

State Employee Health Plan

Plan Year 2015 Non State Employer Group Information

Visit us online at:

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

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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 [here](#):

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

1. 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.
2. Eligible dependents include
 - The employee's lawful spouse.
 - Children or step children up to age 26.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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.
8. 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.

Rates

- **Employer** 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 **employee** contribution rate will be a monthly rate reflecting a percentage of the selected individual health plan costs.
- The **employer** 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 selection 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 employees those working a minimum of 630 hours are eligible, 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 2015

Health Plan Comparison Chart

	Plan A		Plan C with HSA or HRA	
	Aetna / Blue Cross and Blue Shield of Kansas		Aetna / Blue Cross and Blue Shield of Kansas	
	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	\$2,600 Single / \$5,200 Family	\$2,600 Single / \$5,200 Family
Annual Coinsurance <i>(for all eligible expenses, unless otherwise noted)</i>	20% Coinsurance	50% Coinsurance	No Member Coinsurance	20% Coinsurance
Out of Pocket Max - TOTAL	\$4,750 Single / \$9,500 Family	\$4,750 Single / \$9,500 Family	\$2,600 Single / \$5,200 Family	\$4,100 Single / \$8,200 Family
Covered Services				
Inpatient Services	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Physician Hospital Visits	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Physician Office Visits				
Primary Care Provider	\$25 Copayment	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Specialist	\$45 Copayment	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Urgent Care Center	\$50 Copayment	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Outpatient Surgery	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Emergency Room Visits	\$100 Copayment (waived if admitted) than Deductible & 20% Coinsurance	\$100 Copayment (waived if admitted) then Deductible & 20% Coinsurance	Deductible & 0% Coinsurance	Deductible & 0% Coinsurance
Other Outpatient Services	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Ambulance Services	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 0% Coinsurance	Deductible & 0% Coinsurance
Major Diagnostic Tests	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
X-Ray and Laboratory	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance

Health Plan Comparison Chart

	Plan A		Plan C with HSA or HRA	
	Aetna / Blue Cross and Blue Shield of Kansas		Aetna / Blue Cross and Blue Shield of Kansas	
	Network Providers	Non Network Providers	Network Providers	Non Network Providers
Rehabilitation Services: <i>Services are limited to those medically necessary and appropriate medical records must show continued improvement.</i>				
Inpatient Facility	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Outpatient Facility	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Office Based	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Durable Medical Equipment	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Allergy Testing	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Antigen Administration: <i>desensitization/ treatment; allergy shots</i>	Covered in full	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Autism Services	Deductible & 20% 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 & 0% Coinsurance - Limited to 30 visits per year	Deductible & 20% Coinsurance - Limited to 30 visits per year
Licensed Dietitian Consultation: <i>for medical management of documented disease</i>	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Mental Health				
Mental Illness & Drug or Alcohol Treatment:		Same Coverage as Medical		
Preventive Care: <i>Limited to one visit or service per year unless otherwise noted. Review the benefit description for details on exact coverage.</i>				
Well Baby Exams <i>includes newborn screenings & age appropriate office visits</i>	Covered in Full	Not Covered	Covered in Full	Not Covered
Well Child Exam <i>includes office visit, age appropriate screenings and counseling</i>	Covered in Full	Not Covered	Covered in Full	Not Covered

Health Plan Comparison Chart

	Plan A		Plan C with HSA or HRA	
	Aetna / Blue Cross and Blue Shield of Kansas		Aetna / Blue Cross and Blue Shield of Kansas	
	Network Providers	Non Network Providers	Network Providers	Non Network Providers
Well Woman Exam <i>includes office visit, age appropriate screenings, contraception and counseling</i>	Covered in Full	Not Covered	Covered in Full	Not Covered
Well Man Exam <i>includes office visit, age appropriate screenings, contraception and counseling</i>	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
Age Appropriate Bone Density Screening	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 & 20% Coinsurance
Mammography (not limited to one)	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
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
Routine Hearing Exam	Covered in Full	Not Covered	Covered in Full	Not Covered
Routine Vision Exam	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

Delta Dental Benefits			
	PPO Network Provider	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 <i>(Benefit subject to Annual Benefit Maximum above)</i>	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%
<p><i>*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.</i></p> <p><i>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.</i></p>			

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 \$64
Trifocal lenses, pair	Covered in Full after Copayment	Covered in Full after Copayment	Up to \$64
Lenticular lenses, pair	Cover 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*	Not Covered
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 proved 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:			
<ul style="list-style-type: none"> • 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. 			

Caremark Prescription Drug Benefits for Plan A

Preferred Drug List, Specialty Drug List and Discount Tier List available on the web at www.caremark.com

Tier	Type of Prescription Medication	You Pay	Your Out-of-Pocket Maximum
1	Generic Drugs	20% Coinsurance	There is an Out of Pocket maximum of \$4,750 for single and \$9,500 for family combined Medical and Pharmacy per year.
2	Preferred Brand Name Drugs	35% Coinsurance	
3	Special Case Medications	Maximum of \$75 per standard unit of therapy	
4	Non Preferred Brand Name Drugs	60% Coinsurance	
5	Discount Tier Medications	100% Coinsurance	N/A
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 \$10/30 days	Applies to the Out of Pocket maximum (See above)
Value Based	Asthma		

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 \$2,600 Single / \$5,200 Family, is satisfied. 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.

NueSynergy Flexible Spending Account

Payroll Deductions	Health Care FSA for Plan A		Limited Health Care FSA for Plan C - Dental and Vision Services Only		Dependent Care FSA for Plans A and C	
	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
24 semi-monthly	\$8.00	\$104.16	\$8.00	\$104.16	\$16.00	\$208.33*
16 semi-monthly	\$12.00	\$156.25	\$12.00	\$156.25	\$24.00	\$312.50*
Total Deductions Per year	\$192.00	\$2,500.00	\$192.00	\$2,500.00	\$384.00	\$5,000.00*

*Subject to tax filing status

Health Savings Account - Available Only 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 \$77.08	\$25.00 to \$183.32	\$25.00 to \$92.69	\$25.00 to \$206.76

Employer contributions will be made in two installments - the 2nd pay period in January and the 1st pay period in July.

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

**Employee Contribution represents 24 semi-monthly payments. For nine-month Regents employees, contributions are distributed evenly over 16 pay periods each year.

Health Savings Account (HSA) Banking Information for Aetna and Blue Cross Blue Shield of Kansas

Banking Institution	US Bank
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	Please contact US Bank at 877-470-1771 for the most accurate rates available.
Excess Contribution Refund Fee	\$0
Minimum Balance Requirement	No Minimum
Investment Threshold	\$1,000

Health Reimbursement Account (HRA)

The HRA employer contribution frequency and amounts will be identical to that of the Health Savings Account. US Bank will be the HRA administrator. Members will also be eligible to enroll in a Health Care FSA through NueSynergy in order to make pre-tax contributions to pay for eligible health expenses. Reimbursements for either account can be made via debit card, online, fax or mail.

State Employee Health Plan Non State Employer Group Rates for Plan Year 2015

Non State Group Rates (Monthly Rates) Effective January 1, 2015

Full Time Employee Rates								
Coverage Level	Plan A		Plan C		Delta Dental	Superior Vision		Employer Total
	BCBS	Aetna	BCBS	Aetna		Basic	Enhanced	
E	\$67.71	\$70.79	\$46.86	\$48.32	\$0.00	\$4.66	\$9.16	\$593.28
ES	\$248.86	\$270.93	\$74.02	\$78.64	\$15.46	\$9.12	\$18.08	\$1,039.26
EC	\$211.32	\$229.98	\$67.44	\$71.85	\$12.38	\$8.24	\$16.30	\$1,039.26
ESC	\$396.93	\$439.97	\$99.30	\$108.19	\$27.78	\$12.72	\$25.28	\$1,039.26
Part Time Employee Rates								
Coverage Level	Plan A		Plan C		Delta Dental	Superior Vision		Employer Total
	BCBS	Aetna	BCBS	Aetna		Basic	Enhanced	
E	\$204.24	\$222.78	\$68.88	\$72.14	\$8.64	\$4.66	\$9.16	\$462.72
ES	\$392.10	\$431.88	\$100.06	\$106.84	\$28.04	\$9.12	\$18.08	\$812.36
EC	\$343.80	\$378.12	\$91.90	\$97.76	\$24.16	\$8.24	\$16.30	\$812.36
ESC	\$585.38	\$647.02	\$134.32	\$144.96	\$43.58	\$12.72	\$25.28	\$812.36

Please Note: The HSA Contribution is added to the Employer rate. The employer will need to deduct the HSA contribution from the Employer rate and Submit to the financial institution.
 There is now only one salary tier for everyone.
 Employer Total includes medical and dental contributions.

Coverage Level Key:

E	Employee Only
ES	Employee and Spouse
EC	Employee and Children
ESC	Employee and Family