

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.

Humana Group Medicare PPO Service Area

