

# Open Enrollment 2012

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

## State Employee Health Plan For Retirees/ Direct Bill Members

- ✓ Review the information in this book
- ✓ Check out the "Highlights and Reminders for Plan Year 2012" on page 10
- ✓ Attend an open enrollment meeting in my area – check the schedule on pages 4 and 5 for dates and times
- ✓ If I am Medicare eligible, check out the Medicare Eligibility and plans on pages 17-22. If I am on either Plan A or Plan B, check out page 14
- ✓ **I DO NOT NEED TO DECLARE MY TOBACCO STATUS FOR PLAN YEAR 2012**
- ✓ **IF I DO NOT WISH TO MAKE ANY CHANGES TO MY COVERAGE FOR PLAN YEAR 2012, I DO NOT NEED TO DO ANYTHING. MY CURRENT COVERAGE WILL CONTINUE FOR PLAN YEAR 2012**
- ✓ **IF I WANT TO MAKE CHANGES TO MY COVERAGE FOR PLAN YEAR 2012**, I must either complete and submit the enclosed enrollment form **or** enroll on-line using the instructions included in my open enrollment packet.  
Paper forms may be faxed to 785-368-7180 or mailed to the address on the bottom of the form.  
All enrollments, either paper or on-line, must be received by Membership Services  
**NO LATER THAN NOVEMBER 30, 2011.**
- ✓ **Mail my completed form to:**  
Direct Bill Membership Services  
Rm 900-N, Landon State Office Bldg.  
900 SW Jackson Street  
Topeka, KS 66612  
DB Call Center Toll Free 1-866-541-7100

*Plan Year 2012 Open Enrollment is  
November 1 - November 30, 2011.*

***Open enrollment elections are effective  
January 1, 2012.***

# Contact Information

## State of Kansas Health Plan Vendors Website

[www.kdheks.gov/sehp/vendors.htm](http://www.kdheks.gov/sehp/vendors.htm)

## Blue Cross and Blue Shield of Kansas

Members/

Customer Service

Plan A, Plan B

Kansas Senior Plan C

[www.bcbsks.com/Customerservice/State](http://www.bcbsks.com/Customerservice/State)

All Areas (Toll Free): 800-332-0307

In Topeka: 785-291-4185

All Areas (Toll Free): 800-332-0307

In Topeka: 785-291-4185

All Areas (Toll Free): 800-952-5906

In Topeka: 785-233-1165

New Directions

## CVS Caremark Prescription Drug Plan

Customer Service

Plan A, Plan B

Caremark Connect Specialty Pharmacy

[www2.caremark.com/kse/](http://www2.caremark.com/kse/)

All Areas (Toll Free): 800-294-6324

TDD (Toll Free): 800-863-5488

All Areas (Toll Free): 800-237-2767

## Coventry/PHS

Customer Service

Plan A, Plan B

Coventry Advantra Freedom PPO

[www.chckansas.com](http://www.chckansas.com)

All Areas (Toll Free): 855-326-2088

All Areas (Toll Free): 800-727-9712

TDD (Toll Free): 866-347-2459

All Areas (Toll Free): 866-607-5970

Behavioral Health

## Delta Dental of Kansas, Inc. Dental Plan

Customer Service

[www.deltadentalks.com](http://www.deltadentalks.com)

All Areas (Toll Free): 800-234-3375

Wichita: 316-264-4511

## Direct Bill Membership

State Employee Health Benefits Plan - For Enrollment, Qualifying Event, Report a Death, Address Changes

All Areas (Toll Free): 866-541-7100

In Topeka: 785-296-1715

## Hewlett Packard Member Services

Billing

All Areas (Toll Free): 866-688-5009

## HealthQuest

Customer Service

All Areas: 785-296-5624

## Humana Group Medicare PPO

Customer Service

All Areas (Toll Free): 866-396-8810

TTY: 800-833-3301

## KPERS

Kansas Public Employee Retirement Systems

All Areas (Toll Free): 888-275-5737

In Topeka: 785-296-6166

## Preferred Lab Benefit Program

### • Quest Diagnostics Lab Card Program

Customer Service

Collection Site Listings

[www.labcard.com](http://www.labcard.com)

All Areas (Toll Free): 800-646-7788

[www.labcard.com/collection.html](http://www.labcard.com/collection.html)

### • Stormont-Vail Regional Lab Program

Customer Service

Benefit Information and Collection Site Listings

[www.stormontvail.org/stateemployeeslab](http://www.stormontvail.org/stateemployeeslab)

All Areas (Toll Free): 800-637-4716

Topeka: 785-354-1150

## SilverScript for Medicare Part D

Customer Care (year round) & Billing

All Areas (Toll Free): 800-837-4092

TDD (Toll Free): 866-236-1069

Pre-Enrollment

All Areas (Toll Free): 866-808-7084

TDD (Toll Free): 866-552-6288

## Superior Vision Services Vision Plan

Customer Service – Billing

[www.superiorvision.com](http://www.superiorvision.com)

All Areas (Toll Free): 800-507-3800

## UnitedHealthcare

Customer Service

Plan A, Plan B

[www.welcometouhc.com/kansas](http://www.welcometouhc.com/kansas)

All Areas (Toll Free): 866-799-1324

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Take advantage of the information available online 24/7 on our Open Enrollment website.

Go to **[www.kdheks.gov/hcf/sehp.htm](http://www.kdheks.gov/hcf/sehp.htm)**

On this site, you can:

- View your 2012 open enrollment plan options and other benefits communications
- And more!

## **Direct Bill Call Center**

Outside Topeka: 1-866-541-7100 | In Topeka: 1-785-296-1715

*The information in this booklet is intended to summarize the benefits offered in language that is clear and easy to understand. Every effort has been made to ensure that this information is accurate. It is not intended to replace the legal plan document (Benefit Description), which contains the complete provisions of a program. In case of any discrepancy between this booklet and the legal plan document, the legal plan document will govern in all cases. You may review the legal plan document upon request or go to **[www.kdheks.gov/hcf/sehp/vendors.htm](http://www.kdheks.gov/hcf/sehp/vendors.htm)** and select **Health Plan Carriers**. Benefit Descriptions are listed under each carrier.*

# 2012 Direct Bill/Retiree Open Enrollment Meeting Schedule

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## **Emporia**

Wednesday, October 19  
9:30 a.m. and 1:30 p.m.

**Flint Hills Technical College**  
3301 W. 18th Avenue

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## **Great Bend**

Thursday, October 20  
9:00 a.m.

**Barton County Community College**  
245 NE 30th Rd.

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## **Hays**

Wednesday, October 19  
9:30 a.m. and 1:30 p.m.

**Ellis County Fairgrounds**  
1343 Fairground Rd.  
Unrein Family Building

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## **South Hutchinson**

Thursday, October 27  
2:00 p.m.

**SRS Area Office**  
Training Room  
600 Andrew Avenue

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## **Lawrence**

Thursday, October 27  
9:30 a.m. and 1:30 p.m.

**4-H County Fairgrounds**  
Building 21  
2101 Harper Building

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## **Manhattan**

Monday, October 24  
9:30 a.m. and 1:30 p.m.

**Cico Park - Pottorf Hall**  
Konza Room  
Avery Drive - Fairgrounds

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## **Osawatomie**

Thursday, October 20  
9:30 a.m. and 1:30 p.m.

**Osawatomie State Hospital**  
Sun ower Room  
Highway 169-South  
500 State Hospital Drive

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## **Overland Park**

Friday, October 28  
9:30 a.m. and 1:30 p.m.

**KU Edwards Campus**  
**Regents Center**  
Rm110  
126th & Quivera

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## **Pittsburg**

Tuesday, October 25  
9:30 a.m. and 1:30 p.m.

**Homer Cole Community Center**  
Conference Room  
3003 N. Joplin

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**Pratt**

Thursday, October 27  
9:00 a.m.

**Community Center**  
Large Room  
619 N. Main

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**Salina**

Tuesday, October 18  
9:30 a.m. and 1:30 p.m.

**College Center**  
Conference Room  
2310 Centennial Road

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**Topeka**

Monday, October 17  
9:30 a.m.

**Topeka and Shawnee  
County Public Library**  
Marvin Auditorium  
Rooms A, B & C  
1515 W 10th Street

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**Topeka**

Friday, October 21  
9:30 a.m.

**Topeka and Shawnee  
County Public Library**  
Marvin Auditorium  
Rooms A, B & C  
1515 W 10th Street

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**Topeka**

Tuesday, October 25  
9:30 a.m. and 1:30 p.m.

**Topeka and Shawnee  
County Public Library**  
Marvin Auditorium  
Rooms A, B & C  
1515 W 10th Street

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**Topeka**

Wednesday, October 26  
9:30 a.m. and 1:30 p.m.

**Topeka and Shawnee  
County Public Library**  
Marvin Auditorium  
Rooms A, B & C  
1515 W 10th Street

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**Wichita**

Wednesday, October 26  
9:30 a.m. and 1:30 p.m.

**Holiday Inn Select**  
South Ballroom  
549 S. Rock Road

# Direct Bill Member Eligibility

An individual is eligible for participation in the State Employee Health Plan as a Direct Bill member if he or she is:

- A.** A retired official or member who is eligible for a retirement benefit through the State of Kansas.
- B.** A totally disabled former State official or member who is receiving a disability benefit through the State of Kansas.
- C.** A former elected State official who was covered under the State plan immediately before the date the person ceased to be an elected official.
- D.** A blind person licensed to operate a vending facility, or any licensed blind person who has ceased to operate a vending facility.
- E.** A surviving spouse or dependent of a former State member or retiree. The spouse or dependents must have been covered under the State plan immediately before the date of death of the member or retiree.
- F.** An active State member who was covered under the State plan immediately before going on approved leave without pay. Participation due to leave without pay status is limited to one year.

# Qualifying Events

Open Enrollment is your annual opportunity to make changes to your health care coverage. Changes cannot be made to your health or dental elections until next year's Open Enrollment unless you experience a qualifying event. The effective date of change for qualifying events will be the first day of the month following the event. Qualifying events include:

- A.** The member's marriage, annulment, divorce or legal separation
- B.** Birth or adoption of a dependent
- C.** Gain or loss of legal custody of a dependent
- D.** Change from part-time to full-time or from full-time to part-time employment by spouse which affects cost, benefit level or benefit coverage for the member and/or dependents
- E.** Termination or commencement of employment (including retirement) of spouse or dependent which affects benefits coverage for the member and/or spouse or dependents
- F.** Unpaid leave of absence by spouse or dependent which affects the benefits coverage for the member and/or spouse or dependent

- G. Significant changes during a spouse's Open Enrollment for group health insurance, such as premium increases, benefits levels or enrollment in coverage
- H. A member, spouse or dependent being called to active military duty
- I. Expiration of COBRA continuation benefits from a previous employer for the member, spouse or dependent
- J. The member's change in residence which requires a change in insurance plan
- K. Death of a spouse or dependent
- L. Spouse or dependent moving out of an enrollment area, if applicable
- M. A dependent turning age 26
- N. Spouse or dependent gaining or losing government-sponsored medical card coverage
- O. The member, spouse or dependent becoming Medicare eligible, the effective date of the change will be the date listed on the Medicare card
- P. Dependent children identified under a Medical Withholding Order (K.S.A. 43-2105) or Medical Child Support Order
- Q. Court order requiring adding or dropping coverage for a dependent
- R. All spouse changes as listed above but including events involving coverage of dependent children by an ex-spouse

## Dropping Coverage

Direct Bill members may drop medical, dental and prescription coverage for themselves and/or any covered dependents at any time by notifying the Direct Bill Membership Office at the number listed below. **If a member terminates his or her coverage, all coverage for dependents will also be terminated.** The effective date of termination will be the first day of the month following notification. **Note: Once a member opts out of dental coverage, the member will not be able to re-enroll in dental coverage at a later date.**

Vision coverage may not be dropped during the plan year unless due to a dependent becoming an ineligible dependent or unless medical coverage is dropped.

Coverage may be dropped by notifying the Direct Bill Membership Office at **1-866-541-7100** (outside of Topeka) or **296-1715** (in Topeka) and completing necessary forms.

Once coverage has been terminated, the member cannot re-enroll at a later date.

# Dependent Definitions

## **Proof of Dependency and/or Residency**

When enrolling a dependent for coverage with the State of Kansas Health Plan, the member must certify that a dependent meets the requirements for dependent coverage for the year in which the dependent is being enrolled. The member must also provide appropriate supporting documentation for each dependent. Any attempt to enroll dependent(s) who do not meet the requirements will be considered fraud and will be subject to penalties as prescribed by law.

## **Deceased Members and Spouses**

In the event of a Direct Bill member's death, a family member or beneficiary should call the Direct Bill Membership Office as soon as possible to report the date of death. Prompt notification to the State of Kansas prevents additional premiums from being charged to the member's estate; however, the premium for the deceased member is still owed for the entire month in which the death occurs. If the premium is paid, health care claims for the deceased member will be paid up to and including the date of death.

If the Direct Bill member is covering a spouse and/or child(ren) as of the date of death, the surviving spouse and/or child(ren) will be offered continuous Direct Bill group health insurance coverage in his or her own name effective the first day of the month following the date of death. The premium for the remaining family members is generally lower; therefore, prompt notification to the Direct Bill Membership Office may reduce the premium cost.

If a spouse is deceased, the Direct Bill member should call the Direct Bill Membership Office as soon as possible to report the date of death. Premium for a single member is lower than for a member and spouse; therefore, prompt notification to the Direct Bill Membership Office will reduce the premium cost for the member. The premium for the deceased spouse is still owed for the entire month in which death occurs. If the premium is paid, health care claims for the deceased spouse will be paid up to and including the date of death.

### Mid-Year Change Requirements

Non-newly eligible members and/or dependents may be added to group health insurance coverage during the plan year but only if all of the following mid-year change requirements are met:

- A.** The change is a result of a qualifying event.
- B.** The change in coverage is consistent with the event.
- C.** Written documentation of the event (such as a divorce decree, death certificate or custody agreement) or a statement from spouse's employer is provided to the Direct Bill Membership Office.
- D.** The change is requested within 31 calendar days of the event (by calling the Direct Bill Membership Office number listed in the "Contact Information" section).
- E.** A change form will be sent to the member for their signature. This form must be signed, dated and returned to our office for the changes to take effect.

# Highlights for Plan Year 2012

## What's New in 2012

- **If you do not wish to make any changes to your coverage for Plan Year 2012, you do NOT need to do anything. Your current coverage will continue for Plan Year 2012.**
- Direct Bill members do NOT have to declare their tobacco status for Plan Year 2012, as all members will be paying the discounted rate.
- Online enrollment is available for Direct Bill members for Plan Year 2012. Instructions are included in your packet.
- All MEDICAL plans, Delta Dental and SilverScript will issue NEW ID cards for Plan Year 2012.
- Coventry has completed its purchase of Preferred Health Systems (PHS) and will now have a combined offering as Coventry/PHS.
- United HealthCare will be offered instead of UMR a United HealthCare Company. This will provide members access to a broader network of health care providers.
- Stormont Vail Healthcare is being added as a new regional preferred lab service provider. To access the benefit you will use labs located at Stormont Vail Health Center and Cotton-O'Neil draw sites.
- Quest will continue to offer the statewide preferred lab benefit as well, giving all employees the option to access the preferred lab benefit.
- The pilot Autism coverage program will continue for another year with the same benefits. Coverage details are in the benefit description.

In July of 2011, SilverScript Insurance Company began billing the Direct Bill members who pay their premiums by paper invoice or automatic bank draft (ACH) directly for the cost of their SilverScript Medicare Part D prescription drug coverage.

HP Enterprise Services (HP) will continue to bill these members for their SEHP medical, dental and vision coverage.

SilverScript members who pay their premiums through KPERS are NOT affected by the above change. **HP will continue to process all premiums for Direct Bill members who have their premiums deducted from their KPERS warrants.**

For questions concerning SilverScript coverage, members should contact SilverScript Customer Care at 1-800-837-4092. Customer Care representatives are available 24 hours a day, 7 days a week.

## What's Changing

### Health Plans:

- Open Enrollment for "Private Market" Medicare Part D prescription drug coverage is from October 15th through December 7th, 2011.

**Preferred Lab Benefits for Direct Bill Members on either Plan A or Plan B:**

- To receive this benefit, just show your plan Year 2012 SEHP Medical Plan ID card. Both the Quest and Stormont Vail logos will be printed on your ID card.

**Reminders**

- Members can opt out of Delta Dental Coverage. **Important Note: Once a member opts out of dental coverage, the member will not be able to re-enroll in dental coverage at a later date.**
- If you decide to opt out of the Part D prescription drug coverage offered through the State Employee Health Plan, you must have “creditable drug coverage” from the “Private Market” to be eligible to return to the SEHP Part D coverage during Open Enrollment without having to pay a penalty.

## Open Enrollment

The 2012 State of Kansas Open Enrollment period for Direct Bill members is **November 1, 2011 through November 30, 2011. If you are not making any changes to your coverage, you do not need to do anything. Your current coverage will continue for Plan Year 2012.**

If you have questions contact the **Direct Bill Call Center between October 24, 2011 thru January 6, 2012 at 1-866-541-7100 (In Topeka 296-1715)**. Representatives are available to assist you Monday through Friday from 8:30 a.m. to 4:30 p.m. Central time. The office will be closed on Veterans Day (November 11, 2011), the Thanksgiving Holiday (November 24-25, 2011), Christmas Holiday (December 26, 2011) and New Year’s Holiday (January 2, 2012).

Open Enrollment changes made to your health plans will become effective January 1, 2012. You will receive a statement confirming your changes in late December. Please make sure the coverage listed on this statement is the coverage you elected for Plan Year 2012.

New ID cards will be issued from ALL medical plans, Delta Dental and SilverScript for Plan Year 2012.

## How to Enroll

- **Review all of your enrollment materials including this Open Enrollment booklet to become familiar with your options.** You can also go online to [www.kdheks.gov/hcf/sehp/directbill.htm](http://www.kdheks.gov/hcf/sehp/directbill.htm)
- **Read *Medicare and You*, a handbook from the Social Security Administration, if you or a covered dependent is eligible for Medicare.**
- **Attend an Open Enrollment Meeting.** If you are enrolling during the annual open enrollment period, we encourage you to attend an Open Enrollment Meeting to hear explanations of your benefit options and to ask questions. See pages 4-5 for dates and times of meetings near you.
- **Learn about your health plan options.** Make sure your health care providers, medical facilities and pharmacy are included in your health plan's network of preferred providers.
- **If you want to make changes to your coverage for Plan year 2012,** either complete and submit the enclosed enrollment form or enroll on-line using the instructions included in your open enrollment packet. Paper forms may be faxed to 785-368-7180 or mailed to the address on the bottom of the form. All enrollments, either paper or on-line, must be received by Membership Services NO LATER THAN NOVEMBER 30, 2011.

## Changing Your Coverage

If you either made changes during Open Enrollment or are continuing with your current coverage, this coverage will continue until the next plan year Open Enrollment period, except as provided in this section.

You may cancel or drop coverage for you or your dependent(s) at any time. If you drop coverage, you may not re-enroll.

You may make other changes to your coverage if you experience a "qualifying event" that allows you to make a change. Qualifying events include life-altering events such as becoming Medicare eligible, the birth or adoption of a child, marriage, divorce, death of a spouse or a dependent, or gain or loss of employment and benefits for a spouse or a dependent.

**Documentation of the qualifying event (for example, a copy of the following: Medicare card, marriage certificate, death certificate, obituary) will be required, before the change is made.**

**Important:** Health plan changes due to a qualifying event must be consistent with the event. You must notify the Direct Bill Membership Office within 31 days of the qualifying event in order for the change to be effective the first day of the month following the event. If you do not submit your change form within this 31-day period, you will not be able to make the change until the next Open Enrollment period. If there is a qualifying event that would result in a refund and you do not notify the Direct Bill Membership Office of the change, refunds may not be made retroactively. The only exception would be death.

# Choosing Your Health Plan:

## Plan A, Plan B, Kansas Senior Plan C, Coventry Advantra Freedom Plan or Humana Group Medicare Plan

### General Information

You have choices when it comes to your health coverage. Choosing the appropriate health plan for you and your family may be easier than you think!

The State offers the following plans to Direct Bill members:

- Plan A — Blue Cross and Blue Shield of Kansas, Coventry/PHS, or UnitedHealthcare
- Plan B — Blue Cross and Blue Shield of Kansas, Coventry/PHS, or UnitedHealthcare
- Coventry Advantra Freedom PPO (with Coventry Part D)
- Coventry Advantra Freedom PPO (with SilverScript Part D)
- Humana PPO (with Humana Part D)
- Humana PPO (with SilverScript Part D)
- Kansas Senior Plan C (with or without SilverScript Part D)

**Reminder:** Kansas Senior Plan C is the **ONLY** plan Direct Bill members can enroll in without Prescription Drug coverage and select a Part D prescription drug plan from the Private Market.

If you elect the Kansas Senior Plan C and do not take Prescription Drug coverage under the State plan, and do not enroll in a Part D prescription drug coverage from the Private Market, you will be allowed to re-enroll in the State's Part D Prescription Drug Coverage but you will pay a penalty.

When making your health plan choices, Direct Bill members should always consider present health conditions and the financial status of all individuals to be covered under the chosen plan.

Direct Bill members and their dependents generally fall into two categories: Medicare eligible and non-Medicare eligible.

- **All Direct Bill members and their dependents**, regardless of Medicare eligibility, may choose between traditional health plans such as Plan A and Plan B. Both of these plans have the same prescription drug coverage offered by CVS/Caremark.
- **Individuals who are Medicare eligible** may be able to save money on premiums and/or out-of-pocket costs if they choose one of the State of Kansas' Direct Bill plans, such as Kansas Senior Plan C, the Coventry Advantra Freedom plan or the Humana Group Medicare plan.

# Choosing Your Health Plan: Plan A or Plan B

## **You have access to all health plans regardless of where you live.**

You have choices when it comes to your health care coverage. Choosing the appropriate health plan for you and your family may be easier than you think!

The State Employee Health Plan offers two medical plan options:

- Plan A
- Plan B

Each option is designed differently (for example, deductibles, coinsurance and annual maximums). Please review Comparison Chart 1 Plans A & B to see the differences for Plans A and B.

There are three health plan vendors:

- Blue Cross and Blue Shield of Kansas
- Coventry/PHS
- UnitedHealthcare

Each health plan vendor has a different network of preferred providers. Network providers have agreed to accept the plan allowance as payment in full. Non network providers have not agreed to accept the plan allowance so any amount above the plan allowance will be your responsibility. In addition, each health plan vendor offers unique features to consider before making your selection.

## **All options offer the following:**

- Access to a broad network of providers nationwide which allows you flexibility in obtaining care with coverage for both network and non network providers.
- 100 percent coverage for certain preventive care services, such as annual exams, colonoscopy screenings, mammograms and age-appropriate immunizations (including flu shots and allergy shots).
- No dollar limit on the care you may need during the lifetime of the policy.
- Prescription drug coverage through Caremark. See page 24 for details.
- Preferred Lab Benefit program. See page 23 for details.

# Direct Bill Members and Dependents Eligible for Medicare

The retiree and any Medicare Eligible Dependents must be enrolled in Medicare Part A and Medicare Part B.

Many Direct Bill members are eligible for benefits under Medicare. Medicare enrollment may be achieved when an individual reaches age 65 or becomes disabled and is deemed eligible for Medicare by the Social Security Administration. Additional information about enrolling in Medicare may be obtained by calling **1-800-MEDICARE**, visiting your local Social Security Office or accessing the Medicare website (**[www.medicare.gov](http://www.medicare.gov)**). In any event, you should contact Social Security three months before you turn age 65.

## Medicare Components

Medicare is comprised of four components. A short explanation of each component is provided below:

- **Part A—Hospital Insurance.** Medicare Part A helps pay for medically necessary care in hospitals, nursing homes following a hospital stay (not custodial or long term care), home health care, hospice care and blood transfusions.
- **Part B—Medical Insurance.** Medicare Part B helps pay for physician's services, outpatient hospital services, emergency room care, diagnostic tests, durable medical equipment, ambulance services, 80 percent of the Medicare-approved amount for blood, starting with the fourth pint, and many other health services and supplies not covered by Medicare Part A. Medicare Part B enrollees pay a monthly premium to Social Security.
- **Part C—Medicare Advantage Plans.** Medicare Part C (Medicare Advantage Plans) are arrangements between Medicare and private insurance companies for providing your Medicare Part A and Part B benefits as well as additional benefits to Medicare beneficiaries through an insurance company. In Medicare Advantage Plans, you pay the basic Medicare Part B premium **and** pay an additional premium to the Medicare Advantage Plan.
- **Part D—Prescription Drug Coverage.** Medicare Part D is designed to assist in the payment of prescription drug costs. The program, which became effective on January 1, 2006, is administered through private insurance companies. Medicare recipients may enroll in Medicare Part D programs when they become Medicare eligible or during the annual enrollment period from October 15 - December 7. Additional information about Medicare Part D may be obtained from the *Medicare and You* handbook issued annually, by calling Medicare at 1-800-633-4227 or by going online to **[www.medicare.gov](http://www.medicare.gov)**

## Medicare Supplement Plans

As noted earlier, Medicare Part A and Part B do not pay 100 percent of health care costs. Both have deductibles and coinsurances which must be paid by the beneficiaries in addition to the monthly premium. Medicare supplement programs are designed to supplement Medicare coverage by paying these additional charges. Enrollees in Medicare supplement plans pay an additional monthly premium to the insurance provider offering the plan.

## State of Kansas Health Care Plans for Medicare Eligible Members, Spouses and/or Dependents

The State of Kansas offers several health care plans designed to work with Medicare. The differences between the plans include how the services are delivered and how much you have to pay out of your own pocket. You pay a monthly premium for each of these plans.

In addition to deciding which health care plan is best for your situation, you should also decide which prescription drug coverage you wish to enroll in. Each of the Advantage plans offer two prescription drug options. The Medicare Supplement Plan offers coverage with or without Prescription Drug Coverage.

The plans are:

- **Medicare Supplement Plans.** The State of Kansas offers Kansas Senior Plan C as a Medicare supplement. Under this plan, when you visit a facility or physician that accepts Medicare assignment, Medicare is billed first for the services. Any remaining balance is covered in full by Kansas Senior Plan C. The plan is available without optional prescription drug coverage or with SilverScript Part D, an optional Medicare Part D component. Additional information about Kansas Senior Plan C may be found on page 18.
- **Medicare Advantage Plans.** Two Medicare Advantage plans are offered through the State of Kansas for Direct Bill members — Coventry Advantra Freedom Preferred Provider Organization (PPO) and Humana Group Medicare PPO. With each of these options, you will have copays for certain services.

Like all PPO plans, the Coventry Advantra Freedom PPO and the Humana Group Medicare PPO use physicians, specialists and hospitals that are included in the particular plan's network of preferred providers. You can go to medical professionals not in the network, but it may cost extra. You do not need referrals to see medical professionals who are not part of the network.

The Coventry Advantra Freedom and Humana Group Medicare plans have a Part D plan included in the premium. (See pages 19-21 for more information about the Coventry Advantra Freedom and Humana Group Medicare plans).

Regardless of the medical plan chosen, the dental and vision plans offered by the State of Kansas to Direct Bill members are identical. Prescription drug plans offered to Direct Bill members and/or dependents who are Medicare eligible are discussed within the specific plan explanation.

# Medicare Eligibility

Medicare is a federal health plan designed for the elderly and disabled. It assists enrollees in the payment of health costs subject to certain copays and/or coinsurances. A person may be eligible for Medicare by virtue of reaching age 65 or by being approved for total disability by the Social Security Administration.

Medicare consists of several components including Part A Hospitalization and Part B Medical. Medicare is described in detail in the *Medicare and You* handbook available by calling **1-800-MEDICARE** or from a local Social Security Office. You can also access Medicare information at **[www.medicare.gov](http://www.medicare.gov)**

Direct Bill members eligible for Medicare, either as a result of age or approved disability, are subject to certain rules and conditions that differ from other Direct Bill members. This section of the book focuses on these rules and conditions as well as pointing out information that is important to Medicare eligible Direct Bill members.

## Medicare Member Definition

“Medicare member” is a member in the State Employee Health Plan who is also eligible for Medicare benefits. For these members, Medicare is the primary payer of medical benefits. The member’s or covered spouse’s status will be changed during the year when he or she is first eligible for Medicare. This is not just an Open Enrollment change.

## Coverage Information

Medicare eligible members who are enrolled in State Plan A or Plan B will receive the same benefits as active members, provided their doctor accepts Medicare assignments.

Other plans, designed specifically to work with Medicare such as Kansas Senior Plan C, Coventry Advantra Freedom and Humana, offer low-cost, high value health insurance coverage. Although dental coverage is not offered through Medicare, the State of Kansas Health Plans offer dental coverage for its members.

## Coverage Conditions

**1. Over Age 65 or otherwise Medicare Eligible.** If a member or covered spouse is age 65 or older, he or she will be considered an eligible Medicare member even if they do not elect coverage under Medicare. Claims will be processed as if the member or spouse is enrolled in both Parts A and B of Medicare, even if Medicare Part A is not free or if he or she does not sign up for Medicare Part B. For this reason, it is very important that the member or spouse applies for Medicare, both Parts A and B, when first eligible and no longer actively employed with the State of Kansas. To receive full benefits, an individual who does not have sufficient quarters to qualify or who does not qualify through his or her spouse for free Part A coverage, must purchase Part A coverage. It is the member’s responsibility to work with his or her local Social Security office to enroll for the proper levels of Medicare coverage. The member and/or covered spouse must send a copy of the Medicare card to the Direct Bill Membership Office at Room 900-N, LSOB, 900 SW Jackson Street, Topeka, Kansas 66612.

**2. Under Age 65 and Disabled.** If a member or covered spouse under age 65 has been approved for total disability by the Social Security Administration, he or she will be considered a Medicare member following 24 months from the date of total disability. When under age 65 and covered by Medicare, the member or covered spouse must send a copy of the Medicare card to the Direct Bill Membership Office.

## Kansas Senior Plan C

Kansas Senior Plan C is a State of Kansas Medigap policy administered by Blue Cross and Blue Shield designed to lower costs for Medicare eligible Direct Bill members, spouses and/or dependents.

With Kansas Senior Plan C, members can choose the plan that includes SilverScript Part D prescription drug coverage or they can choose Kansas Senior Plan C without drug coverage and purchase prescription drug coverage under Medicare Part D on the Private Market.

- Kansas Senior Plan C is one of the 10 standardized Medicare supplement insurance plans. It has the same medical benefits as any other Medicare Supplement Plan C. Medicare Supplement Insurance exists to help fill the gaps that Medicare approves but does not pay. Unlike individual medigap policies such as Plan 65, Kansas Senior Plan C is group rated rather than individually age rated. Kansas Senior Plan C offers optional prescription drug, dental and vision benefits while most individual policies offer only medical benefits. The retiree and any Medicare Eligible Dependents must be enrolled in Medicare Part A and Medicare Part B. There is no network for physicians or hospitals.

Kansas Senior Plan C is the only plan offered to Direct Bill members that allows the member to elect Part D coverage from the Private Market.

- The medical portion of the plan pays what Medicare approves but does not pay. This includes both the Part A and Part B deductibles each year, as well as any coinsurance required by Medicare coverage rules. **Important Note: If Medicare does not cover a service, there is no benefit under the medical portion of Kansas Senior Plan C.**
- Simply utilize providers who accept Medicare assignment. These providers agree to accept the Medicare allowance as payment in full. This means that between the Medicare payment and the Kansas Senior Plan C payment, the member has no out-of-pocket costs.
- Travel with confidence because Kansas Senior Plan C coverage is accepted by doctors and hospitals everywhere in the United States so you'll have access to care if you need it. Foreign travel emergencies are also covered with some limitations.
- Members may elect Kansas Senior Plan C coverage with or without Delta Dental coverage. **However, once a member opts out of dental coverage, the member will not be able to re-enroll in dental coverage at a later date.**

# Coventry Advantra Freedom PPO

Coventry Advantra Freedom PPO is available for Direct Bill members enrolled in Medicare Part A and Part B. It is a Medicare Advantage Plan under Part C of Medicare. You have peace of mind knowing that Advantra meets all of Medicare's stringent regulations and offers you more benefits with no up front deductibles. Coventry Advantra Freedom PPO is offered with the Coventry Part D or SilverScript Part D.

The funding that Advantra receives allows it to offer products that have more benefits than Medicare for premiums that may be significantly lower than other policies. Direct Bill members enrolled in the Advantra PPO Plan continue to pay the Part B premium and a monthly premium for the Advantra Plan. **You do not need to buy additional supplemental Medicare insurance.**

Coventry Advantra Freedom PPO is sponsored by Coventry Health Care of Kansas, Inc. If members consider the Coventry Advantra Freedom PPO Plan, they need to make sure they live in a county where the plan operates and whether their preferred doctor and hospital are members of the plan.

Although this plan gives members the freedom to seek care without referral from any physician who treats people enrolled in Medicare, members receive the highest level of benefit if they seek care from doctors who are part of the PPO network. To view the Advantra Freedom PPO provider directory, go to [www.kc.chcadvantra.com](http://www.kc.chcadvantra.com) or contact Coventry customer service at **1-800-727-9712**.

Coventry is available in 33 Kansas counties and 41 Missouri counties. (See the Medicare Plan Comparison Chart 2 included in this booklet for a list of counties where Advantra Freedom PPO is available.)

The PPO option includes Medicare Part D prescription drug coverage which features unlimited preferred generic drugs. The member can select either Coventry Part D or the State of Kansas SilverScript Part D.

Coverage under Advantra Freedom PPO also includes:

- Unlimited hospital days
- \$10 copayment for Primary Care Physician and \$25 Specialist office visits
- No copayments, coinsurance or deductible for preventive care services such as colonoscopy screenings, mammograms and immunizations
- Hearing and vision exams
- Access to a telephonic nurse advice line, available 24 hours a day, seven days a week
- Mail order prescription drug service available

If you use medical services, the Advantra Freedom PPO limits the out-of-pocket cost a member will pay for health care services to \$1,000 per year for network services, excluding prescription drugs (see Summary of Benefits for details). Once this level is reached, Advantra will cover applicable medical services at 100 percent. The out-of-pocket maximum resets to zero each year on January 1.

The out-of-pocket maximum does not apply to services provided outside the PPO network.

Members may elect the Coventry Advantra Freedom PPO with or without Delta Dental coverage. **However, once a member opts out of dental coverage, the member will not be able to re-enroll in dental coverage at a later date.**

### **Additional Coventry Advantra Freedom Services**

Advantra Freedom offers additional services at no cost to members. These Choose Healthy services are not connected with the medical benefits plans and are completely optional and voluntary. Choose Healthy services include:

- Discounted rates on health club memberships with participating clubs.
- In addition to the many discounts available through the Choose Healthy program, Coventry Advantra also offers members our Silver & Fit program - providing unlimited access to participating fitness centers anywhere in the country.
- Savings on thousands of health products including nutritional supplements and vitamins, health education products and skin care items. Standard shipping is free for Advantra members.

## **Humana Group Medicare PPO**

Humana Group Medicare PPO is available for Direct Bill members enrolled in Medicare Part A and Part B. To be eligible you must have both Medicare Part A and Part B, and you must continue to pay your Part B premiums. If you are enrolled in this plan, Medicare services are covered and are not paid for under Original Medicare.

The Humana Group Medicare PPO Plan gives you more benefits than Original Medicare, including coverage for doctor's visits, annual routine physical exams and hospital stays—without the Medicare deductibles. Because prescription drug coverage is included, you get a full range of benefits in one plan. You may choose from either Humana Part D or the State of Kansas SilverScript prescription drug coverage with this option.

You don't need a referral to see any health care provider, but you'll reduce your out-of-pocket costs by using providers in Humana's network. You can see a Humana network provider in any of the Humana Group Medicare PPO service areas and receive an in-network benefit. So, for example, if you live in Kansas and vacation in Florida, in-network providers are available in both locations.

Coverage under the Humana Group Medicare PPO Plan includes:

- Freedom to see health care providers of your choice (although with the Humana Group Medicare PPO Plan, you will pay more for services received out of network)
- All the benefits of Original Medicare without the Medicare deductibles
- No referral needed to see provider
- Low copayments for doctor's visits
- Prescription drug coverage
- Prescription home-delivery service
- A lower premium than you'd pay for most Medicare supplement plans
- Coverage for annual routine physical exam

To see whether your doctor is in the Humana Group Medicare PPO network, or if you have any questions about the Humana Group Medicare PPO Plan, call **1-866-396-8810**. If you have a speech or hearing impairment and use a TTY, call **1-800-833-3301**, Monday through Friday, 8:30 a.m. to 5 p.m. Eastern time.

Members may elect the Humana Group Medicare PPO with or without Delta Dental coverage. **However, once a member opts out of dental coverage, the member will not be able to re-enroll in dental coverage at a later date.**

## SilverScript Medicare Part D Drug Plan

SilverScript Insurance Company began billing our Direct Bill members who pay their premiums by paper invoice or automatic bank draft (ACH) for the cost of their SilverScript coverage beginning July 2011. HP Enterprise Services (HP) continues to bill these members for their SEHP medical, dental and vision coverage. For questions concerning SilverScript prescription drug Part D coverage, members should contact SilverScript Customer Care at 1-800-837-4092. Customer Care representatives are available 24 hours a day, 7 days a week.

Note: SilverScript members who pay their premiums through KPERS are not affected by the above change. HP will continue to process all premiums for Direct Bill members who have their premiums deducted from their KPERS warrants.

SilverScript Part D is an optional Medicare Part D prescription drug component offered under the Medicare Supplemental Plan or one of the Medicare Advantage Plans. **It is not available as a stand-alone product.**

### How Medicare Part D Works

Medicare Part D began in 2006 and is designed to assist Medicare beneficiaries in paying the cost of medically-necessary prescription drugs. To get Medicare coverage for your prescription drugs, you must choose and join a Medicare prescription drug plan.

Regardless of how a Medicare prescription drug plan offers this coverage, there are some key factors that may vary. Some of these factors might be more important to you than others, depending on your situation and drug needs. Some of these factors are:

- **Premium Cost.** All plans require payment of a monthly premium.
- **Deductible.** This is the amount you pay for your prescriptions before your plan starts to share in the costs. Deductibles vary by plans. **SilverScript Part D, unlike many other plans, does not have a deductible.**
- **Copayment/Coinsurance.** This is the amount you pay for your prescriptions. In some plans, you pay the same copayment (a set amount) or coinsurance (a percentage of the cost) for any prescription. In other plans, there might be different levels or “tiers” with different costs. (For example, you might have to pay less for generic drugs than brand name drugs. Or, some brand name drugs might have a lower copayment than other brand name drugs.) Also, in some plans your share of the cost can increase when your prescription drug costs reach a certain limit.
- **Formulary.** A formulary is a list of drugs covered by a specific Medicare prescription drug plan. Formularies include generic and brand-name drugs. The formulary varies from provider to provider, but all plans must include at least two drugs in categories and classes of most commonly prescribed drugs to people with Medicare. This

ensures that people with different medical conditions can get the treatment they need. SilverScript Part D uses a formulary. Your drugs must be on the formulary in order to be covered. In the event you take a drug that is not on the formulary, it is possible that an exception may be granted. Contact SilverScript Part D at **1-800-837-4092** for more information on the exception process or formulary. You also can find formulary information online at **www.sehbp.org**.

- **Prior Authorization.** Some drugs are more expensive than others even though some less expensive drugs work just as well. Other drugs may have more side effects, or have restrictions on how long they can be taken. To be sure certain drugs are used correctly and only when truly necessary, plans may require a “prior authorization.” This means before the plan will cover these prescriptions, your doctor must first contact the plan and show there is a medically-necessary reason why you must use that particular drug for it to be covered. Plans might have other rules like this to ensure that your drug use is effective.
- **Coverage Gap.** If you have high drug costs, you may want to consider the state’s SilverScript Part D prescription drug plan. This plan does not have a deductible or coverage gap unlike plans offered out on the Private Market.

### **SilverScript Part D Overview**

**SilverScript Part D will generally cover the drugs listed in their formulary as long as:**

- The drug is medically necessary,
- The prescription is filled at a plan network pharmacy, and
- Other coverage rules are followed.

**SilverScript Part D does not pay for drugs that are covered by Medicare Part B, such as:**

- Drugs usually supplied by and administered in your doctor’s office (such as chemotherapy drugs)
- Drugs used with durable medical equipment (DME) that you obtained through DME services, such as respiratory drugs given through a nebulizer
- Some immunosuppressive drugs (if you had a Medicare covered transplant) and some oral anti-cancer drugs
- Drugs provided in Hospital Outpatient Departments and drugs such as erythropoietin (EPO) if you are undergoing dialysis

### **Reminders**

In order to participate in Medicare Part D, you must enroll in one of the Part D programs. Once you have enrolled in a program, should you later enroll in another Medicare Part D program, you are automatically dis-enrolled in the earlier program. This is important to know because if you are enrolled in a Medicare Part D program coupled with other health insurance, enrollment in a subsequent Part D program may result in loss of your health insurance benefits.

Retirees currently enrolled in the State of Kansas SilverScript Plan will automatically be enrolled in SilverScript Part D for the 2012 Plan Year. If you do not want to participate in SilverScript Part D you must contact the **Direct Bill Call Center at 1-866-541-7100 (In Topeka 296-1715)**. Representatives are available to assist you beginning October 24, 2011, Monday through Friday from 8:30 a.m. to 4:30 p.m. Central time. The office will be

closed on Veterans Day (November 11, 2011), the Thanksgiving Holiday (November 24-25, 2011), Christmas Holiday (December 26, 2011) and New Year's Holiday (January 2, 2012).

If, in the past, you have been eligible for a Medicare Part D program and were not enrolled in a State of Kansas prescription drug plan, you must provide a letter of creditable prescription drug coverage in order to enroll in SilverScript Part D. To enroll in the program, obtain a letter of creditable coverage and submit it along with your enrollment form included with your current coverage letter or call the Direct Bill Call Center.

## Preferred Lab Benefit *Available with State Plans A & B Only*

For Plan Year 2012, members have more location options to get 100% coverage of routine and diagnostic outpatient lab tests. All you need is your Plan Year 2012 State Employee Health Plan ID card identifying your membership in either Plan A or B. Quest and Stormont Vail logos will be printed on this ID card.

**Quest Diagnostics** continues to offer collection sites at various locations throughout the State of Kansas and nationwide. Also, you can arrange to have specimens picked up from your doctor's office. All it takes is a telephone call to the number on the back of your ID card.

**Stormont Vail HealthCare** now offers 8 locations in northeast Kansas, for ALL State Employee Health Plan members. You do NOT have to be a Cotton O'Neil patient to access this benefit. Just bring the lab orders from your physician. For details, go to [www.kdheks.gov/hcf/sehp/PreferredLab.htm](http://www.kdheks.gov/hcf/sehp/PreferredLab.htm)

### *PLEASE REMEMBER:*

**You must verbally request to use your Preferred Lab Benefit.**

#### **The Preferred Lab Benefit Program does NOT cover:**

- Testing ordered during hospitalization
- Lab work needed on an emergency or STAT basis
- Testing done at any other laboratory
- Non-laboratory work such as mammography, x-rays, imaging and dental work
- Time sensitive, esoteric testing such as fertility testing, bone marrow studies and spinal fluid tests
- Testing not approved and/or covered by the State of Kansas Plans A or B
- Lab work billed to your health plan by your doctor or another laboratory

**The Preferred Lab Benefit is completely voluntary.** If you and your health care provider choose to use a lab other than those provided by either Quest Diagnostics or Stormont Vail HealthCare, you still have laboratory coverage. However you will be responsible for any deductible, copayments or coinsurance applied by the health plan.

# CVS/Caremark Prescription Drug Plan

Prescription drug coverage is provided through Caremark for Plans A, B and C, and its cost is included in the health plan rates. While the Preferred Drug List (PDL) is the same for all plans, the amount you pay will vary depending on the plan you select as explained below.

- **Plan A and Plan B.** Under these plans, generally you pay a coinsurance for your prescription drug costs throughout the year, up to a combined coinsurance maximum of \$2,580 per person per year.

Before talking to your physician about prescriptions, it is suggested that you print out the Preferred Drug List (PDL) from the website and take it with you so you can talk to your doctor about your options. If the physician says you must take a brand name drug, ask if there is a preferred brand name drug listed on Caremark's PDL that you can take. This PDL is updated quarterly so please check for updates throughout the year. Regardless of which plan you elect, your out-of-pocket costs will be lower if you use generic and/or preferred brand name drugs. The PDL is available at either [www.kdheks.gov/hcf/sehp/Caremark.htm](http://www.kdheks.gov/hcf/sehp/Caremark.htm) or [www2.caremark.com/kse](http://www2.caremark.com/kse). You can also call Caremark at **800-294-6324**. A number of popular name brand drugs are projected to be available in generic versions during 2012. This list is also on the website.

The Caremark plan is designed to encourage you and your health care provider to choose the most cost-effective and clinically-effective medications available. Plans A and B allow up to a 60-day supply for home delivery through Caremark and reorders are processed in as little as five to seven days. To place an initial order or reorder by phone, call 1-800-294-6324 or e-mail [online@caremark.com](mailto:online@caremark.com)

Specialty and biotech drugs are designed for difficult conditions that don't respond to traditional therapy, and are available only at Caremark Connect Specialty Pharmacy. Contact Caremark Connect at 1-800-237-2767. A Caremark representative will coordinate patient care with the provider and arrange overnight shipping.

For more information on the Caremark Prescription Drug Plan, go to [www.kdheks.gov/hcf/sehp/Caremark.htm](http://www.kdheks.gov/hcf/sehp/Caremark.htm)

## Delta Dental Plan

All employees enrolled in health coverage are also enrolled in the dental plan. You may also choose to purchase dental coverage for your dependents that are enrolled in the health plan. You have access to two Delta Dental provider networks.

**Important Note: Members may elect to opt out of Delta Dental coverage. However, once a member opts out, the member will not be able to re-enroll in dental coverage at a later date.**

### Delta Dental Premier Network

The Delta Dental Premier Network is the broad network of providers that you may use. Delta Dental will make payment directly to the dental provider. You will be responsible only for paying the specific coinsurance and deductibles for covered services in addition to any services not covered. Delta Premier Dentist agree to accept the plan allowance as payment in full.

### Delta Dental PPO Network

Delta Dental also offers the Delta Dental PPO network. The PPO network providers have agreed to a reduced fee for providing dental services. As a result, you generally pay a lower percentage of the total bill than you would when using the Premier Network. The PPO network for our group includes all PPO providers in the national DeltaUSA PPO network. Again, all participants in the Delta Dental program may use the PPO providers whenever desired.

## Preventive Care

Diagnostic and preventative services are covered at 100% with no deductible. Covered services include:

- Prophylaxis/cleanings – twice per plan year.
- Oral examinations – twice per plan year.
- Bitewing x-rays –
  - adults - once per plan year
  - children under 18 - twice per plan year
- Full mouth x-rays – once each five (5) years.
- Limited coverage for children only:
  - Sealants
  - Space maintainers
  - Topical fluoride
- Ancillary – emergency relief of pain.

## Plan Deductibles

A deductible of \$50 per person with a maximum annual family deductible of \$150 now applies to all basic and major restorative care. This includes:

### Basic Restorative

- Regular restorative dentistry - fillings
- Oral surgery
- Endodontics – root canals
- Periodontics – treatment of gum and bone disease
- Additional diagnostic X-rays

### Major Restorative

- Special restorative dentistry – crowns
- Prosthodontics – bridges, implants and dentures
- TMJ Treatment – requires prior authorization

A \$1,000 per person per lifetime benefit applies to orthodontic benefits; and there is an annual benefit maximum of \$1,700 per person per year for all dental services except orthodontics.

## Enhanced & Basic Coverage

Preventive Care Services are always covered at 100 percent of the allowed amount. Ninety days after a preventive office visit or cleaning, the member is eligible for the enhanced benefit level. If the member has had at least one routine prophylaxis (cleaning) and/or preventive oral exam in the preceding 12 months, basic restorative services are subject to a coinsurance of 20% when provided by a PPO provider and 40% coinsurance when provided by a Premier or Non Network provider. Major restorative services are covered at the 50% coinsurance rate for all providers.

The basic benefit applies when the member has not had at least one routine prophylaxis (cleaning) and/or preventive oral exam in the prior 12 months. The member is responsible for paying 50% coinsurance for all basic and major restorative services, regardless of provider. For those at the basic benefit level, you must wait 90 days from your cleaning or exam to qualify for the enhanced benefit level.

# Superior Vision Services Plan

You are offered two vision plans through Superior Vision Services\* — the Basic Plan and the Enhanced Plan. You may choose to enroll yourself and any eligible dependents in one of the vision plans, whether or not you or your dependents are enrolled in the health plan. However, if you choose dependent vision coverage, and dependent children also are enrolled in the medical plan, the dependent children enrolled in the vision plan must match those enrolled in the health plan.

Please note that you can enroll or change your coverage **only** when you or a dependent first becomes eligible, during the annual open enrollment period, or if a dependent becomes ineligible.

### Basic Vision Plan Coverage

Exams under the Basic plan are subject to a \$50 copay. A \$25 material copay to lenses also applies to frame purchases but not contacts, then the policy covers:

- 100% on single-vision, standard bifocal or trifocal lenticular lenses.
- Up to \$100 retail allowance for frames
- Elective contact lens allowance of \$150
- Home delivery of contacts via **SVcontacts.com**

### Enhanced Vision Plan Coverage

The enhanced vision plan includes all basic plan coverage, along with

- Progressive lenses covered up to \$165
- High-index lenses or poly-carbonate lenses covered up to \$116
- Scratch and UV coating
- Contact lens fitting fee (subject to a \$35 copay with limited coverage)

Enhanced benefits are **not available** from non network providers.

### Special Features From Superior Vision Services

Discounts are available for lens add-ons or upgrades not otherwise covered by the plan. The discount is 20 percent and is available from providers identified in the Superior Vision provider directory with a "DP."

Discounts on additional eye wear. Discounts are available for additional eyewear purchases. The discounts range from 10 percent to 30 percent and are available at providers identified in the provider directory with a "DP." Discounts on refractive surgeries such as LASIK, RK and PRK. Providers listed in the provider directory with the "RF" designation will provide Superior Vision members with a discount of 20 percent on refractive surgeries. For more details on vision benefits go to **[www.kdheks.gov/hcf/sehp/Superior.htm](http://www.kdheks.gov/hcf/sehp/Superior.htm)**

*\*The Superior Vision Plan is underwritten by National Guardian Life Insurance Company. National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, aka The Guardian or Guardian Life.*

## Privacy Rights and Appointment of Personal Representative for Health Care Choices

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 gives you certain privacy rights with respect to health-related issues. More information about HIPAA may be found online at **[www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa)** (United States Department of Health and Human Services website) or **[www.medicare.gov](http://www.medicare.gov)** (Medicare website).

As a health insurance provider for Direct Bill members, the State of Kansas is covered under HIPAA. As a result, we cannot discuss specific aspects of your health insurance coverage with anyone without your express written permission.

Therefore, if you need assistance in making health care decisions and wish to appoint someone to act on your behalf on health care issues, including your health plan choices, please complete a copy of the Appointment of Personal Representative form included in your packet. Submit your completed form to Direct Bill Membership Services at Room 900-N, LSOB, 900 SW Jackson, Topeka, KS 66612 or submit it by fax to **1-785-368-7180**. If you have already submitted this form, resubmission is not required unless you choose to make a change.



