

Open Enrollment 2012

State Employee Health Plan

Medicare Plans and other information

Comparison Chart 2

If you do not wish to make any changes to your coverage, you do not need to complete and submit an enrollment form.

For Retiree/Direct Bill Members

Monthly Premiums (Medicare Plans with or without Part D, Superior Vision Services and Delta Dental): Member Only

Medical Plan (with or without Part D)	Monthly Premium for Medical Plan (with or without Part D)	Superior Vision Services: Basic Plan	Superior Vision Services: Enhanced Plan	Delta Dental
Coventry Advantra Freedom PPO with Coventry Part D	\$139.00	\$6.54	\$10.89	\$21.49
Coventry Advantra Freedom PPO with SilverScript	\$238.00	\$6.54	\$10.89	\$21.49
Humana PPO with Humana Part D	\$184.00	\$6.54	\$10.89	\$21.49
Humana PPO with SilverScript	\$233.00	\$6.54	\$10.89	\$21.49
Kansas Senior Plan C with SilverScript	\$351.97	\$6.54	\$10.89	\$21.49
Kansas Senior Plan C without SilverScript	\$188.97	\$6.54	\$10.89	\$21.49

IMPORTANT REMINDERS:

The premiums provided for vision and dental coverage above are separate from the premiums provided for the medical plans. Therefore, when calculating your total monthly premium, please be sure to add all three premium amounts, as applicable.

Kansas Senior Plan C - Medicare Payment Information

Medicare A – Hospitalization	Medicare B – Medical	Kansas Senior Plan C Supplement
<p>Inpatient hospital</p> <ul style="list-style-type: none"> • First 60 Days: \$1,132.00 deductible* • Days 61 through 90: \$283 per day Coinsurance* • Lifetime reserve: \$566 per day Coinsurance* <p>Skilled Nursing Facility</p> <ul style="list-style-type: none"> • First 20 days: 100% payment—no co-pay • Days 21-100: \$141.50 per day Coinsurance* <p>Services Paid at 100%</p> <ul style="list-style-type: none"> • Home health • Hospice • Benefit period ends when the patient is out of the hospital or skilled nursing facility for 60 consecutive days <p>There is usually no premium associated with Medicare Part A.</p> <p>Coverage shown is per benefit period. A benefit period ends when the patient is out of the hospital or skilled nursing facility for 60 consecutive days.</p>	<p>Annual Deductible \$162 deductible per calendar year* (January 1 through December 31)</p> <p>Medicare Coverage for Physician’s Charges Medicare pays 80% of allowed charge; Beneficiary pays 20% Coinsurance* (in- or out-of-hospital)</p> <p>Durable Medical Expenses and Supplies</p> <ul style="list-style-type: none"> • Ambulance • Outpatient hospital charges • Blood (first 3 pints) • Lab services <p>Preventive Services</p> <ul style="list-style-type: none"> • Bone mass measurement • Cardiovascular screenings • Colorectal screenings • Diabetes screenings • Flu shots • Glaucoma tests • Hepatitis B shots • Pap tests 	<p>Kansas Senior Plan C pays for all costs shown in green to the left under Medicare Part A and Part B. In addition, Kansas Senior Plan C pays the following:</p> <ul style="list-style-type: none"> • An additional 365 hospital days per lifetime • Foreign emergency travel medical services: \$250 deductible, then the plan pays 80% to a maximum of \$50,000 lifetime • If Medicare A and B do not cover the service, there is no benefit under the medical portion of Kansas Senior Plan C

- Pneumococcal shot
 - Prostate cancer screening
 - Screening mammograms
 - Well Woman Exam
 - Well Man Exam
- Beneficiary must pay a monthly Medicare Part B Premium**

* The deductible and coinsurance amounts listed on this chart reflect 2011 rates. Be sure to review your *Medicare and You* handbook for the new 2012 amounts.

Health Plan Comparison Chart				
	Coventry Advantra Freedom		Humana Group Medicare	
	Preferred Provider Organization (PPO) - with Coventry Part D or SilverScript prescription drug		Preferred Provider Organization (PPO) - with Humana Part D or SilverScript prescription drug	
	Network Providers	Non Network Providers	Network Providers	Non Network Providers
Basic Provisions				
Provider Choice	Freedom to use provider of choice, benefits based on plan description: coverage level based on provider network status		Coverage level based on provider network status	
Coinsurance (for all eligible expenses, unless otherwise noted)	\$0	20% Coinsurance	\$0	30% Coinsurance
Deductible	\$0	\$0	\$100	\$300
Annual Out-of-Pocket Maximum	\$1,000	20% with no max	\$3,000	\$5,000
Lifetime Benefit Maximum	No limit	No limit	No limit	No limit
Amounts Above Plan Allowance	Provider to write off	Balance billed to member	Provider to write off	Balance billed to member
Preventive Care			* Humana Only - If your annual exam is coded with a diagnosis, you will pay a \$10 primary care office visit co-pay	
Preventive Care Services	\$0	20%	\$0 in all places of treatment	30% in all places of treatment
Age Appropriate Routine Physical Exam	\$0	20%	\$0 in all places of treatment	30% in all places of treatment
Well-Woman Care: office visit, PAP smear test & STD testing	\$0	20%	\$0 in all places of treatment	30% in all places of treatment

Well-Man Care: office visit & PSA blood test	\$0	20%	\$0 in all places of treatment	30% in all places of treatment	3
Mammogram	\$0	20%	\$0 in all places of treatment	30% in all places of treatment	
Licensed Dietitian Consultation: for medical management of a documented disease	\$0	20%	\$0 in all places of treatment	30% in all places of treatment	
Age Appropriate Bone Density Screening	Covered in full	20%	\$0 in all places of treatment	30% in all places of treatment	
Routine Age Appropriate Colonoscopy	Covered in full	20%	\$0 in all places of treatment	30% in all places of treatment	
Covered Services					
Routine Hearing Exam	\$0 Copay for each routine hearing test up to 1 per year, \$500 every 3 years for hearing aids	20%	Deductible and \$35 copayment per visit - Medicare-covered services only, routine services not covered	30% after annual deductible - Medicare-covered services only, routine services not covered	
Routine Vision Exam: refraction exam for glasses; lenses & frames not covered	\$0 Copay for PCP; \$0 Copay for specialist (limited to 1 routine visit per year)	20%	Deductible and \$35 copayment per visit - Medicare-covered services only, routine services not covered	30% after annual deductible - Medicare-covered services only, routine services not covered	
Inpatient Services	\$150 Copay per day up to 5 days	20%	Deductible and \$165 copayment per day (days 1-5) per admission	30% after annual deductible	
Physician Hospital Visits	Included in the inpatient services Copay	Included in the inpatient services Copay	\$0 in all places of treatment	30% after annual deductible in all places of treatment	
Physician Office Visits					
Primary Care Provider	\$10	20%	Deductible and \$10 Copay	30% after annual deductible	
Specialist	\$25	20%	Deductible and \$35 Copay	30% after annual deductible	
Urgent care center	\$30 Copay, worldwide coverage	\$30 Copay, worldwide coverage	Deductible and \$35 Copay	30% after annual deductible	
Outpatient Surgery	\$150 Copay	20%	Deductible and \$125 Copay	30% after annual deductible	
Emergency Room Visits	\$50 Copay (waived if admitted)	\$50 Copay (waived if admitted)	\$65 Copay (waived if admitted within 24 hrs.)	\$65 Copay (waived if admitted within 24 hrs.)	
Ambulance Services	\$100 per one-way trip	\$100 per one-way trip	\$100 per date of service	\$100 per date of service	

Major Diagnostic Tests*	\$75 Copay	\$75 Copay	Deductible and \$50 for freestanding clinic, \$75 outpatient hospital	30% after annual deductible 4
Home Health Care <i>services must be pre-approved by health plan</i>	Services must be pre-approved by health plan	Services must be pre-approved by health plan	\$0 after annual deductible	30% after annual deductible
Hospice <i>services must be pre-approved by health plan; limited to six months</i>	Services must be pre-approved by health plan	Services must be pre-approved by health plan	Services must be pre-approved by health plan	Services must be pre-approved by health plan
X-Ray and Laboratory Services	\$0 Copay for clinical/diagnostic lab service	20%	Covered at 100% after deductible	30% after annual deductible
Physical Rehabilitation Services: <i>(services limited to those medically necessary and appropriate; medical records must show continued improvement)</i>	\$30 Copay per visit	20%	\$0 after annual deductible and \$35 Copay per visit to specialist & comprehensive outpatient rehabilitation facility; \$0 after annual deductible and \$75 copayment per visit to outpatient hospital	30% after annual deductible
Inpatient facility	\$150 Copay per day up to 5 days	20%	\$0 after room & board benefit is applied	30% after annual deductible for total admission
Outpatient facility	\$0 Copay for PCP; \$0 Copay for specialist	20%	\$0 after \$175 Copay	30% after annual deductible
Office based <i>(including chiropractic care)</i>	\$15 Copay for PCP; \$30 Copay for specialist	20%	\$0 after annual deductible and \$20 Copay	30% after annual deductible
Durable Medical Equipment	20% Coinsurance	20% Coinsurance	20%	30% after annual deductible
Allergy Testing	\$15 Copay for PCP; \$30 Copay for specialist	20%	Network PCP: After annual deductible, \$10 Copay per visit Network Specialist: After annual deductible, \$35 Copay per visit	30% after annual deductible in all places of treatment
Antigen Administration: <i>desensitization/treatment; allergy shots</i>	\$15 Copay for PCP; \$30 Copay for specialist	20%	\$0 after annual deductible	30% after annual deductible
Covered Immunizations	Covered in full	20%	\$0 Copay	30%
Prescription Drugs				
Prescription Drug Services	Prescription Drug Plan Details		Prescription Drug Plan Details	
	Preferred Generic drug	\$5 Copay	Preferred Generic drug	\$0 mail-order, \$5 retail (30-day supply)

Preferred brand name drug	\$30 Copay	Preferred brand name drug	\$30 retail
Non-preferred Generic and Brand name drug	\$60 Copay	Non-preferred Brand name drug	\$60 retail
Injectables	33% Coinsurance for speciality drugs	Injectables	33%
Limit	The initial coverage limit is \$2,930 and is based on the applicable Copay plus the plan cost. After this amount is reached, there is generic-only coverage until your out-of-pocket costs reach \$4,700.	Limit	Once the Total drug cost (member + Humana) totals \$2,930, the members will pay 50% for all drugs until they reach TrOOP of \$4,700.
Catastrophic coverage	\$2.60 Copay for generic or preferred brand name drugs and \$6.50 Copay or 5% Coinsurance, whichever is highest, for all other drugs. Catastrophic coverage becomes effective when your out-of-pocket costs reach \$4,700.	Catastrophic coverage	\$2.60 for generic or preferred brand drugs and \$6.50 for all other drugs, or 5% Coinsurance, whichever is highest. Catastrophic coverage becomes effective when your out-of-pocket costs reach \$4,700.

Mental Health

Mental Illness and Drug or Alcohol Treatment	Same coverage as medical	Same coverage as medical
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* **Major Diagnostic Tests:** includes but not limited to; PET scans, CT scans, nuclear cardiology studies, magnetic resonance angiography and computerized topography angiography. Most major diagnostic tests require pre-approval by the Health Plan.

The comparison chart is NOT the governing document. Members need to refer to each Provider’s Benefit Description posted on www.kdheks.gov/hcf/sehp/BenefitDescriptions.htm under the Health Plan Carriers (Providers) button.

SilverScript Part D Plan Benefits	
Prescription	Members Pay
Generic drugs	25% Coinsurance up to a \$30 maximum
Preferred brand name drugs	35% Coinsurance up to a \$100 maximum
Non preferred brand name drugs	60% Coinsurance up to a \$150 maximum
Special case medications	35% Coinsurance up to a \$200 maximum
If out-of-pocket expenses exceed \$4,700	Generics: \$2.60 or 5% Coinsurance Brands: \$6.50 or 5% Coinsurance
Maximum supply	60-day supply

Benefits are the same for retail or mail order purchases.

Delta Dental Benefits			
	Delta Dental PPO Network Provider	Delta Dental Premier Network Provider	Non Network* Provider
Annual Benefit Maximum	\$1,700 per member		
Lifetime Orthodontic Benefit Maximum	50% Coinsurance to a \$1,000 per member		
DEDUCTIBLE			
Diagnostic and Preventive Services	No Deductible		
Basic Restorative Services	\$50 per person per Plan year		
Major Restorative Services	Not to exceed an annual family deductible of \$150		
COINSURANCE			
BASIC BENEFIT			
Applies when you have <u>NOT</u> had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months			
Diagnostic and Preventive Services	Allowed Amount covered in full by the Plan*		
Basic Restorative Services	50%	50%	50%
Major Restorative Services	50%	50%	50%
ENHANCED BENEFIT			
Applies when you have had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months			
Diagnostic and Preventive Services	Allowed Amount covered in full by the Plan*		
Basic Restorative Services	20%	40%	40%
Major Restorative Services	50%	50%	50%

*Services by Non Network providers are subject to the Allowed Amount including the Maximum Plan Allowance for Non Network Providers. Any amounts in excess of the Allowed Amount will be the member's responsibility.

Your coinsurance will increase for Basic Restorative Services when you have not had a routine prophylaxis (cleaning) and/or preventive oral exam in the preceding twelve (12) month period. Ninety (90) days following receipt of a qualifying prophylaxis (cleaning) or preventive oral exam, you will qualify for the Enhanced Benefit Level. The Plan reserves the right to determine what services will qualify as meeting the definition of a routine prophylaxis (cleaning) and preventive oral exam. Routine prophylaxis (cleanings) and preventive exams shall not include any services provided on an emergency basis or for treatment of an injury to the teeth.

Vision Benefits			
Service or Item	Basic Plan: Network	Enhanced Plan: Network	Both Plans: Non Network
Eye Exams: Subject to \$50 Copayment			
• Eye exam, M.D.	Covered in full after Copayment	Covered in full after Copayment	Up to \$38
• Eye exam, O.D.	Covered in full after Copayment	Covered in full after Copayment	Up to \$38
Eyeglasses: Subject to \$25 materials Copayment			
• Frame	Up to \$100 retail*	Up to \$100 retail*	Up to \$45
• Single vision lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to \$31
• Bifocal lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to \$51
• Trifocal lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to \$64
• Lenticular lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to \$80
• Progressive lenses, pair	Not covered	Covered up to \$165*	Not covered
• High index lenses, pair**	Not covered	Covered up to \$116*	Not covered
• Polycarbonate lenses, pair**	Not covered	Covered up to \$116*	Not covered
• Scratch coat	Not covered	Covered in full	Not covered
• UV coat	Not covered	Covered in full	Not covered
Contact Lenses: Not subject to materials Copayment			
• When medically necessary	Covered in full	Covered in full	Up to \$210 retail*
• Elective/cosmetic retail	Up to \$150 retail*	Up to \$150 retail*	Up to \$105 retail*
Contact Lens Exam (fitting fee) (\$35 Copayment)			
• Specialty contacts***	Not Covered	Up to \$50*	Not Covered
• Standard Contacts****	Not Covered	Covered in full	Not Covered

*You are responsible for any charges above the allowance.

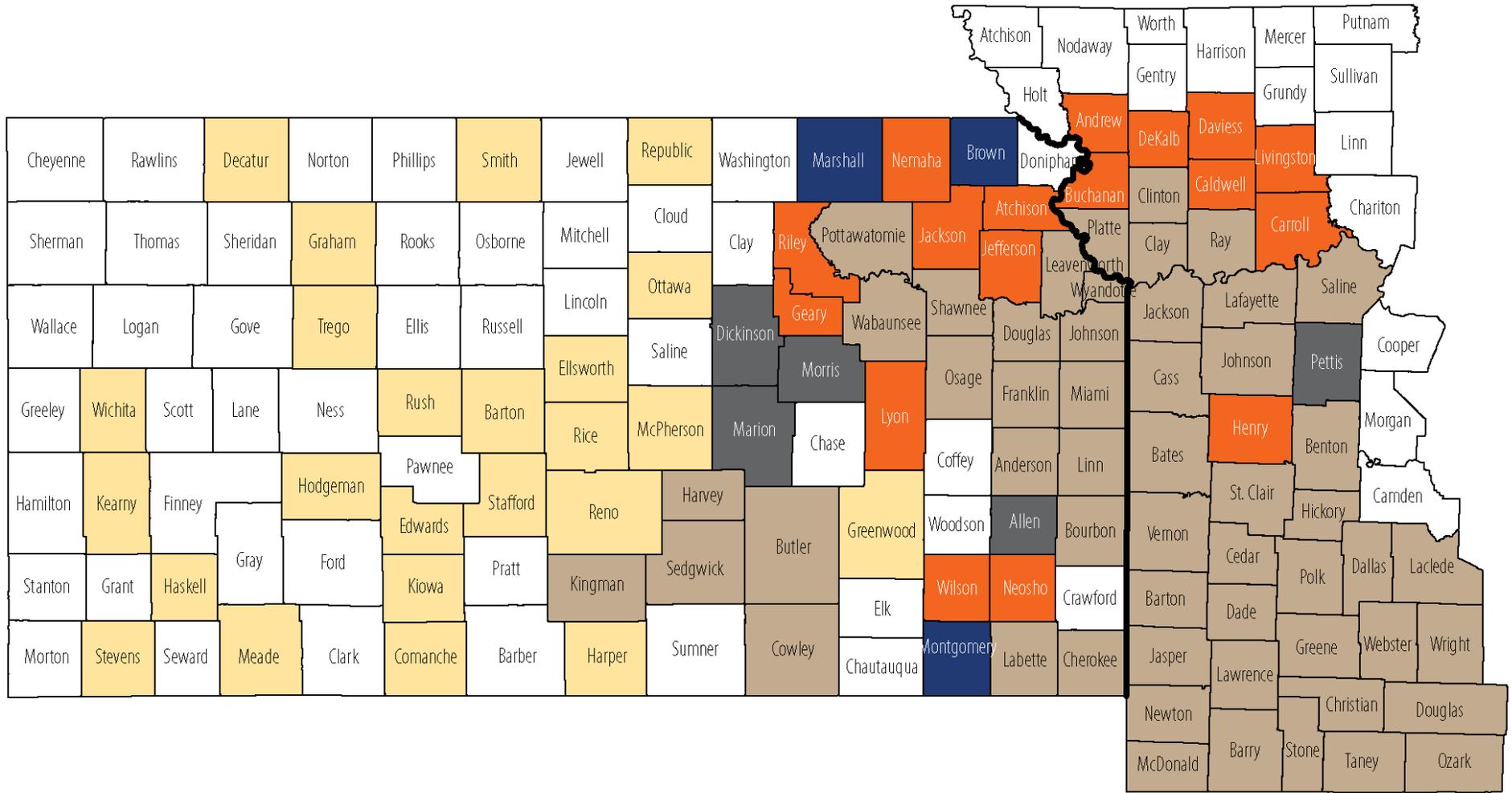
** You may only be covered for one pair of high index lenses or polycarbonate lenses under the Enhanced Plan (up to the allowance provided above).

*** Specialty contacts are for new contact lens wearers or patients who wear toric, gas permeable or multi-focal lenses; includes two follow-up visits within three months of initial fitting.

**** Standard contacts are for existing contact lens wearers of disposable, daily wear or extended lenses; includes two follow-up visits within three months of initial fitting.

Notes:

- Members can use either the contact lens benefit or the eyeglass benefit, but not both in the same plan year.
- For non network claims, copayment amounts are deducted from the benefit allowance at the time of reimbursement.
- Covered lenses are standard glass or plastic (CR-39), clear.



- Coventry Advantra PPO Service Area
- Humana Local PPO Service Area
- Humana Local PPO Contracting
- Both Coventry Advantra PPO & Humana Local PPO Service Areas
- Both Coventry Advantra PPO & Humana Local PPO Limited Hospitals & Providers for Humana available

*The entire states of Kansas and Missouri are covered under the Humana Regional PPO