic conditions show higher admission rates than both private and public sectors, except for diabetes.

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

Exhibit 44: 2017 Admissions Per 1,000 Members

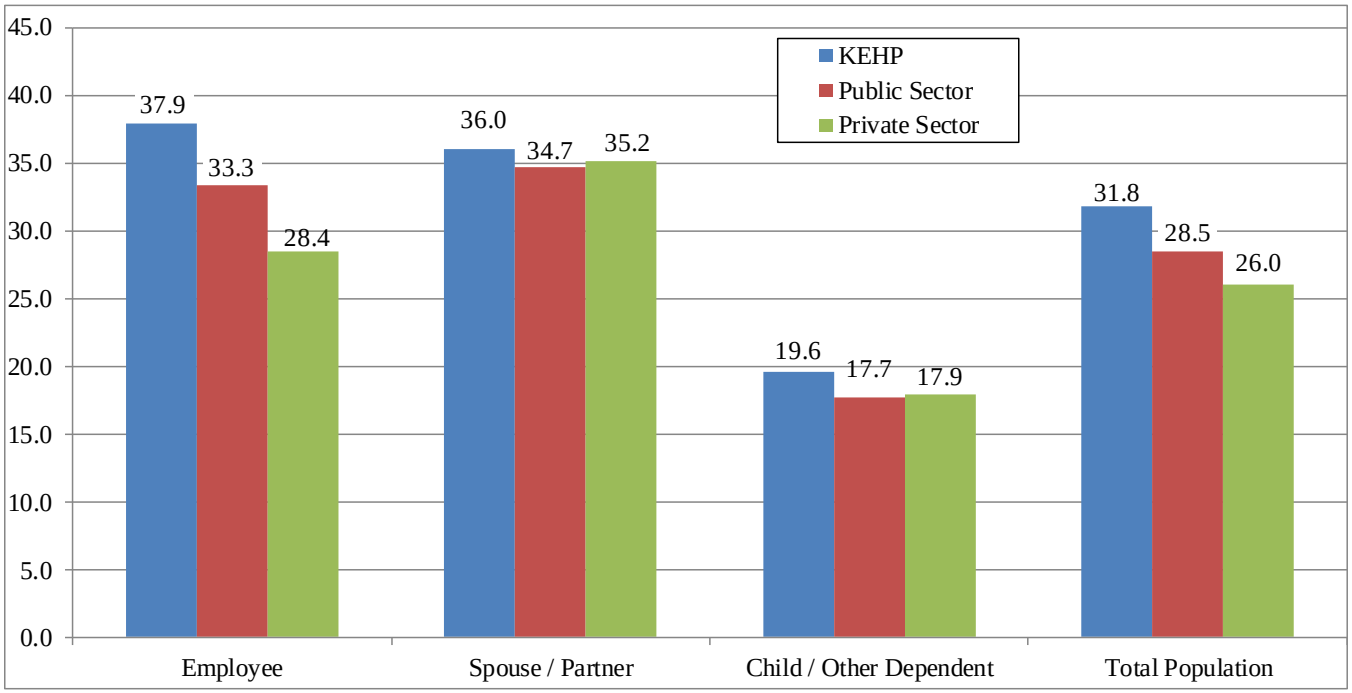


Source: *IBM Watson Benchmark Report*

KEHP employee population has considerable higher admission rates than both the public and private sector.

Exhibit 45 compares the outpatient service rates of KEHP members against those in the public and private sectors, split by relationship. Outpatient services include wellness and prevention, diagnosis (i.e. lab tests and MRI scans), treatment (i.e. surgeries and chemotherapy), and rehabiliation (i.e. drug or alcohol rehab and physical therapy).

Exhibit 45: 2017 KEHP Outpatient Services Per Member



Source: *IBM Watson Benchmark Report*

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

FEDERAL HEALTH CARE REFORM

The Patient Protection and Affordable Care Act

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

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

Some Key Provisions of PPACA That Impact KEHP

Changes to Health Plans

PPACA creates unprecedented change in the U.S. health care system. It impacted all stakeholders in health care, including employers, government, payers, providers, and pharmaceutical companies. It has and will continue to have a significant impact on employers, their health plans, and related administration for years to come. Some provisions were already effective, while some were deferred as late as 2020, with many provisions gradually phased in. For KEHP, many provisions became effective January 1, 2011 and January 1, 2014 when KEHP lost grandfather status.

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

- Plans must offer coverage for the children of covered individuals until age 26 and may opt to continue to do so through the end of the plan year during which they attain age 26.
- Plans may not place lifetime limits on the dollar value of coverage.
- Beginning in 2014, plans may not impose any annual limits on coverage; prior to 2014, only “reasonable” annual limits, as determined by the Secretary, may be imposed.
- Plans may not have waiting periods longer than 90 days.
- Plans must eliminate pre-existing condition exclusions, effective for children under 19 in 2011; effective for adults in 2014.
- Plans may not rescind coverage except in the case of fraud or intentional misrepresentation.
-
- All non-grandfathered group health plans, including self-insured plans, must adopt an annual OOPM for covered, in-network essential health benefits (EHBs) for self-only coverage and family coverage. The 2018 limits are $7,350 and $14,700 for individual and family coverage, respectively. Group health plans must “embed” an individual OOPM within any “other than self-only” coverage limit.
- Employer plans must have an HHS-approved binding external review process.
- Employers are required to report the aggregate value of health benefits on employees’ W-2 forms beginning with the 2012 tax year.
- Changes to FSAs:
  - The cost of over-the-counter drugs not prescribed by a doctor may not be reimbursed through a stand-alone HRA or health FSA beginning January 1, 2011.
  - Increased penalty for nonqualified Health Savings Account (HSA) or Archer Medical Savings Account (MSA) purchases or distributions increased from 10% to 20%, effective for distributions in 2011.

  - The maximum contribution to an FSA is limited to $2,500 annually, beginning in 2013. The 2018 limit is $2,650.
  - The limit may be adjusted annually for inflation, not to exceed $50.
- Discrimination in insured group health plans based on the employee's salary is prohibited. IRS has delayed the application of this requirement until it issues further regulations.
- Self-insured plans are subject to Patient-Centered Outcomes Research Institute (PCORI) fees for plan years 2012 through 2018 and transitional reinsurance fees for plan years 2014 through 2016.
- Plans are required to provide coverage for certain in-network preventive health services, including women's preventive health services, at no cost sharing.
- Employers are required to provide Summary of Benefits and Coverage to participants in writing and free of charge by the first day of coverage, upon renewal or reissuance and upon request.
- Employers are required to provide notice to inform employees of coverage options in the exchange.
- Beginning in 2014, plans are required to provide benefit coverage for certain routine patient costs for qualified individuals who participate in an approved clinical trial.
- Beginning in 2014, rewards for wellness programs must not exceed 30% of the total cost of coverage, except this percentage is increased to 50% to the extent that the wellness program is designed to prevent or reduce tobacco use.
- Beginning in 2015, employers are required to provide affordable minimum essential coverage that meets minimum value.
- Beginning in 2015, employers are required to report health insurance information to government and participants.
- Beginning in 2018, a 40% excise tax will be imposed on the value of health insurance benefits exceeding a certain threshold. This was delayed until 2022.

Mandated Health Insurance Coverage

Under the ACA's individual mandate, a taxpayer must be covered by a health plan that provides at least "minimum essential coverage" or be subject to a tax for failure to maintain such coverage. Most forms of health insurance coverage (e.g., employer group health plans, individual health insurance policies, and government health plans) qualify as minimum essential coverage. The tax is imposed for any month that an individual does not have minimum essential coverage, unless the individual qualifies for an exemption. With the enactment of the Tax Cut and Jobs Act of 2017, the amount of the individual mandate's penalty was reduced to zero, effectively repealing it. This provision is effective beginning after December 31, 2018, making individuals potentially liable for individual mandate penalties for years prior to 2019. As a result, some states have been adopting individual mandates to prevent state health insurance markets from being adversely impacted.

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

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

- The penalty amounts will be indexed for inflation.

The ACA requires employers, plans, and health insurance issuers to report health coverage information to the IRS and to participants annually. ACA reporting became mandatory for responsible entities starting in 2015. The first forms were provided in 2016 and reflect the 2015 calendar year. The forms that must be filed and distributed depend on whether the employer is an ALE and the type of coverage provided. Employers filing 250 or more of a particular form are required to file with the IRS electronically.

In consideration of the individual mandate that is in place through 2018, special consideration was made regarding the benefit provided to employees that waive coverage in KEHP. Currently, these employees are provided $175 per month to cover health care expenses via an HRA. Starting from 2015, employees who are eligible to waive KEHP health insurance coverage and choose a waiver HRA may do so only if the employee has other group health plan coverage that provides minimum value and the employee attests or declares, in writing that the employee has such other coverage. An employee that cannot attest to having other group health plan coverage can still waive KEHP health insurance coverage and choose the limited waiver dental/vision only HRA.

State-Based Health Insurance Exchanges

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

- Bronze Plan (the standard for "minimum creditable coverage") covers 60% of the benefit costs
- Silver Plan covers 70% the benefit costs
- Gold Plan covers 80% of benefit costs
- Platinum Plan covers 90% of benefit costs
- Catastrophic Plan (for those up to age 30) provides catastrophic coverage only, based on current law HSA levels, except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is not available to employers.

Excise Tax on High-Cost Coverage

Section 9001 of the ACA will impose an excise tax on medical plan issuers and sponsors based on the gross annual premium value of the coverage that exceeds predetermined thresholds. This provision is best described as the "High-Cost Plan Excise Tax." While the IRS has not yet released regulations implementing this provision, it is generally anticipated that the tax will have wide-ranging implications across employer-sponsored plans.

This high-cost plan excise tax (aka "Cadillac Tax"), originally scheduled to become effective for tax years beginning in 2018, was postponed and the new Act changes the tax effective year to 2022. Further, the Consolidated Appropriations Act amends the Internal Revenue Code making the tax deductible to payers. Finally, the Act calls for a demographic study to be commissioned to study the appropriateness of using the federal health benefits plan as a benchmark for the age and gender adjustment of the applicable dollar limit for the excise tax.

Excise Tax 101

In 2022, the excise tax will impose a 40% tax on the aggregate cost of employer-provided group health coverage that exceeds certain thresholds. The aggregate cost of coverage includes employer contributions to medical coverage, HRAs, HSAs, and employee salary-reduction contributions under cafeteria plans. The tax applies to both fully insured and self-funded plans. In short, nearly all group-related medical coverage and contributions will be factored in, with the exception of stand-alone dental and vision plans. Because the tax applies to current and former employees, surviving spouses, and other insured individuals who are considered primary under the plan, its impact is far reaching, even including retirees who are still connected to the employer's group plan in some way.

A Harder Hit for Early Retirees

Due to the structure of the excise tax, early retiree plans stand to be hit harder than those for active employees. Even though the thresholds for early retirees are 12% to 15% higher than the active thresholds, that likely won't offset their higher cost of health care, which typically runs at least 50% more than for active employees. So overall, early retiree plans will arrive at the tax threshold much sooner than active plans.

While the ACA allows plan sponsors to consider the cost of early retiree and Medicare retiree coverage together in determining whether the tax applies, there is no clear guidance yet on which blending approaches will be allowed. Since many plan sponsors in the public sector currently blend active employees and retirees for pricing purposes, early retiree coverage presents a special challenge in light of the new tax. It is expected that this remains ambiguous, as regulations tend to address combining ERISA plans, which is not pertinent in the public sector.

Projected KEHP Excise Tax Liability

The projected excise tax liability for KEHP ranges from $0M to $0.2M in 2022, $0M to $0.9M in 2023, and $0M to $2M in 2024, respectively, based on different trend assumptions. The single rate tier and higher-cost plans drive most of the excise tax exposure. Final rules and regulations regarding the excise tax have not been issued. The calculation is based on the legislation that has been published.

Wellness Program Rules Under ADA and GINA

On May 16, 2016, the EEOC issued final regulations on wellness programs under the Americans with Disability Act (ADA) and Genetic Information Nondiscrimination Act (GINA). The regulations regarding the use of financial inducements apply to plan years beginning on or after January 1, 2017. The final ADA regulations address how plan sponsors may use incentives to encourage employees to participate in the wellness plans. This significantly affects the LivingWell plans since an employer may not deny coverage under any group health plan to employees for nonparticipation or limit the extent of benefits. However, an employer still may offer incentives up to 30% of the total cost of self-only coverage based on participation in a wellness program. Thus, an employee who chooses a more comprehensive health plan but declines to participate in a wellness program could pay more for the same comprehensive health plan than an employee who participates in a wellness program.

As a result, in 2017, all members could enroll in the LivingWell plans, but if they did not complete the LivingWell Promise by completing a health assessment or getting a biometric screening, they will not receive the wellness premium incentive in 2018. The LivingWell Promise was first rolled out for plan year 2014. In 2014, if a member chose a LivingWell plan, they made a LivingWell Promise to complete a health risk assessment and keep updated contact information. For plan years 2015 and after, the LivingWell Promise was to complete a health risk assessment or biometric screening. The completion rate has increased year over year and was 94% in 2018. Also, the number of biometric screenings continues to increase significantly with a peak of 50,000.

Trump Administration and PPACA

President Elect Donald J. Trump was sworn into office on January 20, 2017. Hours after being sworn into the presidency, President Trump signed his first executive order in efforts to repeal and replace PPACA. Throughout most of 2017, policymakers engaged in a national debate over health care reform and the role of employers in delivering health care.

Since then, the Trump administration repealed the individual mandate effective January 1, 2019 and forward. The Trump administration still faces several critical short-term and long-term issues including the following:

- Employer Mandate: IRS and the Treasury indicated full effect of enforcing the mandate.
- CSR Payments: As of October 13, 2017, the Trump administration announced, effective immediately, it would discontinue cost-sharing reduction payments to insurers under PPACA, stating that CSR payments were illegal because Congress had not appropriated funds.
- Excise Tax: The excise tax becomes effective in 2022 unless Congress acts.

- Enrollment in Public Exchanges: The Trump administration reduced advertising budget for open enrollment from $100 million down to $10 million and the PPACA navigator funding was reduced from $65 million to $37 million.

Employer Concerns

- Employer Mandate: Employers are still awaiting guidance from IRS and Treasury on enforcement of the mandate. Employers should be prepared to respond to inquiries from IRS and exchanges.
- Excise Tax: Employers should continue to assess mitigation strategies, watch for additional guidance or proposed regulations, and develop communication strategies for employees.

Some Key Considerations

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

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

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

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

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

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

Aggressive health management involves:

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

Managed defined contribution involves:

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

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

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

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

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

BOARD RECOMMENDATIONS

For this year's report, Board members were surveyed and voted on the desired outcome and recommendations. The strategic initiatives are ranked from the highest priority:

- Provide state-of-the-art benefits while maintaining reasonable employer and employee premiums.
- Offer competitive health insurance benefits that meet the needs of a diverse workforce.
- Improve employee health and wellbeing.
- Provide members with the tools and benefits to be able to manage chronic disease conditions.
- Increase member engagement in the variety of free to low-cost health and wellness programs available.
- Continue to educate and drive members to the highest quality, safe, effective, and cost-effective care based on the patient's health care needs.
- Help employees understand the tools and resources available to them; as well as initiatives of the KEHP.

Based on the results of the recent survey of Board members, the Board considers the following to be the most significant challenges and obstacles:

- Understand and navigate the increasing complexity of the health care delivery system.
- Offer affordable coverage for plan participants.
- Low employee engagement in programs desired to help members manage their health.
- Administer and implement future health care strategies.
- Deliver a benefit selection and enrollment experience that is easy-to-use by multiple employer groups.

In the near future, DEI and Aon will address the new strategic initiatives and how to overcome the challenges that KEHP faces. Below is a summary of progress that is based on the results of the prior year survey:

- KEHP should continue to explore alternative methods for controlling and managing the cost of the plans and improving the health of members.

  The KEHP continues to focus on engaging members in their own health and wellness, and in becoming better consumers of health care. Starting in 2014, KEHP offered two LivingWell options as part of the overall wellness program and two CDHP options to encourage consumerism. By completing the steps of the LivingWell Promise, members can access the best benefit options, learn about their health status and history, learn about and understand their health risk, and take actions to get and stay healthy. Effective January 1, 2019, all four plans with be eligible for the LivingWell Promise to receive the premium discount for the following plan year.

  KEHP implemented Go365 (formerly HumanaVitality) on January 1, 2012, to provide a robust wellness program for members. The implementation of Go365 aligned with the strategic goal to increase personal health awareness for KEHP members.

  In 2016 and into 2017, the engagement of members in Go365 continued to grow. In an effort to continuously improve KEHP's wellness programs, and to provide data on how members are engaging in those programs, KEHP worked with Go365 to track engagement at the worksite level. The goal of this reporting is to help leadership and worksite wellness staff create local wellness programs that encourage greater engagement.

  In 2016, KEHP implemented a Diabetes Value Benefit that provided diabetes drugs and supplies at a reduced copay and coinsurance, with no deductibles. Results revealed that while diabetic prescriptions increased, member out-of-pocket expenses decreased. Also, a greater number of members with diabetes have taken their medications more regularly. Due to getting diabetes under control, members reduced their need for other medications. To continue on this success, asthma and COPD prescriptions and supplies will now be available to the members at a reduced copay and coinsurance, with no deductibles beginning in plan year 2019.

Another benefit to encourage medication benefits was added in 2016 with select preventive/maintenance drugs bypassing the deductible on both CDHPs. The goal is to increase the members' adherence to medication and control chronic diseases preventing long-term higher medical claims.

KEHP also implemented other actions to offset pharmacy trends such as a contract market check and formulary changes. KEHP engaged Aon to conduct market checks with CVS/caremark. The improved contract terms were effective January 1, 2017 and January 1, 2018. Formulary changes were made to ensure that members are utilizing the most cost-effective brand drugs. Beginning in plan year 2019, two of the health plans will utilize a value-based formulary that covers more generics and less brand-named prescription drugs.

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

- KEHP should evaluate programs and options for improving the clinical and administrative quality of programs and services. This study should consider practical steps to evaluate and improve administrative services including claims payment, customer service, and others. It should consider programs to measure and improve quality of care currently available in the marketplace.

  Since 2015, KEHP members have had access to Anthem's Integrated Health Model (IHM) clinical programs. IHM is a fully integrated disease management platform. IHM programs include the Diabetes Prevention Program, LiveHealth Online Medical and Psychology, Behavioral Health programs including a Substance Abuse Disorder telephone resource, Future Moms, 24/7 NurseLine, MyHealth Advantage, and Case Management.

  In 2016, KEHP staff met with vendors providing services related to KEHP's business to discuss strategies to improve program quality and cost of care. KEHP's vendor partners include Anthem as the medical network and claims administrator, CVS/caremark as pharmacy benefit administrator, WageWorks as FSA/HRA/COBRA benefit administrator, Vitals SmartShopper (formerly Compass ChoiceRewards) as transparency vendor, and Go365 as wellness/health promotion service vendor. Several innovative programs were implemented in plan year 2017 based on these discussions, including LiveHealth Online Psychology and offering online Diabetes Prevention Program classes.

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

  DEI works closely with the Personnel Cabinet's Office of Public Affairs. In 2016, the Cabinet and KEHP began sharing information with members through social media including Facebook and Twitter. The KEHP staff also provides a variety of webinars on health insurance information such as how to select a plan and how a CDHP works.

  Members also receive co-branded communications from the various health plan administrators on their unique programs. For example, Vitals SmartShopper used multiple targeted mailings to promote shopping for services related to preventive care and pediatric specialty care.

  The KEHP also communicates frequently with the local agency insurance coordinators and HR generalists as they can meet with members face to face.

  KEHP's wellness vendor, Go365, has five wellness specialists assigned to regions across the Commonwealth. The Go365 staff works closely with the state agencies in their region to communicate wellness benefits

directly to KEHP members. The process has improved as those team members now also communicate other KEHP benefits such as LiveHealth Online, Vitals SmartShopper, and the Value Benefits.

- The KEHP should develop a long-term policy for funding strategies to ensure that adequate funds are budgeted each year towards the self-insured plans.

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

  Due to the increase in CDHP enrollments and the use of HRAs, based on Aon's recommendation the Plan created a separate HRA reserve in the event that members start to draw down the HRA fund balance. HRA balances are also being capped at a maximum of $7,500. These changes were implemented as the HRA balances and number of accounts grow as more members elect CDHPs.

  The budget for each plan year is self-sufficient such that funds are not rolled over from prior years. As a result of this, surplus balances have been drawn from the KEHP account to offset budget shortfalls within other government agencies. Withdrawals of $50M from plan year 2008, $93M from plan year 2012, and $63.5M from plan year 2014 were transferred to the General Fund. The 2016 budget bill authorized fund transfers from KEHP to the Kentucky Permanent Pension Fund in the amount of $187.5M for fiscal year 2016–2017, and $312.5M in fiscal year 2017–2018.

  An approach that some states have taken is to set aside the excess funds in a solvency or claims fluctuation reserve. In years when there are adverse deviations in claims or any unforeseen budget constraints, the funds can be available to the plan. This reserve would be in addition to the incurred but not reported (IBNR) and HRA reserves. The methodology of solvency reserves varies by state. Some states base the solvency reserve utilizing a percentage of annual claims. For example, Tennessee's and Virginia's solvency reserve is 10% of annual claims. While other states base the reserve on risk-based capital (RBC) methodology; this approach is developed for insurance companies to prevent insolvency. The RBC calculation is developed by the National Association of Insurance Commissioners (NAIC). Oklahoma and Delaware utilize this approach.

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

  Working with Aon, the KEHP has evaluated the impact of federal health care reform law and regulations as information became available. DEI will continue to evaluate the emerging impact of the law as regulations are finalized and market impact information becomes available.

- The KEHP should continue to provide increased focus on wellness initiatives.

  The State Wellness Director, in partnership with the Go365 regional staff, has continued to expand the outreach and communication to KEHP members about the many wellness benefits available to them. The Wellness Director travels across the Commonwealth to work with local Wellness Coalition members as they engage their employees and KEHP members in wellness activities. In 2016, the number of Wellness Coalition members grew and continues to grow, further spreading the news related to KEHP's wellness initiatives.

  Completion of the LivingWell Promise continued to be positive with 94% of members who elected a LivingWell Promise plan completing their Promise in 2017. Almost 120,000 members completed their Go365 health assessment and 48,000 members completed a biometric screening. Effective January 1, 2019, all four plans with be eligible for the LivingWell Promise to receive the premium discount for the following plan year.

  For the work KEHP has done in the area of nutrition and weight management, physical activity, and organizational wellbeing, KEHP was awarded the 2017 American Diabetes Association's Health Champion designation. The KEHP was one of only 21 national organizations to earn the designation.

- The KEHP should develop a plan to improve the education of membership about plan options, mechanics of health care, and selecting the most appropriate plan option and medical services.

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

  KEHP also works closely with the plan administrators to provide educational material through mail, email, websites, and webinars.

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

  DEI continues efforts to better educate KEHP membership on CDHPs and health care and pharmaceutical costs. To that end, DEI provides, through Vitals SmartShopper, a tool that provides transparency to cost, quality, and access information—paired with member engagement, actionable data, and predictive analytics—to empower members to make more informed and effective health care decisions. When members shop with SmartShopper and select a cost-effective location for their health care service, they save themselves and KEHP money, and they earn a cash reward.

APPENDIX

Program Changes & Plan Design Provisions (by year)

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

In 2000:

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

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

In 2001:

- The insurance carriers offering health insurance coverage to members of the KEHP program changed as follows:
  - Aetna was reintroduced as a health care option for the KEHP program in 28 Kentucky counties.
  - Anthem expanded its PPO service area for members by 14 counties.
  - Advantage Care ceased to exist.
  - PacifiCare stopped offering health insurance to anyone in Kentucky.
  - Bluegrass Family Health expanded its service area for members by nine counties.
  - CHA withdrew its HMO and POS options from 23 counties; however, it introduced PPO options in four eastern counties in eastern Kentucky where it previously offered only HMO and POS options.
  - Humana discontinued its KPPA HMO for KEHP members.

- The following changes were made to the benefits offered by the plan:
  - Prescription drug copayments in the PPO B option were reduced. For generic drugs, the member's copayment decreased from $15 to $10, for brand name drugs from $20 to $15, and for nonformulary drugs from $40 to $30.
  - The cost for members in the PPO A option for diagnostic tests, performed in a setting other than a physician's office, was changed from a 20% coinsurance after meeting the annual deductible, to a flat $10 copayment.
  - Inpatient (per day) and outpatient (per visit) limits on mental health and substance abuse services were eliminated from all the KEHP program's health insurance options, in accordance with House Bill 268 enacted by the 2000 General Assembly.
  - Benefit coverage for amino acid preparations and low-protein modified food products was added to all of the KEHP program's plan options pursuant to House Bill 202 enacted by the 2000 General Assembly.

In 2002:

- In response to requests from Legislators and members of the Commonwealth's KEHP program, the Commonwealth adopted two new requirements that must be met before a prospective health plan (bidding as part of the RFP process) could be offered to members of the KEHP program in a particular county. Before it can be offered in a county, a health plan must:
  - Include at least one hospital in that county in its network, provided one or more hospitals exist in the county, and any other bidder includes at least one of those hospitals in its network.
  - Include at least 25% of the largest number of physicians in any other bidder's network for that county.
- In an effort to lessen the potential impact of adverse selection (i.e., when a person takes the likelihood that they'll need medical care into account when choosing a health plan, often resulting in "more costly" individuals in one option and "less costly" in another), the Commonwealth stipulated that a health plan's B option premium rates must be at least 5% lower, but no more than 10% lower than the A option premium rates for the same plan type (i.e., HMO, POS, or PPO) and coverage level (i.e., single, parent plus, couple, or family).
- The following changes in carrier offerings occurred:
  - As in 2001, Anthem expanded its PPO service area for KEHP program members by 14 counties.
  - Aetna was discontinued as an offering for KEHP program members in 11 counties.
  - While Bluegrass Family Health's HMO and POS options were newly offered in five counties, these options were discontinued in three counties. Bluegrass Family Health's PPO option was no longer available in one county where it was available in 2001. However, this option was newly introduced in eight counties.
  - CHA's HMO and POS options were discontinued in 14 counties and newly added in 13 counties. Its PPO options were added in four counties, but discontinued in the four counties where offered in 2001, due to provider contracting difficulties.
  - Humana's HMO and POS options were no longer available in three counties where offered in 2001 and its PPO options were discontinued in 10 counties.

In 2003:

- Again, in response to requests from Legislators and members of the KEHP program, the Commonwealth tightened the network requirements applicable to 2003 bids:
  - The 2002 RFP hospital requirement was continued.
  - However, to qualify as an offered health plan in a particular county in 2003, a health plan's network had to:
    - Include at least 25% of the largest number of primary care physicians (PCPs) in any other bidder's network bidding for the same plan type (i.e., HMO, POS, or PPO) for that county.
    - Include at least 40% of the largest number of specialist physicians in any other bidder's network bidding for the same plan type (i.e., HMO, POS, or PPO) for that county, provided any bidder has more than five specialists in a county.
- Aetna did not respond to the Commonwealth's RFP, as it was not willing to continue to provide health insurance to members of the Commonwealth's KEHP program. This affected 18 counties and about 8,500 employees/retirees.
- Anthem withdrew from 50 counties, affecting around 15,600 employees and retirees.
- Bluegrass Family Health extended coverage to eight additional counties; however, due to either the Commonwealth's more stringent network requirements or termination of some providers' contracts, Bluegrass Family Health was not an option in six counties in 2003 where it was available in 2002.
- While CHA did not extend its service area to include more Commonwealth counties in its 2003 bid, it did extend its HMO and POS options to six additional counties and its PPO option to 46 additional counties. However, it failed to meet the Commonwealth's 2003 network requirements in two counties where it was available in 2002.
- Humana extended coverage (PPO only) to two additional Western Kentucky counties. However, due to its failure to meet the Commonwealth's 2003 network requirements, Humana failed to qualify in 2003 as an option in 14 counties where it had been available in 2002.
- The following changes were made to the benefits offered by the plan:
  - Coverage of dental services was limited to care required as a result of an accidental injury, including anesthesia and hospital services that are medically required to safely provide dental care for children below the age of nine and persons with serious mental or physical conditions.
  - As specified in SB 152, enacted by the 2002 General Assembly, coverage was added for hearing aids and related services for persons under the age of 18, up to one hearing aid per impaired ear, up to $1,400 every 36 months.
  - Coverage limits were revised for low-protein modified foods and medical formulas for individuals with inherited metabolic diseases.
  - Coverage of routine vision care was eliminated.
  - A mail order pharmacy feature was added to allow members to receive a three-month supply of maintenance prescription drugs for a two-month copayment.

- Finally, as enacted by the 2002 General Assembly:
  - Through HB 821, KEHP members were allowed to select coverage in a contiguous county and receive the Commonwealth's subsidy for that county, if the hospital in the county where member lived and worked did not offer certain services and a hospital in the contiguous county did.
  - Through HB 846:
    - Restricted KEHP employees and retirees to one state subsidy for health insurance.
    - Required entities participating in the KEHP program to sign a contract with the Personnel Cabinet.
    - Allowed KEHP members to select coverage in a contiguous county and receive the Commonwealth's subsidy for that county, if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does (same provision as HB 821).

In 2004:

- The 2003 RFP hospital requirement was continued; however, the physician network requirements were modified such that the specialist physician network requirement only had to be met in counties where at least one bidder reported 10 or more specialists, rather than in counties with five or more specialists as applied in 2003.
- The point at which members' prescription drug copayments are reduced was increased from 50 copayments per year, for a member and all his/her covered family members combined, to 75.
- Coverage was not available through Anthem under the KEHP program. This affected 16 counties where Anthem offered PPO coverage to KEHP members in 2003.
- Humana:
  - Discontinued offering HMO or POS options to KEHP members, except in six northern Kentucky counties.
  - Failed to meet the Commonwealth's network requirements, with respect to its PPO options, in three counties where it offered PPO coverage to KEHP members in 2003.
  - Extended PPO coverage options in 40 counties.
- Bluegrass Family Health failed to meet the Commonwealth's network requirements in one county where it offered PPO coverage to KEHP members in 2003; however, it extended PPO coverage options in eight counties, and HMO and POS options in four counties.
- CHA newly offered HMO, POS, and PPO options in two counties.
- Through the Governor's executive order, the Commonwealth provided a health insurance subsidy for employees electing the PPO A option dependent health insurance under the lowest cost carrier in the 21 counties where the cost of this coverage exceeded the cost in the other 99 counties. This subsidy was set to an amount in each affected county that resulted in all employees paying the same employee contribution, for all coverage tiers, for the lowest cost PPO A option.
- Legislation enacted by the 2003 General Assembly:
  - Through HB 95, the requirement that an employee's employment must be in the same county as his/her residence for the employee to be eligible to elect coverage in an adjacent county and receive the Commonwealth's subsidy for that county, if the hospital in the county where the member lives does not offer certain services and a hospital in the adjacent county does, was removed.
  - Through HB 430, the service required for KRS participants to be eligible to participate in the KEHP program was increased from five years to 10 years for individuals hired on or after July 1, 2003.

In 2005:

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

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

  A *fully insured arrangement* is the type of health care funding arrangement currently used by the Commonwealth. It requires insurers to assume the full risk of all the state employee health care costs in exchange for premium payments from the state. In contrast, a *self-insured arrangement* is one in which no insurance company collects premiums or assumes risk. Instead, the state would—in effect—act as its own insurance company, assume the cost risk and pay actual claims with the money normally earmarked for insurance company premiums.
- For scenarios one through four, the following network requirements had to be met:
  - Hospital Requirement: If one or more hospitals exist in a county, the vendor must have at least one of the county's hospitals in its network, unless no bidder for the county, under the scenario being considered, have any of that county's hospitals in its network.
  - Physician Requirement: The vendor must have at least 25% of the county's PCPs in its network. If there are 10 or more specialist physicians submitted as practicing in the county, the vendor must have at least 40% of the county's specialist physicians in its network.
- For scenarios one and three the following requirements were in addition to the above:
  - Must meet both hospital and physician network requirements in 85% of the counties within the region and in counties where at least 85% of the group members reside.
- For scenarios two and four, the following requirements were in addition to the above:
  - Must meet both hospital and physician network requirements in each of the eight in-state regions in 85% of the counties within a region and in counties where at least 85% of the group members reside.

- For scenarios five and six, the following network requirements had to be met:
  - Hospital Network Requirement: The vendor must have at least one network hospital in 75% of the counties having a hospital in each region.
  - PCP Network Requirement: The vendor must have at least eight PCPs per 1,000 eligible Commonwealth members per region. Additionally, each vendor must have at least one PCP in each county where it has a hospital.
  - Specialist Network Requirement: Vendor must have at least six specialists per 1,000 eligible Commonwealth members per region.
- Contracts were signed and the following carriers were awarded the following regions:
  - Anthem was awarded Region 1 and Region 2 under a self-insured basis.
  - UnitedHealthcare was awarded Region 3 and Region 6 under a fully insured basis.
  - Bluegrass Family Health was awarded Region 4 and Region 5 under a fully insured basis.
  - CHA Health was awarded Region 7 and Region 8 under a fully insured basis.
- For the first time in many years, Humana was not awarded any area in the Commonwealth.
- For the first time, the employee's cost for health insurance was based on their salary.
- For the first time, the Commonwealth offered an additional subsidy to employees that did not smoke.
- Out-of-state retirees were assigned to the county of their last employment for purposes of selecting health care. This created concern from the out-of-state retirees who worked for the state or for those that retired from Regions 4, 5, 7, and 8 because Bluegrass Family Health and CHA Health were regional carriers and did not immediately have a nationwide network. This caused members to accept out-of-network benefits.
- Because this was the first major benefit change in a number of years, state employees and teachers (led by the Kentucky Education Association) held protests throughout the Commonwealth, many were bused to Frankfort for a day of protest and teachers threatened to strike.
- After several weeks, Governor Fletcher called the General Assembly into a special session to deal with the shortage of money available to fund the program. As a result of the special session, HB 1 was passed. In summary, HB 1 made the following:
  - Retained the Commonwealth Essential Option Plan and removed the Commonwealth Preferred and Commonwealth Premium Options.
  - Restored the 2004 PPO A plan benefits as the Commonwealth Enhanced Option.
  - Offered the Commonwealth Premier Option.
  - Provided additional funding for these three options, including additional dependent subsidies.
  - Set the employee contributions as outlined in HB 1.
  - Restored the employer contribution to the health care FSA for employees waiving coverage to $234.
  - Required the Personnel Cabinet to submit the benefits for the 2006 Plan Year to the Employee Advisory Committee 30 days prior to the release of the RFP.
  - Created the Blue Ribbon Panel on Public Employee Health Benefits for the purpose of examining all aspects of health benefits available to public employees including the procurement process, benefits offered, plan membership, implementation, maintenance and administration of the plan; alternative methods of providing benefits and services, and any other issues related to public employee health benefits the panel determines to be relevant.

In 2006:

- An RFP for the 2006 plan year was released, marking a dramatic change in the Commonwealth's strategy for providing employee health care benefits. This RFP solicited bids for:
  - A single vendor to provide third-party administration (TPA) services on a state-wide basis.
  - A single vendor to provide Pharmacy Benefits Administration (PBA) services on a state-wide basis.
  - A single vendor to provide administrative services for FSAs, HIPAA, and COBRA. The contract for these services was to be awarded to the vendor for medical TPA services, but was structured as a separate contract to provide flexibility to the Commonwealth in future years.
- The Commonwealth moved from a program that had historically been fully insured to a program that was self-insured statewide.
- Emphasis was placed on experience with a large employer group, having at least 100,000 covered lives.
- A national provider network was also critical to a successful bid, to ensure adequate provider networks for out-of-state retirees.
- To provide further emphasis to this change in direction, the plan was given a name change, and is now called the KEHP.
- Benefits for 2006 would remain the same as those offered in 2005, with the same three benefit plan options available:
  - "Commonwealth Essential"
  - "Commonwealth Enhanced"
  - "Commonwealth Premier"
- Contracts were awarded and signed as follows:
  - Humana was awarded a contract for medical claims administration.
  - Humana was also awarded a contract for administration of FSAs, HIPAA, and COBRA.
  - Express Scripts was awarded a contract for pharmacy benefits administration.
- For the first time, contracts were awarded for a multi-year term. The initial term of the contracts was 30 months, with eight optional one-year renewals—meaning the contracts could be in place for 10-1/2 years.
- None of the insurance carriers who had provided coverage in 2005 were awarded contracts for 2006:
  - Bluegrass Family Health and CHA Health did not meet the minimum vendor requirements and were ineligible to bid.
  - Anthem and UnitedHealthcare were not selected.
- The incentive for those employees who do not smoke was continued in 2006, with a $15 per month incentive for employees with single (employee-only) coverage, and a $30 per month incentive for employees who chose to cover their dependents.
- Employee contributions did not change from 2005 to 2006. The Commonwealth absorbed any claims or other costs in 2006 that are above the employee contributions.
- The Commonwealth's contribution for those employees who waive coverage was reduced again, from $234 per month, to $200 per month, for the period July–December.

- Legislation passed during the 2006 Regular Session of the General Assembly (HB380) mandated a 12% reduction in the employer contribution amount for July–December, effectively reducing total monthly premium equivalents by about $10 million per month, to about $85 million. There was no corresponding decrease in employee contributions.

In 2007:

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

In 2008:

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

2008 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Essential		Commonwealth Enhanced	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - $750 Family - $1,500	Single - $1,500 Family - $3,000	Single - $250 Family - $500	Single - $500 Family - $1,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $3,500 Family - $7,000	Single - $7,000 Family - $14,000	Single - $1,250 Family - $2,500	Single - $2,500 Family - $5,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Not Applicable	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	25%*	50%*	20%*	40%*
Outpatient services—physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, immunizations, injections, lab fees, x-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	25%*	50%*	$10 copay	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	25%*	50%*	$10 copay	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	25%*	50%*	20%*	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%		$10 copay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$50 copay plus 25%*	$50 copay plus 50%*	$50 copay plus 20%	$50 copay plus 40%
Emergency room physician charges	25%*	50%*	20%	40%
Urgent care center treatment	25%*	50%*	$20 copay	40%*
Ambulance services	25%*	25%*	20%*	20%*
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	25%*	50%*	$10 copay In-hospital care coinsurance applies*	40%*
Prescription drugs—Retail (30 day supply)	25%			
	Min / Max			
Generic Preferred Brand Nonpreferred Brand	$10 / $25 $20 / $50 $35 / $100		$5 $15** $30**	40% 40% 40%
Prescription drugs—Mail Order (90 day supply)	25%			
	Min / Max			
Generic Preferred Brand Nonpreferred Brand	$20 / $50 $40 / $100 $70 / $200		$10 $30 $60	
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	25%*	50%*	$10 copay	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	25%*	50%*	$10 copay	40%*
▪ Respite care for children ages two through 21 ($500 maximum per month)	25%*	50%*	50%*	50%*
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*	20%*	40%*
Prosthetic devices	25%*	50%*	20%*	40%*
Home health—limited to 60 visits per year	25%*	50%*	20%*	40%*
Physical therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Occupational therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Speech therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Skilled nursing facility services—limited to 30 days per year	25%*	50%*	20%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	25%*	50%*	20%*	40%*

* Subject to annual deductible.

** After the 75th prescription has been filled, excluding mail order, the copayment will reduce to $10 preferred brand and $20 nonpreferred brand.

2008 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	Commonwealth Premier		Commonwealth Select	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - $250 Family - $500	Single - $500 Family - $1,000	Single - $2,000 Family - $3,000	Single - $2,000 Family - $3,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $1,000 Family - $2,000	Single - $2,000 Family - $4,000	Single - $3,000 Family - $4,500	Single - $4,000 Family - $6,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $1,000 Parent Plus - $1,500 Couple - $1,500 Family - $2,000	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	10%*	30%*	10%*	40%*
Outpatient services—physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, immunizations, injections, lab fees, x-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	$10 copay	30%*	10%*	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	$10 copay	30%*	10%*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	10%*	30%*	10%*	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	$10 copay per visit	30%*	Plan pays 100%	
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$50 copay plus 10%	$50 copay plus 30%*	10%*	40%*
Emergency room physician charges	10%	30%*	10%*	40%*
Urgent care center treatment	$20 copay	30%*	10%*	40%*
Ambulance services	10%*	10%*	10%*	10%*
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	$10 copay In-hospital care coinsurance applies*	30%*	10%*	40%*
Prescription drugs—Retail (30 day supply) Generic Preferred Brand Nonpreferred Brand	 $5** $15** $30**	 30% 30% 30%	 10%* 10%* 10%*	 40%* 40%* 40%*
Prescription drugs—Mail Order (90 day supply) Generic Preferred Brand Nonpreferred Brand	 $10 $30 $60		 10%* 10%* 10%*	
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	$10 copay	30%*	10%*	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	$10 copay	30%*	10%*	40%*
▪ Respite care for children ages two through 21 ($500 maximum per month)	10%*	30%*	10%*	40%*
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	10%*	30%*	10%*	40%*
Prosthetic devices	10%*	30%*	10%*	40%*
Home health—limited to 60 visits per year	10%*	30%*	10%*	40%*
Physical therapy—limited to 30 visits per year	10%*	30%*	10%*	40%*
Occupational therapy—limited to 30 visits per year	10%*	30%*	10%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	10%*	30%*	10%*	40%*
Speech therapy—limited to 30 visits per year	10%*	30%*	10%*	40%*
Skilled nursing facility services—limited to 30 days per year	10%*	30%*	10%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	10%*	30%*	10%*	40%*

* Subject to annual deductible.

** After the 75th prescription has been filled, excluding mail order, the copayment will reduce to $10 preferred brand and $20 nonpreferred brand.

In 2009:

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

2009 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Standard PPO		Commonwealth Capitol Choice	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - $750 Family - $1,500	Single - $1,500 Family - $3,000	Single - $500 Family - $1,500	Single - $1,000 Family - $3,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $3,500 Family - $7,000	Single - $7,000 Family - $14,000	Single - $2,000 Family - $6,000	Single - $4,000 Family - $12,000
Up-Front Benefit Allowance	Not Applicable		$500/family member	Not Applicable
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Not Applicable	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	25%*	50%*	$100 copay plus 0%*	40%*
Outpatient services—physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, immunizations, injections, lab fees, x-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	25%*	50%*	20%*	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	25%*	50%*	20%*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	25%*	50%*	$50 copay plus 0%*	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%		$15 copay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$50 copay plus 25%*	$50 copay plus 50%*	$100 copay plus 0%*	$100 copay plus 0%*
Emergency room physician charges	25%*	50%*	0%*	0%*
Urgent care center treatment	25%*	50%*	$50 copay	40%*
Ambulance services	25%*	25%*	20%*	20%*
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	25%*	50%*	$15 copay In-hospital care coinsurance applies*	40%*
Prescription drugs—Retail (30 day supply)	25%			
	Min / Max			
Generic Preferred Brand Nonpreferred Brand	$10 / $25 $20 / $50 $35 / $100		$5 $20** $40**	
Prescription drugs—Mail Order (90 day supply)	25%			
	Min / Max			
Generic Preferred Brand Nonpreferred Brand	$20 / $50 $40 / $100 $70 / $200		$10 $40 $80	
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	25%*	50%*	$15 copay	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	25%*	50%*	20%*	40%*
▪ Respite care for children ages two through 21 ($500 maximum per month)	25%*	50%*	20%*	40%*
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*	20%*	40%*
Prosthetic devices	25%*	50%*	20%*	40%*
Home health—limited to 60 visits per year	25%*	50%*	20%*	40%*
Physical therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Occupational therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Speech therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Skilled nursing facility services—limited to 30 days per year	25%*	50%*	20%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	25%*	50%*	20%*	40%*

* Subject to annual deductible.

** After the 75th prescription has been filled, excluding mail order, the copayment will reduce to $15 preferred brand and $30 nonpreferred brand.

2009 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	Commonwealth Optimum PPO		Commonwealth Maximum Choice	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - $250 Family - $500	Single - $500 Family - $1,000	Single - $2,000 Family - $3,000	Single - $2,000 Family - $3,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $1,125 Family - $2,250	Single - $2,250 Family - $4,500	Single - $3,000 Family - $4,500	Single - $4,000 Family - $6,000
Up-Front Benefit Allowance	Not Applicable		Not Applicable	
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $1,000 Parent Plus - $1,500 Couple - $1,500 Family - $2,000	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	15%*	30%*	10%*	40%*
Outpatient services—physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, immunizations, injections, lab fees, x-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	$10 copay	30%*	10%*	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	$10 copay	30%*	10%*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	15%	30%*	10%*	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	$10 copay per visit	30%*	Plan pays 100%	
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$50 copay plus 15%*	$50 copay plus 30%*	10%*	40%*
Emergency room physician charges	15%	30%*	10%*	40%*
Urgent care center treatment	$20 copay	30%*	10%*	40%*
Ambulance services	15%*	15%*	10%*	10%*
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	$10 copay In-hospital care coinsurance applies*	30%*	10%*	40%*
Prescription drugs—Retail (30 day supply) Generic Preferred Brand Nonpreferred Brand	 $5** $20** $40**	 30% 30% 30%	 10%* 10%* 10%*	 40%* 40%* 40%*
Prescription drugs—Mail Order (90 day supply) Generic Preferred Brand Nonpreferred Brand	 $10 $40 $80		 10%* 10%* 10%*	
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	$10 copay	30%*	10%*	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	$10 copay	30%*	10%*	40%*
▪ Respite care for children ages two through 21 ($500 maximum per month)	15%*	30%*	10%*	40%*
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	15%*	30%*	10%*	40%*
Prosthetic devices	15%*	30%*	10%*	40%*
Home health—limited to 60 visits per year	15%*	30%*	10%*	40%*
Physical therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Occupational therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Speech therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Skilled nursing facility services—limited to 30 days per year	15%*	30%*	10%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	15%*	30%*	10%*	40%*

* Subject to annual deductible.

** After the 75th prescription has been filled, excluding mail order, the copayment will reduce to $15 preferred brand and $30 nonpreferred brand.

In 2010:

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

2010 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Standard PPO		Commonwealth Capitol Choice	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - $500 Family - $1,500	Single - $1,500 Family - $3,000	Single - $500 Family - $1,500	Single - $1,000 Family - $3,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $3,500 Family - $7,000	Single - $7,000 Family - $14,000	Single - $2,000 Family - $6,000	Single - $4,000 Family - $12,000
Up-Front Benefit Allowance	Not Applicable		$500/family member	Not Applicable
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Not Applicable	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	25%*	50%*	$100 copay plus 0%*	40%*
Outpatient services—physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, immunizations, injections, lab fees, x-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	25%*	50%*	20%*	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	25%*	50%*	20%*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	25%*	50%*	$50 copay plus 0%*	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%		$15 copay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$50 copay plus 25%*	$50 copay plus 50%*	$100 copay plus 0%*	$100 copay plus 0%*
Emergency room physician charges	25%*	50%*	0%*	0%*
Urgent care center treatment	25%*	50%*	$50 copay	40%*
Ambulance services	25%*	25%*	20%*	20%*
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	25%*	50%*	$15 copay In-hospital care coinsurance applies*	40%*
Prescription drugs—Retail (30 day supply)	25%			
	Min	Max		
Generic Preferred Brand Nonpreferred Brand	$10 $20 $35	$25 $50 $100	$5 $20** $40**	
Prescription drugs—Mail Order (90 day supply)	25%			
	Min	Max		
Generic Preferred Brand Nonpreferred Brand	$20 $40 $70	$50 $100 $200	$10 $40 $80	
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	25%*	50%*	$15 copay	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	25%*	50%*	20%*	40%*
▪ Respite care for children ages two through 21 ($500 maximum per month)	25%*	50%*	20%*	40%*
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*	20%*	40%*
Prosthetic devices	25%*	50%*	20%*	40%*
Home health—limited to 60 visits per year	25%*	50%*	20%*	40%*
Physical therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Occupational therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Speech therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Skilled nursing facility services—limited to 30 days per year	25%*	50%*	20%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	25%*	50%*	20%*	40%*

* Subject to annual deductible.

** After the 75th prescription has been filled, excluding mail order, the copayment will reduce to $15 preferred brand and $30 nonpreferred brand.

2010 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	Commonwealth Optimum PPO		Commonwealth Maximum Choice	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - $300 Family - $600	Single - $600 Family - $1,200	Single - $2,000 Family - $3,000	Single - $2,000 Family - $3,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $1,125 Family - $2,250	Single - $2,250 Family - $4,500	Single - $3,000 Family - $4,500	Single - $4,000 Family - $6,000
Up-Front Benefit Allowance	Not Applicable		Not Applicable	
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $1,000 Parent Plus - $1,500 Couple - $1,500 Family - $2,000	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	15%*	30%*	10%*	40%*
Outpatient services—physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, immunizations, injections, lab fees, x-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	$10 copay	30%*	10%*	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	$10 copay	30%*	10%*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	15%*	30%*	10%*	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	$10 copay per visit	30%*	Plan pays 100%	
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$75 copay plus 15%*	$75 copay plus 30%*	10%*	40%*
Emergency room physician charges	15%	30%*	10%*	40%*
Urgent care center treatment	$20 copay	30%*	10%*	40%*
Ambulance services	15%*	15%*	10%*	10%*
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	$10 copay In-hospital care coinsurance applies*	30%*	10%*	40%*
Prescription drugs—Retail (30 day supply) Generic Preferred Brand Nonpreferred Brand	 $5** $20** $40**	 30% 30% 30%	 10%* 10%* 10%*	 40%* 40%* 40%*
Prescription drugs—Mail Order (90 day supply) Generic Preferred Brand Nonpreferred Brand	 $10 $40 $80		 10%* 10%* 10%*	
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	$10 copay	30%*	10%*	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	$15 copay	30%*	10%*	40%*
▪ Respite care for children ages two through 21 ($500 maximum per month)	15%*	30%*	10%*	40%*
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	15%*	30%*	10%*	40%*
Prosthetic devices	15%*	30%*	10%*	40%*
Home health—limited to 60 visits per year	15%*	30%*	10%*	40%*
Physical therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Occupational therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Speech therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Skilled nursing facility services—limited to 30 days per year	15%*	30%*	10%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	15%*	30%*	10%*	40%*

* Subject to annual deductible.

** After the 75th prescription has been filled, excluding mail order, the copayment will reduce to $15 preferred brand and $30 nonpreferred brand.

In 2011:

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

2011 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Standard PPO		Commonwealth Capitol Choice	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - $500 Family - $1,500	Single - $1,500 Family - $3,000	Single - $575 Family - $1,725	Single - $1,150 Family - $3,455
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $3,500 Family - $7,000	Single - $5,000 Family - $9,500	Single - $2,300 Family - $6,900	Single - $3.800 Family - $9,400
Up-Front Benefit Allowance	Not Applicable		$500/family member	Not Applicable
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Not Applicable	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	25%*	50%*	$115 copay plus 0%*	40%*
Doctor's Office Visits	25%	50%*	$20 copay - PCP $25 copay - Spec	40%*
Allergy Serums & injections	25%	50%*	$10 copay	40%*
Physician Care (Inpatient/Outpatient/Other)	25%*	50%*	20%*	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	25%*	50%*	20%*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	25%*	50%*	$55 copay plus 0%*	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%		$15 copay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$50 copay plus 25%*	$50 copay plus 50%*	$115 copay plus 0%*	$115 copay plus 0%*
Emergency room physician charges	25%*	50%*	0%*	0%*
Urgent care center treatment	25%*	50%*	$50 copay	40%*
Ambulance services	25%*	25%*	20%*	20%*
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	25%*	50%*	$20 copay In-hospital care coinsurance applies*	40%*
Prescription drugs—Retail (30 day supply)	25%			
	Min / Max			
Generic Preferred Brand Nonpreferred Brand	$10 / $25 $20 / $50 $35 / $100		$10 $25** $45**	
Prescription drugs—Mail Order (90 day supply)	25%			
	Min / Max			
Generic Preferred Brand Nonpreferred Brand	$20 / $50 $40 / $100 $70 / $200		$15 $45 $90	
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	25%*	50%*	$20 copay	40%*
Autism Services Benefits payable based on services rendered	Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000		Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*	20%*	40%*
Prosthetic devices	25%*	50%*	20%*	40%*
Home health—limited to 60 visits per year	25%*	50%*	20%*	40%*
Physical therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Occupational therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Speech therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Skilled nursing facility services—limited to 30 days per year	25%*	50%*	20%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	25%*	50%*	20%*	40%*

* Subject to annual deductible.

** After the 75th prescription has been filled, excluding mail order, the copayment will reduce to $20 preferred brand and $35 nonpreferred brand.

2011 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	Commonwealth Optimum PPO		Commonwealth Maximum Choice	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - $345 Family - $690	Single - $690 Family - $1380	Single - $2,300 Family - $3,455	Single - $2,300 Family - $3,455
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $1,295 Family - $2,590	Single - $2,590 Family - $5,185	Single - $3,455 Family - $5,185	Single - $4,600 Family - $6,900
Up-Front Benefit Allowance	Not Applicable		Not Applicable	
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $1,000 Parent Plus - $1,500 Couple - $1,500 Family - $2,000	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	15%*	30%*	10%*	40%*
Doctor's Office Visits	$15 copay - PCP $20 copay - Specialist	30%*	10%*	40%*
Allergy Serums & injections	$15 copay	30%*	10%*	40%*
Physician Care (Inpatient/Outpatient/Other)	15%*	30%*	10%*	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	$15 copay	30%*	10%*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	15%*	30%*	10%*	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	$10 copay per visit	30%*	Plan pays 100%	
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$85 copay plus 15%*	$85 copay plus 30%*	10%*	40%*
Emergency room physician charges	15%	30%*	10%*	40%*
Urgent care center treatment	$20 copay	30%*	10%*	40%*
Ambulance services	15%*	15%*	10%*	10%*
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	$15 copay In-hospital care coinsurance applies*	30%*	10%*	40%*
Prescription drugs—Retail (30 day supply) Generic Preferred Brand Nonpreferred Brand	 $10** $25** $45**	 30% 30% 30%	 10%* 10%* 10%*	 40%* 40%* 40%*
Prescription drugs—Mail Order (90 day supply) Generic Preferred Brand Nonpreferred Brand	 $15 $45 $90		 10%* 10%* 10%*	
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	$15 copay	30%*	10%*	40%*
Autism Services Benefits payable based on services rendered	Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000		Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	15%*	30%*	10%*	40%*
Prosthetic devices	15%*	30%*	10%*	40%*
Home health—limited to 60 visits per year	15%*	30%*	10%*	40%*
Physical therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Occupational therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Speech therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Skilled nursing facility services—limited to 30 days per year	15%*	30%*	10%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	15%*	30%*	10%*	40%*

* Subject to annual deductible.

** After the 75th prescription has been filled, excluding mail order, the copayment will reduce to $20 preferred brand and $35 nonpreferred brand.

In 2012:

- KEHP evaluated the advantages and disadvantages of continuing "grandfathered health plan" status under PPACA and determined grandfathered status would be maintained for 2012.
- As PPACA regulations limit the amounts that group health plans can change benefit provisions and employee contributions to maintain grandfathered status, only slight changes were made in 2012:
  - Most plan deductibles and OOPM amounts were increased slightly (except for Standard PPO).
  - Employee contributions were increased slightly according to the limits allowed under PPACA while still maintaining grandfathered status (Optimum PPO, Maximum Choice, and Capitol Choice plans). Employee contributions for the Standard PPO plan were not increased.
- The Commonwealth offered the same four benefit plans which were offered in 2011 with slight changes to benefit designs, as noted above. The plans were:
  - Commonwealth Standard PPO: a $500/$1,500 deductible PPO plan
  - Commonwealth Capitol Choice: a $600/$1,800 deductible hybrid PPO plan (changed from $575/$1,725 in 2011) with an up-front benefit allowance of $500 per member
  - Commonwealth Optimum PPO: a $355/$720 deductible PPO plan (changed from $345/$690 in 2011)
  - Commonwealth Maximum Choice: a $2,325/$3,530 deductible consumer-directed plan (changed from $2,300/$3,455 in 2011) with an embedded HRA
- Coverage was offered to dependent children up to age 26, whom do not have other equivalent coverage available.
- The Commonwealth's contribution for employees who waive coverage was maintained at $175 per month, the same amount as in 2011.

2012 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Standard PPO		Commonwealth Capitol Choice	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - $500 Family - $1,500	Single - $1,500 Family - $3,000	Single - $600 Family - $1,800	Single - $1200 Family - $3,600
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $3,500 Family - $7,000	Single - $5,000 Family - $9,500	Single - $2,400 Family - $7,000	Single - $4,000 Family - $9,650
Up-Front Benefit Allowance	Not Applicable		$500/family member	Not Applicable
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Not Applicable	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	25%*	50%*	$115 copay plus 0%*	40%*
Doctor's Office Visits	25%*	50%*	$20 copay - PCP $25 copay - Spec	40%*
Allergy Serums & injections	25%*	50%*	$15 copay	40%*
Physician Care (Inpatient/Outpatient/Other)	25%*	50%*	20%*	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	25%*	50%*	20%*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital.	25%*	50%*	$55 copay*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in an ambulatory center.	25%*	50%*	$55 copay	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%		$15 copay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$50 copay plus 25%*	$50 copay plus 50%*	$115 copay plus 0%*	$115 copay plus 0%*
Emergency room physician charges	25%*	50%*	0%*	0%*
Urgent care center treatment	25%*	50%*	$50 copay	40%*
Ambulance services	25%*	25%*	20%*	20%*
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	25%*	50%*	$20 copay In-hospital care coinsurance applies*	40%*
Prescription drugs—Retail (30 day supply) Generic Preferred Brand Nonpreferred Brand	25% Min / Max $10 / $25 $20 / $50 $35 / $100		 $10 $25** $45**	
Prescription drugs—Mail Order (90 day supply) Generic Preferred Brand Nonpreferred Brand	25% Min / Max $20 / $50 $40 / $100 $70 / $200		 $15 $45 $90	
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	25%*	50%*	$20 copay	40%*
Autism Services Benefits payable based on services rendered	Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000		Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*	20%*	40%*
Prosthetic devices	25%*	50%*	20%*	40%*
Home health—limited to 60 visits per year	25%*	50%*	20%*	40%*
Physical therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Occupational therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Speech therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Skilled nursing facility services—limited to 30 days per year	25%*	50%*	20%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	25%*	50%*	20%*	40%*

* Subject to annual deductible.

** After the 75th prescription has been filled, excluding mail order, the copayment will reduce to $20 preferred brand and $35 nonpreferred brand.

2012 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	Commonwealth Optimum PPO		Commonwealth Maximum Choice	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - $355 Family - $720	Single - $720 Family - $1,430	Single - $2,325 Family - $3,530	Single - $2,400 Family - $3,600
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $1,350 Family - $2,700	Single - $2,700 Family - $5,350	Single - $3,550 Family - $5,280	Single - $4,700 Family - $7,000
Up-Front Benefit Allowance	Not Applicable		Not Applicable	
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $1,000 Parent Plus - $1,500 Couple - $1,500 Family - $2,000	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	15%*	30%*	10%*	40%*
Doctor's Office Visits	$15 copay - PCP $20 copay - Specialist	30%*	10%*	40%*
Allergy Serums & injections	$10 copay	30%*	10%*	40%*
Physician Care (Inpatient/Outpatient/Other)	15%*	30%*	10%*	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	$15 copay	30%*	10%*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	15%*	30%*	10%*	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	$10 copay per visit	30%*	Plan pays 100%	
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$85 copay plus 15%*	$75 copay plus 30%*	10%*	40%*
Emergency room physician charges	15%	30%*	10%*	40%*
Urgent care center treatment	$20 copay	30%*	10%*	40%*
Ambulance services	15%*	15%*	10%*	10%*
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	$15 copay In-hospital care coinsurance applies*	30%*	10%*	40%*
Prescription drugs—Retail (30 day supply) Generic Preferred Brand Nonpreferred Brand	 $10** $25** $45**	 30% 30% 30%	 10%* 10%* 10%*	 40%* 40%* 40%*
Prescription drugs—Mail Order (90 day supply) Generic Preferred Brand Nonpreferred Brand	 $15 $45 $90		 10%* 10%* 10%*	
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	$15 copay	30%*	10%*	40%*
Autism Services Benefits payable based on services rendered	Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000		Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	15%*	30%*	10%*	40%*
Prosthetic devices	15%*	30%*	10%*	40%*
Home health—limited to 60 visits per year	15%*	30%*	10%*	40%*
Physical therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Occupational therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Speech therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Skilled nursing facility services—limited to 30 days per year	15%*	30%*	10%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	15%*	30%*	10%*	40%*

* Subject to annual deductible.

** After the 75th prescription has been filled, excluding mail order, the copayment will reduce to $20 preferred brand and $35 nonpreferred brand.

In 2013:

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

2013 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Standard PPO		Commonwealth Capitol Choice	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - $600 Family - $1,800	Single - $1,200 Family - $3,000	Single - $615 Family - $1,850	Single - $1,230 Family - $3,700
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $3,000 Family - $6,000	Single - $6,000 Family - $9,000	Single - $2,470 Family - $7,400	Single - $4,900 Family - $9,000
Up-Front Benefit Allowance	Not Applicable		$500/family member	Not Applicable
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Not Applicable	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	25%*	50%*	$122 copay plus 0%*	40%*
Doctor's Office Visits	25%*	50%*	$21 copay - PCP $26 copay - Spec	40%*
Allergy Serums & injections	25%*	50%*	$11 copay	40%*
Physician Care (Inpatient/Outpatient/Other)	25%*	50%*	20%*	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	25%*	50%*	Office copay plus 20%*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital.	25%*	50%*	$61 copay*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in an ambulatory center.	25%*	50%*	$61 copay	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%		$16 copay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$50 copay plus 25%*	$50 copay plus 50%*	$122 copay plus 0%*	$122 copay plus 0%*
Emergency room physician charges	25%*	50%*	0%*	0%*
Urgent care center treatment	25%*	50%*	$60 copay	40%*
Ambulance services	25%*	25%*	20%*	20%*
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copy is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	25%*	50%*	$21 copay In-hospital care coinsurance applies*	40%*
Prescription drugs—Retail (30 day supply) Min / Max Generic Preferred Brand Nonpreferred Brand	25% Min / Max $10 / $25 $20 / $50 $35 / $100	Not Covered	 $11 $26** $48**	
Prescription drugs—Mail Order (90 day supply) Min / Max Generic Preferred Brand Nonpreferred Brand	25% Min / Max $20 / $50 $40 / $100 $70 / $200	Not Covered	 $16 $46 $95	Not Covered
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	25%*	50%*	$21 copay	40%*
Autism Services Benefits payable based on services rendered	Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000		Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*	20%*	40%*
Prosthetic devices	25%*	50%*	20%*	40%*
Home health—limited to 60 visits per year	25%*	50%*	20%*	40%*
Physical therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Occupational therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Speech therapy—limited to 30 visits per year	25%*	50%*	20%*	40%*
Skilled nursing facility services—limited to 30 days per year	25%*	50%*	20%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	25%*	50%*	20%*	40%*

* Subject to annual deductible.

** After the 75th prescription has been filled, excluding mail order, the copayment will reduce to $21 preferred brand and $37 nonpreferred brand.

2013 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	Commonwealth Optimum PPO		Commonwealth Maximum Choice	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - $370 Family - $740	Single - $740 Family - $1,480	Single - $2,450 Family - $3,650	Single - $2,450 Family - $3,700
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $1,390 Family - $2,780	Single - $2,780 Family - $5,550	Single - $3,700 Family - $5,400	Single - $4,945 Family - $7,400
Up-Front Benefit Allowance	Not Applicable		Not Applicable	
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $1,000 Parent Plus - $1,500 Couple - $1,500 Family - $2,000	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	15%*	30%*	10%*	40%*
Doctor's Office Visits	$16 copay - PCP $21 copay - Specialist	30%*	10%*	40%*
Allergy Serums & injections	$16 copay	30%*	10%*	40%*
Physician Care (Inpatient/Outpatient/Other)	15%*	30%*	10%*	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	Office copay	30%*	10%*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	15%*	30%*	10%*	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	$11 copay per visit	30%*	Plan pays 100%	Not Covered
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$92 copay plus 15%*	$92 copay plus 30%*	10%*	40%*
Emergency room physician charges	15%	30%*	10%*	40%*
Urgent care center treatment	$21 copay	30%*	10%*	40%*
Ambulance services	15%*	15%*	10%*	10%*
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	$16 copay In-hospital care coinsurance applies*	30%*	10%*	40%*
Prescription drugs—Retail (30 day supply) Generic Preferred Brand Nonpreferred Brand	 $11** $26** $48**	 30% 30% 30%	 10%* 10%* 10%*	 40%* 40%* 40%*
Prescription drugs—Mail Order (90 day supply) Generic Preferred Brand Nonpreferred Brand	 $16 $46 $95	Not Covered	 10%* 10%* 10%*	Not Covered
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	$21 copay	30%*	10%*	40%*
Autism Services Benefits payable based on services rendered	Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000		Ages 1 - 6 Annual Maximum of $50,000 Ages 7 - 21 Monthly Maximum of $1,000	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	15%*	30%*	10%*	40%*
Prosthetic devices	15%*	30%*	10%*	40%*
Home health—limited to 60 visits per year	15%*	30%*	10%*	40%*
Physical therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Occupational therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Speech therapy—limited to 30 visits per year	15%*	30%*	10%*	40%*
Skilled nursing facility services—limited to 30 days per year	15%*	30%*	10%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	15%*	30%*	10%*	40%*

* Subject to annual deductible.

** After the 75th prescription has been filled, excluding mail order, the copayment will reduce to $20 preferred brand and $35 nonpreferred brand.

In 2014:

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

2014 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Standard PPO		Standard CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, prescription drugs, chiropractic services and hospital emergency room services)	Single - $750 Family - $1,500	Single - $1,500 Family - $3,000	Single - $1,750 Family - $3,500	Single - $3,000 Family - $6,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $3,500 Family - $7,000	Single - $7,000 Family - $10,000	Single - $3,500 Family - $7,000	Single - $7,000 Family - $10,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $250 Family - $500	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	30%*	50%*	30%*	50%*
Doctor's Office Visits	30%*	50%*	30%*	50%*
Allergy Serums & injections	30%*	50%*	30%*	50%*
Physician Care (Inpatient/Outpatient/Other)	30%*	50%*	30%*	50%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	30%*	50%*	30%*	50%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital.	30%*	50%*	30%*	50%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in an ambulatory center.	30%*	50%*	30%*	50%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%	50%*	Plan pays 100%	50%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$150 copay plus 30%* (copay waived if admitted)		30%*	
Emergency room physician charges	30%*		30%*	
Urgent care center treatment	30%*		30%*	
Ambulance services	30%*		30%*	
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	30%*	50%*	30%*	50%*
Prescription drugs—Out-of-Pocket Maximum	Single $3,500 Family $7,000	Not Applicable	Combined with Medical	Combined with Medical
Prescription drugs—Retail (30 day supply)	30%	Not Covered	30%*	50%*
	Min / Max			
Generic Preferred Brand Nonpreferred Brand	$10 / $25 $20 / $50 $60 / $100			
Prescription drugs—Mail Order (90 day supply)	30%	Not Covered	30%*	Not Covered
	Min / Max			
Generic Preferred Brand Nonpreferred Brand	$20 / $50 $40 / $100 $120 / $200			
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	30%*	50%*	30%*	50%*
Autism Services Benefits payable based on services rendered	Treated the same as any other health condition.		Treated the same as any other health condition.	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	30%*	50%*	30%*	50%*
Prosthetic devices	30%*	50%*	30%*	50%*
Home health—limited to 60 visits per year	30%*	50%*	30%*	50%*
Physical therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Occupational therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Cardiac rehabilitation therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Speech therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Skilled nursing facility services—limited to 30 days per year	30%*	50%*	30%*	50%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	30%*	50%*	30%*	50%*

* Subject to annual deductible.

2014 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	LivingWell PPO		LivingWell CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, prescription drugs, chiropractic services and hospital emergency room services)	Single - $500 Family - $1,000	Single - $1,000 Family - $2,000	Single - $1,250 Family - $2,500	Single - $2,500 Family - $5,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $2,500 Family - $5,000	Single - $5,000 Family - $10,000	Single - $2,500 Family - $5,000	Single - $5,000 Family - $10,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $500 Family - $1,000	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	20%*	40%*	15%*	40%*
Doctor's Office Visits	$25 copay - PCP $45 copay - Specialist	40%*	15%*	40%*
Allergy Serums & injections	$25 copay	40%*	15%*	40%*
Physician Care (Inpatient/Outpatient/Other)	20%*	40%*	15%*	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	Office copay	40%*	15%*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	20%*	40%*	15%*	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%	40%*	Plan pays 100%	40%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$150 copay plus 20%* (copay waived if admitted)		15%*	
Emergency room physician charges	20%*		15%*	
Urgent care center treatment	$50 copay		15%*	
Ambulance services	20%*		15%*	
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	$25 copay Delivery charge: 20%*	40%*	15%*	40%*
Prescription drugs—Out-of-Pocket Maximum	Single $2,500 Family $5,000	Not Applicable	Combined with Medical	Combined with Medical
Prescription drugs—Retail (30 day supply) Generic Preferred Brand Nonpreferred Brand	 $10 $35** $55**	Not Covered	 15%* 15%* 15%*	 40%* 40%* 40%*
Prescription drugs—Mail Order (90 day supply) Generic Preferred Brand Nonpreferred Brand	 $20 $70 $110	Not Covered	 15%* 15%* 15%*	Not Covered
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	$25 copay	40%*	15%*	40%*
Autism Services Benefits payable based on services rendered	Treated the same as any other health condition.		Treated the same as any other health condition.	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	20%*	40%*	15%*	40%*
Prosthetic devices	20%*	40%*	15%*	40%*
Home health—limited to 60 visits per year	20%*	40%*	15%*	40%*
Physical therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Occupational therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Speech therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Skilled nursing facility services—limited to 30 days per year	20%*	40%*	15%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	20%*	40%*	15%*	40%*

* Subject to annual deductible.

** After the 75th prescription has been filled, excluding mail order, the copayment will reduce to $30 preferred brand and $44 nonpreferred brand.

In 2015:

- Anthem became the new medical network and claims administrator, CVS/caremark became the new pharmacy benefits administrator, and WageWorks became the new FSA/HRA/HIPAA/COBRA benefit administrator.
- The Commonwealth offered the same four benefit plans which were offered in 2014 with minor changes to benefit designs:
  - LivingWell PPO: Reduce allergy shot copay from $25 to $15; reduce mental health/substance abuse copay to PCP levels.
  - Standard PPO: Reduce in-network pharmacy OOPM from $3,500/$7,000 to $2,500/5,000.
- The plan design highlights for the four plan options are:
  - LivingWell CDHP: a $1,250/$2,500 deductible consumer-directed plan with 85% coinsurance and $500/$1,000 embedded HRA
  - LivingWell PPO: a $500/$1,000 deductible PPO plan with 80% coinsurance
  - Standard PPO: a $750/$1,500 deductible PPO plan with 70% coinsurance
  - Standard CHDP: a $1,750/$3,500 deductible consumer-directed plan with 70% coinsurance and $250/$500 embedded HRA
- The Commonwealth's contribution for employees who waive coverage was maintained at $175 per month, the same amount as in 2014.

2015 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Standard PPO		Standard CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, prescription drugs, chiropractic services and hospital emergency room services)	Single - $750 Family - $1,500	Single - $1,500 Family - $3,000	Single - $1,750 Family - $3,500	Single - $3,000 Family - $6,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $3,500 Family - $7,000	Single - $7,000 Family - $10,000	Single - $3,500 Family - $7,000	Single - $7,000 Family - $10,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $250 Family - $500	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	30%*	50%*	30%*	50%*
Doctor's Office Visits	30%*	50%*	30%*	50%*
Allergy Serums & injections	30%*	50%*	30%*	50%*
Physician Care (Inpatient/Outpatient/Other)	30%*	50%*	30%*	50%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	30%*	50%*	30%*	50%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital.	30%*	50%*	30%*	50%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in an ambulatory center.	30%*	50%*	30%*	50%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%	50%*	Plan pays 100%	50%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$150 copay plus 30%* (copay waived if admitted)		30%*	
Emergency room physician charges	30%*		30%*	
Urgent care center treatment	30%*		30%*	
Ambulance services	30%*		30%*	
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	30%*	50%*	30%*	50%*
Prescription drugs—Out-of-Pocket Maximum	Single $2,500 Family $5,000	Not Applicable	Combined with Medical	Combined with Medical
Prescription drugs—Retail (30 day supply)	30%	Not Covered	30%*	50%*
	Min / Max			
Generic Preferred Brand Nonpreferred Brand	$10 / $25 $20 / $50 $60 / $100			
Prescription drugs—Mail Order (90 day supply)	30%	Not Covered	30%*	Not Covered
	Min / Max			
Generic Preferred Brand Nonpreferred Brand	$20 / $50 $40 / $100 $120 / $200			
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	30%*	50%*	30%*	50%*
Autism Services Benefits payable based on services rendered	Treated the same as any other health condition.		Treated the same as any other health condition.	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	30%*	50%*	30%*	50%*
Prosthetic devices	30%*	50%*	30%*	50%*
Home health—limited to 60 visits per year	30%*	50%*	30%*	50%*
Physical therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Occupational therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Cardiac rehabilitation therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Speech therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Skilled nursing facility services—limited to 30 days per year	30%*	50%*	30%*	50%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	30%*	50%*	30%*	50%*

* Subject to annual deductible.

2015 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	LivingWell PPO		LivingWell CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, prescription drugs, chiropractic services and hospital emergency room services)	Single - $500 Family - $1,000	Single - $1,000 Family - $2,000	Single - $1,250 Family - $2,500	Single - $2,500 Family - $5,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $2,500 Family - $5,000	Single - $5,000 Family - $10,000	Single - $2,500 Family - $5,000	Single - $5,000 Family - $10,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $500 Family - $1,000	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	20%*	40%*	15%*	40%*
Doctor's Office Visits	$25 copay - PCP $45 copay - Specialist	40%*	15%*	40%*
Allergy Serums & injections	$15 copay	40%*	15%*	40%*
Physician Care (Inpatient/Outpatient/Other)	20%*	40%*	15%*	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	Office copay	40%*	15%*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	20%*	40%*	15%*	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%	40%*	Plan pays 100%	40%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$150 copay plus 20%* (copay waived if admitted)		15%*	
Emergency room physician charges	20%*		15%*	
Urgent care center treatment	$50 copay		15%*	
Ambulance services	20%*		15%*	
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	$25 copay Delivery charge: 20%*	40%*	15%*	40%*
Prescription drugs—Out-of-Pocket Maximum	Single $2,500 Family $5,000	Not Applicable	Combined with Medical	Combined with Medical
Prescription drugs—Retail (30 day supply) Generic Preferred Brand Nonpreferred Brand	 $10 $35 $55	Not Covered	 15%* 15%* 15%*	 40%* 40%* 40%*
Prescription drugs—Mail Order (90 day supply) Generic Preferred Brand Nonpreferred Brand	 $20 $70 $110	Not Covered	 15%* 15%* 15%*	Not Covered
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	$25 copay	40%*	15%*	40%*
Autism Services Benefits payable based on services rendered	Treated the same as any other health condition.		Treated the same as any other health condition.	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	20%*	40%*	15%*	40%*
Prosthetic devices	20%*	40%*	15%*	40%*
Home health—limited to 60 visits per year	20%*	40%*	15%*	40%*
Physical therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Occupational therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Speech therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Skilled nursing facility services—limited to 30 days per year	20%*	40%*	15%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	20%*	40%*	15%*	40%*

* Subject to annual deductible.

In 2016:

- The Commonwealth offered the same four benefit plans which were offered in 2015 with minor changes to benefit designs:
  - All plans: Value-Based Benefit Design (VBBD) to encourage members with diabetes to adhere to treatment regimens. KEHP diabetic members pay a reduced copayment and coinsurance, with no deductibles, for most of their maintenance diabetic prescriptions and supplies.
- The plan design highlights for the four plan options were:
  - LivingWell CDHP: a $1,250/$2,500 deductible consumer-directed plan with 85% coinsurance and $500/$1,000 embedded HRA
  - LivingWell PPO: a $500/$1,000 deductible PPO plan with 80% coinsurance
  - Standard PPO: a $750/$1,500 deductible PPO plan with 70% coinsurance
  - Standard CHDP: a $1,750/$3,500 deductible consumer-directed plan with 70% coinsurance and $250/$500 embedded HRA
- All plans had no increase in employee contributions.
- The Commonwealth's contribution for employees who waive coverage was maintained at $175 per month, the same amount as in 2015.

2016 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Standard PPO		Standard CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, prescription drugs, chiropractic services and hospital emergency room services)	Single - $750 Family - $1,500	Single - $1,500 Family - $3,000	Single - $1,750 Family - $3,500	Single - $3,000 Family - $6,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $3,500 Family - $7,000	Single - $7,000 Family - $10,000	Single - $3,500 Family - $7,000	Single - $7,000 Family - $10,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $250 Family - $500	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	30%*	50%*	30%*	50%*
Doctor's Office Visits	30%*	50%*	30%*	50%*
Allergy Serums & injections	30%*	50%*	30%*	50%*
Physician Care (Inpatient/Outpatient/Other)	30%*	50%*	30%*	50%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	30%*	50%*	30%*	50%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital.	30%*	50%*	30%*	50%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in an ambulatory center.	30%*	50%*	30%*	50%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%	50%*	Plan pays 100%	50%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$150 copay plus 30%* (copay waived if admitted)		30%*	
Emergency room physician charges	30%*		30%*	
Urgent care center treatment	30%*		30%*	
Ambulance services	30%*		30%*	
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	30%*	50%*	30%*	50%*
Prescription drugs—Out-of-Pocket Maximum	Single $2,500 Family $5,000	Not Applicable	Combined with Medical	Combined with Medical
Prescription drugs—Retail (30 day supply)	30%	Not Covered	30%*	50%*
	Min / Max			
Generic Preferred Brand Nonpreferred Brand	$10 / $25 $20 / $50 $60 / $100			
Prescription drugs—Mail Order (90 day supply)	30%	Not Covered	30%*	Not Covered
	Min / Max			
Generic Preferred Brand Nonpreferred Brand	$20 / $50 $40 / $100 $120 / $200			
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	30%*	50%*	30%*	50%*
Autism Services Benefits payable based on services rendered	Treated the same as any other health condition.		Treated the same as any other health condition.	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	30%*	50%*	30%*	50%*
Prosthetic devices	30%*	50%*	30%*	50%*
Home health—limited to 60 visits per year	30%*	50%*	30%*	50%*
Physical therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Occupational therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Cardiac rehabilitation therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Speech therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Skilled nursing facility services—limited to 30 days per year	30%*	50%*	30%*	50%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	30%*	50%*	30%*	50%*

* Subject to annual deductible.
** Copays do not accumulate toward the deductible, but they do accumulate toward the applicable out-of-pocket.
*** For the LivingWell CDHP and the Standard CDHPs, all covered expenses apply to the OOPM. For the LivingWell PPO and the Standard PPO plans, the OOPM accumulates separately and independently for medical and prescription drug benefits.

2016 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	LivingWell PPO		LivingWell CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, prescription drugs, chiropractic services and hospital emergency room services)	Single - $500 Family - $1,000	Single - $1,000 Family - $2,000	Single - $1,250 Family - $2,500	Single - $2,500 Family - $5,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $2,500 Family - $5,000	Single - $5,000 Family - $10,000	Single - $2,500 Family - $5,000	Single - $5,000 Family - $10,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $500 Family - $1,000	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	20%*	40%*	15%*	40%*
Doctor's Office Visits	$25 copay - PCP $45 copay - Specialist	40%*	15%*	40%*
Allergy Serums & injections	$15 copay	40%*	15%*	40%*
Physician Care (Inpatient/Outpatient/Other)	20%*	40%*	15%*	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	Office copay	40%*	15%*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	20%*	40%*	15%*	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%	40%*	Plan pays 100%	40%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$150 copay plus 20%* (copay waived if admitted)		15%*	
Emergency room physician charges	20%*		15%*	
Urgent care center treatment	$50 copay		15%*	
Ambulance services	20%*		15%*	
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	$25 copay Delivery charge: 20%*	40%*	15%*	40%*
Prescription drugs—Out-of-Pocket Maximum	Single $2,500 Family $5,000	Not Applicable	Combined with Medical	Combined with Medical
Prescription drugs—Retail (30 day supply) Generic Preferred Brand Nonpreferred Brand	 $10 $35 $55	Not Covered	 15%* 15%* 15%*	 40%* 40%* 40%*
Prescription drugs—Mail Order (90 day supply) Generic Preferred Brand Nonpreferred Brand	 $20 $70 $110	Not Covered	 15%* 15%* 15%*	Not Covered
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	$25 copay	40%*	15%*	40%*
Autism Services Benefits payable based on services rendered	Treated the same as any other health condition.		Treated the same as any other health condition.	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	20%*	40%*	15%*	40%*
Prosthetic devices	20%*	40%*	15%*	40%*
Home health—limited to 60 visits per year	20%*	40%*	15%*	40%*
Physical therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Occupational therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Speech therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Skilled nursing facility services—limited to 30 days per year	20%*	40%*	15%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	20%*	40%*	15%*	40%*

* Subject to annual deductible.
** Copays do not accumulate toward the deductible, but they do accumulate toward the applicable out-of-pocket.
*** For the LivingWell CDHP and the Standard CDHPs, all covered expenses apply to the OOPM. For the LivingWell PPO and the Standard PPO plans, the OOPM accumulates separately and independently for medical and prescription drug benefits.

In 2017:

- The Commonwealth offered the same four benefit plans which were offered in 2016 with small changes to benefit designs:
  - LivingWell CDHP:
    - Increase OOPM from $2,500 single/$5,000 family to $2,750 single/$5,500 family.
  - LivingWell PPO:
    - Increase deductible from $500 single/$1,000 family to $750 single/$1,500 family.
    - Increase OOPM from $2,500 single/$5,000 family to $2,750 single/$5,500 family.
  - Standard PPO:
    - Increase OOPM from $3,500 single/$7,000 family to $3,750 single/$7,500 family.
  - Standard CDHP:
    - Increase OOPM from $3,500 single/$7,000 family to $3,750 single/$7,500 family.
- The plan design highlights for the four plan options were:
  - LivingWell CDHP: a $1,250/$2,500 deductible consumer-directed plan with 85% coinsurance and $500/$1,000 embedded HRA
  - LivingWell PPO: a $750/$1,500 deductible PPO plan with 80% coinsurance
  - Standard PPO: a $750/$1,500 deductible PPO plan with 70% coinsurance
  - Standard CHDP: a $1,750/$3,500 deductible consumer-directed plan with 70% coinsurance and $250/$500 embedded HRA
- There was no employee contribution increase for LivingWell plans and a 1% employee contribution increase for Standard plans
- In previous plan years, the LivingWell Promise was a gateway to the LivingWell Plans. Beginning in 2017, for members enrolled in one of the LivingWell plans, completing the LivingWell promise was required in order to receive the $40 discount.
- The Commonwealth's contribution for employees who waive coverage was maintained at $175 per month, the same amount as in 2016. The waiver and embedded HRA carryover was limited to $7,500.
- The Standard PPO plan became the default plan.
- Select preventive/maintenance drugs bypass the deductible on both CDHPs.

2017 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Standard PPO		Standard CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, prescription drugs, chiropractic services and hospital emergency room services)	Single - $750 Family - $1,500	Single - $1,500 Family - $3,000	Single - $1,750 Family - $3,500	Single - $3,000 Family - $6,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $3,750 Family - $7,500	Single - $7,500 Family - $11,000	Single - $3,750 Family - $7,500	Single - $7,500 Family - $11,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $250 Family - $500	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	30%*	50%*	30%*	50%*
Doctor's Office Visits	30%*	50%*	30%*	50%*
Allergy Serums & injections	30%*	50%*	30%*	50%*
Physician Care (Inpatient/Outpatient/Other)	30%*	50%*	30%*	50%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	30%*	50%*	30%*	50%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital.	30%*	50%*	30%*	50%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in an ambulatory center.	30%*	50%*	30%*	50%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%	50%*	Plan pays 100%	50%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$150 copay plus 30%* (copay waived if admitted)		30%*	
Emergency room physician charges	30%*		30%*	
Urgent care center treatment	30%*		30%*	
Ambulance services	30%*		30%*	
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	30%*	50%*	30%*	50%*
Prescription drugs—Out-of-Pocket Maximum	Single $2,500 \Family $5,000	Not Applicable	Combined with Medical	Combined with Medical
Prescription drugs—Retail (30 day supply)	30%	Not Covered	30%*	50%*
	Min / Max			
Generic Preferred Brand Nonpreferred Brand	$10 / $25 $20 / $50 $60 / $100			
Prescription drugs—Mail Order (90 day supply)	30%	Not Covered	30%*	Not Covered
	Min / Max			
Generic Preferred Brand Nonpreferred Brand	$20 / $50 $40 / $100 $120 / $200			
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	30%*	50%*	30%*	50%*
Autism Services Benefits payable based on services rendered	Treated the same as any other health condition.		Treated the same as any other health condition.	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	30%*	50%*	30%*	50%*
Prosthetic devices	30%*	50%*	30%*	50%*
Home health—limited to 60 visits per year	30%*	50%*	30%*	50%*
Physical therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Occupational therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Cardiac rehabilitation therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Speech therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Skilled nursing facility services—limited to 30 days per year	30%*	50%*	30%*	50%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	30%*	50%*	30%*	50%*

* Subject to annual deductible.
** Copays do not accumulate toward the deductible, but they do accumulate toward the applicable out-of-pocket.
*** For the LivingWell CDHP and the Standard CDHPs, all covered expenses apply to the OOPM. For the LivingWell PPO and the Standard PPO plans, the OOPM accumulates separately and independently for medical and prescription drug benefits.

2017 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	LivingWell PPO		LivingWell CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, prescription drugs, chiropractic services and hospital emergency room services)	Single - $750 Family - $1,500	Single - $1,500 Family - $3,000	Single - $1,250 Family - $2,500	Single - $2,500 Family - $5,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $2,750 Family - $5,500	Single - $5,500 Family - $11,000	Single - $2,750 Family - $5,500	Single - $5,500 Family - $11,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $500 Family - $1,000	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	20%*	40%*	15%*	40%*
Doctor's Office Visits	$25 copay - PCP $45 copay - Specialist	40%*	15%*	40%*
Allergy Serums & injections	$15 copay	40%*	15%*	40%*
Physician Care (Inpatient/Outpatient/Other)	20%*	40%*	15%*	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	Office copay	40%*	15%*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	20%*	40%*	15%*	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%	40%*	Plan pays 100%	40%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$150 copay plus 20%* (copay waived if admitted)		15%*	
Emergency room physician charges	20%*		15%*	
Urgent care center treatment	$50 copay		15%*	
Ambulance services	20%*		15%*	
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	$25 copay Delivery charge: 20%*	40%*	15%*	40%*
Prescription drugs—Out-of-Pocket Maximum	Single $2,500 Family $5,000	Not Applicable	Combined with Medical	Combined with Medical
Prescription drugs—Retail (30 day supply) Generic Preferred Brand Nonpreferred Brand	 $10 $35 $55	Not Covered	 15%* 15%* 15%*	 40%* 40%* 40%*
Prescription drugs—Mail Order (90 day supply) Generic Preferred Brand Nonpreferred Brand	 $20 $70 $110	Not Covered	 15%* 15%* 15%*	Not Covered
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	$25 copay	40%*	15%*	40%*
Autism Services Benefits payable based on services rendered	Treated the same as any other health condition.		Treated the same as any other health condition.	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	20%*	40%*	15%*	40%*
Prosthetic devices	20%*	40%*	15%*	40%*
Home health—limited to 60 visits per year	20%*	40%*	15%*	40%*
Physical therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Occupational therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Speech therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Skilled nursing facility services—limited to 30 days per year	20%*	40%*	15%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	20%*	40%*	15%*	40%*

* Subject to annual deductible.
** Copays do not accumulate toward the deductible, but they do accumulate toward the applicable out-of-pocket.
*** For the LivingWell CDHP and the Standard CDHPs, all covered expenses apply to the OOPM. For the LivingWell PPO and the Standard PPO plans, the OOPM accumulates separately and independently for medical and prescription drug benefits.

In 2018:

- The Commonwealth offered the same four benefit plans which were offered in 2017 with small changes to benefit designs.
- The plan design highlights for the four plan options were:
  - LivingWell CDHP: a $1,250/$2,500 deductible consumer-directed plan with 85% coinsurance and $500/$1,000 embedded HRA
  - LivingWell PPO: a $750/$1,500 deductible PPO plan with 80% coinsurance
  - Standard PPO: a $750/$1,500 deductible PPO plan with 70% coinsurance
  - Standard CHDP: a $1,750/$3,500 deductible consumer-directed plan with 70% coinsurance and $250/$500 embedded HRA
- There were employee contribution increases for all plans. The employee only Standard CDHP employee contribution doubled while there was a 3% increase for all other tiers and plans. There was still a $40 surcharge for enrolling in LivingWell Plans without completing the LivingWell Promise.
- The Commonwealth's contribution for employees who waive coverage was maintained at $175 per month, the same amount as in 2017.
- KEHP adopted CVS/caremark Advanced Control Formulary.
- For specialty prescriptions that were processed through the medical benefit, there was a precertification with Clinical Site of Care Review to guide members to lower cost of care facilities (out of the hospitals).
- Health care FSA maximum contribution increased to $2,600.

2018 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Standard PPO		Standard CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, prescription drugs, chiropractic services and hospital emergency room services)	Single - $750 Family - $1,500	Single - $1,500 Family - $3,000	Single - $1,750 Family - $3,500	Single - $3,000 Family - $6,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $3,750 Family - $7,500	Single - $7,500 Family - $11,000	Single - $3,750 Family - $7,500	Single - $7,500 Family - $11,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $250 Family - $500	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	30%*	50%*	30%*	50%*
Doctor's Office Visits	30%*	50%*	30%*	50%*
Allergy Serums & injections	30%*	50%*	30%*	50%*
Physician Care (Inpatient/Outpatient/Other)	30%*	50%*	30%*	50%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	30%*	50%*	30%*	50%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital.	30%*	50%*	30%*	50%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in an ambulatory center.	30%*	50%*	30%*	50%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%	50%*	Plan pays 100%	50%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$150 copay plus 30%* (copay waived if admitted)		30%*	
Emergency room physician charges	30%*		30%*	
Urgent care center treatment	30%*		30%*	
Ambulance services	30%*		30%*	
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	30%*	50%*	30%*	50%*
Prescription drugs—Out-of-Pocket Maximum	Single $2,500 Family $5,000	Not Applicable	Combined with Medical	Combined with Medical
Prescription drugs—Retail (30 day supply)	30%	Not Covered	30%*	50%*
	Min / Max			
Generic Preferred Brand Nonpreferred Brand	$10 / $25 $20 / $50 $60 / $100			
Prescription drugs—Mail Order (90 day supply)	30%	Not Covered	30%*	Not Covered
	Min / Max			
Generic Preferred Brand Nonpreferred Brand	$20 / $50 $40 / $100 $120 / $200			
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	30%*	50%*	30%*	50%*
Autism Services Benefits payable based on services rendered	Treated the same as any other health condition.		Treated the same as any other health condition.	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	30%*	50%*	30%*	50%*
Prosthetic devices	30%*	50%*	30%*	50%*
Home health—limited to 60 visits per year	30%*	50%*	30%*	50%*
Physical therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Occupational therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Cardiac rehabilitation therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Speech therapy—limited to 30 visits per year	30%*	50%*	30%*	50%*
Skilled nursing facility services—limited to 30 days per year	30%*	50%*	30%*	50%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	30%*	50%*	30%*	50%*

* Subject to annual deductible.

** Copays do not accumulate toward the deductible, but they do accumulate toward the applicable out-of-pocket.

*** For the LivingWell CDHP and the Standard CDHPs, all covered expenses apply to the OOPM. For the LivingWell PPO and the Standard PPO plans, the OOPM accumulates separately and independently for medical and prescription drug benefits.

2018 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	LivingWell PPO		LivingWell CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, prescription drugs, chiropractic services and hospital emergency room services)	Single - $750 Family - $1,500	Single - $1,500 Family - $3,000	Single - $1,250 Family - $2,500	Single - $2,500 Family - $5,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $2,750 Family - $5,500	Single - $5,500 Family - $11,000	Single - $2,750 Family - $5,500	Single - $5,500 Family - $11,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $500 Family - $1,000	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	20%*	40%*	15%*	40%*
Doctor's Office Visits	$25 copay - PCP $45 copay - Specialist	40%*	15%*	40%*
Allergy Serums & injections	$15 copay	40%*	15%*	40%*
Physician Care (Inpatient/Outpatient/Other)	20%*	40%*	15%*	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	Office copay	40%*	15%*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	20%*	40%*	15%*	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%	40%*	Plan pays 100%	40%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$150 copay plus 20%* (copay waived if admitted)		15%*	
Emergency room physician charges	20%*		15%*	
Urgent care center treatment	$50 copay		15%*	
Ambulance services	20%*		15%*	
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	$25 copay Delivery charge: 20%*	40%*	15%*	40%*
Prescription drugs—Out-of-Pocket Maximum	Single $2,500 Family $5,000	Not Applicable	Combined with Medical	Combined with Medical
Prescription drugs—Retail (30 day supply) Generic Preferred Brand Nonpreferred Brand	 $10 $35 $55	Not Covered	 15%* 15%* 15%*	 40%* 40%* 40%*
Prescription drugs—Mail Order (90 day supply) Generic Preferred Brand Nonpreferred Brand	 $20 $70 $110	Not Covered	 15%* 15%* 15%*	Not Covered
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	$25 copay	40%*	15%*	40%*
Autism Services Benefits payable based on services rendered	Treated the same as any other health condition.		Treated the same as any other health condition.	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	20%*	40%*	15%*	40%*
Prosthetic devices	20%*	40%*	15%*	40%*
Home health—limited to 60 visits per year	20%*	40%*	15%*	40%*
Physical therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Occupational therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Speech therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Skilled nursing facility services—limited to 30 days per year	20%*	40%*	15%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	20%*	40%*	15%*	40%*

* Subject to annual deductible.
** Copays do not accumulate toward the deductible, but they do accumulate toward the applicable out-of-pocket.
*** For the LivingWell CDHP and the Standard CDHPs, all covered expenses apply to the OOPM. For the LivingWell PPO and the Standard PPO plans, the OOPM accumulates separately and independently for medical and prescription drug benefits.

In 2019:

- KEHP offered two new plan options—LivingWell Limited High Deductible Plan and LivingWell Basic CDHP health plan options and continued to offer the LivingWell PPO and LivingWell CDHP options.
- KEHP adopted CVS/Caremark Value Formulary for the two new plans.
- COPD and asthma are included in the Value Benefits, where the member pays a reduced copay and coinsurance with no deductible for most maintenance prescriptions and supplies. Prior to 2019 plan year, the Value Benefits only included diabetic prescriptions and supplies.
- The plan design highlights for the new plan options are:
  - LivingWell Limited High Deductible Plan: new plan that provides "catastrophic" coverage for members who do not elect a plan during open enrollment or as new hire;
    - a $4,000/$8,000 deductible consumer-directed plan with 50% coinsurance and no embedded HRA
  - LivingWell Basic CDHP: the same premium and benefits as the Standard CDHP offered in 2018, except with the new Value Formulary
    - $1,750/$3,500 deductible consumer-directed plan with 70% coinsurance and $250/$500 embedded HRA
- There were no employee contribution increases for all plans, except for low premium increases to the LivingWell CDHP couple and family with an increase of $8 and $10 per month, respectively.
- All health plans require planholders to complete the LivingWell Promise in 2019 to receive a $40 premium discount in 2020. Previously, this was only required on the two LivingWell Plans.
- The Commonwealth's contribution for employees who waive coverage was maintained at $175 per month, the same amount as in 2017.
- Healthcare FSA maximum annual contribution increased to $2,650.
- A new benefit to support members that care for children with learning or behavioral challenges, including autism.
- Optional dental and vision insurance is offered to members.

2019 Public Employee Health Insurance Program Benefit Provisions

Covered Services	LivingWell Limited HDHP		LivingWell Basic CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, prescription drugs, chiropractic services and hospital emergency room services)	Single - $4,000 Family - $8,000	Single - $8,000 Family - $16,000	Single - $1,750 Family - $3,500	Single - $3,000 Family - $6,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $5,000 Family - $10,000	Single - $10,000 Family - $20,000	Single - $3,750 Family - $7,500	Single - $7,500 Family - $11,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $250 Family - $500	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	50%*	60%*	30%*	50%*
Doctor's Office Visits	50%*	60%*	30%*	50%*
Allergy Serums & injections	50%*	60%*	30%*	50%*
Physician Care (Inpatient/Outpatient/Other)	50%*	60%*	30%*	50%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	50%*	60%*	30%*	50%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital.	50%*	60%*	30%*	50%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in an ambulatory center.	50%*	60%*	30%*	50%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%	60%*	Plan pays 100%	50%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	50%*		30%*	
Emergency room physician charges	50%*		30%*	
Urgent care center treatment	50%*		30%*	
Ambulance services	50%*		30%*	
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	50%*	60%*	30%*	50%*
Prescription drugs—Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical	Combined with Medical
Prescription drugs—Retail (30 day supply) Generic Preferred Brand Nonpreferred Brand	 50%* 50%* Tier 3 – Not Covered	 60%* 60%* Tier 3 – Not Covered	 30%* 30%* Tier 3 – Not Covered	 50%* 50%* Tier 3 – Not Covered
Prescription drugs—Mail Order (90 day supply) Generic Preferred Brand Nonpreferred Brand	 50%* 50%* Tier 3 - Not Covered	Not Covered	 30%* 30%* Tier 3 – Not Covered	Not Covered
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	50%*	60%*	30%*	50%*
Autism Services Benefits payable based on services rendered	Treated the same as any other health condition.		Treated the same as any other health condition.	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	50%*	60%*	30%*	50%*
Prosthetic devices	50%*	60%*	30%*	50%*
Home health—limited to 60 visits per year	50%*	60%*	30%*	50%*
Physical therapy—limited to 30 visits per year	50%*	60%*	30%*	50%*
Occupational therapy—limited to 30 visits per year	50%*	60%*	30%*	50%*
Cardiac rehabilitation therapy—limited to 30 visits per year	50%*	60%*	30%*	50%*
Speech therapy—limited to 30 visits per year	50%*	60%*	30%*	50%*
Skilled nursing facility services—limited to 30 days per year	50%*	60%*	30%*	50%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	50%*	60%*	30%*	50%*

* Subject to annual deductible.

** Copays do not accumulate toward the deductible, but they do accumulate toward the applicable out-of-pocket.

*** LivingWell CDHP, LivingWell Basic CDHP, and LivingWell Limited High Deductible Plan: all covered expenses apply to the out-of-pocket maximum, except routine well child and routine well adult. LivingWell PPO: the out-of-pocket maximum accumulates separately and independently for medical and prescription drug benefits.

2019 Public Employee Health Insurance Program Benefit Provisions (continued)

Covered Services	LivingWell PPO		LivingWell CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit copay, preventive care services, outpatient diagnostic testing, prescription drugs, chiropractic services and hospital emergency room services)	Single - $750 Family - $1,500	Single - $1,500 Family - $3,000	Single - $1,250 Family - $2,500	Single - $2,500 Family - $5,000
Out-of-pocket maximum (excludes prescription drug copays, office visits, hospital emergency room visits and urgent care services)	Single - $2,750 Family - $5,500	Single - $5,500 Family - $11,000	Single - $2,750 Family - $5,500	Single - $5,500 Family - $11,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - $500 Family - $1,000	
In-hospital care—provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	20%*	40%*	15%*	40%*
Doctor's Office Visits	$25 copay - PCP $45 copay - Specialist	40%*	15%*	40%*
Allergy Serums & injections	$15 copay	40%*	15%*	40%*
Physician Care (Inpatient/Outpatient/Other)	20%*	40%*	15%*	40%*
Outpatient diagnostic testing—laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	Office copay	40%*	15%*	40%*
Ambulatory hospital and outpatient surgery services—outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	20%*	40%*	15%*	40%*
Preventive care—annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%	40%*	Plan pays 100%	40%*
Emergency services				
Emergency room treatment (Emergency room copay waived if admitted).	$150 copay plus 20%* (copay waived if admitted)		15%*	
Emergency room physician charges	20%*		15%*	
Urgent care center treatment	$50 copay		15%*	
Ambulance services	20%*		15%*	
Maternity care—prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit copay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no copay required.	$25 copay Delivery charge: 20%*	40%*	15%*	40%*
Prescription drugs—Out-of-Pocket Maximum	Single $2,500 Family $5,000	Not Applicable	Combined with Medical	Combined with Medical
Prescription drugs—Retail (30 day supply) Generic Preferred Brand Nonpreferred Brand	 $10 $35 $55	Not Covered	 15%* 15%* 15%*	 40%* 40%* 40%*
Prescription drugs—Mail Order (90 day supply) Generic Preferred Brand Nonpreferred Brand	 $20 $70 $110	Not Covered	 15%* 15%* 15%*	Not Covered
Chiropractic services—limited to 26 visits per year, with no more than one visit per day	$25 copay	40%*	15%*	40%*
Autism Services Benefits payable based on services rendered	Treated the same as any other health condition.		Treated the same as any other health condition.	
Hospice care—subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	20%*	40%*	15%*	40%*
Prosthetic devices	20%*	40%*	15%*	40%*
Home health—limited to 60 visits per year	20%*	40%*	15%*	40%*
Physical therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Occupational therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Cardiac rehabilitation therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Speech therapy—limited to 30 visits per year	20%*	40%*	15%*	40%*
Skilled nursing facility services—limited to 30 days per year	20%*	40%*	15%*	40%*
Hearing aids—individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	20%*	40%*	15%*	40%*

* Subject to annual deductible.
** Copays do not accumulate toward the deductible, but they do accumulate toward the applicable out-of-pocket.
*** LivingWell CDHP, LivingWell Basic CDHP, and LivingWell Limited High Deductible Plan: all covered expenses apply to the out-of-pocket maximum, except routine well child and routine well adult. LivingWell PPO: the out-of-pocket maximum accumulates separately and independently for medical and prescription drug benefits.

Historical Contribution Rates

	Non-Tobacco User Rates				Tobacco User Rates			
2013	**Standard PPO**	**Maximum Choice**	**Capitol Choice**	**Optimum PPO**	**Standard PPO**	**Maximum Choice**	**Capitol Choice**	**Optimum PPO**
Single	$ -	$ 30.88	$ 37.28	$ 62.76	$ 25.50	$ 56.76	$ 63.10	$ 88.36
Parent	$ 20.00	$ 140.00	$ 179.00	$ 220.00	$ 72.32	$ 193.80	$ 232.48	$ 274.00
Couple	$ 298.00	$ 396.00	$ 518.00	$ 546.00	$ 350.32	$ 450.34	$ 572.12	$ 600.78
Family	$ 310.00	$ 470.00	$ 610.00	$ 650.00	$ 362.32	$ 524.20	$ 664.00	$ 704.76
Cross Reference	$ 5.00	$ 45.24	$ 52.76	$ 69.80	$ 29.72	$ 70.38	$ 78.04	$ 95.04

2014	**Standard CDHP**	**Standard PPO**	**LivingWell PPO**	**LivingWell CDHP**	**Standard CDHP**	**Standard PPO**	**LivingWell PPO**	**LivingWell CDHP**
Single	$ 12.98	$ 47.98	$ 79.98	$ 47.98	$ 52.98	$ 87.98	$ 119.98	$ 87.98
Parent	$ 72.98	$ 122.98	$ 227.98	$ 122.98	$ 152.98	$ 202.98	$ 307.98	$ 202.98
Couple	$ 262.98	$ 287.98	$ 512.98	$ 287.98	$ 342.98	$ 367.98	$ 592.98	$ 367.98
Family	$ 312.98	$ 337.98	$ 642.98	$ 337.98	$ 392.98	$ 417.98	$ 722.98	$ 417.98
Cross Reference	$ 32.98	$ 77.98	$ 152.98	$ 77.98	$ 72.98	$ 117.98	$ 192.98	$ 117.98

2015	**Standard CDHP**	**Standard PPO**	**LivingWell PPO**	**LivingWell CDHP**	**Standard CDHP**	**Standard PPO**	**LivingWell PPO**	**LivingWell CDHP**
Single	$ 12.98	$ 47.98	$ 79.98	$ 47.98	$ 52.98	$ 87.98	$ 119.98	$ 87.98
Parent	$ 59.98	$ 122.98	$ 227.98	$ 122.98	$ 139.98	$ 202.98	$ 307.98	$ 202.98
Couple	$ 249.98	$ 287.98	$ 512.98	$ 287.98	$ 329.98	$ 367.98	$ 592.98	$ 367.98
Family	$ 299.98	$ 337.98	$ 642.98	$ 337.98	$ 379.98	$ 417.98	$ 722.98	$ 417.98
Cross Reference	$ 27.98	$ 77.98	$ 152.98	$ 77.98	$ 67.98	$ 117.98	$ 192.98	$ 117.98

2016	**Standard CDHP**	**Standard PPO**	**LivingWell PPO**	**LivingWell CDHP**	**Standard CDHP**	**Standard PPO**	**LivingWell PPO**	**LivingWell CDHP**
Single	$ 12.98	$ 47.98	$ 79.98	$ 47.98	$ 52.98	$ 87.98	$ 119.98	$ 87.98
Parent	$ 59.98	$ 122.98	$ 227.98	$ 122.98	$ 139.98	$ 202.98	$ 307.98	$ 202.98
Couple	$ 249.98	$ 287.98	$ 512.98	$ 287.98	$ 329.98	$ 367.98	$ 592.98	$ 367.98
Family	$ 299.98	$ 337.98	$ 642.98	$ 337.98	$ 379.98	$ 417.98	$ 722.98	$ 417.98
Cross Reference	$ 27.98	$ 77.98	$ 152.98	$ 77.98	$ 67.98	$ 117.98	$ 192.98	$ 117.98

2017 - Complete LW Promise	**Standard CDHP**	**Standard PPO**	**LivingWell PPO**	**LivingWell CDHP**	**Standard CDHP**	**Standard PPO**	**LivingWell PPO**	**LivingWell CDHP**
Single	$13.10	$48.46	$79.98	$47.98	$53.10	$88.46	$119.98	$87.98
Parent	$60.58	$124.20	$227.98	$122.98	$140.58	$204.20	$307.98	$202.98
Couple	$252.48	$290.86	$512.98	$287.98	$332.48	$370.86	$592.98	$367.98
Family	$302.98	$341.36	$642.98	$337.98	$382.98	$421.36	$722.98	$417.98
Cross Reference	$28.26	$78.76	$152.98	$77.98	$68.26	$118.76	$192.98	$117.98

2017 - Not Completing LW Promise	**Standard CDHP**	**Standard PPO**	**LivingWell PPO**	**LivingWell CDHP**	**Standard CDHP**	**Standard PPO**	**LivingWell PPO**	**LivingWell CDHP**
Single	$13.10	$48.46	$119.98	$87.98	$53.10	$88.46	$159.98	$127.98
Parent	$60.58	$124.20	$267.98	$162.98	$140.58	$204.20	$347.98	$242.98
Couple	$252.48	$290.86	$552.98	$327.98	$332.48	$370.86	$632.98	$407.98
Family	$302.98	$341.36	$682.98	$377.98	$382.98	$421.36	$762.98	$457.98
Cross Reference	$28.26	$78.76	$192.98	$117.98	$68.26	$118.76	$232.98	$157.98

2018 - Complete LW Promise	**Standard CDHP**	**Standard PPO**	**LivingWell PPO**	**LivingWell CDHP**	**Standard CDHP**	**Standard PPO**	**LivingWell PPO**	**LivingWell CDHP**
Single	$26.20	$49.92	$82.38	$49.42	$ 66.20	$ 89.92	$ 122.38	$ 89.42
Parent	$62.40	$127.92	$234.82	$126.66	$ 142.40	$ 207.92	$ 314.82	$ 206.66
Couple	$260.06	$299.58	$528.36	$296.62	$ 340.06	$ 379.58	$ 608.36	$ 376.62
Family	$312.06	$351.60	$662.26	$348.12	$ 392.06	$ 431.60	$ 742.26	$ 428.12
Cross Reference	$29.10	$81.12	$157.56	$80.32	$ 69.10	$ 121.12	$ 197.56	$ 120.32

2018 - Not Completing LW Promise	**Standard CDHP**	**Standard PPO**	**LivingWell PPO**	**LivingWell CDHP**	**Standard CDHP**	**Standard PPO**	**LivingWell PPO**	**LivingWell CDHP**
Single	$26.20	$49.92	$122.38	$89.42	$66.20	$89.92	$162.38	$129.42
Parent	$62.40	$127.92	$274.82	$166.66	$142.40	$207.92	$354.82	$246.66
Couple	$260.06	$299.58	$568.36	$336.62	$340.06	$379.58	$648.36	$416.62
Family	$312.06	$351.60	$702.26	$388.12	$392.06	$431.60	$782.26	$468.12
Cross Reference	$29.10	$81.12	$177.56	$100.32	$69.10	$121.12	$217.56	$140.32

2019 - Complete LW Promise	**LivingWell Limited CDHP**	**LivingWell Basic CDHP**	**LivingWell PPO**	**LivingWell CDHP**	**LivingWell Limited CDHP**	**LivingWell Basic CDHP**	**LivingWell PPO**	**LivingWell CDHP**
Single	$23.58	$26.20	$82.38	$49.42	$63.58	$66.20	$122.38	$89.42
Parent	$56.16	$62.40	$234.82	$126.66	$136.16	$142.40	$314.82	$206.66
Couple	$234.06	$260.06	$528.36	$304.62	$314.06	$340.06	$608.36	$384.62
Family	$280.86	$312.06	$662.26	$358.12	$360.86	$392.06	$742.26	$438.12
Cross Reference	$26.20	$29.10	$157.56	$80.32	$66.20	$69.10	$197.56	$120.32

2019 - Not Completing LW Promise	**LivingWell Limited CDHP**	**LivingWell Basic CDHP**	**LivingWell PPO**	**LivingWell CDHP**	**LivingWell Limited CDHP**	**LivingWell Basic CDHP**	**LivingWell PPO**	**LivingWell CDHP**
Single	$63.58	$66.20	$122.38	$89.42	$103.58	$106.20	$162.38	$129.42
Parent	$96.16	$102.40	$274.82	$166.66	$176.16	$182.40	$354.82	$246.66
Couple	$274.06	$300.06	$568.36	$344.62	$354.06	$380.06	$648.36	$424.62
Family	$320.86	$352.06	$702.26	$398.12	$400.86	$432.06	$782.26	$478.12
Cross Reference	$66.20	$69.10	$197.56	$120.32	$106.20	$109.10	$237.56	$160.32

Legislative Mandates

The following legislative mandates enacted by the Kentucky General Assemblies may affect the PEHI program. This is intended for context and historical purposes only. The PEHI program is subject to the Kentucky Insurance Code (KRS 304.17A and 304.18) only to the extent specifically stated in either the Insurance Code or KRS Chapter 18A.

History of Legislation Enacted by the General Assemblies That Impacts the PEHIP		
Year Enacted	**Bill**	**Key Provisions**
2001	HB 97	The Office of PEHI was established under the Personnel Cabinet.
2001	HB 138	Coverage of physician assistants assisting in surgery.
2001	HB 145	Personnel Cabinet and Cabinet for families and children to prepare recommendations regarding allowing foster parents to participate in the PEHI program.
2002	HB 39	Coverage of anesthesia and hospital or facility charges in connection with dental procedures for children below the age of nine, persons with serious mental or physical conditions, and persons with significant behavioral problems.
2002	HB 163	Expands KGHIB to include: ▪ The Director of the Administrative Office of the Courts ▪ KRS retiree ▪ TRS retiree ▪ Active teacher ▪ Active state employee ▪ Active classified education support employee
2002	HB 369	Mail order prescription drug coverage for PEHI program.
2002	HB 395	Revised caps for inherited metabolic diseases to be $4,000 annually for low-protein modified foods and $25,000 annually for medical formulas.
2002	HB 801	Entities that join the KRS must join the PEHI program for their active employees.
2002	HB 821	▪ Personnel Cabinet to study whether to allow health insurance bidders to bid different rates in different geographic areas of the Commonwealth. ▪ Allows PEHI members to select coverage in a contiguous county and receive the state subsidy for that county if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does.
2002	HB 846	Restricts individuals to one state subsidy for health insurance. Entities participating in the PEHI program must sign a contract with the Personnel Cabinet. Expands the Advisory Committee of State Health Insurance Subscribers to include two members from the Kentucky Association of Counties and two from the Kentucky League of Cities. Directs the LRC to study the cost to members of the state health insurance group as a result of entities covering their retirees under the PEHI program but not their active employees and recommend administrative procedures to collect this cost from these entities. Directs the LRC to study the PEHI program. Allows PEHI members to select coverage in a contiguous county and receive the state subsidy for that county if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does.
2002	SB 152	Coverage for hearing aids and related services for persons under 18 years of age for the full cost of one hearing aid per impaired ear up to $1,400 every 36 months.
2002	SCR 34	Directs the Interim Joint Committee on Banking and Insurance to study the feasibility of self-funding at least one health insurance option for state employees.

History of Legislation Enacted by the General Assemblies That Impacts the PEHIP		
Year Enacted	**Bill**	**Key Provisions**
2003	HB 95	Removes the requirement that an employee's employment must be in the same county as his residence for the employee to be eligible to elect coverage in an adjacent county and receive the state subsidy for that county, if the hospital in the county where the member lives does not offer certain services and a hospital in the adjacent county does.
2003	HB 183	Requires that the sponsor of a bill that contains a mandated health benefit request, have prepared, and attach a financial impact statement before final consideration by a standing committee.
2003	HB 370	Required the Commonwealth's PEHI program to include a scenario that allows regional rating in its 2004 health insurance RFP, with regions defined as the partnership regions designated by the Department for Medicaid Services.
2003	HB 430	For individuals hired on or after July 1, 2003, increased the service required of participants in the KRS from a minimum of 5 years to 10 years to be eligible to participate in the Commonwealth's retiree health insurance program.
2004	HB 1	Legislation that changed the PEHI program from fully funded to self-funded. Requires that group health care coverage contain three health plans named Commonwealth Essential, Commonwealth Enhanced, and Commonwealth Premier. Permits married couples who are both eligible to participate in the state health insurance plan to be covered under one family health benefit plan and to apply each employer contribution for the single premium of the plan they select toward family coverage, not to exceed the total premium. Requires the state contribute $234 per month to the employee's FSA for those who waive health insurance coverage. Allows employees to carry forward to the succeeding plan year, any unused funds remaining in an FSA at the end of the plan year to the extent permissible by the Internal Revenue Code in effect on the date the plan year ends.
2006	HB131	Includes provision to pay optometrists the same amount as physicians or osteopaths when the services provided are rendered by an optometrist.
2006	HB131	Adds language requiring the PEHI program to be in compliance with certain specifically enumerated provisions of the Insurance Code, including appeals and grievance procedures, utilization review, claims payment, and emergency medical care.
2006	HB380	Reduced the employer contribution for 2006 health insurance premiums by 12% for the period July–December, 2006.
2006	HB380	Provided explicit statutory authority to establish a self-insured health plan for public employees.
2006	HB380	Requires the plan to be established by administrative regulations.
2006	HB380	Provides appeal rights for formulary changes, and ensures independent review of any proposed changes in formulary.
2006	HB380	Establishes a PEHI program Trust Fund for the plan, and defines the allowable expenses to be paid by the Trust Fund.
2006	HB380	Requires an HRA to be provided for those employees who waive coverage under the plan, to be funded by the employer at an amount no less than $175 per month.
2006	HB380	Requires an audit of the Trust Fund within 90 days of the end of each fiscal year.
2006	HB380	Establishes quarterly reporting requirements for the plan.

History of Legislation Enacted by the General Assemblies That Impacts the PEHIP		
Year Enacted	**Bill**	**Key Provisions**
2007	SB22	Create a new section of KRS Chapter 18A to require the Personnel Cabinet, Department for Employee Insurance, to offer TRICARE supplement insurance to eligible TRICARE insurance beneficiaries; require the Commonwealth to pay for individual TRICARE supplement insurance; permit an employee eligible for TRICARE to choose between the Commonwealth sponsored TRICARE supplemental insurance or other coverage offered through the PEHI program; permit the secretary of the Personnel Cabinet to promulgate administrative regulations. Note this legislation is pre-empted by federal law which prohibits employers from offering incentives to employees if they elect coverage under a federally sponsored program.
2008	HB 321	Provides the General Assembly with the authority to review Trust Fund expenditures and authorize spending for Trust Fund receipts. Outlines quarterly report content, formulary review changes, deadlines, and other administrative regulations regarding the Trust.
2008	HB 406	Requires agencies to coordinate the timing of employer payments to PEHI program in such a manner as to provide the agencies the flexibility to lapse $7 million in General Fund moneys in each fiscal year.
2009	HB 143	Allows the Governor to direct a one-time transfer of up to $50 million from the PEHI Trust Fund's surplus to the General Fund. Outlines the conditions under which the transfer is authorized.
2010	HB 159	Requires coverage for the diagnosis and treatment of autism spectrum disorders for individuals ages 1 to 21, limited to an annual maximum of $50,000 for individuals ages 1 through 6, and limited to a $1,000 monthly maximum for individuals ages 7 through 21.
2010	HB 1	Report of the KGHIB: Notwithstanding KRS 18A.226(5)(b) and (c), the report of the KGHIB shall be submitted to the Governor, the Legislative Research Commission, and the Chief Justice of the Supreme Court by December 15 of each calendar year.
2011	HB 229	Amend KRS 78.530 to allow agencies that are established by a merger or interlocal agreement consisting of agencies who participated in the County Employees Retirement System (CERS) on or before April 9, 2002, to be exempt from the requirement of signing a contract for employee health insurance with the Personnel Cabinet as a condition of participation in CERS; apply the amendments to KRS 78.530 to existing agencies established before the effective date of the Act.
2012	HB 265	State Group Health Insurance Plan—Plan Year Closure: Notwithstanding KRS 18A.2254, plan years 2006, 2007, 2008, and 2009 shall be considered closed as of December 31, 2011, and all balances from those plan years shall be transferred to Plan Year 2010. All other income and expenses attributable to the closed plan years shall be deposited in or charged to the Plan Year 2010 account after that date. Notwithstanding KRS 18A.2254, no transfer of funds from Plan Year 2010 is authorized.
2014	HB 235	State Group Health Insurance Plan—Plan Year Closure: Notwithstanding KRS 18A.2254, Plan Years 2010 and 2011 shall be considered closed as of December 31, 2013, and all balances from those plan years shall be transferred to Plan Year 2012. All other income and expenses attributable to the closed plan years shall be deposited in or charged to the Plan Year 2012 account after that date. This section shall apply retroactively to December 31, 2013, and any action to the contrary shall be considered null and void. HB 235 also authorized a fund transfer from the Trust Fund to the General Fund in the amount of $93,000,000.
2014	HB 138	Amend KRS 18A.2254 to add health FSAs as an option for public employees in addition to the PEHI program.
2015	HB 510	KRS 48.705 the fund transfer of $63,500,000 to the General Fund in Fiscal Year 2015–2016 shall be appropriated to the Budget Reserve Trust Fund Account.

History of Legislation Enacted by the General Assemblies That Impacts the PEHIP		
Year Enacted	**Bill**	**Key Provisions**
2015	HB 69	Any cost-savings demonstration projects provided for the state employee health plan shall through use of interactive technology, known as telehealth, capture the potential for improved medical outcomes at reduced cost.
2016	SB 117	Amends provisions of KRS 304.17A regarding pharmacy benefit managers (PBMs) and the establishment of maximum allowable cost for the reimbursement of certain drugs.
2016	HB 303	Authorizes fund transfers from the PEHI Trust Fund as follows: ▪ $125,000,000 in Fiscal Year 2017–2018 to be transferred to the Kentucky Permanent Pension Fund. These funds represent a portion of excess prior health insurance plan years and are not needed to fulfill health insurance claims payments for any prior plan year. These funds shall not be expended or appropriated without the express authority within an enacted biennial budget. ▪ $187,500,000 in Fiscal Year 2016–2017 to partially support employer retirement contributions. ▪ $187,500,000 in Fiscal Year 2017–2018 to partially support employer retirement contributions.
2016	SB 193 and SB 18	Both bills amend KRS 304.17A.258 to include additional coverage for therapeutic food, formulas, and supplements for the treatment of inborn errors of metabolism or genetic conditions.
2017	SB 177	Amends KRS 18A.2254 to remove the requirement that the Personnel Cabinet submit the administrative regulation for the state employee self-insurance plan to the Cabinet for Health and Family Services prior to filing with the Legislative Research Commission. Also amends KRS 18A.2254 to add the option of an HSA to the PEHI program, and require the administrative fees associated with the employee's HSA be an authorized expense charged to the PEHI Trust Fund.
2018	HB 200	Closes Plan Years 2010 through 2015 and transfers all funds from the closed Plan Years into Plan Year 2016. Authorizes the Secretary of the Finance and Administration Cabinet and the Secretary of the Personnel Cabinet to use the excess funds from Plan Years 2016, 2017, and 2018 or any combination thereof to satisfy claims or expenses in Plan Years 2019 and 2020. Authorizes fund transfers from the KEHP trust fund to the General Fund to partially support employer retirement contributions in the following amounts: 2018 – 2019 - $135,140,500 2019 – 2010 - $175,364,400

General Kentucky Insurance Code Legislative Mandates

Below is a list of health insurance coverage and other mandates for basic health benefit plans and/or large group health plans. The PEHI program is subject to the Kentucky Insurance Code (KRS 304.17A and 304.18) only to the extent specifically stated in either the Insurance Code or KRS Chapter 18A. Otherwise, the coverage mandate is not applicable to the PEHI program, although the program may voluntarily cover the service. The listing below is intended for context and historical purposes only.

Kentucky Mandated Health Insurance Benefits	
Ambulatory Surgical Centers	Coverage for treatment rendered by an ambulatory surgical center. KRS 304.18-035.
Hospice	Coverage of hospice care at least equal to the Medicare benefits. KRS 304.17A-096 and 304.17A-250(6).
Home Health	Coverage for home health care. KRS 304.17A-096 and 304.18-037.
Emergency	Coverage for emergency medical conditions and emergency department services. KRS 304.17A-096 and 304.17A-580.
Maternity Coverage	Coverage to include specified amounts of inpatient care for mothers and newly-born children. KRS 304.17A-145.
Breast Cancer	Coverage for the treatment of breast cancer by high-dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation. KRS 304.17A-135 and KRS 304.18-0985.
Autism Spectrum Disorders	Coverage for the treatment of autism. KRS 304.17A-141, KRS 304.17A-142, KRS 18A.225(15).
Hearing aids	Coverage for hearing aids and hearing aid-related services. KRS 304.17A-132 and KRS 18A.225(14).
Colorectal Cancer Screening	Coverage for colorectal cancer examinations and laboratory tests specified in current American Cancer Society guidelines. KRS 304.17A-257.
Mammogram	Coverage for mammography screening. KRS 304.17A-096(3), KRS 304.17A-133 referencing KRS 304.17-316, KRS 304.18-098.
Pap Smear	Coverage for an annual pap smear performed by an obstetrician or gynecologist without a referral from a primary care provider. KRS 304.17-647.
Diabetes	Coverage for equipment, supplies, outpatient self-management training and education, including medical nutrition therapy and medications. KRS 304.17A-096 and KRS 304.17A-148.
Temporomandibular Joint (TMJ) Disorder and Craniomandibular Jaw (CMJ) Disorder	Coverage for specific services related to TMJ and associated disorders. KRS 304.18-0365 and 806 KAR 17:090.
Mastectomy, Endometrioses, Endometritis, and Bone Density Testing	Coverge for medical and surgical benefits with respect to mastectomy, diagnosis and treatment of endometrioses and endometritis, and bone density testing. KRS 304.17A-134 and KRS 304.18-0983.
Inherited Metabolic Disease	Coverage for therapeutic food, formulas, supplements, low-protein modified food products, and amino acid-based elemental formula for the dietary treatment of inborn errors of metabolism or genetic conditions. KRS 304.17A-258 and KRS 18A.225(16).
Anesthesia in Connection With Dental Procedures	Coverage for general anesthesia and hospitalization services for services performed in a hospital or ambulatory surgical facility in connection with dental procedures under specified circumstances. KRS 304.17A-149 and 806 KAR 17:095.
Second Opinion	Coverage for consultation with a participating health care provider for a second opinion. KRS 304.17A-520(4).
Cochlear Implants	Coverage for cochlear implants. KRS 304.17A-131.

Kentucky Mandated Health Insurance Benefits	
Newborn Coverage	Coverage for newborn children from the moment of birth, including necessary care and treatment of medically diagnosed inherited metabolic diseases for newborns. KRS 304.17A-139(2) and KRS 304.18-032.
Optometrists, Osteopaths, Physicians, Podiatrists, and Chiropractors	Coverage for services performed by certain providers under specified circumstances. KRS 304.17A-275 and KRS 304.18-095.
Chiropractors	Requires access to primary chiropractic provider of choice without referral from any other provider or entity. KRS 304.17A-170 and KRS 304.17A-171.
Dentists	Coverage of services provided by dentists under specified circumstances. KRS 304.18-097.
Psychologists and Clinical Social Workers	Coverage of services provided by licensed clinical social workers and licensed psychologist under specified circumstances. KRS 304.18-0363
Registered Nurse First Assistant	Coverage of services provided by registered nurse first assistant who performs the services within the scope of their license. KRS 304.17A-146.
Conversion Benefits	Establishes minimum benefits for conversion policies. KRS 304.18-120(1) and 806 KAR 17:260.
Work Related Illness/Injuries	No contract can exclude coverage solely on the basis that the health condition is work related. KRS 304.12-250.
Disabled Children	Individual health insurance contracts must continue coverage for disabled children beyond the limiting age. Although this statute is applicable only to individual contracts, group carriers commonly use it. KRS 304.17-310.
Adopted Children	Coverage for children includes coverage for legally adopted children or children under a court-appointed guardianship. KRS 304.17A-140.
Human Immunodeficiency Virus	Coverage for human immunodeficiency virus infection. KRS 304.12-013(5).
Mental Health Parity	Treatment of mental health conditions to be covered under the same terms and conditions as treatment of physical health conditions. KRS 304.17A-661.
Surgical First Assistant	Coverage for surgical first assisting or intraoperative surgical care includes services performed by certified surgical assistant. KRS 304.17A-147.
Wellness Programs	Authorizes health benefit plans to offer incentives or rewards to members who participate in a voluntary wellness or health improvement program. KRS 304.17A-098.

Source: *Kentucky Department of Insurance*

Glossary

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

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

Biometric Screening: A biometric screening provides a clinical assessment of key health measures. These results may be used to identify certain health conditions, such as diabetes and heart disease, or to indicate an increased risk for these conditions.

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

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

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

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

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

Consumer-Driven Health Plan (CDHP): Health insurance plans that allow members to use HSAs, HRAs, or similar medical payment products to pay routine health care expenses directly, but a high-deductible health plan (HDHP) protects them from catastrophic medical expenses. High-deductible policies cost less, but the member pays medical claims using a prefunded spending account.

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

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

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

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

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

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

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

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

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

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

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

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

Health Risk Assessment: A health questionnaire, used to provide individuals with an evaluation of their health risks and quality of life.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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