

# State Employee Health Benefits Plan Open Enrollment 2008 *For Retiree/Direct Bill Members*

## Health Plan Comparison Chart

	Plan A		Plan B		Coventry Advantra Freedom
	Blue Cross and Blue Shield Coventry Preferred Health Systems		Blue Cross and Blue Shield Coventry Preferred Health Systems		Preferred Provider Organization (PPO) Private Fee For Service (PFFS) – with or without prescription drug
	Network Providers	Non Network Providers	Network Providers	Non Network Providers	Network Providers
<b>Basic Provisions</b>					
<b>Co-insurance Maximum</b>	\$1,000 single/ \$2,000 family	\$3,650 single/ \$7,300 family	\$2,200 single/ \$4,400 family	\$3,650 single/ \$7,300 family	\$2,000
<b>Deductible:</b> <i>not included in co-insurance maximums</i> Single/Family	N/A	\$500 single/\$1,500 family	N/A	\$500 single/\$1,500 family	N/A
<b>Co-payments:</b> <i>not included in co-insurance maximum</i>					
Physician office visit	\$20 Primary Care Medical Home/\$40 Specialist	Deductible & 50% co-insurance	\$20 Primary Care Medical Home/\$40 Specialist	Deductible & 50% co-insurance	\$15 co-pay for PCP; \$30 co-pay for specialist
Emergency room	\$100 co-pay & 10% co-insurance	\$200 co-pay & 50% co-insurance	\$100 co-pay & 35% co-insurance	\$200 co-pay & 50% co-insurance	\$50 co-pay (waived if admitted)
Urgent care	10% co-insurance	Deductible & 50% co-insurance	35% co-insurance	Deductible & 50% co-insurance	\$30 co-pay, worldwide coverage
Hospital admission	10% co-insurance	\$600 co-pay, deductible & 50% co-insurance	35% co-insurance	Deductible, \$600 co-pay & 50% co-insurance	\$100 per day for day(s) 1-5
Outpatient mental health: <i>not biologically based</i>	First 3 visits, plan pays 100%, \$20 co-pay each additional visit	Deductible & 50% co-insurance	First 3 visits, plan pays 100%, \$20 co-pay each additional visit	Deductible & 50% co-insurance	\$30 co-pay for individual therapy \$15 co-pay for group therapy
Outpatient surgery	10% co-insurance	Deductible & 50% co-insurance	35% co-insurance	Deductible & 50% co-insurance	\$150 per visit
Major diagnostic tests	10% co-insurance	Deductible & 50% co-insurance	35% co-insurance	Deductible & 50% co-insurance	\$0 co-pay for clinical/diagnostic lab service
<b>Lifetime Benefit Maximum</b>	No limit	No limit	No limit	No limit	No limit
<b>Provider Choice</b>	Freedom to use provider of choice, benefits based on plan description: coverage level based on provider network status	Freedom to use provider of choice, benefits based on plan description: coverage level based on provider network status	Freedom to use provider of choice, benefits based on plan description: coverage level based on provider network status	Freedom to use provider of choice, benefits based on plan description: coverage level based on provider network status	Freedom to use provider of choice, benefits based on plan description: coverage level based on provider network status—only applies to PPO
<b>Out of Area Care</b>	N/A	N/A	N/A	N/A	N/A

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<b>Amounts Above Plan Allowance</b>	Provider to write off	Member responsibility	Provider to write off	Member responsibility	Provider to write off
<b>Covered Services</b>					
<b>Inpatient Services</b>	10% co-insurance	Deductible, 50% co-insurance & \$600 co-pay	35% co-insurance	Deductible, 50% co-insurance & \$600 co-pay	\$100 co-pay per day up to 5 days
<b>Physician Hospital Visits</b>	10% co-insurance	Deductible & 50% co-insurance	35% co-insurance	Deductible & 50% co-insurance	Included in the inpatient services co-pay
<b>Physician Office Visits</b>					
Medical Home	\$20 co-pay	Deductible & 50% co-insurance	\$20 co-pay	Deductible & 50% co-insurance	\$15 co-pay
Specialist	\$40 co-pay	Deductible & 50% co-insurance	\$40 co-pay co-insurance	Deductible & 50% co-insurance	\$30 co-pay
Urgent care center	10% co-insurance	Deductible & 50% co-insurance	35% co-insurance	Deductible & 50% co-insurance	\$30 co-pay, worldwide coverage
<b>Outpatient Surgery</b>	10% co-insurance	Deductible & 50% co-insurance	35% co-insurance	Deductible & 50% co-insurance	\$150 co-pay
<b>Emergency Room Visits</b>	\$100 co-pay (waived if admitted) then 10% co-insurance	Deductible, 50% co-insurance & \$200 co-pay	Co-pay & 35% co-insurance	Deductible, 50% co-insurance & \$200 co-pay	\$50 co-pay (waived if admitted)
<b>Other Outpatient Services</b>	10% co-insurance	50% co-insurance	35% co-insurance	50% co-insurance	See specific services on this chart
<b>Ambulance Services</b>	10% co-insurance	10% co-insurance	35% co-insurance	35% co-insurance	\$100 per one-way trip
<b>Major Diagnostic Tests*</b>	10% co-insurance	Deductible & 50% co-insurance	35% co-insurance	Deductible & 50% co-insurance	\$75 co-pay
<b>Home Health Care</b>	Services must be pre-approved by health plan; 10% co-insurance	Services must be pre-approved by health plan; deductible & 50% co-insurance	Services must be pre-approved by health plan; 35% co-insurance	Services must be pre-approved by health plan; deductible & 50% co-insurance	Services must be pre-approved by health plan
<b>Hospice</b>	Services must be pre-approved by health plan; limited to 6 months; 10% co-insurance	Services must be pre-approved by health plan; limited to 6 months; deductible & 50% co-insurance	Services must be pre-approved by health plan; limited to 6 months; 35% co-insurance	Services must be pre-approved by health plan; limited to 6 months; deductible & 50% co-insurance	Services must be pre-approved by health plan

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<b>X-Ray and Laboratory</b>	10% co-insurance	Deductible & 50% co-insurance	35% co-insurance	Deductible & 50% co-insurance	\$0 co-pay for clinical/diagnostic lab service
<b>Physical Rehabilitation Services:</b> <i>including chiropractic care</i>	Services limited to those medically necessary and appropriate: medical records must show continued improvement	Services limited to those medically necessary and appropriate: medical records must show continued improvement	Services limited to those medically necessary and appropriate: medical records must show continued improvement	Services limited to those medically necessary and appropriate: medical records must show continued improvement	\$30 co-pay per visit
Inpatient facility	10% co-insurance: must show continued improvement	\$600 co-pay, deductible & 50% co-insurance: must show continued improvement; must be pre-approved by health plan	35% co-insurance: must show continued improvement; must be pre-approved by health plan	\$600 co-pay, deductible & 50% co-insurance: must show continued improvement; must be pre-approved by health plan	\$100 co-pay per day up to 5 days
Outpatient facility	10% co-insurance: must show continued improvement	Deductible & 50% co-insurance: must show continued improvement	35% co-insurance: must show continued improvement	Deductible & 50% co-insurance: must show continued improvement	\$15 co-pay for PCP; \$30 co-pay for specialist
Office based	10% co-insurance: limited to 30 visits per year	Deductible & 50% co-insurance: limited to 30 visits per year	35% co-insurance: limited to 30 visits per year	Deductible & 50% co-insurance: limited to 30 visits per year	\$15 co-pay for PCP; \$30 co-pay for specialist
<b>Durable Medical Equipment</b>	Services must be pre-approved by health plan; limited to \$5,000 per person per year of covered services; 10% co-insurance	Deductible & 50% co-insurance; limited to \$5,000 per person per year; must be pre-approved by health plan	35% co-insurance; limited to \$5,000 per person per year; must be pre-approved by health plan	Deductible & 50% co-insurance; limited to \$5,000 per person per year; must be pre-approved by health plan	20% co-insurance
<b>Allergy Testing</b>	10% co-insurance: must be pre-approved by health plan	Deductible & 50% co-insurance: must be pre-approved by health plan	35% co-insurance: must be pre-approved by health plan	Deductible & 50% co-insurance: must be pre-approved by health plan	\$15 co-pay for PCP; \$30 co-pay for specialist
<b>Antigen Administration:</b> <i>desensitization/treatment; allergy shots</i>	Covered in full: must be pre-approved by health plan	Deductible & 50% co-insurance: must be pre-approved by health plan	Covered in full: must be pre-approved by health plan	Deductible & 50% co-insurance: must be pre-approved by health plan	\$15 co-pay for PCP; \$30 co-pay for specialist
<b>Infertility Treatment:</b> <i>limited to testing &amp; three attempts at artificial insemination per year</i>	Office visit co-pay & 10% co-insurance: must be pre-approved by health plan	Deductible & 50% co-insurance: must be pre-approved by health plan	35% co-insurance: must be pre-approved by health plan	Deductible & 50% co-insurance: must be pre-approved by health plan	Not covered
<b>Covered Immunizations</b>	Covered in full	To age 5: Covered in full Adult: Deductible & 50% co-insurance	Covered in full	To age 5: Covered in full Adult: Deductible & 50% co-insurance	Covered in full

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<b>Mental Health</b>					
<b>Inpatient Nervous &amp; Mental</b>	10% co-insurance	\$600 co-pay per admission, deductible & 50% co-insurance (60-day limit per year)	35% co-insurance	\$600 co-pay per admission, deductible & 50% co-insurance (60-day limit per year)	\$100 per day (90-day limit per year)
<b>Inpatient Drug &amp; Alcohol</b>	10% co-insurance (60-day limit per year)	\$600 co-pay per admission, deductible & 50% co-insurance (30-day limit per year)	35% co-insurance (60-day limit per year)	\$600 co-pay per admission, deductible & 50% co-insurance (30-day limit per year)	\$100 per day (90-day limit per year)
<b>Outpatient Nervous &amp; Mental</b>	First 3 visits, plan pays 100%; \$20 co-pay each additional visit	Deductible & 50% co-insurance	First 3 visits, plan pays 100%; \$20 co-pay each additional visit	Deductible & 50% co-insurance	\$30 co-pay for individual therapy; \$15 co-pay for group therapy
<b>Outpatient Drug &amp; Alcohol</b>	First 3 visits, plan pays 100%; next 22 visits \$25 co-pay each visit (both network and non network visits count toward 25-visit limit); 50% co-insurance for additional visits	First 3 visits, plan pays 100%; next 22 visits 50% co-insurance (limited to 25 visits per year; both network and non network visits count toward 25-visit limit)	First 3 visits, plan pays 100%; next 22 visits \$25 co-pay each visit (both network and non network visits count toward 25-visit limit); 50% co-insurance for additional visits	First 3 visits, plan pays 100%; next 22 visits 50% co-insurance (limited to 25 visits per year; both network and non network visits count toward 25-visit limit)	\$30 co-pay for individual therapy; \$15 co-pay for group therapy
<b>Preventive Care**</b>					
<b>Preventive Care Services</b>	Covered in full	Not covered	Covered in full	Not covered	Covered in full
<b>Age Appropriate Routine Physical Exam</b>	Covered in full	Not covered	Covered in full	Not covered	\$15 co-pay, limited to 1 exam per year
<b>Well-Woman Care:</b> <i>office visit, PAP smear test, &amp; STD testing</i>	Covered in full	Not covered	Covered in full	Not covered	\$15 co-pay, limited to 1 exam per year
<b>Well-Man Care:</b> <i>office visit &amp; PSA blood test</i>	Covered in full	Not covered	Covered in full	Not covered	\$15 co-pay, limited to 1 exam per year
<b>Mammogram</b>	Covered in full	Not covered	Covered in full	Not covered	Covered in full
<b>Licensed Dietitian Consultation:</b> <i>for medical management of a documented disease</i>	10% co-insurance	Not covered as preventive care; deductible & 50% co-insurance apply	35% co-insurance	Not covered as preventive care; deductible & 50% co-insurance apply	Covered in full

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<b>Routine Hearing Exam</b>	Covered in full	Not covered	Covered in full	Not covered	\$30 co-pay for each routine hearing test up to 1 per year, \$500 every 3 years for hearing aids	
<b>Routine Vision Exam:</b> <i>refraction exam for glasses; lenses &amp; frames not covered</i>	Covered in full	Not covered	Covered in full	Not covered	\$15 co-pay for PCP; \$30 co-pay for specialist (limited to 1 routine visit per year)	
<b>Age Appropriate Bone Density Screening</b>	Covered in full	Not covered	Covered in full	Not covered	Covered in full	
<b>Routine Age Appropriate Colonoscopy</b>	Covered in full	Not covered	Covered in full	Not covered	Covered in full	
Prescription Drugs						
Prescription Drug Services	Covered by separate contract with Caremark	Covered by separate contract with Caremark	Covered by separate contract with Caremark	Covered by separate contract with Caremark	Prescription Drug Plan Details	
					Generic drug	\$5 co-pay
					Preferred brand name drug	\$25 co-pay
					Non-preferred brand name drug	\$50 co-pay
					Injectables	25% co-insurance
					Limit	The initial coverage limit is \$2,510 and is based on the applicable co-pay plus the plan cost. After this amount is reached, there is generic-only coverage until your out-of-pocket costs reach \$4,050.
					Catastrophic coverage	\$2.25 co-pay for generic or preferred brand name drugs and \$5.60 co-pay or 5% co-insurance, whichever is highest, for all other drugs. Catastrophic coverage becomes effective when your out-of-pocket costs reach \$4,050.
<p><i>The comparison chart is NOT the governing document. Members need to refer to the Certificate of Coverage and Benefit Descriptions posted on <a href="http://www.khpa.ks.gov">http://www.khpa.ks.gov</a> (Kansas Health Policy Authority web site).</i></p> <p><b>* Major Diagnostic Tests (for Plan A and Plan B) :</b> includes but not limited to; PET scans, CT scans, nuclear cardiology studies, magnetic resonance angiography, &amp; computerized topography angiography. Most major diagnostic tests require pre-approval by the Health Plan.</p> <p><b>** Preventive Care:</b> The plan pays preventive care benefits for services coded as routine (as for a routine exam). For services coded in connection with the diagnosis of a condition, regular benefits apply. <b>Example:</b> If you go to you primary care physician for an annual exam and the exam is coded with a diagnosis, you'll pay a \$20 office visit co-pay. If the annual exam is coded as routine, the exam is covered in full. <b>Exception:</b> Colonoscopies and mammograms obtained from a network provider will be covered as preventive care (covered in full) whether they are routine or coded with a diagnosis.</p>					Out-of-Network Coverage: 20% co-insurance; The co-insurance is based on Medicare allowables—applies to PPO only.	
	<b>Phone Numbers:</b>					
	Coventry Advantra Freedom	<b>PFFS:</b> 1-866-714-9291 <b>TDD</b> 1-866-386-2335	<b>PPO:</b> 1-800-727-9712 <b>TDD</b> 1-866-347-2335			

# Kansas Senior Plan C

Medicare Payment Information		
Medicare A – Hospitalization	Medicare B – Medical	Kansas Senior Plan C Supplement
<p><b>Inpatient hospital</b></p> <ul style="list-style-type: none"> <li>• First 60 Days: \$992 deductible*</li> <li>• Days 61 through 90: \$248 per day co-insurance*</li> <li>• Lifetime reserve: \$496 per day co-insurance*</li> </ul> <p><b>Skilled Nursing Facility</b></p> <ul style="list-style-type: none"> <li>• First 20 days: 100% payment—no co-pay</li> <li>• Days 21-100: \$124 per day co-insurance*</li> </ul> <p><b>Services Paid at 100%</b></p> <ul style="list-style-type: none"> <li>• Home health</li> <li>• Hospice</li> <li>• Benefit period ends when the patient is out of the hospital or skilled nursing facility for 60 consecutive days</li> </ul> <p>There is usually no premium associated with Medicare Part A.</p> <p>Coverage shown is per benefit period. A benefit period ends when the patient is out of the hospital or skilled nursing facility for 60 consecutive days.</p>	<p><b>Annual Deductible</b></p> <p>\$131 deductible per calendar year (January 1 through December 31)*</p> <p><b>Medicare Coverage for Physician’s Charges</b></p> <p>Medicare pays 80% of allowed charge; Beneficiary pays 20% co-insurance* (in- or out-of-hospital)</p> <p><b>Durable Medical Expenses and Supplies</b></p> <ul style="list-style-type: none"> <li>• Ambulance</li> <li>• Outpatient hospital charges</li> <li>• Blood (first 3 pints)</li> <li>• Lab services</li> </ul> <p><b>Preventive Services</b></p> <ul style="list-style-type: none"> <li>• Bone mass measurement</li> <li>• Cardiovascular screenings</li> <li>• Colorectal screenings</li> <li>• Diabetes screenings</li> <li>• Flu shots</li> <li>• Glaucoma tests</li> <li>• Hepatitis B shots</li> <li>• Pap tests</li> <li>• Pneumococcal shot</li> <li>• Prostate cancer screening</li> <li>• Screening mammograms</li> <li>• “Welcome to Medicare” physical exam (one-time)</li> </ul> <p><i>Routine physical exams with no specific diagnosis are not covered</i></p> <p><b>Beneficiary must pay a monthly Medicare Part B Premium</b></p>	<p>Kansas Senior Plan C pays for all costs shown in orange to the left under Medicare Part A and Part B. In addition, Kansas Senior Plan C pays the following:</p> <ul style="list-style-type: none"> <li>• An additional 365 hospital days per lifetime</li> <li>• Foreign emergency travel medical services: \$250 deductible, then the plan pays 80% to a maximum of \$50,000 lifetime</li> <li>• If Medicare A and B do not cover the service, there is no benefit under the medical portion of Kansas Senior Plan C</li> </ul>

\*The deductible and co-insurance amounts listed in this chart reflect 2007 rates. Be sure to review your Medicare and You handbook from Social Security for the new 2008 amounts.