

For members on either Plan A or Plan B - don't forget to declare your tobacco status. You must do this every year!

Choose Your Health Benefits

State Employee Health Plan Open Enrollment 2010

Open Enrollment November 15th - December 15th, 2009

FOR RETIREE/DIRECT BILL MEMBERS

- Review the information in this book
- Check out the "Highlights and Reminders for Plan Year 2010" on page 6
- Attend an open enrollment meeting in my area – **check the schedule on pages 4 and 5 for dates and times**
- If I am Medicare eligible, check out the Medicare Eligibility and plans on pages 13-19
- If I am eligible for "split" enrollment, call the Direct Bill Call Center at 1-866-541-7100
- If I am on either Plan A or Plan B, check out page 10
- Complete my paper enrollment form (included with this 2010 health benefits booklet). If I am on Plan A or Plan B, **don't forget to declare my tobacco status on my form - this must be done every year!**
- Learn more about non tobacco user incentives & the Tobacco Cessation Program! Go to www.khpa.ks.gov click on the **2010 Open Enrollment** button then select **HealthQuest**

Open enrollment elections are effective January 1, 2010

Contact Information

State of Kansas Health Plan Providers Website

www.khpa.ks.gov - click on the **2010 Open Enrollment** button and select **Providers**

Blue Cross and Blue Shield

Customer Service
Plan A, Plan B
Kansas Senior Plan C

www.bcbsks.com/Customerservice/Members/State/index.htm

All Areas (Toll Free): 800-332-0307
In Topeka: 785-291-4185

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In Topeka: 785-291-4185

New Directions

All Areas (Toll Free): 800-952-5906
In Topeka: 785-233-1165

Coventry Health Care of Kansas

Customer Service
Plan A, Plan B
Coventry Advantra Freedom
PPO
Behavioral Health

www.chckansas.com

All Areas (Toll Free): 866-611-7337

All Areas (Toll Free): 800-727-9712
TDD (Toll Free): 866-347-2459

All Areas (Toll Free): 866-607-5970

Humana Group Medicare

Customer Service
PPO

All Areas (Toll Free): 866-396-8810
TTY: 800-833-3301

Preferred Health Systems

Customer Service
Plan A, Plan B

www.phsystems.com

All Areas (Toll Free): 866-618-1691
Wichita: 316-609-2555

UMR, A UnitedHealthcare Company

Customer Service
Plan A, Plan B

www.umar.com/oss/cms/UMR/Kansas

All Areas (Toll Free): 866-281-2993

Quest Diagnostics Lab Card Program

Customer Service
Lab Card

www.labcard.com

All Areas (Toll Free): 800-646-7788

Collection Sites Website

www.labcard.com/collection.html

Delta Dental of Kansas, Inc. Dental Plan

Customer Service

www.deltadentalks.com

All Areas (Toll Free): 800-234-3375
Wichita: 316-264-4511

Fax: 913-438-8385

Caremark Prescription Drug Plan

Customer Service
Plan A, Plan B

www2.caremark.com/kse/

All Areas (Toll Free): 800-294-6324

TDD (Toll Free): 800-863-5488

Caremark Connect Specialty Pharmacy

All Areas (Toll Free): 800-237-2767

SilverScript for Medicare Part D

Customer Care (year round)

All Areas (Toll Free): 800-837-4092

TDD (Toll Free): 866-236-1069

Pre-Enrollment

All Areas (Toll Free): 866-808-7084

TDD (Toll Free): 866-552-6288

Superior Vision Services Vision Plan (Optional)

Customer Service

www.superiorvision.com

All Areas (Toll Free): 800-507-3800

KPERS

(Kansas Public Employee Retirement Systems)

All Areas (Toll Free): 888-275-5737

In Topeka: 785-296-6166

EDS

Billing

All Areas (Toll Free): 866-688-5009

Direct Bill Membership

KHPA – State Employee Health Benefits Plan Staff Enrollment,
Qualifying Event, Report a Death, Address Changes

All Areas (Toll Free): 866-541-7100

In Topeka: 785-296-1715

HealthQuest

Customer Service

All Areas: 785-296-5624

contents

2010 Direct Bill/Retiree Open Enrollment Meeting Schedule.....	4
Highlights and Reminders for Plan Year 2010	6
Open Enrollment.....	7
How to Enroll.....	7
Split Coverage Enrollment.....	8
Changing Your Coverage	8
Choosing Your Health Plan: Plan A, Plan B, Kansas Senior Plan C, a Coventry Advantra Freedom Plan or a Humana Group Medicare Plan?.....	9
Plan A and Plan B.....	10
Direct Bill Members and Dependents Eligible for Medicare.....	11
Medicare Eligibility.....	13
Kansas Senior Plan C.....	14
Coventry Advantra Freedom PPO	15
Humana Group Medicare PPO	16
SilverScript Medicare Part D Drug Plan	17
Quest Lab Card	19
Caremark Prescription Drug Plan	20
Delta Dental Plan	21
Superior Vision Services Plan	22
Personal Representative Form	23
Appendix	25

Take advantage of the information available online 24/7 on our open enrollment website. Go to www.khpa.ks.gov and click on the **2010 Open Enrollment** button. On this site, you can:

- View your 2010 open enrollment plan options and other benefits communications.
- And more!

Direct Bill Call Center

Outside Topeka: 1-866-541-7100 | In Topeka: 1-785-296-1715

*The information in this booklet is intended to summarize the benefits offered in language that is clear and easy to understand. Every effort has been made to ensure that this information is accurate. It is not intended to replace the legal plan document (Certificate of Coverage or Benefit Description), which contains the complete provisions of a program. In case of any discrepancy between this booklet and the legal plan document, the legal plan document will govern in all cases. You may review the legal plan document upon request or go online to www.khpa.ks.gov and click on the **2010 Open Enrollment** button and select **2010 Benefit Descriptions**.*

2010 Direct Bill/Retiree Open Enrollment Meeting Schedule

Chanute	Friday, November 6 9:30 a.m.	SRS Office Kansas Room 1500 West 7th Street
Colby	Friday, November 6 9:30 a.m.	Colby Convention Center Otterbourne Room 2227 S. Range East End of the Comfort Inn
Emporia	Wednesday, November 4 9:30 a.m. and 1:30 p.m.	Rodeway Inn & Suites Bluestem Room 3181 W. Hwy. 50
Garden City	Monday, November 9 9:30 a.m.	Best Western Wheatlands Hotel and Conference Center Meeting Room 1408 E. Fulton
Great Bend	Tuesday, November 10 9:30 a.m.	Best Western Angus Inn-Perkins Restaurant Kansas Room 2920 10th Street
Hays	Thursday, November 5 9:30 a.m. and 1:30 p.m.	Ramada Inn Meeting Rooms A, B and C 3603 Vine St
Hutchinson	Friday, November 13 2:00 p.m.	KDOT District 5 Office Conference Room 1220 W. 4th
Kansas City	Tuesday, November 10 9:30 a.m. and 1:30 p.m.	Holiday Inn at the Plaza Ballroom A and B One E. 45th Street
Lawrence	Thursday, November 12 9:30 a.m. and 1:30 p.m.	4-H County Fairgrounds Building 21 2101 Harper Building
Manhattan	Monday, November 9 9:30 a.m. and 1:30 p.m.	Cico Park - Pottorf Hall Konza Room Avery Drive - Fairgrounds
Osawatomie	Thursday, November 5 9:30 a.m. and 1:30 p.m.	Osawatomie State Hospital Sunflower Room Highway 169-South 500 State Hospital Drive

Overland Park	Friday, November 13 9:30 a.m. and 1:30 p.m.	KU Edwards Campus Regents Center Rm110 126th & Quivera
Parsons	Wednesday, November 4 9:30 a.m. and 1:30 p.m.	Parsons Recreation Commission Multipurpose Room 200 Heacock Avenue
Pittsburg	Thursday, November 5 9:30 a.m. and 1:30 p.m.	Homer Cole Community Center Conference Room 3003 N. Joplin
Pratt	Friday, November 13 9:00 a.m.	Community Center Large Room 619 N. Main
Salina	Wednesday, November 4 9:30 a.m. and 1:30 p.m.	College Center Conference Room 2310 Centennial Road
Topeka	Monday, November 2 9:30 a.m. and 1:30 p.m.	Topeka and Shawnee County Public Library Marvin Auditorium 101AB 1515 SW 10th Avenue
Topeka	Wednesday, November 4 9:30 a.m. and 1:30 p.m.	Kansas Museum of History All Classrooms 6425 W 6th Street
Topeka	Tuesday, November 10 9:30 a.m. and 1:30 p.m.	Kansas Museum of History All Classrooms 6425 W 6th Street
Wichita	Tuesday, November 3 9:30 a.m. and 1:30 p.m.	Holiday Inn Select South Center Ballroom 549 S. Rock Road
Wichita	Thursday, November 12 9:30 a.m. and 1:30 p.m.	Hawthorn Suites West Bogey Room North 2405 N. Ridge Road

Highlights and Reminders for Plan Year 2010

The Non Tobacco User Discount is offered again for Plan Year 2010!

- Non tobacco users will receive a total premium discount of \$40 per month.
- Tobacco Users who enroll in and successfully complete the Tobacco Cessation Program offered thru HealthQuest will also receive the discount. **If you tried the program last year and were not successful, you can try again!**

What's New in 2010

New Coverage Codes:

- 1** = Member Only
- 2** = Member and Spouse Only
- 3** = Member and Children Only
- 4** = Member and Family (Spouse AND Children)
- B** = Medicare Member Only

What's Changing

Health Plans:

PLAN A

- The annual deductible maximum will increase from \$50 to \$150 per person and from \$100 to \$300 per family for services. Copayments for office visits do not count toward the annual deductible.
- The annual coinsurance maximum will increase from \$1,100 to \$1,200 per person and \$2,200 to \$2,400 per family. After the coinsurance maximum is met, eligible services are covered at 100 percent for the remainder of the calendar year.
- The Quest Lab Card, which provides a way to save you money on outpatient laboratory tests, is now included on Plan A as well as Plan B.

PRESCRIPTION DRUG COVERAGE

CAREMARK FOR PLANS A & B

- The State is implementing the Performance Drug List for certain high blood pressure (ACE/ARB's), stomach acid reducers (PPI) and cholesterol lowering (HMGs) drugs.
- For these three classes of drugs, you must try a generic drug before you can be approved for a non preferred brand name drug. The claim system will review each member's history to determine if a generic has been tried.
- Those currently using a non preferred drug affected by this change will be notified by Caremark.

DENTAL COVERAGE

- Plan deductible is increased to a maximum of \$50 per person and \$150 per family. The deductible now applies to both basic and major restorative care.

- Basic restorative services are now covered by a NEW value-based plan design! This plan design encourages members to seek preventive care services. Basic benefits are 50% for all basic restorative services regardless of the provider. However, those who have had at least one preventive or office visit for cleaning or exam of their teeth in the preceding 12 month period will qualify for the enhanced benefit level.
- For members that qualify for the enhanced benefit level, coinsurance for basic restorative services is 20% when performed by Delta PPO providers and 40% for Delta Premier and non network providers.

Reminders

- New Billing Vendor - EDS
- Split Medicare Enrollment
- Members can opt out of Delta Dental Coverage. **Important Note: Once a member opts out of dental coverage, the member will not be able to re-enroll in dental coverage at a later date.**
- If you elect not to take Prescription Drug coverage under the State plan, you will not be allowed back in, so be sure to select some type of prescription coverage from the private market.

Open Enrollment

The 2010 State of Kansas Open Enrollment period for direct bill members is **November 15, 2009 through December 15, 2009**. You must complete the form included in your Open Enrollment packet or contact the **Direct Bill Call Center between November 9, 2009 thru January 8, 2010 at 1-866-541-7100 (In Topeka 296-1715)**. Representatives are available to assist you Monday through Friday from 8:30 a.m. to 4:30 p.m. Central time. The office will be closed on Veterans Day (November 11, 2009), the Thanksgiving Holiday (November 26-27, 2009), Christmas (December 25, 2009) and New Year's Day (January 1, 2010).

Open Enrollment changes made to your health plans will become effective January 1, 2010. You will receive new identification cards at your home address a few weeks after your enrollment is complete. You will also receive a statement confirming your changes in late December.

How to Enroll

- **Review all of your enrollment materials including this Open Enrollment booklet to become familiar with your options.** You can also go online to www.khpa.ks.gov.
- **Read *Medicare and You*, a booklet from the Social Security Administration, if you or a covered dependent is eligible for Medicare.**
- **Attend an Open Enrollment Meeting.** If you are enrolling during the annual open enrollment period, we encourage you to attend an Open Enrollment Meeting to hear explanations of your

benefit options and to ask questions. See pages 4-5 for dates and times of meetings near you.

- **Learn about your health plan options.** Make sure your health care providers, medical facilities and pharmacy are included in your health plan's network of preferred providers.
- **Submit your completed Enrollment Change Form.** Complete the form included in your Open Enrollment packet and submit it to the Direct Bill Membership Office **no later than December 15, 2009**. You may fax it to **1-785-368-7180** or mail it to the address provided on the form.

Split Coverage Enrollment

Mixed Eligibility (Some Members Are Eligible for Medicare and Some Are Not). In this case, the member eligible for Medicare could enroll in a Medicare-only plan while the spouse or dependent not eligible for Medicare could enroll in another non-Medicare plan offered by the State of Kansas. For example: If you are eligible for Medicare and your spouse is not, you may enroll in the Kansas Senior Plan C with or without drugs and your spouse may enroll in Plan A. Whether the Medicare Eligible member elects one of the Medicare Plans, or elects to continue on Plan A or Plan B, your coverage will still be split.

When you enroll, make sure to indicate "Split Enrollment." Both member and spouse must complete an enrollment form for the health plan they choose. The member and spouse are enrolled separately and each enrollment is treated as an individual policy with its own unique billing arrangements.

All Members That Are Eligible for Medicare. If the member and all of his or her dependent(s) are eligible for Medicare, each family member may enroll in a different Medicare plan option. For example: If you and your spouse are both eligible for Medicare, you may enroll in the Kansas Senior Plan C with or without drugs and your spouse may enroll in the Coventry Advantra PPO.

When you enroll, make sure to indicate "Split Enrollment." Each family member must complete a form for the Medicare plan he or she chooses. Again, each member is enrolled separately and each enrollment is treated as an individual policy with its own unique billing arrangements.

Changing Your Coverage

Once you enroll, or if you do not enroll before the deadline, your choices are binding until the next annual Open Enrollment period except as provided in this section.

You may cancel or drop coverage for you or your dependent(s) at any time. If you drop coverage, you may not re-enroll.

You may make other changes to your coverage if you experience a "qualifying event" that allows you to make a change. Qualifying events include life-altering events such as the birth or adoption of a child,

marriage, divorce, death of a spouse or a dependent, or gain or loss of employment and benefits for a spouse or a dependent. Documentation of the qualifying event (for example, a marriage certificate or death certificate or copy of the obituary) will be required.

Important: Health plan changes due to a qualifying event must be consistent with the event. You must notify the Direct Bill Membership Office within 31 days of the qualifying event in order for the change to be effective the first day of the month following the event. If the event takes place on the first day of the month, the effective date will be that day. If you do not submit your change form within this 31-day period, you will not be able to make the change until the next Open Enrollment period. If there is a qualifying event that would result in a refund and you do not notify the Direct Bill Membership Office of the change, refunds may not be made retroactively. The only exception would be death.

Choosing Your Health Plan: Plan A, Plan B, Kansas Senior Plan C, a Coventry Advantra Freedom Plan or a Humana Group Medicare Plan?

General Information

You have choices when it comes to your health coverage. Choosing the appropriate health plan for you and your family may be easier than you think!

The State offers the following plans to direct bill members:

- Plan A — Blue Cross and Blue Shield, Coventry, Preferred Health Systems, or UMR, A UnitedHealthcare Company
- Plan B — Blue Cross and Blue Shield, Coventry, Preferred Health Systems, or UMR, A UnitedHealthcare Company
- Coventry Advantra Freedom PPO (with Coventry Part D)
- Coventry Advantra Freedom PPO (with SilverScript Part D)
- Humana PPO (with Humana Part D)
- Humana PPO (with SilverScript Part D)
- Kansas Senior Plan C (with or without SilverScript Part D)

Reminder: If you elect the Kansas Senior Plan C and do not take Prescription Drug coverage under the State plan, and do not enroll in a Part D prescription drug coverage from the private market, you will not be allowed to re-enroll in the State's Part D Prescription Drug Coverage.

When making your health plan choices, direct bill members should always consider present health conditions and the financial status of all individuals to be covered under the chosen plan.

Direct bill members and their dependents generally fall into two categories: Medicare eligible and non-Medicare eligible.

- **All direct bill members and their dependents**, regardless of Medicare eligibility, may choose between traditional health plans

such as Plan A and Plan B. Both of these plans have the same prescription drug coverage offered to Direct Bill members.

- **Individuals who are Medicare eligible** may be able to save money on premiums and/or out-of-pocket costs if they choose one of the State of Kansas' direct bill offerings specifically designed to work with Medicare such as Kansas Senior Plan C, the Coventry Advantra Freedom plan or the Humana Group Medicare plan.

Plan A and Plan B

You have access to all health plans regardless of where you live.

The State Employee Health Plan offers two medical plan options:

- Plan A
- Plan B

Each option is designed differently (for example, deductibles, coinsurance and annual maximums).

There are four health plan vendors:

- Blue Cross and Blue Shield
- Coventry Health Care
- Preferred Health Systems
- UMR, A UnitedHealthcare Company

Each health plan vendor has a different network of preferred providers. Network providers have agreed to accept the plan allowance as payment in full. Non network providers have not agreed to accept the plan allowance so any amount above that will be your responsibility.

In addition, each health plan vendor offers unique features. Be sure that you take into consideration these features before making your selection.

All options offer the following:

- Access to a broad network of providers nationwide which allows you flexibility in obtaining care with coverage for both network and non network providers.
- 100 percent coverage for certain preventive care services, such as annual exams, colonoscopy screenings, mammograms and age-appropriate immunizations (including flu shots and allergy shots).
- No dollar limit on the care you may need during the lifetime of the policy.
- Prescription drug coverage through Caremark.

Please review the Health Plan Comparison Chart provided with this book to see the differences of the deductible, coinsurance and annual coinsurance maximums for Plans A and B.

Here are a few differences to note:

- Plan A has a deductible - Plan B does not
- The Primary Care and Specialists office visit copays for dependents under the age of 18 are lower on Plan B
- Coinsurance percentages are different
- Coinsurance maximums are lower on Plan A

Both plans A and B have the Quest Lab Card available. The Plan A Lab Card benefit is new this year.

Direct Bill Members and Dependents Eligible for Medicare

The retiree and any Medicare Eligible Dependents must be enrolled in Medicare Part A and Medicare Part B.

Many direct bill members are eligible for benefits under Medicare. Medicare enrollment may be achieved when an individual reaches age 65 or becomes disabled and is deemed eligible for Medicare by the Social Security Administration. Additional information about enrolling in Medicare may be obtained by calling **1-800-MEDICARE**, visiting your local Social Security Office or accessing the Medicare website (**www.medicare.gov**). In any event, you should contact Social Security three months before you turn age 65.

Members eligible for Medicare should remember that Medicare pays a large part of medical expenses, but it does not pay all medical expenses. Both Medicare Parts A and B have deductibles, coinsurance and/or copayments that are the beneficiary's responsibility. In addition, Medicare does not pay for most dental care or for routine eye care. Because Medicare leaves certain 'gaps' in benefits, members are responsible for paying these uncovered medical costs. The State of Kansas offers direct bill members plans to assist in paying these costs not covered by Medicare.

Medicare Components

Medicare is comprised of four components. A short explanation of each component is provided below:

- **Part A—Hospital Insurance.** Medicare Part A helps pay for medically necessary care in hospitals, nursing homes following a hospital stay (not custodial or long term care), home health care, hospice care and blood transfusions.
- **Part B—Medical Insurance.** Medicare Part B helps pay for physician's services, outpatient hospital services, emergency room care, diagnostic tests, durable medical equipment, ambulance services, 80 percent of the Medicare-approved amount for blood, starting with the fourth pint, and many other health services and supplies not covered by Medicare Part A. Medicare Part B enrollees pay a monthly premium automatically deducted from Social Security benefits.
- **Part C—Medicare Advantage Plans.** Medicare Part C (Medicare Advantage Plans) are arrangements between Medicare and private insurance companies for providing your Medicare Part A and Part B benefits as well as additional benefits to Medicare beneficiaries through an insurance company. In Medicare Advantage Plans, you pay the basic Medicare Part B premium and may pay an additional premium to the Medicare Advantage Plan.
- **Part D—Prescription Drug Coverage.** Medicare Part D is designed to assist in the payment of prescription drug costs. The program, which became effective on January 1, 2006, is administered through private insurance companies. Medicare recipients may enroll in Medicare Part D

programs when they become Medicare eligible or during annual enrollment periods, generally from November 15 - December 31 of each year. Additional information about Medicare Part D may be obtained from the Medicare and You booklet issued annually, by calling Medicare or by going online to www.medicare.gov (Medicare website).

Medicare Supplement Plans

As noted earlier, Medicare Part A and Part B do not pay 100 percent of health care costs. Both have deductibles and coinsurances which must be paid by the beneficiaries in addition to the monthly premium. Medicare supplement programs are designed to supplement Medicare coverage by assisting you in paying these additional charges. Enrollees in Medicare supplement plans pay an additional monthly premium to the insurance provider offering the plan.

State of Kansas Health Care Plans for Medicare Eligible Members, Spouses and/or Dependents

The State of Kansas offers several health care plans designed to work with Medicare. The differences between the plans include how the services are delivered and how much you have to pay out of your own pocket. You pay a monthly premium for each of these plans.

In addition to deciding which health care plan is best for your situation, you should also decide which prescription drug coverage you wish to enroll in. Each of the Advantage plans offer two prescription drug options. The Medicare Supplement Plan offers coverage with or without Prescription Drug Coverage.

The plans are:

- **Medicare Supplement Plans.** The State of Kansas offers Kansas Senior Plan C as a Medicare supplement. Under this plan, when you visit a facility or physician that accepts Medicare assignment, Medicare is billed first for the services. Any remaining balance is covered in full by Kansas Senior Plan C. The plan is available without optional prescription drug coverage or with SilverScript Part D, an optional Medicare Part D component. Additional information about Kansas Senior Plan C may be found on page 14.
- **Medicare Advantage Plans.** Two Medicare Advantage plans are offered through the State of Kansas for direct bill members — Coventry Advantra Freedom Preferred Provider Organization (PPO) and Humana Group Medicare PPO. With each of these options, you will have copays for certain services.

Like all PPO plans, the Coventry Advantra Freedom PPO and the Humana Group Medicare PPO use physicians, specialists and hospitals that are included in the particular plan's network of preferred providers. You can go to medical professionals not in the network, but it may cost extra. You do not need referrals to see medical professionals who are not part of the network.

The Coventry Advantra Freedom and Humana Group Medicare plans have a Part D plan included in the premium. (See pages 15-17 for more information about the Coventry Advantra Freedom and Humana Group Medicare plans).

Regardless of the plan chosen, the dental and vision plans offered by the State of Kansas to direct bill members are identical. Prescription drug plans offered to direct bill members and/or dependents who are Medicare eligible are discussed within the specific plan explanation.

Medicare Eligibility

Medicare is a federal health plan designed for the elderly and disabled. It assists enrollees in the payment of health costs subject to certain copays and/or coinsurances. A person may be eligible for Medicare by virtue of reaching age 65 or by being approved for total disability by the Social Security Administration.

Medicare consists of several components including Part A Hospitalization and Part B Medical. Medicare is described in detail in a book entitled Medicare and You available by calling **1-800-MEDICARE** or from a local Social Security Office. You can also access Medicare information at **www.medicare.gov** (Medicare website).

Direct bill members eligible for Medicare, either as a result of age or approved disability, are subject to certain rules and conditions that differ from other direct bill members. This section of the book focuses on these rules and conditions as well as pointing out information that is important to Medicare eligible direct bill members.

Medicare Member Definition

“Medicare member” is a member in the State Employee Health Plan who is also eligible for Medicare benefits. For these members, Medicare is the primary payer of medical benefits. The member’s or covered spouse’s status will be changed during the year when he or she is first eligible for Medicare. This is not just an Open Enrollment change.

Coverage Information

Medicare eligible members who are enrolled in Plan A or Plan B will receive the same benefits as active members, provided their doctor accepts Medicare assignments.

Other plans, designed specifically to work with Medicare such as Kansas Senior Plan C, Coventry Advantra Freedom and Humana, offer low-cost, high value health insurance coverage. Although dental coverage is not offered through Medicare, the State of Kansas Health Plans offer dental coverage for its members.

Coverage Conditions

- 1. Over Age 65 or otherwise Medicare Eligible.** If a member or covered spouse is age 65 or older, he or she will be considered an eligible Medicare member even if they do not elect coverage under Medicare. Claims will be processed as if the member or spouse is enrolled in both Parts A and B of Medicare, even if Medicare Part A is not free or if he or she does not sign up for Medicare Part B. For this reason, it is very important that the member or spouse applies for Medicare, both Parts A and B, when first eligible and no longer actively employed. To receive full benefits, an individual who does not have sufficient quarters to qualify or who does not qualify through his or her spouse for free Part A coverage, must purchase Part A coverage. It is the member’s responsibility to work with his or her local Social Security office to enroll for the proper levels of Medicare coverage. The member and/or covered spouse must send a copy of the Medicare card to the Direct Bill Membership Office at Room 900-N, LSOB, 900 SW Jackson Street, Topeka, Kansas 66612.
- 2. Under Age 65 and Disabled.** If a member or covered spouse under age 65 has been approved for total disability by the Social Security Administration,

he or she will be considered a Medicare member following 24 months from the date of total disability. When under age 65 and covered by Medicare, the member or covered spouse must send a copy of the Medicare card to the Direct Bill Membership Office.

State of Kansas Medicare Eligible Plans Versus Other Plans on the Market

Health insurance programs for Medicare eligible seniors is a growing market. There are many plans available and it is often difficult to compare one plan against another. Often the State plan is compared to individual Medigap policies, such as Plan 65. The State plan differs from many of these plans. Not only does it provide medical coverage, but it includes prescription drug, dental and optional vision benefits while most individual policies offer only medical benefits. In comparison, the premium for the State plan may be higher because of the additional benefits available. Some other plans are "age-banded" in which the premium increases as a person ages. State of Kansas premiums are not "age-banded."

Kansas Senior Plan C

Kansas Senior Plan C is a State of Kansas Medigap policy offered by Blue Cross and Blue Shield designed to lower costs for Medicare eligible direct bill members, member spouses and/or dependents.

With Kansas Senior Plan C, members can choose the plan that includes SilverScript Part D prescription drug coverage in the premium or they can choose Kansas Senior Plan C without drug coverage and purchase prescription drug coverage under Medicare Part D on the private market.

- Kansas Senior Plan C is one of the 10 standardized Medicare supplement insurance plans. It has the same medical benefits as any other Medicare Supplement Plan C. Medicare Supplement Insurance exists to help fill the gaps that Medicare approves but does not pay. Kansas Senior Plan C is group rated, rather than individually age rated. The retiree and any Medicare Eligible Dependents must be enrolled in Medicare Part A and Medicare Part B. There is no network for physician or hospital selection, but there is likely to be better coverage if the physician or hospital accepts Medicare assignment for your claims.
- The medical portion of this Medigap policy is administered by Blue Cross and Blue Shield.
- The medical portion of the plan pays what Medicare approves but does not pay. This includes both the Part A and Part B deductibles each year, as well as any coinsurance required by Medicare coverage rules. **Important Note: If Medicare does not cover a service, there is no benefit under the medical portion of Kansas Senior Plan C.**
- Simply utilize providers who accept Medicare assignment. These providers agree to accept the Medicare allowance as payment in full. This means that between the Medicare payment and the Kansas Senior Plan C payment, the member has no out-of-pocket costs.
- Travel with confidence because Kansas Senior Plan C coverage is accepted by doctors and hospitals everywhere in the United States so you'll have access to care if you need it. Foreign travel emergencies are also covered with some limitations.
- Members may elect Kansas Senior Plan C coverage with or without Delta Dental coverage. **However, once a member opts out of dental coverage, the member will not be able to re-enroll in dental coverage at a later date.**

Optional Medicare Part D Coverage

Kansas Senior Plan C provides you with the option of Medicare Part D. You can obtain Kansas Senior Plan C without SilverScript Part D coverage and obtain your coverage on the private market. As an option, you may obtain a State of Kansas Medicare Part D coverage known as SilverScript Part D. **This Medicare Part D coverage is unlike most plans in that there is no deductible nor is there a “gap” or “donut hole” found in many other plans.** SilverScript Part D is covered in detail beginning on page 17 of this booklet. More information about federal Medicare Part D coverage may be obtained by calling Medicare at **1-800-633-4227** or going online to **www.medicare.gov** (Medicare website).

Coventry Advantra Freedom PPO

Coventry Advantra Freedom PPO is available for direct bill members enrolled in Medicare part A and part B. It is a Medicare Advantage Plan under Part C of Medicare. You have peace of mind knowing that Advantra meets all of Medicare’s stringent regulations and offers you more benefits with no up front deductibles. Coventry Advantra Freedom PPO is offered with the Coventry Part D or Silver Script Part D.

The funding that Advantra receives allows it to offer products that have more benefits than Medicare for premiums that may be significantly lower than other policies. Direct bill members enrolled in the Advantra PPO Plan continue to pay the Part B premium and a monthly premium for the Advantra Plan. **You do not need to buy additional supplemental Medicare insurance.**

Coventry Advantra Freedom PPO is sponsored by Coventry Health Care of Kansas, Inc. If members consider the Coventry Advantra Freedom PPO Plan, they need to make sure they live in a county where the plan operates and whether their preferred doctor and hospital are members of the plan.

Although this plan gives members the freedom to seek care without referral from any physician who treats people enrolled in Medicare, members receive the highest level of benefit if they seek care from doctors who are part of the PPO network. To view the Advantra Freedom PPO provider directory, go to **www.kc.chcadvantra.com** or contact Coventry customer service at **1-800-727-9712**.

Coventry is available in 30 Kansas counties and 35 Missouri counties. (See the Medicare Plan Comparison Chart 2 included in this booklet for a list of counties where Advantra Freedom PPO is available.)

The PPO option includes Medicare Part D prescription drug coverage which features unlimited preferred generic drugs. The member can select either Coventry Part D or the State of Kansas SilverScript Part D.

Coverage under Advantra Freedom PPO also includes:

- Unlimited hospital days
- \$0 copayment for Primary Care Physician and Specialist office visits
- No copayments, coinsurance or deductible for preventive care services such as colonoscopy screenings, mammograms and immunizations
- Hearing and vision exams
- Access to a telephonic nurse advice line, available 24 hours a day, seven days a week

If you use medical services, the Advantra Freedom PPO limits the out-of-pocket cost a member will pay for health care services to \$1,000 per year for network services,

excluding prescription drugs (see Summary of Benefits for details). Once this level is reached, Advantra will cover applicable medical services at 100 percent. The out-of-pocket maximum resets to zero each year on January 1.

The out-of-pocket maximum does not apply to services provided outside the PPO network.

Members may elect the Coventry Advantra Freedom PPO with or without Delta Dental coverage. **However, once a member opts out of dental coverage, the member will not be able to re-enroll in dental coverage at a later date.**

Additional Coventry Advantra Freedom Services

Advantra Freedom offers additional services at no cost to members. These Members Choice services are not connected with the medical benefits plans and are completely optional and voluntary. Members Choice services include:

- Discounted rates for participating acupuncturists, massage therapists and chiropractors.
- Discounted rates on health club memberships with participating clubs.
- In addition to the many discounts available through the Members Choice program, Coventry Advantra also offers members our Silver & Fit program - providing unlimited access to participating fitness centers anywhere in the country.
- Savings on thousands of health products including nutritional supplements and vitamins, health education products and skin care items. Standard shipping is free for Advantra members.

Humana Group Medicare PPO

Humana Group Medicare PPO plan is offered by a private company—that contracts with Medicare—to provide you with all your Medicare Part A and Part B benefits. To be eligible you must have both Medicare Part A and Part B, and you must continue to pay your Part B premiums. If you are enrolled in this plan, Medicare services are covered and are not paid for under Original Medicare.

The Humana Group Medicare PPO Plan gives you more benefits than Original Medicare, including coverage for doctor's visits, annual routine physical exams and hospital stays—without the Medicare deductibles. Because prescription drug coverage is included, you get a full range of benefits in one plan. You may choose from either Humana Part D or the State of Kansas SilverScript prescription drug coverage with this option.

You don't need a referral to see any health care provider, but you'll reduce your out-of-pocket costs by using providers in Humana's network. You can see a Humana network provider in any of our Humana Group Medicare PPO service areas and receive an in network benefit. So, for example, if you live in Kansas and vacation in Florida, in network providers are available in both locations.

Coverage under the Human Group Medicare PPO Plan includes:

- Freedom to see health care providers of your choice (although with the Humana Group Medicare PPO Plan, you will pay more for services received out of network)
- All the benefits of Original Medicare without the Medicare deductibles
- No referral needed to see provider
- Low copayments for doctor's visits
- Prescription drug coverage

- Prescription home-delivery service
- A lower premium than you'd pay for most Medicare supplement plans
- Coverage for annual routine physical exam

To see whether your doctor is in the Humana Group Medicare PPO network, or if you have any questions about the Humana Group Medicare PPO Plan, call **1-866-396-8810**. If you have a speech or hearing impairment and use a TTY, call **1-800-833-3301**, Monday through Friday, 8:30 a.m. to 5 p.m. Eastern time.

Members may elect the Humana Group Medicare PPO with or without Delta Dental coverage. **However, once a member opts out of dental coverage, the member will not be able to re-enroll in dental coverage at a later date.**

SilverScript Medicare Part D Drug Plan

SilverScript Part D is an optional Medicare Part D prescription drug component offered under each Medicare Supplement Plan or Medicare Advantage Plan. It is not available as a stand-alone product.

How Medicare Part D Works

Medicare Part D began in 2006 and is designed to assist Medicare beneficiaries in paying the cost of medically-necessary prescription drugs. To get Medicare coverage for your prescription drugs, you must choose and join a Medicare prescription drug plan.

Regardless of how a Medicare prescription drug plan offers this coverage, there are some key factors that may vary. Some of these factors might be more important to you than others, depending on your situation and drug needs. Some of these factors are:

- **Premium Cost.** All plans require payment of a monthly premium.
- **Deductible.** This is the amount you pay for your prescriptions before your plan starts to share in the costs. Deductibles vary by plans. **SilverScript Part D, unlike many other plans, does not have a deductible.**
- **Copayment/Coinsurance.** This is the amount you pay for your prescriptions. In some plans, you pay the same copayment (a set amount) or coinsurance (a percentage of the cost) for any prescription. In other plans, there might be different levels or "tiers" with different costs. (For example, you might have to pay less for generic drugs than brand name drugs. Or, some brand name drugs might have a lower copayment than other brand name drugs.) Also, in some plans your share of the cost can increase when your prescription drug costs reach a certain limit.
- **Formulary.** A formulary is a list of drugs covered by a specific Medicare prescription drug plan. Formularies include generic and brand-name drugs. The formulary varies from provider to provider, but all plans must include at least two drugs in categories and classes of most commonly prescribed drugs to people with Medicare. This ensures that people with different medical conditions can get the treatment they need. SilverScript Part D uses a formulary. Your drugs must be on the formulary in order to be covered. In the event you take a drug that is not on the formulary, it is possible that an exception may be granted. Contact SilverScript Part D at **1-800-837-4092** for more information on the exception process or formulary. You also can find formulary information online at **www.khpa.ks.gov**.

- **Prior Authorization.** Some drugs are more expensive than others even though some less expensive drugs work just as well. Other drugs may have more side effects, or have restrictions on how long they can be taken. To be sure certain drugs are used correctly and only when truly necessary, plans may require a “prior authorization.” This means before the plan will cover these prescriptions, your doctor must first contact the plan and show there is a medically-necessary reason why you must use that particular drug for it to be covered. Plans might have other rules like this to ensure that your drug use is effective.
- **Coverage Gap.** If you have high drug costs, you may consider which plans offer additional coverage until you spend \$4,550 (in 2010) out-of-pocket. In some plans, if your costs reach an initial coverage limit, then you pay 100 percent of your prescription costs. This is called the coverage gap or “donut hole.” This “gap” in coverage is generally above \$2,830 (in 2010) in total drug costs until you spend \$4,550 out-of-pocket. **SilverScript Part D, unlike many other plans, does not have a coverage gap.**

SilverScript Part D Overview

SilverScript Part D will generally cover the drugs listed in their formulary as long as:

- The drug is medically necessary,
- The prescription is filled at a plan network pharmacy, and
- Other coverage rules are followed.

SilverScript Part D does not pay for drugs that are covered by Medicare Part B, such as:

- Drugs usually supplied by and administered in your doctor’s office (such as chemotherapy drugs)
- Drugs used with durable medical equipment (DME) that you obtained through DME services, such as respiratory drugs given through a nebulizer
- Some immunosuppressive drugs (if you had a Medicare covered transplant) and some oral anti-cancer drugs
- Drugs provided in Hospital Outpatient Departments and drugs such as erythropoietin (EPO) if you are undergoing dialysis

Reminders

In order to participate in Medicare Part D, you must enroll in one of the Part D programs. Once you have enrolled in a program, should you later enroll in another Medicare Part D program, you are automatically dis-enrolled in the earlier program. This is important to know because if you are enrolled in a Medicare Part D program coupled with other health insurance, enrollment in a subsequent Part D program may result in loss of your health insurance benefits.

For the 2010 calendar year, retirees enrolled in Kansas Senior Plan C with SilverScript will be automatically enrolled in SilverScript Part D. If you do not want to participate in SilverScript Part D you must contact the **Direct Bill Call Center at 1-866-541-7100 (In Topeka 296-1715)**. Representatives are available to assist you beginning November 9, 2009, Monday through Friday from 8:30 a.m. to 4:30 p.m. Central time. The office will be closed on Veterans Day (November 11, 2009), the Thanksgiving Holiday (November 26-27, 2009), Christmas (December 25, 2009) and New Year’s Day (January 1, 2010).

If, in the past, you have been eligible for a Medicare Part D program and were not enrolled in a State of Kansas prescription drug plan, you must provide a letter of creditable prescription drug coverage in order to enroll in SilverScript Part D. To enroll in the program, obtain a letter of creditable coverage and submit it along with your enrollment form found in the back of this booklet or call the Direct Bill Call Center.

SilverScript Part D Pharmacy Network

As a **SilverScript Part D** beneficiary, members will use an extensive network of 64,000 pharmacies—one in four pharmacies across the country is included in our network. You must use a network pharmacy to receive plan benefits. They may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases which will be described in your Evidence of Coverage.

Quest Lab Card – Only Available with Plans A & B

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.

Lab Card covers routine outpatient lab tests.

Lab Card does **not** cover:

- Testing ordered during hospitalization
- Lab work needed on an emergency or STAT basis
- Testing done at any other laboratory
- Non-laboratory work such as mammography, X-ray, imaging and dental work.
- Time-sensitive esoteric testing such as fertility testing, bone marrow studies and spinal fluid tests
- Testing that is not approved and/or covered by The State of Kansas Plan A or Plan B
- Lab work billed by your doctor or another lab provider to your health plan

If your physician does not collect specimens in the office, Quest Lab Card offers collection sites at various locations throughout the State of Kansas. Quest Lab Card is now available nationwide. A complete list is available at www.labcard.com or by calling **1-800-646-7788**.

Remember, the Quest Lab Card program is completely voluntary. If you and your health care provider choose to use a lab other than Quest Lab Card—including the lab in your health care provider's office—you still have coverage. However, you will be responsible for any deductibles, copayments or coinsurance.

At your health care provider's office or contracted collection site, be sure to verbally request to use your Quest Lab Card benefit.

It's Up to You!

You must request to use the Lab Card program so be sure to present your Plan A or Plan B ID card (with the Lab Card logo on it) and/or your separate Lab Card at your provider's office or Lab Card collection site.

Caremark Prescription Drug Plan

Prescription drug coverage is provided through Caremark for Plans A and B, and its cost is included in the health plan rates. While the Preferred Drug List (PDL) is the same for all plans, the amount you pay will vary depending on the plan you select as explained below.

- **Plan A and Plan B.** Under these plans, generally you pay a coinsurance for your prescription drug costs throughout the year, up to a combined coinsurance maximum.

Regardless of which plan you elect, your out-of-pocket costs will be lower if you use generic and/or preferred brand name drugs. Your cost for generic drugs and preferred brand name drugs is considerably lower than your cost for non preferred brand name drugs.

Before talking to your physician about prescriptions, it is suggested that you print out the preferred drug list from the website and take it with you so you can talk to your doctor about your options. If the physician says you must take a brand name drug, ask if there is a preferred brand name drug listed on Caremark's PDL that you can take. This PDL is updated quarterly so please check for updates throughout the year.

Caremark's PDL is available on the open enrollment website - click on the **2010 Open Enrollment** button at www.khpa.ks.gov then select **Prescription Drug Coverage** or go to www2.caremark.com/kse. You can also call Caremark at **800-294-6324**. A number of popular name brand drugs are projected to be available in generic versions by the end of 2010. This list is also on the website.

A new change to the PDL for 2010 would be that you must try a generic drug before you will be approved for a non preferred brand name drug for three classes of drugs: high blood pressure, high cholesterol and stomach acid reducers called proton pump inhibitors. These effected drugs include high blood pressure medications (ACE/ARBs) such as Diovan, Cozaar and Hyzaar; stomach acid reducers, such as Prilosec and Aciphex, and cholesterol lowering drugs like Vytorin and Zocor. Those currently using a non preferred drug will be notified by Caremark.

The Caremark plan is designed to encourage you and your health care provider to choose the most cost-effective and clinically-effective medications available. The benefits in the tables listed on the comparison chart included apply when you purchase prescription drugs from a participating Caremark network pharmacy or Caremark home delivery. Plans A and B allow up to a 60-day supply for home delivery through Caremark and reorders are processed in as little as five to seven days. To place an initial order or reorder by phone, call 1-800-294-6324 or e-mail [**online@caremark.com**](mailto:online@caremark.com)

Specialty and biotech drugs designed for difficult conditions that don't respond to traditional therapy, including cancer, MS, hemophilia, rheumatoid arthritis, hepatitis C and growth hormones, are available only at Caremark Connect Specialty Pharmacy. Contact Caremark Connect at 1-800-237-2767. A Caremark representative will coordinate patient care with the provider and arrange overnight shipping.

For more information on the Caremark Prescription Drug Plan, go to www.khpa.ks.gov and click on the **2010 Open Enrollment** button - then select **Prescription Drug Coverage** or call Caremark at **1-800-294-6324**.

Delta Dental Plan

All Direct Bill members enrolled in health coverage are also enrolled in the dental plan, unless the member has opted out of the dental plan. For those members that continue with the dental plan, you may also choose to purchase dental coverage for your dependents that are enrolled in the health plan. You have access to two provider networks and are free to use both Delta Dental Networks.

Important Note: Members may elect to opt out of Delta Dental coverage. However, once a member opts out, the member will not be able to re-enroll in dental coverage at a later date.

Delta Dental Premier Network

The Delta Dental Premier Network is the broad network of providers that you may use. Delta Dental will make payment directly to the dental provider. You will be responsible only for paying the specific coinsurance and deductibles for covered services in addition to any services not covered. Delta Premier Dentist agree to accept the plan allowance as payment in full.

Delta Dental PPO Network

Delta Dental also offers the Delta Dental PPO network. The PPO network providers have agreed to a reduced fee for providing dental services. As a result, you generally pay a lower percentage of the total bill than you would when using the Premier Network. The PPO network for our group includes all PPO providers in the national DeltaUSA PPO network. Again, all participants in the Delta Dental program may use the PPO providers whenever desired.

Preventive Care

Diagnostic and preventative services are covered at 100% with no deductible. Covered services include:

- Prophylaxis/cleanings – twice per plan year.
- Oral examinations – twice per plan year.
- Bitewing x-rays –
 - adults - 1x a year
 - children under 18 - 2 x a year
- Full mouth x-rays – once each five (5) years.
- Limited coverage for children only:
 - Sealants
 - Space maintainers
 - Topical fluoride
- Ancillary – emergency relief of pain.

Plan Deductibles

A deductible of \$50 per person with a maximum annual family deductible of \$150 now applies to all basic and major restorative care. This includes:

Basic Restorative

- Regular restorative dentistry - fillings
- Oral surgery
- Endodontics – root canals
- Periodontics – treatment of gum and bone disease
- Additional diagnostic X-rays

Major Restorative

- Special restorative dentistry – crowns
- Prosthodontics – bridges, implants and dentures
- TMJ Treatment – requires prior authorization

A \$1,000 per person per lifetime benefit applies to orthodontic benefits; and there is an annual benefit maximum of \$1,700 per person per year for all dental services except orthodontics.

Coinsurance

Preventive Care Services are always covered at 100 percent of the allowed amount. Ninety days after a preventive office visit or cleaning, the member is eligible for the enhanced benefit.

The basic benefit applies when the member has not had at least one routine prophylaxis (cleaning) and/or preventive oral exam in the prior 12 months. The member is responsible for paying 50% coinsurance for all basic and major restorative services, regardless of provider.

However, if the member has had at least one routine prophylaxis (cleaning) and/or preventive oral exam in the preceding 12 months, basic restorative services are subject to a coinsurance of 20% when provided by a PPO provider and 40% coinsurance when provided by a Premier or Non Network provider. Major restorative service continue to be covered at the 50% coinsurance rate for all providers.

New Direct Bill members will have a one year grace period at the enhanced level to get their annual exam and cleaning.

For more details on Delta Dental Benefits, go to www.khpa.ks.gov and click on the **2010 Open Enrollment** button, then select **Dental Coverage** or call Delta Dental at **1-800-234-3375**.

Superior Vision Services Plan

You are offered two vision plans through Superior Vision Services*: the Basic Plan and the Enhanced Plan.

You may choose to enroll yourself and any eligible dependents in one of the vision plans, whether or not you or your dependents are enrolled in the health plan. However, if you choose dependent vision coverage, and dependent children also are enrolled in the health plan, the dependent children enrolled in the vision plan must match those enrolled in the health plan.

Please note that you can enroll or change your coverage only when you or a dependent first becomes eligible, during the annual Open Enrollment period, or if a dependent becomes ineligible. This holds true even if you have made a special arrangement to pay your rates on an after-tax basis.

Special Features From Superior Vision Services

Discounts on the first pair of fully covered eye wear. Discounts are available for lens add-ons or upgrades not otherwise covered by the plan. The discount is 20 percent and is available from providers identified in the provider directory with a "DP"

Discounts on additional eye wear. Discounts are available for additional eyewear purchases. The discounts range from 10 percent to 30 percent and are available at providers identified in the provider directory with a "DP"

Discounts on refractive surgeries such as LASIK, RK and PRK. Providers listed in the provider directory with the "RF" designation will provide Superior Vision members with a discount of 20 percent on refractive surgeries.

**The Superior Vision Plan is underwritten by National Guardian Life Insurance Company. National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, aka The Guardian or Guardian Life.*



STATE EMPLOYEE HEALTH PLAN (SEHP) Appointment of Personal Representative

Appendix W

Member Information		
Member, Spouse or Dependent Names <small>(LAST, FIRST, MI)</small>	Mailing Address <small>STREET ADDRESS CITY, STATE, ZIP</small>	Phone Number <small>Including Area Code</small>
Member ID number or Social Security Number		

Personal Representative Information			
Personal Representative Name <small>(LAST, FIRST, MI)</small>	Mailing Address <small>STREET ADDRESS CITY, STATE, ZIP</small>	Phone Number <small>Including Area Code</small>	Relationship to the Member

I, the above named member, hereby designate the above named person, to act on my behalf or on behalf of my covered spouse and dependent(s).

I authorize my Personal Representative to act for me (and for my covered spouse and dependents, if named above,) in receiving any information that is (or would be) provided to me as a member of the SEHP, including but not limited to, any information that relates to my claim for coverage or benefits under the SEHP and any individual rights that I have regarding my protected health information under the Health Insurance Portability and Accountability Act (HIPAA).

Or alternatively, ¹I authorize my Personal Representative to act for me, my covered spouse and dependents (if named above) in receiving protected health information to conduct the following functions on my behalf:

--

I understand that this designation is subject to approval by the SEHP. I also understand that once approved, this designation will remain in effect indefinitely or until I revoke it. I understand that I have the right to revoke this designation at any time by submitting a signed statement to that effect to the SEHP.

I certify that I have reviewed the SEHP's Policy for designation of Personal Representative.

Member's Signature	Date
Personal Representative's Signature	Date
Please indicate the password to be used by the SEHP to identify your Personal Representative when they contact the SEHP.	Password:

¹ The SEHP may wish to use this paragraph to allow members and dependents to designate individuals to be a personal representative only for specific activities. The preamble to the privacy rules states that a personal representative must be treated as the individual only to the extent that PHI is relevant to the matters on which the personal representative is authorized to represent the individual. 65 Fed. Reg. 82500.

Appendix

Direct Bill Member Eligibility.....	25
Qualifying Events.....	25
Dropping Coverage.....	26
Dependent Definitions.....	26
Privacy Rights and Appointment of Personal Representative for Health Care Choices.....	27

Direct Bill Member Eligibility

An individual is eligible for participation in the State Employee Health Plan as a direct bill member if he or she is:

- A.** A retired official or member who is receiving a retirement benefit through the State of Kansas.
- B.** A totally disabled former State official or member who is receiving a disability benefit through the State of Kansas.
- C.** A former elected State official who was covered under the State plan immediately before the date the person ceased to be an elected official.
- D.** A blind person licensed to operate a vending facility, or any licensed blind person who has ceased to operate a vending facility.
- E.** A surviving spouse or dependent of a former State member or retiree. The spouse or dependents must have been covered under the State plan immediately before the date of death of the member or retiree.
- F.** An active State member who was covered under the State plan immediately before going on approved leave without pay. Participation due to leave without pay status is limited to one year.

Qualifying Events

Open Enrollment is your annual opportunity to make changes to your health care coverage. Changes cannot be made to your health or dental elections until next year's Open Enrollment unless you experience a qualifying event. The effective date of change for qualifying events will be the first day of the month following the event. Qualifying events include:

- A.** The member's marriage, final divorce or legal separation
- B.** Birth or adoption of a dependent
- C.** Gain or loss of legal custody of a dependent
- D.** Change from part-time to full-time or from full-time to part-time employment by spouse which affects cost, benefit level or benefit coverage for the member and/or dependents
- E.** Termination or commencement of employment (including retirement) of spouse or dependent which affects benefits coverage for the member and/or spouse or dependents
- F.** Unpaid leave of absence by spouse or dependent which affects the benefits coverage for the member and/or spouse or dependent

- G.** Significant changes during a spouse's Open Enrollment for group health insurance, such as premium increases, benefits levels or enrollment in coverage
- H.** A member, spouse or dependent being called to active military duty
- I.** Expiration of COBRA continuation benefits from a previous employer for the member, spouse or dependent
- J.** The member's change in residence which requires a change in insurance plan
- K.** Death of a spouse or dependent
- L.** Spouse or dependent moving out of an enrollment area, if applicable
- M.** A dependent turning age 23 or marrying
- N.** Spouse or dependent gaining or losing government-sponsored medical card coverage
- O.** The member, spouse or dependent becoming Medicare eligible and electing Medicare coverage as primary
- P.** Dependent children identified under a Medical Withholding Order (K.S.A. 43-2105) or Medical Child Support Order
- Q.** Court order requiring adding or dropping coverage for a dependent
- R.** All spouse changes as listed above but including events involving coverage of dependent children by an ex-spouse

Dropping Coverage

Direct bill members may drop medical, dental and prescription coverage for themselves and/or any covered dependents at any time by notifying the Direct Bill Membership Office at the number listed below. If a member terminates his or her coverage, all coverage for dependents will also be terminated. The effective date of termination will be the first day of the month following notification. **Note: Once a member opts out of dental coverage, the member will not be able to re-enroll in dental coverage at a later date.**

Vision coverage may not be dropped during the plan year unless due to a dependent becoming an ineligible dependent or unless medical coverage is dropped.

Coverage may be dropped by notifying the Direct Bill Membership Office at **1-866-541-7100** (outside of Topeka) or **296-1715** (in Topeka) and completing necessary forms.

Once coverage has been terminated, the member cannot re-enroll at a later date.

Dependent Definitions

Proof of Dependency and/or Residency

The State of Kansas and the medical plan reserve the right to request documentation to support proof of dependency and/or residency. When enrolling a dependent for coverage with the State of Kansas Health Plan, the member must certify that a dependent meets the requirements for dependent coverage for the year in which the dependent is being enrolled. The member must also provide appropriate supporting documentation for each dependent. Any attempt to enroll dependent(s) who do not meet the requirements will be considered fraud and will be subject to penalties as prescribed by law.

Deceased Members and Spouses

In the event of a direct bill member's death, a family member or beneficiary should call the Direct Bill Membership Office as soon as possible to report the date of death. Prompt notification to the State of Kansas prevents additional premiums from being charged to the member's estate; however, the premium for the deceased member is still owed for the entire month in which the death occurs. If the premium is paid, health care claims for the deceased member will be paid up to and including the date of death.

If the direct bill member is covering a spouse and/or child(ren) as of the date of death, the surviving spouse and/or child(ren) will be offered continuous Direct Bill group health insurance coverage in his or her own name effective the first day of the month following the date of death. The premium for the remaining family members is generally lower; therefore, prompt notification to the Direct Bill Membership Office may reduce the premium cost.

If a spouse is deceased, the direct bill member should call the Direct Bill Membership Office as soon as possible to report the date of death. Premium for a single member is lower than for a member and spouse; therefore, prompt notification to the Direct Bill Membership Office will reduce the premium cost for the member. The premium for the deceased spouse is still owed for the entire month in which death occurs. If the premium is paid, health care claims for the deceased spouse will be paid up to and including the date of death.

Mid-Year Change Requirements

Non-newly eligible members and/or dependents may be added to group health insurance coverage during the plan year but only if all of the following mid-year change requirements are met:

- A. The change is a result of a qualifying event.
- B. The change is requested within 31 calendar days of the event (by calling the Direct Bill Membership Office number listed in the "Contact Information" section).
- C. The change in coverage is consistent with the event.
- D. Written documentation of the event (such as a divorce decree, death certificate or custody agreement) or a statement from spouse's employer is provided to the Direct Bill Membership Office.
- E. A completed and signed Enrollment Change Form is returned to the Direct Bill Membership Office within seven calendar days of receipt. An Enrollment Change Form is included in your enrollment kit.

Privacy Rights and Appointment of Personal Representative for Health Care Choices

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 gives you certain privacy rights with respect to health-related issues. More information about HIPAA may be found online at www.hhs.gov/ocr/hipaa (United States Department of Health and Human Services website) or www.medicare.gov (Medicare website).

As a health insurance provider for direct bill members, the State of Kansas is covered under HIPAA. As a result, we cannot discuss specific aspects of your health insurance coverage with anyone without your express written permission.

Therefore, if you need assistance in making health care decisions and wish to appoint someone to act on your behalf on health care issues, including your health plan choices, please complete a copy of the Appointment of Personal Representative form included on page 23. Submit your completed form to Membership Services Kansas Health Policy Authority at Room 900-N, LSOB, 900 SW Jackson, Topeka, KS 66612 or submit it by fax to **1-785-368-7180**. If you have already submitted this form to KHPA, resubmission is not required unless you choose to make a change.

