State Employee Health Plan

Plan A, Plan B and other information

Comparison Chart 1

For Retiree/Direct Bill Members

OPEN ENROLLMENT 2010

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Health Plan Comparison Chart

	Plan A		Plan B	
	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	
	Network Providers	**Non Network Providers**	**Network Providers**	**Non Network Providers**
Basic Provisions				
Provider Choice	Freedom to use provider of choice, benefits based on plan description: coverage level based on provider network status			
Annual Deductible: 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
Coinsurance *(for all eligible expenses, unless otherwise noted)*	20% Coinsurance	50% Coinsurance	30% 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)
Annual Out-of-Pocket Maximum	N/A	N/A	N/A	N/A
Lifetime Benefit Maximum	No limit	No limit	No limit	No limit
Amounts Above Plan Allowance	Provider to write off	Member responsibility	Provider to write off	Member responsibility
Preventive Care				
Age Appropriate Routine Physical Exam	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
Well-Man Care: *office visit & PSA blood test*	Covered in full	Not covered	Covered in full	Not covered

Mammogram	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
Routine Hearing Exam	Covered in full	Not covered	Covered in full	Not covered
Routine Vision Exam: *refraction exam for glasses; lenses & frames* ***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
Colonoscopy	Covered in full	Not covered	Covered in full	Not covered
Covered Services				
Inpatient Services	Deductible & 20% Coinsurance	Deductible, 50% Coinsurance & $600 Copayment	30% Coinsurance	Deductible, 50% Coinsurance & $600 Copayment
Physician Hospital Visits	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% 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
Specialist	$40 Copayment	Deductible & 50% Coinsurance	Adults: $40 Copayment / Dependent children age 18 and under: $25 Copayment	Deductible & 50% Coinsurance
Urgent care center	$20 Copayment, Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	$20 Copayment & 30% Coinsurance	Deductible & 50% Coinsurance
Outpatient Surgery	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% 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
Other Outpatient Services	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance
Ambulance Services	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	30% Coinsurance	Deductible & 30% Coinsurance
Major Diagnostic Tests	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance

Home Health Care *services must be pre-approved by health plan*	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance
Hospice *services must be pre-approved by health plan; limited to six months*	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance
X-Ray and Laboratory	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance
Lab Card	*The Quest Lab Card program is now included when you choose either Plan A or Plan B as a way to save you money on outpatient laboratory tests. When you use the Quest Lab Card for outpatient lab work covered by Plan A or Plan B, the cost will be covered at 100 percent of the negotiated amount with no deductible, copayment or coinsurance. Eligible services will be identified by your health plan and paid in full.*			
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
Outpatient facility	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance
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
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
Allergy Testing	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance
Antigen Administration: *desensitization/treatment; allergy shots*	Covered in full	Deductible & 50% Coinsurance	Covered in full	Deductible & 50% Coinsurance
Infertility Treatment: *limited to testing & three attempts at artificial insemination per year*	Office visit Copayment, Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Office visit Copayment & 30% Coinsurance	Deductible & 50% Coinsurance
Licensed Dietitian Consultation: *for medical management of a documented disease*	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	30% Coinsurance	Deductible & 50% Coinsurance

Mental Health	
Inpatient Nervous & Mental	Same Coverage as Medical
Non Covered Services	
TMJ/Orthognathic Treatment	Not covered under medical: see dental, limited
Gastric Surgery and Other Weight Loss Treatments	Not covered

The comparison chart is NOT the governing document. Members need to refer to the Certificate of Coverage and Benefit Descriptions posted on ***http://www.sehp2010ks.org/health-plan-carrier-information/retiree-direct-bill-members/***

Caremark Prescription 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	**Special case medications** (Very high-cost medications used to treat conditions that are generally life threatening)	$75 co-pay 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	**Lifestyle medications** (Medications used primarily to enhance lifestyle rather than treat an illness or condition)	100% of discounted price	n/a

Monthly Premiums (Plan A, Superior Vision and Delta Dental Services)

Coverage Choice	Monthly Medical Plan A Premiums				Monthly Superior Vision Premiums		Monthly Delta Dental Premiums
	Blue Cross and Blue Shield Plan A	Coventry Plan A	Preferred Health Systems Plan A	UMR, A United Healthcare Company Plan A	Superior Vision Services: Basic Plan	Superior Vision Services: Enhanced Plan	
1	$497.52	$474.60	$487.68	$453.68	$4.36	$7.26	$30.64
2	$955.04	$909.20	$935.34	$867.34	$8.72	$14.52	$61.28
3	$863.54	$822.28	$845.82	$784.62	$7.85	$13.07	$55.16
4	$1,321.06	$1,256.88	$1,293.48	$1,198.52	$12.21	$20.33	$85.80
B	$458.94	$479.34	$487.18	$415.14	$6.54	$10.89	$30.64

Monthly Premiums (Plan B, Superior Vision and Delta Dental Services)

Coverage Choice	Monthly Medical Plan B Premiums				Monthly Superior Vision Premiums		Monthly Delta Dental Premiums
	Blue Cross and Blue Shield Plan B	Coventry Plan B	Preferred Health Systems Plan B	UMR, A United Healthcare Company Plan B	Superior Vision Services: Basic Plan	Superior Vision Services: Enhanced Plan	
1	$477.42	$455.64	$468.06	$435.76	$4.36	$7.26	$30.64
2	$914.86	$871.28	$896.12	$831.54	$8.72	$14.52	$61.28
3	$827.36	$788.16	$810.52	$752.38	$7.85	$13.07	$55.16
4	$1,264.80	$1,203.80	$1,238.58	$1,148.36	$12.21	$20.33	$85.80
B	$425.82	$467.98	$475.38	$407.10	$6.54	$10.89	$30.64

Coverage Choice Codes Key

1 – Member only · **2** – Member and spouse only · **3** – Member and child(ren) only · **4** – Member, spouse and child(ren) · **B** – Medicare member only

IMPORTANT REMINDERS:

The premiums provided for vision and dental coverage above are separate from the premiums provided for the medical plans. Therefore, when calculating your total monthly premium, please be sure to add all three premium amounts, as applicable. **In addition, remember, you can receive a $40 discount each month on the medical premiums listed above if you are a Non-Tobacco User. Tobacco Users that complete the Tobacco Cessation Program (offered through HealthQuest) will receive this $40 discount as well! Please subtract $40 from the medical rates above to determine the amount of your discounted premium.**

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.

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 NOT had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months**			
Diagnostic and Preventive Services	Allowed Amount covered in full by the Plan*		
Basic Restorative Services	50%	50%	50%
Major Restorative Services	50%	50%	50%
ENHANCED BENEFIT **Applies when you have had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months**			
Diagnostic and Preventive Services	Allowed Amount covered in full by the Plan*		
Basic Restorative Services	20%	40%	40%
Major Restorative Services	50%	50%	50%

**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.