

*Coordinating health & health care
for a thriving Kansas*



STATE EMPLOYEE HEALTH PLAN

NON STATE GROUPS

Visit us online at:

http://www.sehp2010ks.org/covered_groups/non-state/



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The Kansas State Employees Health Care Commission (HCC) provides for the purchase and administration of a comprehensive health benefit program 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 State Employee Health Plan (SEHP). Administration of the State Employee Health Plan (SEHP) is done by the Kansas Health Policy Authority (KHPA), which is charged with coordinating a statewide health policy agenda that incorporates effective purchasing and administration with health promotion strategies.

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

http://www.khpa.ks.gov/sehp/healthcare_commission.html

The State of Kansas Health Care Commission (HCC) was established in 1984 by the legislature for the purpose of developing and providing for implementation and administration of the State Employee Health Plan (SEHP). In 1999 the HCC established administrative procedures and eligibility requirements to allow for inclusion of Unified School Districts, community colleges, technical colleges and vocational technical schools into the SEHP. K.A.R. 108-1-3 outlines these requirements. The HCC expanded the program to include of public employers (cities, counties, townships etc.) under K.A.R. 108-1-4. The HCC is responsible for determining eligibility of public employers to participate while maintaining the integrity of the state employee plan, and in compliance with the criteria outlined K.S.A. 75-6506. The participation criteria outlined in K.S.A. 75-6506 is included in this packet.

State Employees Health Plan – Non State Entities

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

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

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

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

Documentation Requirements for Enrollment

Employees must provide:

- A copy of their original state marriage certificate – if covering a spouse. A copy of first and last page of the most recent Federal Income Tax form may be used in place of a marriage certificate.
- Copy of birth certificates, if covering children. Birth certificate must list the names of the father, mother and child.
- Social Security Numbers for everyone covered under the policy.
- Medicare information, if Medicare eligible. Medicare eligible employees must complete TEFRA form at time of enrollment.

Billing Administrator: HP Enterprise Services

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

Payment Address:

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

Correspondence Address:

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

Payment Options:

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

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

HealthWave Eligibility and the SEHP

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

Eligibility Rules

- Eligible employees for coverage under the SEHP include:
 - Educational group employees working 630 hours or more per year.
 - Public employees working 1000 hours or more per year.
- Eligible dependents include
 - The employee's lawful spouse.
 - Unmarried children or step children who:
 - Under age 23.
 - Do not file a joint tax return with another taxpayer.
 - Receives more than half their support from the eligible employee.
 - Are U.S. citizens, a U.S. national or a resident of the U.S., Canada, or Mexico.
- Retirees of a participating group are eligible for coverage **if** they are covered by the non state entity's health plan on the day before the group joins the SEHP.
- Employees hired after the effective date of the group with the SEHP will be subject to a 60 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 60 day waiting period.
- Anyone who is eligible to be covered as an employee under either the State or non state entities covered under the State Employee Health Plan (SEHP) may not be covered as a dependent (spouse or child) under the SEHP. This includes married couples who are both eligible employees to enroll in the SEHP regardless of whether they have the same or different employers.
- Dependents may not be covered under more than one SEHP contract. This applies to all dependents covered under the SEHP regardless of whether they are covered under a state or non state entity plan.
- For newly hired employees enrolling in the SEHP, there is a sixty (60) day waiting period. Health plan coverage begins the first day of the month following completion of the sixty (60) day waiting period. The waiting period may be reduced or waived in accordance with K.A.R> 108-1-3 for educational entities and 108-1-4 for all other public employers. The request for a waiver of the waiting period must be submitted and approved by SEHP before an offer of employment is given.
- The SEHP does not apply a waiting period for pre-existing conditions. Therefore, certificates of creditable coverage are not required.

This is a sample of the eligibility requirements for the SEHP. The complete list of eligibility rules and guidelines can be found in the Non State Group, Administrative Manual or in the Non State Group Employee Health Plan Guidebook which is available online at <http://www.sehp2010ks.org> – Just click on the **Quick Links** button labeled **Employee Benefits Guidebook** and select the **Non State Group** button at the top of that page.

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

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, 1,004 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

Health Plan Comparison Chart

	Plan A		Plan B		Plan C – QHDHP with Health Savings Account	
	Blue Cross and Blue Shield Coventry Preferred Health Systems UMR, A UnitedHealthcare Company	Blue Cross and Blue Shield Coventry Preferred Health Systems UMR, A UnitedHealthcare Company	Blue Cross and Blue Shield Coventry Preferred Health Systems UMR, A UnitedHealthcare Company	Blue Cross and Blue Shield Coventry Preferred Health Systems UMR, A UnitedHealthcare Company	Coventry Preferred Health Systems UMR, A UnitedHealthcare Company	Coventry Preferred Health Systems UMR, A UnitedHealthcare Company
Network Providers	Network Providers	Network Providers	Network Providers	Network Providers	Network Providers	
Basic Provisions	Freedom to use provider of choice, benefits based on plan description: coverage level based on provider network status					
Provider Choice	Freedom to use provider of choice, benefits based on plan description: coverage level based on provider network status					
Annual Deductible: not included in Coinsurance maximums in Plans A & B	\$150 single/\$300 family	\$500 single/\$1,500 family	N/A	\$500 single/\$1,500 family	<i>Note: When selecting any level of dependent coverage, the entire family Deductible must be met before claims are paid for any covered person.</i>	
Coinsurance (for all eligible expenses, unless otherwise noted)	20% Coinsurance	50% Coinsurance	30% Coinsurance	50% Coinsurance	20% Coinsurance	50% Coinsurance
Annual Coinsurance Maximum	\$1,200 single/\$2,400 family (does not include Deductible and Copayments)	\$3,650 single/\$7,300 family (does not include Deductible and Copayments)	\$2,200 single/\$4,400 family (does not include Copayments)	\$3,650 single/\$7,300 family (does not include Deductible and Copayments)	N/A	N/A
Annual Out-of-Pocket Maximum	N/A	N/A	N/A	N/A	\$3,000 single/\$6,000 family (includes Deductible and Coinsurance)	\$3,650 single/\$7,300 family (includes Deductible and Coinsurance)
Lifetime Benefit Maximum	No limit	No limit	No limit	No limit	No limit	No limit
Amounts Above Plan Allowance	Provider to write off	Member responsibility	Provider to write off	Member responsibility	Provider to write off	Member responsibility
Covered Services						
Inpatient Services	Deductible & 20% Coinsurance	\$600 Copayment, Deductible & 50% Coinsurance	30% Coinsurance	\$600 Copayment, Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Physician Hospital Visits	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Physician Office Visits						
Primary Care Provider	\$20 Copayment	Deductible & 50% Coinsurance	Adults: \$20 Copayment/ Dependent children age 18 and under: \$10 Copayment	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Specialist	\$40 Copayment	Deductible & 50% Coinsurance	Adults: \$40 Copayment/ Dependent children age 18 and under: \$25 Copayment	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Urgent care center	\$20 Copayment, Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	\$20 Copayment & 30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance

Outpatient Surgery	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Emergency Room Visits	\$100 Copayment (waived if admitted) then Deductible & 20% Coinsurance	\$200 Copayment (waived if admitted) then Deductible & 50% Coinsurance	\$100 Copayment (waived if admitted) then 30% Coinsurance	\$200 Copayment (waived if admitted) then Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
Other Outpatient Services	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Ambulance Services	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	30% Coinsurance	Deductible & 30% Coinsurance	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
Major Diagnostic Tests*	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Home Health Care <i>services must be pre-approved by health plan</i>	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Hospice <i>services must be pre-approved by health plan; limited to six months</i>	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
X-Ray and Laboratory	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Physical Rehabilitation Services: Including chiropractic care (services limited to those medically necessary and appropriate: medical records must show continued improvement)						
Inpatient facility	Deductible & 20% Coinsurance	\$600 Copayment, Deductible & 50% Coinsurance	30% Coinsurance	\$600 Copayment, Deductible & 50% Coinsurance	Deductible & 20% Coinsurance; limited to 20 days per calendar year	Deductible & 50% Coinsurance; limited to 20 days per calendar year
Outpatient facility	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance: • Both facility and office based Outpatient Rehab is limited to 20 visits per calendar year	Deductible & 50% Coinsurance: • Both facility and office based Outpatient Rehab is limited to 20 visits per calendar year
Office based	Deductible & 20% Coinsurance; limited to 30 visits per year	Deductible & 50% Coinsurance; limited to 30 visits per year	30% Coinsurance; limited to 30 visits per year	Deductible & 50% Coinsurance; limited to 30 visits per year	• Chiropractic is limited to 26 visits per calendar year	• Chiropractic is limited to 26 visits per calendar year
Durable Medical Equipment	Deductible & 20% Coinsurance; limited to \$5,000 per person per year	Deductible & 50% Coinsurance; limited to \$5,000 per person per year	30% Coinsurance; limited to \$5,000 per person per year	Deductible & 50% Coinsurance; limited to \$5,000 per person per year	Deductible & 20% Coinsurance; limited to \$1,000 per person per year	Deductible & 50% Coinsurance; limited to \$1,000 per person per year
Allergy Testing	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Antigen Administration: <i>desensitization/treatment; allergy shots</i>	Covered in full	Deductible & 50% Coinsurance	Covered in full	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Infertility Treatment: <i>limited to testing & three attempts at artificial insemination per year</i>	Office visit Copayment, Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Office visit Copayment & 30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance; diagnosis & surgical treatment only; limited to \$2,000 per year

Licensed Dietitian Consultation: for medical management of a documented disease	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Mental Health	Same Coverage as Medical					
Mental Illness & Drug or Alcohol Treatment	Same Coverage as Medical					
Preventive Care						
Age Appropriate Routine Physical Exam	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Well-Woman Care: office visit, PAP smear test & STD testing	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Well-Man Care: office visit & PSA blood test	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Mammogram	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Covered Immunizations	Covered in full	Dependent children up to age 6: Covered in full Adults: Deductible & 50% Coinsurance	Covered in full	Dependent children up to age 6: Covered in full Adults: Deductible & 50% Coinsurance	Covered in full	Dependent children up to age 6: Covered in full Adults: Deductible & 50% Coinsurance
Routine Hearing Exam	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Routine Vision Exam: refraction exam for glasses; lenses & frames <i>not covered</i>	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Age Appropriate Bone Density Screening	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Colonoscopy	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Non Covered Services						
TMJ/Orthognathic Treatment	Not covered under medical: see dental, limited					
Weight Loss Surgery	Not covered					
Prescription Drugs						
Prescription Drug Services	Covered by separate contract with Caremark					
Dental						
Dental Services	Covered by separate contract with Delta Dental					

The comparison chart is NOT the governing document. Members need to refer to the Certificate of Coverage and Benefit Descriptions posted on <http://www.khparks.gov> 2010 Open Enrollment website.

Health Savings Account - Only Available with Plan C

Plan C - QHDHP HSA

	Full-Time Employee		Part-Time Employee	
	Employee Only	Employee + Dependents	Employee Only	Employee + Dependents*
Employer Contribution	\$37.50 (\$900.00 per year)	\$56.25 (\$1,350.00 per year)	\$28.13 (\$675.12 per year)	\$42.19 (\$1,012.56 per year)
Employee Contributions	\$25.00 to \$89.58	\$25.00 to \$200.00	\$25.00 to \$98.95	\$25.00 to \$214.06

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

Note: All columns represent 24 semi-monthly payments. The HSA total State contribution for nine-month Regents employees are distributed evenly over 16 pay periods each year.

Banking Institutions for Plan C – Qualified High Deductible Health Plans with Health Savings Accounts - go to www.khpa.ks.gov for more information.

- Coventry – UMB Bank
- Preferred Health Systems – Health Equity
- UMR, A UnitedHealthcare Company – American Chartered Bank

Prescriptions Drug Benefits for Plan A and Plan B

Tier	Type of Prescription Medication	You Pay	Your Coinsurance Maximum
Tier 1	Generic drugs	20% Coinsurance	There is a combined Coinsurance maximum of \$2,580 per person/year that applies to Tiers 1, 2 and 3.
Tier 2	Preferred brand name drugs	35% Coinsurance	
Tier 3	Specialty medications (Very high-cost medications used to treat conditions that are generally life threatening)	\$75 Copayment per standard fill or 30-day supply	
Tier 4	Non preferred brand name drugs	60% Coinsurance	N/A (unless an override has been granted by Caremark)
Tier 5	Discount Tier medications	100% of discounted price	N/A

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

Prescription Drug Chronic Care Benefit for Plan A and Plan B

Prescription Drugs for:	Prescription Drug Product	Member Responsibility Per 30-Day Supply
Diabetes	Generic drug	10% to a maximum of \$10
	Preferred brand name drug	20% to a maximum of \$20
	Generic drug	10% to a maximum of \$10
Asthma	Preferred brand name drug	20% to a maximum of \$20

Prescription Drug Benefits for Plan C - QHDHP

	Network	Non Network
Generic	Deductible then \$10 Copayment	Deductible then \$20 Copayment
Preferred	Deductible then \$30 Copayment	Deductible then \$60 Copayment
Non Preferred	Deductible then \$55 Copayment	Deductible then \$110 Copayment

Prescription drugs covered by Plan C are subject to an annual Deductible then Copayments. Copay is per each 30 day supply. Plan includes generic Incentive program.

Delta Dental Benefits			
	Delta Dental PPO Network Provider	Delta Dental Premier Network Provider	Non Network* Provider
Annual Benefit Maximum	\$1,700 per member		
Lifetime Orthodontic Benefit Maximum	50% Coinsurance to a \$1,000 per member		
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 <u>NOT</u> had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months			
Diagnostic and Preventive Services	Allowed Amount covered in full by the Plan*		
Basic Restorative Services	50%	50%	50%
Major Restorative Services	50%	50%	50%
ENHANCED BENEFIT			
Applies when you have had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months			
Diagnostic and Preventive Services	Allowed Amount covered in full by the Plan*		
Basic Restorative Services	20%	40%	40%
Major Restorative Services	50%	50%	50%

*Services by Non Network providers are subject to the Allowed Amount including the Maximum Plan Allowance for Non Network Providers. Any amounts in excess of the Allowed Amount will be the member's responsibility.

Your Coinsurance will increase for Basic Restorative Services when you have not had a routine prophylaxis (cleaning) and/or preventive oral exam in the preceding twelve (12) month period. Ninety (90) days following receipt of a qualifying prophylaxis (cleaning) or preventive oral exam, you will qualify for the Enhanced Benefit Level. The Plan reserves the right to determine what services will qualify as meeting the definition of a routine prophylaxis (cleaning) and preventive oral exam. Routine prophylaxis (cleanings) and preventive exams shall not include any services provided on an emergency basis or for treatment of an injury to the teeth.



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 \$100 retail*	Up to \$45
• Single vision lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to \$31
• Bifocal lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to \$51
• Trifocal lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to \$64
• Lenticular lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to \$80
• Progressive lenses, pair	Not covered	Covered up to \$165*	Not covered
• High index lenses, pair**	Not covered	Covered up to \$116*	Not covered
• Polycarbonate lenses, pair**	Not covered	Covered up to \$116*	Not covered
• Scratch coat	Not covered	Covered in full	Not covered
• UV coat	Not covered	Covered in full	Not covered
Contact Lenses: Not subject to materials Copayment			
• When medically necessary	Covered in full	Covered in full	Up to \$210 retail*
• Elective/cosmetic retail	Up to \$150 retail*	Up to \$150 retail*	Up to \$105 retail*
Contact Lens Exam (fitting fee) (\$35 Copayment)			
• Specialty contacts***	Not Covered	Up to \$50*	Not Covered
• Standard Contacts****	Not Covered	Covered in full	Not Covered

*You are responsible for any charges above the allowance.

** You may only be covered for one pair of high index lenses or polycarbonate lenses under the Enhanced Plan (up to the allowance provided above).

*** Specialty contacts are for new contact lens wearers or patients who wear toric, gas permeable or multi-focal lenses; includes two follow-up visits within three months of initial fitting.

**** Standard contacts are for existing contact lens wearers of disposable, daily wear or extended lenses; includes two follow-up visits within three months of initial fitting.

Notes:

- Members can use either the contact lens benefit or the eyeglass benefit, but not both in the same plan year.
- For non network claims, Copayment amounts are deducted from the benefit allowance at the time of reimbursement.
- Covered lenses are standard glass or plastic (CR-39), clear.

Monthly Employee Rates for Calendar Year

**These rates are based on 95/55% Contribution by
Employer**

**2010 RATE SHEET FOR NON STATE GROUP EMPLOYEES
PLAN A (ADD DEPENDENT DENTAL)**

BLUE CROSS AND BLUE SHIELD - PLAN A			
EMPLOYEES EARNING LESS THAN \$28,000 PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$50.58	\$148.06
2	Member and Spouse Only	\$231.52	\$384.26
3	Member and Child(ren) Only	\$195.34	\$337.02
4	Member and Family	\$376.26	\$573.24
EMPLOYEES EARNING \$28,000 TO \$48,000 PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$60.64	\$148.06
2	Member and Spouse Only	\$241.58	\$384.26
3	Member and Child(ren) Only	\$205.38	\$337.02
4	Member and Family	\$386.30	\$573.24
EMPLOYEES EARNING \$48,000 OR MORE PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$70.68	\$148.06
2	Member and Spouse Only	\$251.62	\$384.26
3	Member and Child(ren) Only	\$215.44	\$337.02
4	Member and Family	\$396.36	\$573.24

COVENTRY HEALTH CARE - PLAN A			
EMPLOYEES EARNING LESS THAN \$28,000 PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$50.34	\$145.54
2	Member and Spouse Only	\$227.06	\$376.22
3	Member and Child(ren) Only	\$191.72	\$330.08
4	Member and Family	\$368.42	\$560.80
EMPLOYEES EARNING \$28,000 TO \$48,000 PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$60.18	\$145.54
2	Member and Spouse Only	\$236.88	\$376.22
3	Member and Child(ren) Only	\$201.54	\$330.08
4	Member and Family	\$378.22	\$560.80
EMPLOYEES EARNING \$48,000 OR MORE PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$69.98	\$145.54
2	Member and Spouse Only	\$246.70	\$376.22
3	Member and Child(ren) Only	\$211.36	\$330.08
4	Member and Family	\$388.06	\$560.80

**2010 RATE SHEET FOR NON STATE GROUP EMPLOYEES
PLAN A (ADD DEPENDENT DENTAL)**

PREFERRED HEALTH SYSTEMS - PLAN A			
EMPLOYEES EARNING LESS THAN \$28,000 PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$51.30	\$155.72
2	Member and Spouse Only	\$245.04	\$408.64
3	Member and Child(ren) Only	\$206.30	\$358.06
4	Member and Family	\$400.04	\$611.00
EMPLOYEES EARNING \$28,000 TO \$48,000 PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$62.06	\$155.72
2	Member and Spouse Only	\$255.82	\$408.64
3	Member and Child(ren) Only	\$217.06	\$358.06
4	Member and Family	\$410.78	\$611.00
EMPLOYEES EARNING \$48,000 OR MORE PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$72.82	\$155.72
2	Member and Spouse Only	\$266.56	\$408.64
3	Member and Child(ren) Only	\$227.82	\$358.06
4	Member and Family	\$421.56	\$611.00

UMR, A UNITED HEALTHCARE COMPANY - PLAN A			
EMPLOYEES EARNING LESS THAN \$28,000 PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$49.54	\$136.84
2	Member and Spouse Only	\$211.68	\$348.52
3	Member and Child(ren) Only	\$179.26	\$306.18
4	Member and Family	\$341.46	\$517.98
EMPLOYEES EARNING \$28,000 TO \$48,000 PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$58.56	\$136.84
2	Member and Spouse Only	\$220.70	\$348.52
3	Member and Child(ren) Only	\$188.28	\$306.18
4	Member and Family	\$350.48	\$517.98
EMPLOYEES EARNING \$48,000 OR MORE PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$67.56	\$136.84
2	Member and Spouse Only	\$229.70	\$348.52
3	Member and Child(ren) Only	\$197.28	\$306.18
4	Member and Family	\$359.48	\$517.98

**2010 RATE SHEET FOR NON STATE GROUP EMPLOYEES
PLAN B (ADD DEPENDENT DENTAL)**

BLUE CROSS AND BLUE SHIELD - PLAN B			
EMPLOYEES EARNING LESS THAN \$28,000 PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$50.08	\$142.66
2	Member and Spouse Only	\$221.96	\$367.04
3	Member and Child(ren) Only	\$187.60	\$322.16
4	Member and Family	\$359.46	\$546.58
EMPLOYEES EARNING \$28,000 TO \$48,000 PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$59.64	\$142.66
2	Member and Spouse Only	\$231.52	\$367.04
3	Member and Child(ren) Only	\$197.14	\$322.16
4	Member and Family	\$369.02	\$546.58
EMPLOYEES EARNING \$48,000 OR MORE PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$69.18	\$142.66
2	Member and Spouse Only	\$241.06	\$367.04
3	Member and Child(ren) Only	\$206.70	\$322.16
4	Member and Family	\$378.56	\$546.58

COVENTRY HEALTH CARE - PLAN B			
EMPLOYEES EARNING LESS THAN \$28,000 PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$49.86	\$140.26
2	Member and Spouse Only	\$217.72	\$359.40
3	Member and Child(ren) Only	\$184.16	\$315.58
4	Member and Family	\$352.02	\$534.76
EMPLOYEES EARNING \$28,000 TO \$48,000 PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$59.20	\$140.26
2	Member and Spouse Only	\$227.06	\$359.40
3	Member and Child(ren) Only	\$193.48	\$315.58
4	Member and Family	\$361.36	\$534.76
EMPLOYEES EARNING \$48,000 OR MORE PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$68.52	\$140.26
2	Member and Spouse Only	\$236.38	\$359.40
3	Member and Child(ren) Only	\$202.82	\$315.58
4	Member and Family	\$370.66	\$534.76

**2010 RATE SHEET FOR NON STATE GROUP EMPLOYEES
PLAN B (ADD DEPENDENT DENTAL)**

PREFERRED HEALTH SYSTEMS - PLAN B			
EMPLOYEES EARNING LESS THAN \$28,000 PER YEAR		Full Time Employee Payment	Part Time Employee Payment
CODE	COVERAGE LEVEL		
1	Member Only	\$50.76	\$149.94
2	Member and Spouse Only	\$234.80	\$390.20
3	Member and Child(ren) Only	\$198.02	\$342.14
4	Member and Family	\$382.04	\$582.46
EMPLOYEES EARNING \$28,000 TO \$48,000 PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$61.00	\$149.94
2	Member and Spouse Only	\$245.04	\$390.20
3	Member and Child(ren) Only	\$208.22	\$342.14
4	Member and Family	\$392.28	\$582.46
EMPLOYEES EARNING \$48,000 OR MORE PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$71.20	\$149.94
2	Member and Spouse Only	\$255.26	\$390.20
3	Member and Child(ren) Only	\$218.46	\$342.14
4	Member and Family	\$402.50	\$582.46

UMR, A UNITED HEALTHCARE COMPANY - PLAN B			
EMPLOYEES EARNING LESS THAN \$28,000 PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$49.10	\$132.00
2	Member and Spouse Only	\$203.14	\$333.10
3	Member and Child(ren) Only	\$172.34	\$292.88
4	Member and Family	\$326.42	\$494.08
EMPLOYEES EARNING \$28,000 TO \$48,000 PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$57.66	\$132.00
2	Member and Spouse Only	\$211.70	\$333.10
3	Member and Child(ren) Only	\$180.88	\$292.88
4	Member and Family	\$334.98	\$494.08
EMPLOYEES EARNING \$48,000 OR MORE PER YEAR		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$66.20	\$132.00
2	Member and Spouse Only	\$220.24	\$333.10
3	Member and Child(ren) Only	\$189.44	\$292.88
4	Member and Family	\$343.54	\$494.08

**2010 RATE SHEET FOR NON STATE GROUP EMPLOYEES
 QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP)
 (ADD DEPENDENT DENTAL)**

COVENTRY HEALTH CARE OF KANSAS – QHDHP PREFERRED HEALTH SYSTEMS – QHDHP UMR, A UNITED HEALTHCARE COMPANY - QHDHP							
CODE	COVERAGE LEVEL	FULL TIME PREMIUM	PLUS HSA	FULL TIME TOTAL	PART TIME PREMIUM	PLUS HSA	PART TIME TOTAL
1	Member Only	\$51.80	\$50.00	\$101.80	\$96.26	\$50.00	\$146.26
2	Member and Spouse	\$175.54	\$50.00	\$225.54	\$241.10	\$50.00	\$291.10
3	Member and Child(ren)	\$150.80	\$50.00	\$200.80	\$212.14	\$50.00	\$262.14
4	Member and Family	\$274.56	\$50.00	\$324.56	\$356.98	\$50.00	\$406.98

Included in the total premium rate is a **required** \$50 monthly deduction that is contributed by the employee to their Health Savings Account (HSA). The employer is required to make an additional \$75 (full time employees) or \$56.25 (part time employees) contribution to the employee's HSA. The member may make additional contributions to the HSA as long as the total employer and employee contributions do not exceed the deductible. See the Open Enrollment Booklet for more information.

**2010 RATE SHEET FOR NON STATE GROUP EMPLOYEES
DENTAL AND VISION**

DELTA DENTAL			
		FULL TIME EMPLOYEE PAYMENT	PART TIME EMPLOYEE PAYMENT
CODE	COVERAGE LEVEL		
1	Member Only	\$0.00	\$7.58
2	Member and Spouse Only	\$13.58	\$24.64
3	Member and Child(ren) Only	\$10.88	\$21.24
4	Member and Family	\$24.40	\$38.30

SUPERIOR VISION PLAN			
RATES LISTED ARE FOR VOLUNTARY VISION COVERAGE EMPLOYEE PAID---NO EMPLOYER CONTRIBUTION			
		MONTHLY COST	
CODE	COVERAGE LEVEL	BASIC	ENHANCED
1	Member Only	\$4.36	\$7.26
2	Member and Spouse only	\$8.72	\$14.52
3	Member and Child(ren) Only	\$7.86	\$13.06
4	Member and Family	\$12.20	\$20.32