

State Employee Health Plan

Medicare Plans and other information

Comparison Chart 2

For Retiree/Direct Bill Members

OPEN ENROLLMENT 2010



Health Plan Comparison Chart

	Coventry Advantra Freedom	Humana Group Medicare
	Preferred Provider Organization (PPO) - with Coventry Part D or SilverScript prescription drug	Preferred Provider Organization (PPO) - with Humana Part D or SilverScript prescription drug
	Network Providers	Network Providers

Basic Provisions

Provider Choice	Freedom to use provider of choice, benefits based on plan description: coverage level based on provider network status—only applies to PPO	Coverage level based on provider network status—only applies to PPO
Coinsurance <i>(for all eligible expenses, unless otherwise noted)</i>	Network: \$0 Non Network: 20% Coinsurance	Network: \$0 Non Network: 30% Coinsurance
Deductible	Network: \$0	Network: \$0 Out of Network: \$300
Annual Out-of-Pocket Maximum	\$1,000	Network: \$3,000 Out of Network: \$5,000
Lifetime Benefit Maximum	No limit	No limit
Amounts Above Plan Allowance	Provider to write off	Provider to write off

Preventive Care**

Preventive Care Services	Covered in full	Network: 100% in all places of treatment Non Network: 70% after annual deductible in all places of treatment
Age Appropriate Routine Physical Exam	Covered in full	Network: 100% in all places of treatment Non Network: 70% after annual deductible in all places of treatment
Well-Woman Care: <i>office visit, PAP smear test & STD testing</i>	Covered in full	Network: 100% in all places of treatment Non Network: 70% after annual deductible in all places of treatment
Well-Man Care: <i>office visit & PSA blood test</i>	Covered in full	Network: 100% in all places of treatment Non Network: 70% after annual deductible in all places of treatment
Mammogram	Covered in full	Network: 100% in all places of treatment Non Network: 70% after annual deductible in all places of treatment
Licensed Dietitian Consultation: <i>for medical management of a documented disease</i>	Covered in full	Network: 100% in all places of treatment Non Network: 70% after annual deductible in all places of treatment

Routine Hearing Exam	\$0 Copay for each routine hearing test up to 1 per year, \$500 every 3 years for hearing aids	Network: 100% after \$35 copayment per visit - Medicare-covered services only, routine services not covered Non Network: 70% after annual deductible - Medicare-covered services only, routine services not covered
Routine Vision Exam: <i>refraction exam for glasses; lenses & frames not covered</i>	\$0 Copay for PCP; \$0 Copay for specialist (limited to 1 routine visit per year)	Network: 100% after \$35 copayment per visit - Medicare-covered services only, routine services not covered Non Network: 70% after annual deductible - Medicare-covered services only, routine services not covered
Age Appropriate Bone Density Screening	Covered in full	Network: 100% in all places of treatment Non Network: 70% after annual deductible in all places of treatment
Routine Age Appropriate Colonoscopy	Covered in full	Network: 100% in all places of treatment Non Network: 70% after annual deductible in all places of treatment
Covered Services		
Inpatient Services	\$100 Copay per day up to 5 days	Network: 100% after \$175 copayment per day (days 1-5) per admission Non Network: 70% after annual deductible
Physician Hospital Visits	Included in the inpatient services Copay	Network: 100% in all places of treatment Non Network: 70% after annual deductible in all places of treatment
Physician Office Visits		
Primary Care Provider	\$0	Network: 100% after \$15 Copay Non Network: 70% after annual deductible
Specialist	\$0	Network: 100% after \$35 Copay Non Network: 70% after annual deductible
Urgent care center	\$30 Copay, worldwide coverage	Network: 100% after \$35 Copay Non Network: 70% after annual deductible
Outpatient Surgery	\$150 Copay	Network: 100% after \$125 Copay Non Network: 70% after annual deductible
Emergency Room Visits	\$50 Copay (waived if admitted)	100% after \$50 Copay (waived if admitted within 24 hours)
Other Outpatient Services	See specific services on this chart	See specific services on this chart
Ambulance Services	\$100 per one-way trip	100% after \$100 per date of service
Major Diagnostic Tests*	\$75 Copay	100% after \$50 for freestanding clinic, \$75 hospital
Home Health Care <i>services must be pre-approved by health plan</i>	Services must be pre-approved by health plan	Services must be pre-approved by health plan Network: 100% Non Network: 70% after annual deductible

Hospice <i>services must be pre-approved by health plan; limited to six months</i>	Services must be pre-approved by health plan	N/A
X-Ray and Laboratory	\$0 Copay for clinical/diagnostic lab service	Network: 100% after \$75 copay per visit; 100% for lab services Non Network: 70% after annual deductible
Physical Rehabilitation Services: <i>including chiropractic care (services limited to those medically necessary and appropriate; medical records must show continued improvement)</i>	\$30 Copay per visit	Network: 100% after \$35 Copay per visit to specialist & comprehensive outpatient rehabilitation facility; Plan pays 100% after \$75 copayment per visit to outpatient hospital Non Network: 70% after annual deductible
Inpatient facility	\$100 Copay per day up to 5 days	100% after \$20 Copay
Outpatient facility	\$0 Copay for PCP; \$0 Copay for specialist	100% after \$20 Copay
Office based	\$15 Copay for PCP; \$30 Copay for specialist	100% after \$20 Copay
Durable Medical Equipment	20% Coinsurance	Network: 20% Coinsurance Non Network: 70% after annual deductible in all places of treatment
Allergy Testing	\$15 Copay for PCP; \$30 Copay for specialist	Network PCP: 100% after \$15 Copay per visit Network Specialist: 100% after \$35 Copay per visit Non Network: 70% after annual deductible in all places of treatment
Antigen Administration: <i>desensitization/treatment; allergy shots</i>	\$15 Copay for PCP; \$30 Copay for specialist	\$0 Copay
Infertility Treatment: <i>limited to testing & three attempts at artificial insemination per year</i>	Not covered	Not covered
Covered Immunizations	Covered in full	Network: \$0 Copay Non Network: 70% after annual deductible in all places of treatment Flu & Pneumonia do not apply to the annual deductible

Prescription Drugs

Prescription Drug Services	Prescription Drug Plan Details		Prescription Drug Plan Details	
	Preferred Generic drug	\$5 Copay	Preferred Generic drug	\$0 mail-order, \$5 retail (30-day supply)
	Preferred brand name drug	\$25 Copay	Preferred brand name drug	\$30 retail
	Non-preferred Generic and Brand name drug	\$50 Copay	Non-preferred Generic and Brand name drug	\$60 retail

	Injectables	25% Coinsurance for speciality drugs	Injectables	Speciality drugs 25%
	Limit	The initial coverage limit is \$2,830 and is based on the applicable Copay plus the plan cost. After this amount is reached, there is generic-only coverage until your out-of-pocket costs reach \$4,550.	Limit	Once the Total drug cost (member + Humana) totals \$2,830, the members will pay \$5 for generic and 100% for all other drugs until they reach TrOOP of \$4,550.
	Catastrophic coverage	\$2.50 Copay for generic or preferred brand name drugs and \$6.30 Copay or 5% Coinsurance, whichever is highest, for all other drugs. Catastrophic coverage becomes effective when your out-of-pocket costs reach \$4,550.	Catastrophic coverage	\$2.50 for generic or preferred brand drugs and \$6.30 for all other drugs, or 5% Coinsurance, whichever is highest. Catastrophic coverage becomes effective when your out-of-pocket costs reach \$4,550.
	Phone Numbers: Coventry Advantra Freedom	PPO: 800-727-9712 TDD 866-347-2335	Phone Number: Humana PPO	866-396-8810

Mental Health

Inpatient Nervous & Mental	\$100 per day (90-day limit per year)	Network: 100% after \$175 copayment per day (days 1-5) per admission; 190-day lifetime limit Non Network: 70% after annual deductible; 190-day lifetime limit
Inpatient Drug & Alcohol	\$100 per day (90-day limit per year)	Network: 100% after \$175 copayment per day (days 1-5) per admission Non Network: 70% after annual deductible
Outpatient Nervous & Mental	\$30 Copay for individual therapy; \$15 Copay for group therapy	Network: Outpatient psychiatric care - partial hospitalization - 100% after \$35 copayment per visit Network: Outpatient hospital mental health services - 100% after \$75 copayment per visit Non Network: 70% after annual deductible
Outpatient Drug & Alcohol	\$30 Copay for individual therapy; \$15 Copay for group therapy	Network: Outpatient psychiatric care - partial hospitalization - 100% after \$35 copayment per visit Network: Outpatient hospital mental health services - 100% after \$75 copayment per visit Non Network: 70% after annual deductible

Non Covered Services

TMJ/Orthognathic Surgery	Not covered	Covered same as any other illness
Orthotic Shoe Inserts	Not covered	Network: 80% in all places of treatment Non Network: 70% after annual deductible in all places of treatment
Gastric Surgery & Other Weight Loss Treatments	Not covered	Covered same as any other illness if medically necessary

* **Major Diagnostic Tests:** includes but not limited to; PET scans, CT scans, nuclear cardiology studies, magnetic resonance angiography and computerized topography angiography. Most major diagnostic tests require pre-approval by the Health Plan.

** **Preventive Care:** 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. **Example:** 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 Copayment. If the annual exam is coded as routine, the exam is covered in full. **Exception:** 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.

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/>.

SilverScript Part D Plan Benefits

Prescription	Members Pay
Generic drugs	25% Coinsurance up to a \$30 maximum
Preferred brand name drugs	35% Coinsurance up to a \$100 maximum
Non preferred brand name drugs	60% Coinsurance up to a \$150 maximum
Special case medications	35% Coinsurance up to a \$200 maximum
If out-of-pocket expenses exceed \$4,550	Generics: \$2.50 or 5% Coinsurance Brands: \$6.30 or 5% Coinsurance
Maximum supply	60-day supply

Benefits are the same for retail or mail order purchases.

Monthly Premiums (Medicare Plans with or without Part D, Superior Vision Services and Delta Dental): Member Only

Medical Plan (with or without Part D)	Monthly Premium for Medical Plan (with or without Part D)	Superior Vision Services: Basic Plan	Superior Vision Services: Enhanced Plan	Delta Dental
Coventry Advantra Freedom PPO with Coventry Part D	\$87.50	\$6.54	\$10.89	\$30.64
Coventry Advantra Freedom PPO with SilverScript	\$188.50	\$6.54	\$10.89	\$30.64
Humana PPO with Humana Part D	\$145.50	\$6.54	\$10.89	\$30.64
Humana PPO with SilverScript	\$240.50	\$6.54	\$10.89	\$30.64
Kansas Senior Plan C with SilverScript	\$343.31	\$6.54	\$10.89	\$30.64
Kansas Senior Plan C without SilverScript	\$188.31	\$6.54	\$10.89	\$30.64

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.

Kansas Senior Plan C - Medicare Payment Information

Medicare A – Hospitalization	Medicare B – Medical	Kansas Senior Plan C Supplement
<p>Inpatient hospital</p> <ul style="list-style-type: none"> • First 60 Days: \$1,068 deductible* • Days 61 through 90: \$267 per day Coinsurance* • Lifetime reserve: \$534 per day Coinsurance* <p>Skilled Nursing Facility</p> <ul style="list-style-type: none"> • First 20 days: 100% payment—no co-pay • Days 21-100: \$133.50 per day Coinsurance* <p>Services Paid at 100%</p> <ul style="list-style-type: none"> • Home health • Hospice • Benefit period ends when the patient is out of the hospital or skilled nursing facility for 60 consecutive days <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>Annual Deductible \$135 deductible per calendar year* (January 1 through December 31)</p> <p>Medicare Coverage for Physician’s Charges Medicare pays 80% of allowed charge; Beneficiary pays 20% Coinsurance* (in- or out-of-hospital)</p> <p>Durable Medical Expenses and Supplies</p> <ul style="list-style-type: none"> • Ambulance • Outpatient hospital charges • Blood (first 3 pints) • Lab services <p>Preventive Services</p> <ul style="list-style-type: none"> • Bone mass measurement • Cardiovascular screenings • Colorectal screenings • Diabetes screenings • Flu shots • Glaucoma tests • Hepatitis B shots • Pap tests • Pneumococcal shot • Prostate cancer screening • Screening mammograms • “Welcome to Medicare” physical exam (one-time) <i>Routine physical exams with no specific diagnosis are not covered</i> <p>Beneficiary must pay a monthly Medicare Part B Premium of \$96.40*</p>	<p>Kansas Senior Plan C pays for all costs shown in green 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"> • An additional 365 hospital days per lifetime • Foreign emergency travel medical services: \$250 deductible, then the plan pays 80% to a maximum of \$50,000 lifetime • If Medicare A and B do not cover the service, there is no benefit under the medical portion of Kansas Senior Plan C

* The deductible and coinsurance amounts listed on this chart reflect 2009 rates. Be sure to review your Medicare and You handbook for the new 2010 amounts.

Coventry Advantra Freedom PPO Service Area



