

FAQS

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STATE EMPLOYEE HEALTH BENEFITS PLAN OPEN ENROLLMENT 2008: FOR NON STATE EMPLOYER GROUPS

Frequently asked questions

COBRA

Q1: What is COBRA?

A1: COBRA is an acronym for the Consolidated Omnibus Budget Reconciliation Act of 1986. This federal law requires certain employers to offer continued health insurance coverage when a former member or his or her qualified dependent loses such coverage due to one of the following events:

- Termination
- Reduction in hours
- Death of member
- Divorce
- Loss of dependent status
- Member's entitlement to Medicare

The State and Non State member plans require the employer to offer COBRA coverage.

Q2: How long may I continue on COBRA?

A2: You may continue on COBRA for a maximum of 18 months upon termination or because your hours were reduced; all other dependent qualifying events allow for a maximum of 36 months of continuation.

Q3: What type of coverage is the employer required to offer?

A3: The same coverage you had at the time of termination or reduction in hours.

Q4: How much does COBRA coverage cost?

A4: You or your dependent will pay the full cost of health care coverage plus a 2 percent administrative fee. For more information, go to <http://www.khpa.ks.gov> (KHPA web site).

Delta Dental Plan

Q1: What does Delta Dental cover?

A1: Two examinations by a contracting dentist, including diagnostic and preventive procedures, are covered at 100 percent of allowable charges. Regular restorative dentistry, endodontics, periodontics and oral surgery are covered at 60 percent, and major restorative procedures are covered at 50 percent when they are provided by a Premier provider. Highest coverage is provided when services are provided by a Delta Dental Preferred Provider Organization (PPO) provider (although there is limited availability). Oral surgery, endodontics, periodontics, special restorative, prosthodontics and TMJ are subject to a deductible.

Q2: When does the dental deductible apply?

A2: The annual deductible applies toward any dental treatment greater than regular restorations (fillings). Preventive visits, emergency pain relief, fillings and orthodontic work are not subject to the deductible.

Q3: What happens if I have a dental accident?

A3: Claims are processed first by the dental plan. If the accidental injury includes a fracture to the jaw or damage to the supporting structures of the teeth, claims may be submitted to the medical plan for additional benefit consideration.

Q4: If I end my enrollment in the dental plan, will my dental work continue to be covered?

A4: Specific procedures started under this plan will be covered after termination of coverage only for those procedures completed within 30 days of termination and submitted for payment within six months of termination. You will need to contact the plan to see which procedures are covered after termination.

Q5: What is the difference between the Premier network and the Delta Dental PPO network?

A5: The Premier network is the largest group of dentists who contract with Delta Dental. Delta Dental PPO dentists are a smaller group of providers who take greater discounts and generally cost you less to use.

Q6: What is the DeltaUSA PPO network?

A6: This is a national network of Delta Dental PPO and Premier network providers. State of Kansas members are eligible for PPO and Premier coverage anywhere in the United States if they use a DeltaUSA provider.

Q7: What happens if my crown breaks through no fault of my own?

A7: Individual crowns on the same tooth are covered only once in any five-year period. Only two repairs are allowed in a 12-month period, and recementation is allowed once in a 12 consecutive-month period. Discuss options with your dentist if a crown is damaged.

Q8: Can I find out in advance how much of my dental treatment will be covered?

A8: Yes. Your dentist can request a predetermination of benefits for you so that you will know approximately what will be covered and what you will be expected to pay.

Health Plan Membership and Enrollment

Q1: What is the effective date of coverage in the health plan?

A1: The effective date of coverage is generally the first day of the month following the completion of a 60-day waiting period beginning on your date of hire in a benefits eligible position.

Q2: When can I change my health plan coverage during the year?

A2: Coverage can be changed if you experience a qualifying event and request the change within 31 days. The effective date of the change is generally the first day of the month following the date of the qualifying event. Please see the current Employee Benefits Guidebook online at www.khpa.ks.gov for additional information and restrictions.

Q3: Who can I cover on my health insurance?

A3: You may cover your lawful spouse and unmarried children up to age 23 (includes natural or adopted children, stepchildren or legal custody children). Subject to certain restrictions, the member also may cover grandchildren or handicapped children older than age 23. Please see the current Employee Benefits Guidebook online at www.khpa.ks.gov for additional information.

Q4: If I quit or I am terminated, when will my health plan coverage end?

A4: Coverage will end on the last day of the month during which your last day at work occurs. You then will be offered COBRA continuation coverage.

Plan A and Plan B**Q1: What is changing for plan year 2008?**

- A1:**
- All plans will be available to everyone, no matter where you live.
 - Plan A is like the HMO benefits without the requirement for a primary care physician or referrals.
 - Plan B is like the PPO.
 - Everyone will have access to all the plan options including the lowest-cost plan.
 - There are improvements in preventive care services.
 - There are improvements in mental health benefits.
 - There are new tools (PlanSelect) to help you make better health care decisions for you and your family.
 - There is an increase in the employer contribution for dependent coverage.
 - The cost of single coverage has not increased.
 - There are less co-pays.
 - This is an exciting time for employees making benefit choices and decisions!

Q2: If I don't do anything during open enrollment, what will happen?

A2: If you do nothing during your open enrollment period, you will have missed an opportunity to evaluate the benefit package available to you and your family. You still will have coverage. We will match you to the plan closest to the plan in which you currently are enrolled (see the chart below for details).

Even though we will automatically renew your health plan choice if you don't make any changes during your open enrollment period, we encourage you to take this opportunity to learn more about the changes, so you can determine if you are still in the right plan for 2008.

Remember after the enrollment deadline, you will not have another opportunity to change your coverage decisions until the next open enrollment period (October 2008), unless you experience certain "qualifying events" as explained in your enrollment booklet.

If You Do Not Actively Enroll for 2008	
If You Were Enrolled in This Medical Option in 2007	You Will Be Enrolled in This Medical Option for 2008
HMO – Coventry	Plan A – Coventry
HMO – Preferred Plus of Kansas (Preferred Health Systems)	Plan A – Preferred Health Systems
HMO – Premier Blue (Blue Cross and Blue Shield)	Plan A – Blue Cross and Blue Shield
PPO – Coventry	Plan B – Coventry
PPO – Kansas Choice (Blue Cross and Blue Shield)	PPO – Blue Cross and Blue Shield
QHDHP-HSA – Coventry	QHDHP-HSA – Coventry

In addition to the options listed in the chart above, Preferred Health Systems (PHS) is offering a Plan B (PPO) for 2008. Because a counterpart to this option did not exist in 2007, you can be enrolled in this option only if you actively enroll.

Q3: Can you provide an example of the changes for 2008?

A3: One example will be in the names and categorization of the plans. We will no longer have HMOs and PPOs. Instead we will have Plan A and Plan B. Each of our three vendors, Blue Cross and Blue Shield, Coventry and Preferred Health Systems, will administer a Plan A and a Plan B. All plans will be available to everyone, regardless of where they live.

Q4: If we no longer have HMOs, does that mean I won't need a Primary Care Physician (PCP)?

A4: We want you to have a PCP, although now we're calling it your "medical home." It's important to have one place where all your and your family's health care needs can be addressed. We urge you to find a medical home provider you trust.

Q5: Will all providers be treated alike?

A5: No. Because having network medical home providers is to your advantage, the co-payment system encourages the use of these health care providers. Co-payments for office visits to network medical home providers (see Q7—medical home) will be \$20 and co-payments to network specialists will be \$40. Services from non network providers will be subject to the deductible and then co-insurance.

Q6: What is a medical home?

A6: A medical home is a source of usual care you select (for example, a regular doctor (i.e., a primary care physician or facility). By having a medical home, it's easier for your health care providers to share information and for you to take a more active role in your health care.

Q7: What kind of health care providers are in a medical home. How will I know what my co-payment responsibility will be when I visit a provider?

A7: Providers in the following categories will be considered medical home health care providers and will have the lower co-payment:

- General Practice
- Family Practice
- Internal Medicine
- Pediatrics
- Geriatrics
- Physician Extenders (Physicians Assistants and Advance Registered Nurse Practitioners)

All other providers will be classified as specialists and will have the higher office visit co-payment.

Q8: If I use a Gynecologist for my well-woman exam, will I have to pay the specialist co-payment?

A8: No. Remember, the preventive care benefits are still in place. A well-woman exam is part of the preventive care package and there is no co-payment at all. For visits other than the well-woman exam, yes, a Gynecologist is considered a specialist and will have the higher co-payment.

Q9: What enhancements have been made to preventive care services?

A9: We want you and your family to receive appropriate screening early so you have an opportunity to act, in a timely manner, on anything that might be discovered. We learned this past year that colonoscopies are not always routine. Consequently, colonoscopies will be covered in full—whether they are routine or not. We also have removed co-payment and co-insurance requirements for mammograms—whether or not they are routine. Of course, colonoscopies and mammograms must be medically necessary and appropriate, and preventive care services must be received from network providers to be covered.

Q10: What about flu shots or pneumonia vaccines? Are they covered?

A10: Yes, all immunizations are covered in full. State law requires that certain immunizations be provided for children through age five. We now cover immunizations, regardless of age as long as they are medically necessary and appropriate. Of course, immunizations related to work, where the employer is required to pay for the immunizations as part of the job and immunizations for foreign travel are not covered by the plan.

Q11: Will I receive preventive care benefits if I use a non network provider?

A11: No, you must use network providers for preventive care services. Preventive care can be planned and scheduled in advance. Preventive care will ONLY be covered when received from a network provider.

Q12: With all of this change, what should I focus on?

A12: You should focus on getting the best, most appropriate care for you and your family. We have new tools, including an online benefits calculator (PlanSelect), that will help you and your family understand how you use the health care delivery system (i.e., what you pay for and what the plan pays on your behalf).

Q13: Why can't I change my health plan option during the middle of the year?

A13: Certain changes are allowed during the plan year as the result of a qualifying event. Generally, the changes follow the Internal Revenue Code Section 125 guidelines. Please refer to the current Employee Benefits Guidebook.

Q14: If my physician no longer participates in the insurance plan that I choose, can I change to another insurance company?

A14: Generally, you will remain in the same health plan for the remainder of the plan year even if some of the providers move in and out of the insurance company's network during the year.

Q15: What number do I call if I have questions about my health plan?

A15: The health plan phone numbers are listed on the back of your identification card(s). In addition, they also are available online at <http://www.khpa.ks.gov> (KHPA web site).

Q16: Do the State health plans have a pre-existing condition waiting period?

A16: No. The State's health plans do not have a waiting period for coverage of pre-existing medical conditions. Coverage is in effect for all health conditions from the effective date of enrollment.

Q17: I had some pain and I went to see my physician. I thought this would be paid under the preventive care service but instead it was applied to my co-insurance. Why?

A17: Preventive care services are designed to encourage you to visit your medical home provider while you are healthy, and to work together, with your health care providers, to find problems before they become full blown disease states. Treatment for acute injury or illness would be subject to the standard office visit co-payment. Services covered under preventive care include an annual physical exam and routine screening services and must be received from a network provider.

Q18: Do co-payments for office visits, emergency room, outpatient mental health visits and hospital stays count toward my deductible or co-insurance?

A18: No. Co-payments do not apply toward your deductibles or co-insurance maximums. Co-payments are flat dollar amounts that must be paid each time service is obtained.

Q19: What is the co-insurance maximum and how is it calculated?

A19: Co-insurance is the sharing of expenses between the health plan and you. The health plans have different co-insurance charges for claims received from network and non network providers. As claims are processed by the health insurance company, your share of co-insurance is accumulated based on the network status of the provider. Once your share reaches the co-insurance maximum, any additional claims from your doctors within the same network status are processed and paid at 100 percent of the allowed amount for the remainder of the plan year. For a family, two or more dependents' co-insurance is pooled to reach the co-insurance maximum for the family. Again, this is tracked separately for network and non network providers.

Q20: Does the money I spend out-of-pocket that counts toward my deductible also count toward the co-insurance maximum?

A20: No. The deductible is the amount of covered services you must pay out-of-pocket before the health plan begins to pay benefits. This amount does not count toward the co-insurance maximum.

Q21: Is chiropractic coverage included in the health plans?

A21: Chiropractic care is considered a physical rehabilitation benefit and is covered, subject to medical necessity, for up to 30 visits per year. The health plans will request medical records from the chiropractor, just as they would from a physician or physical therapist. Medical records must show continued improvement in condition.

PlanSelect

Q1: What is PlanSelect?

A1: PlanSelect is a web site that features a variety of tools to help you make your benefit decisions, including selecting the health plan that best meets your personal and financial needs.

Q2: Why do I have to go from one place to another—log in to one system, then log in to another system and then go back to where I started—just to use this new tool?

A2: For security reasons, we were unable to connect these systems. The decision support tool is designed to assist you with various types of decisions. However, to use the tool, some personal information is needed. In order to protect the privacy of your personal information, it is necessary to log in to and out of multiple systems. We will continue to look for ways to streamline this process for future years, but the primary focus will remain the security and privacy of your personal information.

Qualified High Deductible Health Plan with Health Savings Account (QHDHP-HSA)

Q1: What is a Qualified High Deductible Health Plan (QHDHP)?

A1: Sometimes referred to as a “catastrophic” health insurance plan, a QHDHP usually has a lower premium, a higher deductible and higher out-of-pocket limits. Generally, the plan does not pay for the high-dollar deductible, but will cover a portion of your costs after that. A QHDHP must meet the requirements of the federal government.

Q2: What is a Health Savings Account (HSA)?

A2: A Health Savings Account is a savings product that offers a different way for consumers to pay for their health care. HSAs enable you to pay for current health expenses, and save for future qualified health expenses, on a tax-free basis. You must be covered by a QHDHP to take advantage of an HSA. Since the premium for a QHDHP generally is less than for a traditional plan, you can put the savings into the HSA.

Q3: What is the deductible for the State of Kansas QHDHP?

A3: The State’s QHDHP has a \$1,500 deductible for single coverage and a \$3,000 deductible for family coverage if network providers are used. If you elect to use non network providers, the deductible is \$2,000 for single coverage and \$4,000 for family coverage. One member in the family could be responsible for the entire family deductible in a benefit year.

Q4: Once the deductible is satisfied, what does the plan pay and what do I pay? Is there a limit to how much I must pay?

A4: Once the deductible is satisfied, the plan pays 80 percent of the allowed amount for services received from network providers. If your out-of-pocket expenses reach \$5,000 for single coverage and \$10,000 for family coverage, the plan pays 100 percent of allowed charges. The plan will pay 60 percent of the allowed amount for services received from non network providers until your out-of-pocket amount reaches \$6,000 for single coverage and \$12,000 for family coverage.

Q5: Are there any special enrollment requirements for the QHDHP-HSA?

A5: To participate in an HSA, you must be enrolled in a QHDHP. In addition, you cannot be covered by another plan that is not a QHDHP (e.g., a spouse’s plan, TRICARE, VA benefits or Medicare).

Q6: My spouse has a Health Care Flexible Spending Account or Health Reimbursement Arrangement through their employer. Can I have an HSA?

A6: You cannot have an HSA if your spouse’s Health Care FSA or HRA can pay for any of your medical expenses before your QHDHP deductible is met.

Q7: Why does the QHDHP-HSA plan have higher deductibles than the federal government requires for such plans?

A7: The State chose the higher amounts for the deductibles to strike a balance between premiums, deductibles and services, and to provide a vehicle to save for future medical expenses. These limits will be analyzed for adjustment in the future.

Q8: Can I use my HSA to pay for medical expenses incurred before I set up my account?

A8: No. You can only be reimbursed for qualified medical expenses incurred after your account is established.

Q9: What happens when I enroll in the QHDHP-HSA?

A9: Your enrollment will be transmitted to Coventry at the conclusion of the open enrollment period. Coventry will send enrollment information to UMB, the custodian of the HSAs. UMB will send a signature card and beneficiary designation form that you must sign and return before your HSA will be established.

Once you return the signature card, you will receive a debit card. You should not use your debit card until your first payroll deduction has been credited to your account. Payroll deductions will be credited to your account semi-monthly. A \$3.50 monthly service fee will be withdrawn from the account.

Q10: Is my premium for the QHDHP and my contribution to the HSA the same?

A10: No. Your payroll deductions consist of two components. First is the premium for the QHDHP. You may elect to have this premium deducted either before or after taxes are deducted from your paycheck. The second deduction will be for the HSA. The contribution to the HSA will be \$50 per month.

Q11: Does the employer contribute to the HSA as well as to the QHDHP premium?

A11: Yes. The employer will contribute up to \$900 per year for single coverage and up to \$1,350 per year for family coverage.

Q12: How much can I put into my HSA?

A12: The maximum contribution to an HSA for 2008 is \$2,900 for single coverage and \$5,800 for dependent coverage.

Q13: Does the contribution to the HSA have to be made by payroll deduction?

A13: Yes. The Plan requires a minimum contribution of \$50 per month be deducted for the HSA. You can contribute other amounts, up to the maximum, to the HSA at other times. However, you cannot make contributions to the account until the account is opened—for new enrollees, January 2 would be the first day to make a deposit.

Q14: I'm older than age 55 and would like to make "catch-up" contributions to my HSA, like I've done with my IRA. Is that possible?

A14: Yes. Individuals age 55 and older who are covered by a QHDHP can make additional catch-up contributions each year until they enroll in Medicare. The additional catch-up contribution allowed for 2008 is \$900.

Q15: I will turn age 55 next year. Can I make the full catch-up contribution?

A15: If you have a QHDHP for the full year, you can make the full catch-up contribution regardless of when your 55th birthday falls during the year.

Q16: Both my spouse and I are over age 55. Can both of us make catch-up contributions?

A16: Yes, if both spouses are eligible individuals and both spouses have established an HSA in their name. If only one spouse has an HSA in his or her name, only that spouse can make a catch-up contribution.

Q17: What happens if I use the money in my HSA for expenses other than medical expenses?

A17: If the money is used for anything other than qualified medical expenses, the expenditure will be taxed and, for individuals who are not disabled or older than age 65, subject to a 10 percent tax penalty. It is your responsibility to report this information on your income taxes.

Q18: How do I know what is included as a "qualified medical expense"?

A18: HSA funds can pay for any qualified medical expense, even if the expense is not covered by the QHDHP. Unfortunately, we cannot provide a definitive list of "qualified medical services." A partial list is provided in IRS publication 502 (available at www.irs.gov). There have been many nuances of what constitutes medical care for purposes of Section 213(d) of the Internal Revenue Code. A determination of whether an expense is "medical care" is based on all the relevant facts and circumstances. To be considered an expense for "medical care," the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness. The determination often rests on the word "primarily."

Q19: Where can I find more information about HSAs?

A19: Additional information is available at www.treasury.gov (Treasury Department web site).

Q20: Where can I find more information about the QHDHP and the HSA?

A20: Links to the plan documents for the Coventry QHDHP and the UMB HSA are available online at www.khpa.ks.gov (KHPA web site).

Caremark Prescription Drug Plan

Q1: What is a Preferred Drug List?

A1: A Preferred Drug List (PDL) identifies those prescription drug products that are preferred by the plan for dispensing to members when appropriate. This list is subject to periodic review and modification.

Q2: How is the PDL determined?

A2: The group health plan uses the Caremark National Formulary list. Caremark's Pharmacy and Therapeutics Committee is responsible for additions to and deletions from the PDL.

Q3: What are special case medications?

A3: Special case medications are high-cost medications used for treatment of catastrophic conditions. A list of special case medications is available on Caremark's web site at www2.caremark.com/kse and is subject to review. There is a \$75 co-payment per standard fill for 2008.

Q4: Does the prescription drug plan cover diabetic supplies?

A4: Yes. The prescription drug plan covers diabetic supplies that are medically necessary and prescribed by a physician. Diabetic testing equipment (glucometers, etc.) are covered under the health plans.

Q5: How can I save money on my prescription drugs?

A5: Take a copy of your health plan's PDL with you to your doctor's appointment. When your physician gives you a prescription, ask if a generic is available and if it would be appropriate for you. If the physician says you must take a brand name drug, ask if there is a drug listed on the PDL that you can take. You can find the PDL on Caremark's web site at www2.caremark.com/kse or by calling them at 1-800-294-6324. Print off a copy to share with your physician at each office visit.

Q6: How do I use the prescription drug mail order program?

A6: To participate in the mail order program, you will need to complete the mail service profile form available on the Caremark web site. Submit this form along with an original prescription from your physician to Caremark. Please allow two weeks for processing. The initial fill will be 30 days. For faster refills, place your order online at www2.caremark.com/kse (Caremark web site) or call 1-800-294-6342.

Q7: What are lifestyle prescription medications?

A7: Lifestyle medications are used primarily for infertility, erectile dysfunction, medications for cosmetic purposes, dental preparations (toothpaste, mouthwash, etc.) and Drug Efficacy Study Implementation (DESI-5) medications. DESI-5 medications are older medications that require a prescription but that the Food and Drug Administration (FDA) have approved for safety only and not safety and effectiveness. Also included in this category are Reserve RX medications (medications whose active ingredient does not require a prescription but whose manufacturer has decided to sell only with a prescription) and ostomy supplies.

Q8: Does the prescription drug plan pay for lifestyle medications?

A8: In general, the plan does not pay for lifestyle medications.

Q9: Since the prescription drug plan does not pay for lifestyle medications, why is this a benefit?

A9: The benefit to members is that they receive the same discount the State has negotiated for the prescription drug plan on these items. So the member pays the negotiated discount plus a dispensing fee instead of the retail price of the product.

Q10: My physician has prescribed Glucagon, a medication that I inject myself with each day. Is that covered under the health or prescription drug plan?

A10: This self-injectible medication is covered under the Caremark prescription drug plan. A complete list of all self-injectible medications is available at <http://www.khpa.ks.gov> (KHPA web site).

Q11: I have tried several of my health plan's PDL medications and they have not been effective in treating my conditions. I have used a non preferred medication in the past that was effective. Is there any way to add this to my health plan's PDL?

A11: No. The plans utilize Caremark's PDL. Members can not request that Caremark change the PDL. However, the PDL override process addresses this situation since it allows the non preferred medication to be processed at the preferred brand name drug co-insurance rate.

Prescription overrides are available in the following instances:

- The member has tried two preferred medications and medical evidence indicates the preferred medications were ineffective.
- The member could not tolerate the preferred medication.
- There is not a generic or preferred brand name drug available or other plan criteria are met. The prescribing physician must request the prescription override on the member's behalf by calling Caremark at 1-800-294-5979. This telephone number is for use by physicians and their staff only; it is not a customer service line for members. Initial information will be taken by telephone. A form will be faxed to the physician for signature. Approvals may be granted if the member meets the plan criteria. The co-insurance paid on drugs with prescription overrides applies toward the co-insurance maximum.

Q12: Explain how the prescription drug co-insurance/co-payment maximum works.

A12: The co-insurance for generic and preferred brand drugs and the co-payment for special case medications are capped at a set dollar amount. For 2008, the maximum is \$2,580 per person per plan year. Once the member's share of eligible drug costs reaches the co-insurance/co-payment maximum, any additional generic, preferred or special case drugs will be covered by the plan at 100 percent for the remainder of the plan year. There is no cap on the co-insurance for non preferred brand name drugs.

Superior Vision Services Plan

Q1: I am enrolled in the vision plan and I didn't get an ID card for the vision plan; should I?

A1: If you enrolled, the ID card was included on the bottom of the cover letter sent with your enrollment packet. The ID card is not required to access care. Advise your provider of your Superior Vision coverage and they can call to verify coverage.

Q2: Who can be covered under the vision plan?

A2: You may elect any coverage on either the Basic Plan or Enhanced Plan regardless of enrollment in a health plan. Coverage levels include: you; you and your spouse; you and your child(ren); you and your family (spouse and children); or waive.

Q3: Why is the deductible for a routine eye exam so high on the vision insurance?

A3: The deductible is set at \$50 for the vision insurance because the health plans include coverage for a routine eye exam as part of the medical coverage. If you are covered under vision, be sure to advise your physician's office of both insurance plans when seeking treatment.

Q4: What is the difference between the Basic Plan and the Enhanced Plan?

A4: The Enhanced Plan covers everything the Basic Plan does plus basic progressive (no-line bifocals), high index lenses, polycarbonate lenses, scratch coating and ultraviolet protective coating.

Q5: What are progressive power lenses?

A5: Progressive power lenses are an alternative to the typical bifocal and trifocal lens designs that have small "windows" in the lower half of the lens. The progressive power lens has the power for distance vision at the top of the lens, like bifocal and trifocal lenses; however, the power of the lens then becomes progressively stronger from the mid-point of the lens to the bottom of the lens. Hence, the lens design is described as "progressive power." This lens design is also referred to as a "no line" lens. The power change enables the wearer to focus clearly at distance, at mid-point (arm's length) and all the way through to the near-point (reading area). There are definite advantages to wearing progressive power lenses as opposed to standard bifocal and trifocal lenses. However, because there is some visual distortion at the periphery of the progressive power lens, some people have difficulty adjusting to them.

Q6: What kinds of progressive power lenses are there?

A6: Progressive power lenses are available from a number of different manufacturers with many variations in design and curvature configuration. The lenses also are made in different materials, such as glass, plastic, transitions, High Index, Polaroid, etc. As a result, lens prices can vary greatly depending on these variations.

Q7: I went to the eye physician at my local Wal-Mart for an exam but the physician is not in the network. I thought all of the Wal-Mart stores were in Superior Vision's network?

A7: All Wal-Mart Vision Centers are contracted into the Superior Vision Plan Network. The associated optometrists, who are not employees of Wal-Mart must be contracted individually. Superior Vision has contacted all Wal-Mart associated optometrists in Kansas and will continue to promote the participation of those not yet in the network. Superior Vision cannot, however, guarantee that all of the optometrists will contract.

Q8: My physician wrote me a prescription for contact lenses. Does that mean they are considered medically necessary by the plan?

A8: No. Medically necessary contacts are contact lenses required due to a medical condition such as cataracts or glaucoma for which glasses are not an alternative treatment.