

Direct Bill Open Enrollment Plan Year 2017



Our Mission: To protect and improve the health and environment of all Kansans.



Agenda

- Introductions and Announcements
- Open Enrollment
- Major Changes
- Non-Medicare Plan Coverage Details
- Medicare Plan Coverage Details
- Questions to Ask Yourself
- Open Enrollment Portal Instructions
- Direct Bill Call Center
- Resources
- Questions

Today we are going to look at the plan options for 2017. We will talk about what's new and what you need to think about during this open enrollment period. Once we have gone through the prepared presentation, we will open the floor to questions.

Open Enrollment October 16 – November 15, 2016

- All changes take effect January 1, 2017
- Any changes made will be effective for all of 2017
- Your chance to make any change to your current insurance
 - This includes adding dependents

Open Enrollment for 2017 is from October 16 through November 15

Open Enrollment October 16 – November 15, 2016

- Any change made outside of this time period requires a “qualifying event”
- Remember: If you or a dependent are enrolled in Medicare you must have a “Split Enrollment”

Remember, after November 15th, unless you experience a qualifying event, you cannot change your coverage level until the next Open Enrollment period. The choices you make now will be effective starting January 1, 2017.

Who is eligible for enrollment?

- Current Retirees/Direct Bill Members
- Any eligible dependents of a current member:
 - Spouse
 - Dependent children and stepchildren under the age of 26
 - Dependent children and stepchildren over the age of 26 with a total and permanent disability

So who is eligible to enroll in the state health plan? The answer is easy...you, your lawful spouse, and your dependent children and stepchildren.

To enroll your dependent children or stepchildren, they **must**:

- be younger than 26 years old

For a dependent child to be enrolled onto the plan after the age of 26 the Disability Affidavit is required.

2017 Non-Medicare Plan Changes

- Plan A
 - Office visit Co-pays \$40/\$60
 - Three (3) tiered Deductible \$1,000/\$2,000/\$3,000
 - OOP Max \$5,750/\$11,500
- Pharmacy Co-insurance:
- Tiers are now 20%, 40% and 65%
 - Special Case Copay \$100 per 30 day supply

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- The HCC voted to increase the Copay for office visits under Plan A by \$10.
- The current two tiered Deductible has been changed to a three tiered Deductible of \$1,000/\$2,000 and \$3,000. More on how this works in a minute.
- The Out Of Pocket maximum (OOP) has increased by \$1,000 for one or \$2,000 on a member plus dependents plan.
- The pharmacy Coinsurance tiers were adjusted for covered brands.
 - The preferred brand name drug tier will have a 40% Coinsurance and non preferred brand name drugs will have a 65% Coinsurance.
 - For high cost drugs on the Special case tier the Copay for a 30 day supply will be \$100.

2017 Non-Medicare Plan Changes

- Plan C
 - Member pays 100% up to \$2,750/\$5,500
 - 20% Co-insurance for medical services
 - Pharmacy Co-insurance added
 - Co-insurance tiers: 20%, 40% and 65%
 - OOP Max is \$5,000/\$10,000

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- On Plan C, after the Deductible is met, Coinsurance will now apply to both medical and pharmacy claims.
- For medical claims a 20% Coinsurance will apply until the Out Of Pocket Maximum is met.
- On pharmacy claims after the Deductible the same basis Coinsurance levels as Plan A has will apply.
 - 20% Coinsurance for Generics
 - 40% Coinsurance for Preferred Brand Name Drugs
 - 65% Coinsurance for Non Preferred Brand Name Drugs
- The employer contribution to the HSA and HRA has been reduced.
 - For employees with member only or member and child(ren) coverage the reduction is \$500.
 - For employee plus spouse or family coverage the reduction is \$1,000.

Selecting Your Health Plan



- Pick a plan design (A or C)
 - Which plan design is right for you?
 - Premiums, Deductibles, Co-insurance
- Review the provider networks



- Review plan claim example online:
 - <http://www.kdheks.gov/hcf/sehp/default.htm>

- Open Enrollment is your opportunity to decide how you want to finance your healthcare for the upcoming year. We encourage you to review the plan design options, look at the coverage and the out of pocket cost of each plan design and select an option, A or C.
- Each of our health plan vendors offers their own unique provider networks. Being a network provider means that the health care professional has agreed to accept the vendor's allowed charge as payment in full. The provider agrees to write off any difference between what they charge and what the health plan allows. This reduces your cost for care.
- You are free to use any provider that you wish; however, if you use a provider that is not part of your health plan's networks, it will cost you more out of your pocket. Non network providers do not have to accept the health plan's allowed charge and can bill you for the difference.
- Make sure you review the networks before deciding on a medical vendor.
- Review the claim example comparing Plans A and C on the same set of services. It is available on the SEHP website.

Plan A

Network		Non Network	
Medical*		Medical*	
Deductible	\$1,000/\$2,000/\$3,000	Deductible	\$1,200/\$3,600
Co-insurance	20%	Co-insurance	50%
PCP Office Visit	\$40 Co-pay	Out-of-Pocket (OOP) Max*	
Specialist Visit	\$60 Co-pay	Medical & Pharmacy	\$5,750/\$11,500
Pharmacy*			
Co-insurance	20%/40%/65%		
Special Case	\$100 /30 day		
Combined Out-of-Pocket (OOP) Max*			
Medical & Pharmacy	\$5,750/\$11,500		

* Non covered services & discount tier drugs do not count toward Deductible, Co-insurance or OOP Max.

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- Medical services are subject to a \$1,000 Deductible for one person and a maximum of \$3,000 for a family.
- Your out of pocket cost for network Deductible, Co-insurance and Co-pays along with your prescription drug Co-insurance & Co-pays all are added together until you meet the plan Out Of Pocket (OOP) maximums. Once you meet the OOP maximum, additional covered network services are paid at 100% for the remainder of the plan year.
- Services for network and non network care have different benefits and accumulate toward separate OOP maximums. To maximize your benefits and limit your out of pocket costs, use only network providers when possible.
- For non network services, in addition to any amount above what the plan allows, you will be responsible for the Deductible and Coinsurance until you reach the OOP Max for Non Network services.

Plan A - Three Tiered Deductible

- How it works:
 - 1st Person has a \$1,000 Deductible
 - 2nd Person has a \$1,000 Deductible
 - All remaining covered members combine together toward a 3rd \$1,000 Deductible
 - Maximum Deductible on a family with 4 or more members is \$3,000

As a review, the Deductible is the amount of covered health expenses that you must pay out of pocket before the health plan will begin paying on your claims.

So how does a three (3) tier Deductible work?

- On employee only coverage, the member Deductible would be \$1,000.
- If it is employee plus one other person, then each has a \$1,000 Deductible.
- On memberships with three (3) or more covered members, two (2) members would each need to meet their individual \$1,000 Deductibles. The remaining covered family members could combine their expenses to reach the final \$1,000 of Deductible for a total family Deductible of \$3,000.
- On family memberships covering four (4) or more family members, if no one individual meets the individual Deductibles but the family members have had \$3,000 of covered expenses applied to their individual Deductible, then the family will have met the Deductible.
- Once the Deductible is met, Coinsurance applies to services until the member(s) reach the plan Out Of Pocket maximum

Plan A Prescription Drug Plan

Drugs	Coverage Level
Generic	20% Co-insurance
Preferred Brand Name Drugs	40% Co-insurance
Special Case Medications	40% Co-insurance to a Max of \$100 per 30 day supply
Non Preferred Brand Name Drugs	65% Co-insurance
Discount Tier	You pay 100% of discount cost. Does not count toward your OOP

Pharmacy Co-insurance applies to the member's Out Of Pocket Maximum

Note: Non covered & discount tier prescription items do not count toward your OOP maximum.



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- There are changes to the prescription coverage tiers under the pharmacy program.
- Generic drugs are your still your best buy. Your share of the cost is 20 percent on generic drugs.
- Preferred brand name drugs are listed on the Preferred drug list (PDL). You can find the PDL on our website and on Caremark's. For Preferred brand name drugs you will pay 40 percent Coinsurance.
- If you use a Non Preferred brand name drug, you will pay 65 percent Coinsurance. We encourage you to print out the PDL and take it with you to your doctors appointment so you avoid these Non Preferred products.
- Discount tier drugs are non covered items and you will pay the 100 percent of a discounted price for these items. A complete list of discount tier items is available on the SEHP website.

Pharmacy Changes

- Plans A & C will offer 90 day supplies on most medications
- Compound drugs will only be covered if purchased from a Network Pharmacy
- Plan A Only: Asthma and Diabetes drugs:
 - Generics 10% to max of \$20 per 30 day supply
 - Preferred brands 20% to a max of \$40 per 30 day supply
 - Non Preferred brands – 65% Co-insurance



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- The day supply maximums have changed. Both Plan A and C will now allow members to purchase up to a ninety (90) day supply of most drugs. To obtain a ninety (90) day supply, your physician will need to write the prescription to allow this amount.
- Compound medications will only be covered when purchased from a Network pharmacy. Caremark's mail service offers compounding services as do many other network providers and will submit claims directly for reimbursement.
- The Chronic Care benefit for diabetes and asthma has been adjusted.
- Generics will have 10 percent Coinsurance with a maximum of \$20 per 30 day supply.
- Preferred brand name drugs will have a 20 percent Coinsurance with a 30 day maximum of \$40.

Anticipated Generic Releases

- 4th Quarter 2016
 - Seroquel
 - Zetia
- 1st Quarter 2017
 - Minastrin 24 FE
 - Vytorin
- 2nd Quarter 2017
 - Strattera
 - Relpax
- 4th Quarter 2017
 - Viagra
 - Viread

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- The number of medications with generic launches has dropped over the last few years. These are just a few of the drugs scheduled to go generic next year.
- We encourage members to switch to generic as soon as they are released. Generic drugs save you and the plan money.
- FYI – Viagra is a discount tier drug so the member pays the full cost of the brand and will pay the full cost of the generic.

Plan C

Network

Medical & Pharmacy*	
Deductible	\$2,750/\$5,500
Medical Co-insurance	20%
Pharmacy Co-insurance	20%/40%/65%
Out-of-Pocket Max	
Medical & Pharmacy	\$5,000/\$10,000

Non Network

Medical*	
Deductible	\$2,750/\$5,500
Co-insurance	50%
Out-Of-Pocket Max	
Medical & Pharmacy	\$5,000/\$10,000

***Note:**

Discount tier and non covered items or services do not count toward Deductible or OOP Max.

- On Plan C, all of your covered medical and pharmacy claims are subject to the Deductible.
- After you have meet your Deductible, you will pay 20 percent Co-insurance on your medical services.
- On Prescriptions after you meet your Deductible, you will have the same coverage tiers for prescriptions as Plan A has.
- If you use network providers, once your Deductible is met, you will pay Co-insurance on additional covered services with network providers until your medical and pharmacy out of pocket costs reach \$5,000 on an individual and \$10,000 on a family. Once you reach the Out of Pocket Maximum any additional covered services are paid in full for the remainder of the calendar year.
- For services you receive from Non Network Providers there is a separate benefit level. For Non Network providers you will be responsible for a separate Deductible and Co-insurance until you reach the Out of Pocket Maximum for Non Network services. Reminder Non Network providers do not have to accept the health plans allowed amount and you will be responsible for any amount above what the plan allows.

Plan C Prescription Drug Plan

- Uses same Preferred Drug List as Plan A
- Claims subject to Plan C Deductible
- After the Deductible has been met, Co-insurance tiers apply:
 - Uses same Co-insurance tiers as Plan A
 - 20% Generic
 - 40% Preferred Brand Name Drugs
 - 65% Non Preferred Brand Name Drugs



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- The Preferred Drug List is the same as the one used for Plans A. It is available on Caremark.com.
- On Plan C, prescription drugs are subject to the overall plan Deductible and then Co-insurance applies.
 - Generic drugs have a 20 percent Co-insurance
 - Preferred Brand Name Drugs have a 40 percent Co-insurance
 - Non Preferred Brand Name Drugs have a 65 percent Co-insurance

Preferred Lab: Stormont Vail

- Plan A - 100% coverage for eligible outpatient lab services
- Plan C - Discounts on eligible outpatient lab services until Deductible met, then paid at 100%
- Labs drawn at other Cotton-O'Neil locations may be included if by network providers
- Show your medical ID Card to access benefit

BCBS Members: The local BCBS plan of the physician that ordered the lab test will process the lab claim. If your provider is outside of BCBS of Kansas area, Stormont-Vail may not be a network provider and the claim may be subject to non-network benefits.

Stormont-Vail
HealthCare

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Kansas
Department of Health
and Environment

- Stormont-Vail HealthCare is a regional preferred lab vendor for Plans A and C.
- On Plan A, when you have covered outpatient lab work performed and billed by Stormont-Vail, the plan pays 100 percent of the cost of the services.
- Plan C members receive significant discounts on services until the Plan C Deductible is satisfied and then covered services are paid at 100 percent.
- BCBS members - please note that claims for lab services are processed by the local plan of the doctor that ordered the testing. So if they are outside the BCBS of Kansas area, Stormont-Vail or Quest for that matter, may not be a network provider and you may incur additional expenses. This is a national BCBS Association rule and not one the local BCBS plan has any control over.

Preferred Lab: Quest Diagnostics

- Plan A - 100% coverage of outpatient lab tests
- Plan C - Discounts on eligible outpatient lab services until Deductible met, then paid at 100%
- List of collection sites: www.labcard.com
- Your doctor can draw the sample and send to Quest

BCBS Members: The local BCBS plan of the physician that ordered the lab test will process your lab claim. If your provider is outside of BCBS of Kansas area, Quest may not be a network provider for that BCBS plan and the claim may be subject to non-network benefits.



- Quest Diagnostics is the statewide preferred lab vendor for Plans A and C.
- For Plan A, when you have covered outpatient lab work performed and billed by Quest, the plan pays 100 percent of the cost of the services. The plan can pay the additional amounts due to the negotiated discounts with Quest.
- Plan C members receive discounts on services until the Plan C Deductible is satisfied and then covered services are paid at 100 percent.
- Any provider may use the Quest lab service by calling Quest to pick up the sample. You and your provider will decide whether or not to do so.
- Visit Quest's website for a complete list of Quest collection sites.

Dental



• Plan pays for 2 exams & cleanings per year

Basic

Benefit	PPO	Premier	Non Network
Preventive Services	Covered in full	Covered in full	Allowed amount covered in full
Basic Restorative	50%	50%	50%
Major Restorative	60%	70%	70%

Enhanced

Benefit	PPO	Premier	Non Network
Preventive Services	Covered in full	Covered in full	Allowed amount covered in full
Basic Restorative	20%	40%	40%
Major Restorative	50%	50%	50%



- With the change in dental enrollment, there is also a change in the basic dental plan coverage. Members of the health plan who have not have a covered exam or cleaning in the prior 12 months will be at the basic level of benefits. If they need major restorative work, they will be responsible for paying a higher Co-insurance for these services.
- The number of the members not getting their covered exams and cleanings has been greatly reduced but we still have a population that is not getting regular dental care.
- To receive the enhanced benefit level, you must have had a dental exam or cleaning in the prior 12 months to qualify.

Vision Benefits



Basic Plan		Enhanced Plan - Covers everything in the Basic Plan PLUS...	
Office Visit Copay	\$50	Frame Allowance	\$150
Materials Copay	\$25	High Index Allowance	Up to \$116
Frame Allowance	\$100	Polycarbonate lenses	Covered in Full
Lenses: single vision, standard bifocal, trifocal or lenticular	100%	Progressive lenses Allowance	Up to \$165
Contact lenses Allowance	\$150	Scratch & UV coating	Covered in full
Contact Fitting Fee Copay	\$35		



- The vision programs will again be offered through Surency Life and Health Insurance Company, a wholly owned subsidiary of Delta Dental of Kansas.
- You may choose between the Basic and Enhanced plans.
- Basic covers a pair of standard eyeglasses or contact lenses.
- The Enhanced Plan includes everything Basic offers plus offers a higher frame allowance and provides coverage toward lens enhancements like progressive lenses (no line bifocals).

2017 Medicare Plan Changes

Medicare Part D:

- The state will be offering 2 Part D plans for Plan Year 2017
 - Aetna Part D Premier Option
 - Aetna Part D Value Option

Medicare Plan Options

- Coventry Advantra Freedom & Liberty PPO
 - Coventry Part D
 - Aetna Part D—Value & Premier options
- Kansas Senior Plan C – administered by Blue Cross and Blue Shield
 - With or without Aetna Part D—Value & Premier options
- These plans are available for Direct Bill members enrolled in Medicare Part A and Part B
- A copy of your Medicare card is required

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Here are your options and we have reps available after the meeting to answer questions.

For those of you enrolled in Medicare – All Medicare plans will have the option of First Health Part D Prescription Drug Coverage.

Coventry Advantra Freedom & Liberty PPO Medicare Advantage Plans

- Medicare Advantage Plan
 - Takes the place of Medicare Part A and Part B
 - You are still responsible for Part B premium
 - Still have deductibles, co-payment and co-insurance
 - Enrollment in private Part D prescription plan
= loss of ALL State of Kansas Health benefits

Coventry Advantra Freedom & Liberty PPO Medicare Advantage Plans

- You must choose between prescription drug coverage through Coventry Part D or one of the Aetna Part D plans
 - Coverage available statewide in Kansas, Missouri, Oklahoma and Arkansas
 - In order to receive the highest level of benefits members should see a provider who contracts with Coventry Advantra Freedom

Coventry Advantra Freedom & Liberty Medicare Advantage Plans

Plan	Coventry Advantra Freedom	Coventry Advantra Liberty
Deductible	\$0	\$0
Co-Insurance	\$0	\$0
Network Annual Out-of-Pocket Max	\$1,000	\$3,500
Network Providers ONLY amounts Above Plan Allowance	Provider to Write Off	Provider to Write Off
Preventive Services	\$0	\$0
Co-Pay Primary	\$10	\$5
Co-Pay Specialist	\$25	\$30

Coventry Advantra Freedom & Liberty Coventry Part D

- Coverage Gap or the “Donut Hole”
 - Begins when you and your plan have paid \$3,700 toward your medications.
 - Once you reach the coverage gap, you are responsible for the cost of the brand name and some generic medications.
- Catastrophic Coverage
 - Begins when your Out-of-Pocket cost reaches \$4,950

Kansas Senior Plan C Medicare Supplement Plan

- Medicare Supplement
 - Pays after Medicare Part A and Part B
 - You are still responsible for Part B premium
 - Plan pays deductibles, co-payments, co-insurances as long as the service is a Medicare covered procedure and the provider accepts Medicare assignment.

Kansas Senior Plan C Medicare Supplement Plan

	Kansas Sr. Plan C Pays	You Pay
Part A	Inpatient Hospital Care: All deductible and co-insurance for Medicare covered services	\$0
	Skilled Nursing: All co-insurance for Medicare covered services	\$0
Part B	Deductible	\$0
	Out Patient Services	\$0
	Durable Medical Equipment	\$0

Aetna Part D

- Aetna Part D can be added to Coventry Advantra Freedom, Liberty or to Kansas Sr. Plan C.
- If you are enrolled in Kansas Sr. Plan C with Aetna Part D drug coverage and then enroll in a Private Market Medicare Part D plan, your Aetna drug coverage will be terminated.
- If you are enroll in one of the Coventry Advantra plans you cannot enroll in a Part D plan out on the Private Market
- You can receive up to a 90 day supply of medications at the pharmacy or mail order.

Aetna Part D continued

- The Out-of-Pocket max will be the same for a 60 or 90 day supply for the Aetna Value Part D option.
- The Out-of-Pocket max will be the same for a 30 or 60 day supply for the Aetna Premier Part D option.
- Specialty medication can only be filled on a 30 day basis.
- All State of Kansas drug coverage is considered creditable coverage.
 - Coverage that is a good as or better than Medicare prescription drug coverage.
 - You **MUST** have creditable drug coverage to avoid the Late Enrollment Penalty through Medicare.
 - VA and Tricare are considered creditable coverage.

Aetna Part D – PREMIER Option

Aetna Part D Plan Benefits – PREMIER Option			
Prescription	Network Retail 30 Day Supply	Network Retail 60 Day Supply	Network Retail/Mail Order90-Day Supply
Tier 1 – Generic Drugs	25% Coinsurance up to a \$30 maximum	25% Coinsurance up to a \$30 maximum	25% Coinsurance up to a \$45 maximum
Tier 2 – Preferred Generic Drugs	25% Coinsurance up to a \$30 maximum	25% Coinsurance up to a \$30 maximum	25% Coinsurance up to a \$45 maximum
Tier 3 – Preferred Brand Name drugs	25% Coinsurance up to a \$100 maximum	25% Coinsurance up to a \$100 maximum	25% Coinsurance up to a \$150 maximum
Tier 4 – Non Preferred Generic and Brand Name drugs	50% Coinsurance up to a \$150 maximum	50% Coinsurance up to a \$150 maximum	50% Coinsurance up to a \$225 maximum
Tier 5 – Specialty 30 day supply ONLY	25% Coinsurance No maximum	N/A	N/A
If out-of-pocket expenses exceed \$4,950	Generics: the greater of 5% Coinsurance or \$3.30 Brands: the greater of 5% Coinsurance or \$8.25	Generics: the greater of 5% Coinsurance or \$3.30 Brands: the greater of 5% Coinsurance or \$8.25	Generics: the greater of 5% Coinsurance or \$3.30 Brands: the greater of 5% Coinsurance or \$8.25

Aetna Part D – VALUE Option

Aetna Part D Plan Benefits – VALUE Option			
Prescription	Network Retail 30 Day Supply	Network Retail 60 Day Supply	Network Retail/Mail Order 90 Day Supply
Deductible - \$100 deductible for initial out of pocket prior to tier coverage.			
All copayments would be cost of drug or copayment listed below. Whichever is less.			
Network / Preferred Pharmacy			
Tier 1 – Generic Drugs	\$8 Copayment	\$16 Copayment	\$16 Copayment
Tier 2 – Preferred Generic Drugs	\$15 Copayment	\$30 Copayment	\$30 Copayment
Tier 3 – Preferred Brand Name drugs	\$40 Copayment	\$80 Copayment	\$80 Copayment
Tier 4 – Non Preferred Generic and Brand Name drugs	\$80 Copayment	\$160 Copayment	\$160 Copayment
Tier 5 – Specialty 30 day supply ONLY			

Aetna Part D – VALUE Option continued

Non Network / Standard Pharmacy			
Prescription	Retail 30 Day Supply	Retail 60 Day Supply	Retail/Mail Order 90 Day Supply
Tier 1 – Generic Drugs	\$19 Copayment	\$38 Copayment	N/A
Tier 2 – Preferred Generic Drugs	\$20 Copayment	\$40 Copayment	N/A
Tier 3 – Preferred Generic Drugs	\$47 Copayment	\$94 Copayment	N/A
Tier 4 – Non Preferred Generic and Brand Name Drugs	\$100 Copayment	\$200 Copayment	N/A
After you have a total drug spend over \$3,700 coverage in Coverage Gap	Generic Tier 1 Only in Gap		
If out-of-pocket expenses exceed \$4,950	Generics: the greater of 5% Coinsurance or \$3.30 Brands: the greater of 5% Coinsurance or \$8.25	Generics: the greater of 5% Coinsurance or \$3.30 Brands: the greater of 5% Coinsurance or \$8.25	Generics: the greater of 5% Coinsurance or \$3.30 Brands: the greater of 5% Coinsurance or \$8.25

Questions to Ask Yourself

- Which health plan is best for me?
 - How often do I visit the doctor?
 - How many medications do I take?
 - Compare premiums, deductibles and co-insurance
- Which health plan carrier is the best for me?
 - Ask my doctor's office which insurance plans they accept
- What is the total cost to me?
 - Add it all up

Identification Cards

- BCBS, Caremark, Delta and Surency are sending new cards to all members
- Aetna is sending all Plan A members new cards and members who make changes. Plan C members will only get new cards if they make changes
- Quest is only sending cards to new members or members who make changes in coverage
- Kansas Senior Plan C, Coventry Advantra plans and Aetna Part D will only be sending cards to new members or members who make changes in coverage

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- BCBS, Caremark and Delta are sending new id cards to all members.
- Quest is only sending new preferred lab card to members that make changes.

Information Needed at the Time of Enrollment

- Medicare Card and Personal Representative Forms
 - If information is not currently on file
- If adding a NEW dependent you will need
 - Spouse – Marriage Certificate or first two pages of Federal Tax Return 1040 or 1040A from the most current year (2015) signed and dated by employee and spouse
 - Child – Birth Certificate
- Your personal information i.e. Employee ID, DOB, SSN, email address

Open Enrollment Website

- SEHP Membership Administrative Portal (MAP):
<https://sehp.member.hrissuite.com/>
- You will need to upload electronic copies of birth certificates & marriage licenses if you are adding dependents during OE in MAP
 - Scans
 - Photos
- You will be able to update your information & mailing address
 - Address changes are for the health plan information can be made at any time during the year

MAP Questions: SEHPMembership@kdheks.gov

- Open Enrollment is your opportunity to decide which health plan you want for next year. Open Enrollment is the month of October and enrollment will again be done online in the Membership Administration Portal (MAP).
- Employees wanting to enroll in the HealthKIDS program will need to complete a new application during this open enrollment. It is again available online.

Membership Aministrative Portal MAP

- Enroll online with any computer that has internet access
 - Do not have a computer at home? Visit your local public library or Senior Center!
- You will log in using
 - Your Kansas Employee ID
 - Your Social Security Number
 - Your Date of Birth
 - Email Address

Registering for MAP

- Because MAP contains your Protected Health Information (PHI), it is a HIPAA compliant site
- All of your information is encrypted for security
- Once registered, you will set up a unique password for future authentication

- MAP Questions:
SEHPMembership@kdheks.gov

Welcome To MAP

The screenshot displays the Member Portal interface. At the top, there is a navigation bar with 'Home', 'Register', and 'Sign In' links. The main content area is divided into several sections:

- Welcome to the State Employee Health Plan Member Portal:** A large dark banner on the left side.
- Account Overview:** A central panel with tabs for 'Member & Family', 'Benefits', and 'Statements & Events'. It includes a 'Member & Family Information' section with a table of family members and a 'Contact Information' section.
- Getting Started:** A section on the bottom left explaining the registration process, with a 'Register Now' button.
- Sign-in:** A section on the bottom right explaining the sign-in process, with a 'Sign-in' button.

Member & Family Information Table:

Family Member (click to view)	Relationship	Julie Smith
John Smith	Employee	Employee ID: 4000000003
Kathryn Smith	Spouse	State Security Number: 888-88-8888
James Smith	Son	Date of Birth: 01/01/1978
George Smith	Son	Gender: Male
		Member Status: Married

Open Enrollment Website

- Remember to review all contact information that is currently on file and make any necessary changes. All SEHP Benefit information will be sent to the contact information currently in MAP
 - Address, phone number, email address & ACH—bank information
- Complete the enrollment online
 - Follow the instructions on the screen and make election changes
- “Save and Submit” your changes
 - Print off the summary of changes for your records
 - An email confirmation statement will be sent to the email address provided

Open Enrollment Website

- Technical Help Desk
 - This does not apply to benefit questions
- Monday – Friday: 7am – 7pm (central time)
- Saturday – Sunday: 9am – 2pm (central time)
 - 1-800-832-5337 (Toll Free)
 - 1-913-499-4854 (KC Local)
- Email: techsupport@hrissuite.com
 - Available 24/7 and you will be contacted within 24 hours
 - Include your name, Kansas Employee ID number, phone number, and explanation of issue

Direct Bill Call Center

- Call Center Available
 - October 14, 2016 – December 11, 2016
- Hours of Operation
 - 8:30 am – 4:30 pm Monday - Friday
- Call Center Phone Numbers
 - 1-866-541-7100 (Toll Free)
 - 1-785-296-1715 (Topeka)
- Closed for the following holidays
 - Friday, November 11 (Veteran's Day)
 - Thursday, November 24 & Friday, November 25 (Thanksgiving)

Resources

- Open Enrollment Information
 - 2017 Open Enrollment Booklet Online (charts included)
- Direct Bill Newsletter
 - Includes important reminders and announcements
- Medicare and You handbook for all Medicare participants
- Email SEHPMembership@kdheks.gov
- SEHP Website www.kdheks.gov/hcf/sehp
- Medicare Website www.medicare.gov
 - Membership Portal <https://sehp.member.hrissuite.com/>

Resources

- Call Center Phone Numbers
 - 1-866-541-7100 (Toll Free)
 - 1-785-296-1715 (Topeka)
- Health Insurance Counseling (SHICK)
 - 1-800-860-5260
 - Department on Aging
 - County Extension Office
- Medicare
 - 1-800-633-4227
- Social Security Administration
 - 1-800-772-1213
 - 1-800-325-0778 (TTY)

Questions

Link to Open Enrollment book:
www.kdheks.gov/hcf/sehp/default.htm

Benefit & Plan Questions:
Benefits@kdheks.gov



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

Our Mission: To protect and improve the health and environment of all Kansans.

