STATE EMPLOYEE HEALTH PLAN

PLAN YEAR 2014
NON STATE EMPLOYER GROUP INFORMATION

Visit us online at:

www.kdheks.gov/hcf/sehp/NSEGroup.htm

Non State Employer Group Contacts:

Jeanne Kelly, Coordinator
Non State Employer Group
785-296-6205
JKelly@kdheks.gov

Sarah Beck, NSE Group Specialist
Membership Services
785-296-0880
SBeck@kdheks.gov

Stephanie Wywadis Miller, NSE Group Specialist
Membership Services
785-296-5443
SWMiller@kdheks.gov

The State Employee Health Plan (SEHP) is a self insured program governed by The State of Kansas Health Care Commission (HCC). The HCC was established in 1984 by the legislature for the purpose of developing and providing for implementation and administration of a comprehensive health benefit program through the SEHP. This health benefit program is for State of Kansas employees and retirees as well as employees and retirees of other eligible public entities who have elected to participate in the SEHP.

The SEHP has offered self insured programs since the early 1990's, but went fully self insured on all medical plans as of January 1, 2008. Being a self insured program means rather than paying a premium and transferring the risk to an insurance company, the state and affiliated non state entities and their employees pay monthly contributions. Claims for all eligible members are paid out of these contributions. In the event that the SEHP should have insufficient funds to pay claims, the State and affiliated non state groups could be assessed an additional amount determined by the HCC. To date, the HCC has never made such an assessment. Interested parties can track the funding balances by reviewing the HCC minutes at:

www.kdheks.gov/hcf/sehp/healthcare_commission.html

In 1999, the HCC established administrative procedures and eligibility requirements to allow for inclusion of Unified School Districts, community colleges, technical colleges and vocational technical schools into the SEHP. K.A.R. 108-1-3 outlines these requirements The HCC expanded the program to include of public employers (cities, counties, townships etc.) under K.A.R. 108-1-4. The HCC is responsible for determining eligibility of public employers to participate while maintaining the integrity of the state employee plan, and in compliance with the criteria outlined K.S.A. 75-6506. The participation criteria outlined in K.S.A. 75-6506 is included in this packet.

State Employees Health Plan – Non State Entities

Choice is important to employees. Therefore, SEHP provides different medical vendors from which participating employees may choose coverage. SEHP provides a complete package of benefits with medical, prescription drug, dental and vision coverage options available. The health care options are summarized in this packet.

- Participants enrolled in the medical coverage are automatically enrolled in the prescription drug benefit.
- Employees electing medical coverage are automatically enrolled for single dental coverage.
- An employee can choose dependent dental if the dependents are covered under the medical plan.
- The vision plan is an optional program. Participants may choose vision coverage regardless of what they select for their medical or dental plan. Vision coverage is not available to groups enrolling after January 1 until the next calendar year.
- An open enrollment period is held each year so members can make changes in health plan selections to meet their needs.
- Non state entities are responsible for educating their employees about the SEHP options during open enrollment.

Employer contribution is required at 95% of single coverage. If an employee elects dependent coverage the employer is also required to contribute an additional 55% toward the dependent premium cost. The 95% and 55% are composite rates and are the same regardless of the health plan chosen by the employee. If the Commission changes the employer contribution rates/percentage during the contract period all participating employers will be required to meet the changed contribution rates.

For new groups enrolling there are “ramp-up” options available if the public employer cannot otherwise meet the contribution requirements. The “ramp-up” option is a budgetary method of starting at a lower employer contribution amount and increasing the amount over two or three fiscal years (up to five years for dependents) to meet the state’s required contribution. The employee rate will be increased by the difference between the state’s required contribution amount and the “ramp-up” option used. If any “ramp-up” option is used, the contract period is five calendar years: otherwise the contract is for three calendar years.

Documentation Requirements for Enrollment

Employees must provide:

- A copy of their original state marriage certificate – if covering a spouse. A copy of first and last page of the most recent Federal Income Tax form may be used in place of a marriage certificate.

- Copy of birth certificates, if covering children. Birth certificate must list the names of the father, mother and child.

- Social Security Numbers for everyone covered under the policy.

- Medicare information, if Medicare eligible. Medicare eligible employees must complete TEFRA form at time of enrollment.

Billing Administrator: HP Enterprise Services

Non State Groups will receive their monthly statements on or before the 25th of each month. Premiums are due within 10 business days from receipt of their monthly premium bill and considered late if not paid by the 15th of the coverage month.

Payment Address:
HP Kansas Premiums
P.O. Box 842195
Dallas, TX 75284-2195

Correspondence Address:
HP Kansas Premiums
P.O. Box 1778
Topeka, KS 66601

Payment Options:

- Manage your premium bills on the Internet
- Set-up recurring automatic payments
- Make immediate payments online or over the phone
- Pay using a credit/debt card or drafts from checking/savings account
- Mail a check or money order to a post office box

The Member Services line is open weekdays between 8:00 am and 5:00 pm Central Time. Call: 1-866-688-5009 for assistance.

HealthWave Eligibility and the SEHP

Medicaid children's health insurance program (CHIP) is called HealthWave. Eligibility for Health wave is governed under either Title 21 or Title 19. Coverage under the SEHP does not affect those children who are eligible under **Title 19** of Medicaid. Under current Federal law, anyone who is eligible to be covered under the state employee health plan is not eligible for HealthWave under **Title 21.** Please be aware that groups joining the SEHP will be affected if they have children covered under Title 21.

Eligibility Rules

- Eligible employees for coverage under the SEHP include:
  - Educational group employees working 630 hours or more per year.
  - Public employees working 1000 hours or more per year.

- Eligible dependents include
  - The employee's lawful spouse.
  - Children or step children up to age 26.

- Retirees of a participating group are eligible for coverage **if** they are covered by the non state entity's health plan on the day before the group joins the SEHP.

- Employees hired after the effective date of the group with the SEHP will be subject to a 30 day waiting period before they are eligible to join the plan. New employees coverage is effective the first of the month following the completion of the 30 day waiting period.

- Anyone who is eligible to be covered as an employee under either the State or non state entities covered under the State Employee Health Plan (SEHP) may not be covered as a dependent (spouse or child) under the SEHP. This includes married couples who are both eligible employees to enroll in the SEHP regardless of whether they have the same or different employers.

- Dependents may not be covered under more than one SEHP contract. This applies to all dependents covered under the SEHP regardless of whether they are covered under a state or non state entity plan.

- For newly hired employees enrolling in the SEHP, there is a thirty (30) day waiting period. Health plan coverage begins the first day of the month following completion of the thirty (30) day waiting period. The waiting period may be reduced or waived in accordance with K.A.R. 108-1-3 for educational entities and 108-1-4 for all other public employers. The request for a waiver of the waiting period must be submitted and approved by SEHP before an offer of employment is given.

- The SEHP does not apply a waiting period for pre-existing conditions. Therefore, certificates of creditable coverage are not required.

NOTE: This is a sample of the eligibility requirements for the SEHP. The complete list of eligibility rules and guidelines can be found in the Non State Group Administrative Manual which is available online at

www.kdheks.gov/hcf/sehp/NSEGroup/NSEGroupAdminMan.htm

Rates

- Employ**er** contribution rates are determined by the Commission. Currently, the employer contribution shall be a monthly composite rate: a weighted average of all plan premiums or costs.
- The employ**ee** contribution rate will be a monthly rate reflecting a percentage of the selected individual health plan costs.
- The employ**er** contribution rates are assessed and paid during the State's fiscal year: July 1 – June 30
- The employee contribution rates are assessed and paid during the State's plan year: January 1 – December 31.

Information Required by the State Employee Health Benefit Plan

The following information is to give the SEHP a benchmark. It will not be used to allow or disallow participation in the health plan:

- **FEIN Number** (Federal Employee Identification Number) For billing purposes only
- **List of all eligible employees and their annual salaries**
- **Current enrollment by membership type**
  (single, single + spouse, single + child(ren) and family)
- **List of active employees who are also eligible for Medicare**

Looking for a January 1st Effective Date?

Non State Groups can join the State Employee Health Plan at any time throughout the plan year with a 90 day notice, by letter of intent. If your group is looking for a January 1st effective date, we need to have the letter of intent before September 1st and the group needs to be enrolled by the end of September. This is because the State holds open enrollment for Active and Non State employees in October of every year and the State Employee Health Plan employees are busy with open enrollment and are not available to enroll or process paperwork for new groups at this time.

Underwriting

The following requirements of the Plan are the rules of the program to insure the best possible "spread of risk" and avoid adverse selectio n in order to achieve a reasonable premium for the health benefits offered.

Requirements for Non State Groups to Participate in the SEHP

Active Employees

- Employee and Employer contribution rates must be at least equal to the State of Kansas contributions.
- Plan design and funding are not subject to negotiations.
- All employees are eligible who work a minimum of 1000 hours per year, 2,000 hours is considered full time. **For educational group employ ees those working a minimum of 630 hours are elig ible, 1000 hours is considered full time**.
- The group must have and maintain enrollment of at least 70% eligible employee enrolled in the SEHP.
- Employers may not create, maintain or provide incentives for employees not to join the SEHP. Covered groups are prohibited from providing cash out options.
- Must elect to participate for a minimum of three years/ five years if ramp up.
- Must provide the established contribution to HealthQuest (health promotion program), designate a contact person and participate in HealthQuest initiatives.
- Must provide staff for enrollment, answer general information and provide first level assistance to participants.
- Must adhere to established administrative processes and procedures. The Administrative Manual is available on request.

Direct Bill Participants

Direct Bill participants refers to retirees, COBRA participants and those on leave without pay.

- These participants may continue in the plan once active employment has ceased as long as the employer remains enrolled in the SEHP.
- For new non state entities joining the SEHP, retirees must be covered under your current health plan to be eligible to be covered under the SEHP.
- All Direct Bill Participants must pay their premiums by bank draft.

Program Benefits
For Plan Year 2014

Health Plan Comparison Chart

	Plan A		Plan B		Plan C – With Health Savings Account (HSA)	
	Blue Cross and Blue Shield of Kansas Coventry UnitedHealthcare		Blue Cross and Blue Shield of Kansas Coventry UnitedHealthcare		Blue Cross and Blue Shield of Kansas Coventry UnitedHealthcare	
	Network Providers	Non Network Providers	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					
Annual Deductible	$300 Single / $600 Family	$500 Single / $1,500 Family	$150 Single / $300 Family	$500 Single / $1,500 Family	$2,500 Single / $5,000 Family	$2,500 Single / $5,000 Family
Annual Coinsurance and Copay *(for all eligible expenses, unless otherwise noted)*	20% Coinsurance $1,700 Single / $3,400 Family	50% Coinsurance $3,650 Single / $7,300 Family	35% Coinsurance $3,500 Single / $7,000 Family	50% Coinsurance $3,650 Single / $7,300 Family	No Member Coinsurance	20% Coinsurance $1,500 Single / $3,000 Family
Out of Pocket Max	$2,000 Single / $4,000 family	$4,150 Single / $8,800 Family	$3,650 Single / $7,300 Family	$4,150 Single / $8,800 Family	$2,500 Single / $5,000 Family	$4,000 Single / $8,000 Family
Covered Services						
Inpatient Services	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Physician Hospital Visits	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Physician Office Visits						
Primary Care Provider	$25 Copayment	Deductible & 50% Coinsurance	Adults: $20 Copayment/ Dependent children age 18 and under: $10 Copayment	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Specialist	$45 Copayment	Deductible & 50% Coinsurance	Adults: $40 Copayment/ Dependent children age 18 and under: $25 Copayment	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Urgent Care Center	$50 Copayment	Deductible & 50% Coinsurance	$50 Copayment	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Outpatient Surgery	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Emergency Room Visits	$100 Copayment (waived if admitted) then Deductible & 20% Coinsurance	$100 Copayment (waived if admitted) then Deductible & 20% Coinsurance	$100 Copayment (waived if admitted) then Deductible & 35% Coinsurance	$100 Copayment (waived if admitted) then Deductible & 35% Coinsurance	Deductible & 0% Coinsurance	Deductible & 0% Coinsurance

Other Outpatient Services	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Ambulance Services	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 35% Coinsurance	Deductible & 35% Coinsurance	Deductible & 0% Coinsurance	Deductible & 0% Coinsurance
Major Diagnostic Tests	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
X-Ray and Laboratory	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Rehabilitation Services: *(services limited to those medically necessary and appropriate: medical records must show continued improvement)*						
Inpatient Facility	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Outpatient Facility	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Office Based	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Durable Medical Equipment	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance limited to $5,000 per person per year	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance limited to $5,000 per person per year	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance limited to $5,000 per person per year
Allergy Testing	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Antigen Administration: *desensitization/treatment; allergy shots*	Covered in full	Deductible & 50% Coinsurance	Covered in full	Deductible & 50% Coinsurance	Covered in full	Deductible & 20% Coinsurance
Autism Services	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Manipulation Therapies	Deductible & 20% Coinsurance limited to 30 visits per year	Deductible & 50% Coinsurance limited to 30 visits per year	Deductible & 35% Coinsurance limited to 30 visits per year	Deductible & 50% Coinsurance limited to 30 visits per year	Deductible & 0% Coinsurance limited to 30 visits per year	Deductible & 20% Coinsurance limited to 30 visits per year
Licensed Dietitian Consultation: *for medical management of a documented disease*	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Mental Health						
Mental Illness & Drug or Alcohol Treatment	Same Coverage as Medical					

Preventive Care - *Limited to one visit or service per year unless otherwise noted. Review the benefit description for details on exact coverage.*	**Plan A Network**	**Plan A Non Network**	**Plan B Network**	**Plan B Non Network**	**Plan C Network**	**Plan C Non Network**
Well Baby Exams - *includes newborn screenings & age appropriate office visits*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Well Child Exam - *includes office visit, age appropriate screenings and counseling*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Well Woman Exam - *includes office visit, age appropriate screenings, contraception and counseling*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Well Man Exam - *includes office visit, age appropriate screenings, contraception and counseling*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Prenatal Screenings and Counseling - *see benefit description for list of covered services*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Age Appropriate Bone Density Screening	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Immunizations	Covered In Full	Covered in full to age 6 otherwise Deductible & 50% Coinsurance.	Covered In Full	Covered in full to age 6 otherwise Deductible & 50% Coinsurance.	Covered In Full	Covered in full to age 6 otherwise Deductible & 20% Coinsurance.
Mammography - *(not limited to one)*	Covered In Full	Deductible & 50% Coinsurance	Covered In Full	Deductible & 50% Coinsurance	Covered In Full	Deductible & 20% Coinsurance
Colonoscopy - *(not limited to one)*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Ultrasonography for Aortic Aneurysm - *limited to men ages 65 to 75 with history of tobacco use*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Routine Hearing Exam	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Routine Vision Exam	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered

The comparison chart is NOT the governing document. Members need to refer to the Benefit Descriptions posted at ***www.kdheks.gov/hcf/sehp/BenefitDescriptions.htm***

Health Savings Account - Only Available with Plan C

Plan C With Health Savings Account				
	Full-Time Employee		Part-Time Employee	
	Employee Only	Employee + Dependents*	Employee Only	Employee + Dependents*
Employer Contribution	$1,500.00 per year	$2,250.00 per year	$1,125.20 per year	$1,687.60 per year
Employee Contributions**	$25.00 to $75.00	$25.00 to $179.16	$25.00 to $90.61	$25.00 to $202.60

The HSA Employee contribution maximums for Employee + Spouse, Employee + Children or Employee + Family are the same.

****Employee Contribution represents 24 semi-monthly payments.**

Health Savings Account (HSA) Banking Information for Blue Cross Blue Shield of Kansas, Coventry and UnitedHealthcare

Banking Institution	**USBank**
Web Site	**www.mycdh.usbank.com**
Monthly Administrative Fee ** **(waived with an average daily balance of $2,000)**	$2.00
Brokerage Account Fees	$0
ATM Transaction Fee	$0
Setup Fees	$0
Overdraft Fees	$0
Stop Payment	$0
Returned Items	$0
Copies of Checks	$0
Paper Statement	$1.50
Replacement of Debit Cards	$0
Wire (Incoming Transfers)	$0
Wire (Outgoing Transfers)	$0
Account Closing Fee	$0
Inactive Account Fee	$0
Check Reimbursement Fee	$0
Interest Rate	$0 - $999.99 = .05% $1,000 - $2,499 = .15% $2,500 - $14,999 = .25% $15,000 + = 2.25%
Excess Contribution Refund Fee	$0
Minimum Balance Requirement	No Minimum
Investment Threshold	$1,000

Caremark Prescription Drug Benefits for Plan A and Plan B

Tier	Type of Prescription Medication	You Pay	Your Out-of-Pocket Maximum
Tier 1	**Generic Drugs**	20% Coinsurance	There is an Out of Pocket maximum of $2,750 for single and $5,500 for family per year.
Tier 2	**Preferred Brand Name Drugs**	35% Coinsurance	
Tier 3	**Special Case Medications**	Maximum of $75 per standard unit of therapy	
Tier 4	**Non Preferred Brand Name Drugs**	60% Coinsurance	
Tier 5	**Discount Tier Medications**	100% Coinsurance	N/A
Tier 6	**Anticancer Oral Medications**	25% Coinsurance to a maximum of $75 per standard unit of therapy	Separate Coinsurance maximum of $750 per member per year
Value Based	**Diabetes**	**Generic** — 10% to a max of $10/30-days **Preferred brand** — 20% to a max of $20/30-days	Applies to the Out of Pocket maximum (See above)
Value Based	**Asthma**	**Generic** — 10% to a max of $10/30-days **Preferred Brand** — 20% to a max of $20/30-days	Applies to the Out of Pocket maximum (See above)

*Preferred Drug list, specialty drug list and discount tier list available on the web at **www2.caremark.com/kse***

Caremark Prescription Drug Benefits for Plan C With Health Savings Account

Tier	Type of Prescription Medication	
1	**Generic Drugs**	Tiers 1 - 4 are subject to the Deductible. You / Your Family will be responsible for 100% of the cost of prescription drugs until the deductible of $2,500 Single / $5,000 Family, is satisified. There is NO Coinsurance for eligible or covered prescription drugs.
2	**Preferred Brand Name Drugs**	
3	**Non Preferred Brand Name Drugs**	
4	**Anticancer Oral Medications**	

Discount Tier Drugs are not covered and do not count toward the Health Plan Deductible.

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	50% Coinsurance to a maximum of $1,000 per member		
Implant Coverage (Benefit subject to Annual Benefit Maximum above)	50% Coinsurance		
DEDUCTIBLE			
Diagnostic and Preventive Services	No Deductible		
Basic Restorative Services	$50 per person per Plan year Not to exceed an annual family Deductible of $150		
Major Restorative Services			
COINSURANCE			
BASIC BENEFIT Applies when you have NOT 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.

Superior 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 $150 retail*	Basic: Up to $45 Enhanced: Up to $78
• 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***	Up to $50*	Up to $50*	Not Covered
• Standard Contacts****	Covered in full	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.

State Employee Health Plan Non State Employer Group Rates for Plan Year 2013

NON STATE EMPLOYER GROUPS MONTHLY RATES FOR MEDICAL, DENTAL AND VISION COVERAGE
Monthly Base Rate For Plan Year 2014

Employer (ER) rates effective 7/1/14 — **Employee (EE) rates effective 1/1/14**

		Medical Rates																		Dental Rates		Vision Rates	
		Blue Cross and Blue Shield of Kansas						Coventry						UnitedHealthcare								Superior Vision Employee Rates	
		Plan A		Plan B		Plan C		Plan A		Plan B		Plan C		Plan A		Plan B		Plan C		Delta Dental			
Cov Level	Salary Tier	ER Cost	EE Cost	ER Cost	EE Cost	ER Cost	EE Cost	ER Cost	EE Cost	ER Cost	EE Cost	ER Cost	EE Cost	ER Cost	EE Cost	ER Cost	EE Cost	ER Cost	EE Cost	ER Cost	EE Cost	Basic	Enhanced
1	FT1	$552.80	$56.10	$552.80	$55.08	$552.80	$42.32	$552.80	$57.92	$552.80	$56.80	$552.80	$42.56	$552.80	$54.48	$552.80	$53.60	$552.80	$42.08	$40.48	$0.00	$4.36	$8.72
2	FT1	$970.32	$235.88	$970.32	$223.34	$970.32	$71.44	$970.32	$258.02	$970.32	$244.46	$970.32	$75.00	$970.32	$216.22	$970.32	$205.48	$970.32	$68.30	$68.94	$15.46	$8.72	$17.44
3	FT1	$970.32	$198.90	$970.32	$188.72	$970.32	$65.52	$970.32	$216.86	$970.32	$205.86	$970.32	$68.38	$970.32	$182.94	$970.32	$174.22	$970.32	$62.98	$68.94	$12.38	$7.86	$15.70
4	FT1	$970.32	$383.92	$970.32	$361.92	$970.32	$95.22	$970.32	$422.76	$970.32	$399.00	$970.32	$101.44	$970.32	$349.40	$970.32	$330.56	$970.32	$89.68	$68.94	$27.78	$12.20	$24.42
1	FT2	$552.80	$71.38	$552.80	$69.38	$552.80	$42.72	$552.80	$74.92	$552.80	$72.76	$552.80	$43.04	$552.80	$68.22	$552.80	$66.50	$552.80	$42.46	$40.48	$0.00	$4.36	$8.72
2	FT2	$970.32	$246.20	$970.32	$233.00	$970.32	$73.08	$970.32	$269.48	$970.32	$255.22	$970.32	$76.82	$970.32	$225.50	$970.32	$214.18	$970.32	$69.80	$68.94	$15.46	$8.72	$17.44
3	FT2	$970.32	$209.14	$970.32	$198.32	$970.32	$66.86	$970.32	$228.26	$970.32	$216.56	$970.32	$69.90	$970.32	$192.18	$970.32	$182.90	$970.32	$64.16	$68.94	$12.38	$7.86	$15.70
4	FT2	$970.32	$394.20	$970.32	$371.52	$970.32	$98.12	$970.32	$434.20	$970.32	$409.70	$970.32	$104.70	$970.32	$358.64	$970.32	$339.22	$970.32	$92.28	$68.94	$27.78	$12.20	$24.42
1	FT3	$552.80	$86.62	$552.80	$83.64	$552.80	$44.08	$552.80	$91.90	$552.80	$88.68	$552.80	$44.54	$552.80	$81.96	$552.80	$79.40	$552.80	$43.66	$40.48	$0.00	$4.36	$8.72
2	FT3	$970.32	$256.44	$970.32	$242.60	$970.32	$81.36	$970.32	$280.90	$970.32	$265.92	$970.32	$86.04	$970.32	$234.72	$970.32	$222.84	$970.32	$77.22	$68.94	$15.46	$8.72	$17.44
3	FT3	$970.32	$219.44	$970.32	$207.98	$970.32	$73.58	$970.32	$239.72	$970.32	$227.32	$970.32	$77.38	$970.32	$201.44	$970.32	$191.60	$970.32	$70.20	$68.94	$12.38	$7.86	$15.70
4	FT3	$970.32	$404.50	$970.32	$381.16	$970.32	$112.64	$970.32	$445.66	$970.32	$420.46	$970.32	$120.84	$970.32	$367.90	$970.32	$347.92	$970.32	$105.34	$68.94	$27.78	$12.20	$24.42
1	PT1	$432.12	$204.24	$432.12	$193.72	$432.12	$68.88	$432.12	$222.78	$432.12	$211.42	$432.12	$72.14	$432.12	$187.76	$432.12	$178.74	$432.12	$65.98	$30.60	$8.64	$4.36	$8.72
2	PT1	$760.28	$392.10	$760.28	$369.58	$760.28	$100.06	$760.28	$431.88	$760.28	$407.52	$760.28	$106.84	$760.28	$356.76	$760.28	$337.44	$760.28	$94.02	$52.08	$28.04	$8.72	$17.44
3	PT1	$760.28	$343.80	$760.28	$324.34	$760.28	$91.90	$760.28	$378.12	$760.28	$357.10	$760.28	$97.76	$760.28	$313.30	$760.28	$296.64	$760.28	$86.70	$52.08	$24.16	$7.86	$15.70
4	PT1	$760.28	$585.38	$760.28	$550.48	$760.28	$134.32	$760.28	$647.02	$760.28	$609.28	$760.28	$144.96	$760.28	$530.64	$760.28	$500.74	$760.28	$124.84	$52.08	$43.58	$12.20	$24.42

NOTE: THE QHDHP EMPLOYER RATES ABOVE (BCBS Plan C, Coventry Plan C and UnitedHealthcare Plan C) INCLUDE THE EMPLOYER HSA CONTRIBUTION. YOUR MONTHLY BILLING WILL BE THE AMOUNT ABOVE, LESS THE MONTHLY HSA CONTRIBUTION. YOU ARE RESPONSIBLE FOR SENDING THE HSA CONTRIBUTIONS TO THE HSA BANK EACH MONTH.

SALARY TIERS (EFFECTIVE 1/1/2010)	
FT1	Full-time employee earning less than $28,000 per year
FT2	Full-time employee earning $28,000-$48,000 per year
FT3	Full-time employee earning $48,000 or more per year
PT1	Part-time employee

Coverage Levels	
1	Member Only
2	Member + Spouse
3	Member + Children
4	Member + Family