STATE OF
KANSAS

Health Plan Summary

For Direct Bill Members

2006

Open Enrollment

November 1, 2005 through November 30, 2005

http://da.state.ks.us/hcc/direct.htm

Taking Healthy Steps Together!

Summary of Plans

Medical Plans

Blue Cross Blue Shield

• Kansas Choice (PPO)	Outside Topeka	800-332-0307
	In Topeka	785-291-4185
• Premier Blue (HMO)	Outside Topeka	800-332-0028
	In Topeka	785-291-4010
• Kansas Senior Plan C	Outside Topeka	800-332-0307
	In Topeka	785-291-4185

Coventry Health Care of Kansas

• PPO, HMO	Kansas City Area	800-969-3343
	Wichita Area	866-320-0697
• Advantra Freedom	All Areas	800-727-9712
		TTD 866-347-2459

Preferred Health Systems

• Preferred Plus of Kansas (HMO)	Outside Wichita	866-618-1691
	In Wichita	361-609-2555

Lab Card Plan

LabOne services for participants in Kansas Choice & Coventry PPO plans	All Areas	800-646-7788

Dental Plan

Delta Dental of Kansas, Inc.	Outside Wichita	800-234-3375
	In Wichita	316-264-4511

Prescription Drug

Caremark	All Areas	800-294-6324

Vision Plan

Superior Vision Services	All Areas	800-507-3800

Direct Bill Membership

	Toll free	866-541-7100
	Topeka	785-296-1715

Billing

CONEXIS (http://www.conexis.org)	All Areas	866-214-2978

KPERS

	Toll free	888-275-5737
	Topeka	785-296-6166

Service provider web site links can be found at: **http://da.state.ks.us/ps/subject/benlink.htm**

NOTE: 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 view them at our website: http://da.state.ks.us. The Health Care Commission reserves the right to suspend, revoke or modify the benefit programs offered to employees. Nothing in this booklet shall be construed as a contract of employment between the State of Kansas and any employee, nor as a guarantee of any employee to be continued in the employment of the State, nor as a limitation on the right of the State to discharge any of its employees with or without cause.

Dear Direct Bill Health Plan Participant:

The State of Kansas Health Care Commission believes the benefits provided by the State Employee Health Plan make your participation in the plan very valuable. Plan Year 2006 is a landmark year as Medicare Part D, prescription drugs, becomes available to all Medicare beneficiaries. Please carefully review this booklet and your options to determine your best choice.

Open Enrollment Period

Your Open Enrollment period is from **November 1, 2005 through November 30, 2005**. Please review the information in this booklet carefully before making any enrollment changes for the new plan year. Coverage elections will become effective on January 1, 2006.

Open Enrollment Meetings

A list of Open Enrollment meetings is located behind this letter in your booklet. We encourage you to attend a meeting in your area.

Enrollment Process

For convenience, a pull-out Enrollment Form for Plan Year 2006 is in the back of this booklet. Complete an Enrollment Form to change medical plans, elect your prescription drug plan, opting for the split enrollment, add/drop medical or vision coverage, or add/drop your spouse and/or dependents form coverage. If you need help with your enrollment, please call the Direct Bill Call Center before November 30, 2005.

Direct Bill Call Center

The Call Center will open beginning October 24 for any questions and assistance you might require. It will be open from 8:30 a.m. to 4:30 p.m. Monday-Friday through November 30, 2005, except holidays.

The Call Center will be closed on the following dates:
Veterans Day, November 11
Thanksgiving Holiday, November 24 &25

Please call the Direct Bill Call Center toll free at:
1-888-523-4976
Or in Topeka
1-785-291-3575
October 24 – November 30

Bill Service

CONEXIS provides billing and remittance services for the State. Please contact CONEXIS at 1-866-214-2978 if you have any questions about premium payments.

Membership Issues

Questions or concerns about membership or covered benefits should be addressed to the Benefits Staff, Attn: Deb Dumas, Division of Health Policy and Finance, 900 SW Jackson, Room 920-N, Topeka, KS 66612 or call toll free at 1-866-541-7100, or local 785-296-1715 or by email at: deb.dumas@da.state.ks.us

Thank you for your cooperation during Open Enrollment.

2006 Retiree/Direct Bill Open Enrollment Meetings

DATE	DAY	CITY	FACILITY/AGENCY	ADDRESS	TIME
Friday	10/28/2005	Wichita	Wichita State University Hughes Metropolitan Complex	5015 E. 29th Street North Sudermann Commons (Corner of 29th & Oliver) Entrance C - East side of the Bldg.	9:30 AM
	10/28/2005	Wichita	Wichita State University Hughes Metropolitan Complex	5015 E. 29th Street North Sudermann Commons (Corner of 29th & Oliver) Entrance C - East side of the Bldg.	1:30 PM
Monday	10/31/2005	Manhattan	Cico Park - Konza Room	Avery Drive - Fairgrounds	9:30 AM
	10/31/2005	Manhattan	Cico Park - Konza Room	Avery Drive - Fairgrounds	1:30 PM
Tuesday	11/1/2005	Larned	Larned State Hospital-Chapel	3 Miles W. of Larned on Hwy. 156	9:00 AM
	11/1/2005	Hutchinson	KDOT-Dist. 5 - Conference Room	1220 W. 4th	2:00 PM
Wednesday	11/2/2005	Parsons	Senior Community Center	1800 Belmont	1:30 PM
Thursday	11/3/2005	Emporia	Lyon County Extension Office Enter off of Mechanic St. Free Parking in lot	618 Commercial	9:30 AM
Friday	11/4/2005	Osawatomie	Osawatomie State Hospital Administration Building - Kansas Room	Highway 169 South	9:30 AM

DATE	DAY	CITY	FACILITY/AGENCY	ADDRESS	TIME
Monday	11/7/2005	Salina	KHP Training Center	2025 E. Iron-Troop J - Admin. Bldg.	1:30 PM
Tuesday	11/8/2005	Hays	Kansas Highway Patrol Building	1821 Frontier Road	9:00 AM
Wednesday	11/9/2005	Garden City	Community Center of Finney County	907 N 10th - Blue Room	9:00 AM
Thursday	11/10/2005	Pratt	Community Center	619 N Main - Large Room	2:00 PM
Friday	11/11/2005	Pittsburg	Homer Cole Community Center	3003 N Joplin	9:30 AM
	11/11/2005	Pittsburg	Homer Cole Community Center	3003 N Joplin	1:30 PM
Monday	11/14/2005	Overland Park	KU Regents Center	126th and Quivira - Room 110	9:30 AM
	11/14/2005	Overland Park	KU Regents Center	126th and Quivira - Room 110	1:30 PM
Tuesday	11/15/2005	Topeka	KS Museum of History	6425 SW 6th - Museum Classroom	1:30 PM
Wednesday	11/16/2005	Topeka	KS Museum of History	6425 SW 6th - Museum Classroom	1:30 PM
Friday	11/18/2005	Lawrence	4-H County Fairgrounds	2110 Harper, Bldg. #21 South	9:30 AM
	11/18/2005	Lawrence	4-H County Fairgrounds	2110 Harper, Bldg. #21 South	1:30 PM
Monday	11/21/2005	Topeka	KS Museum of History	6425 SW 6th - Museum Classroom	9:30 AM
	11/21/2005	Topeka	KS Museum of History	6425 SW 6th - Museum Classroom	1:30 PM

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Positive Changes for You in 2006

Benefit Changes:

PPO:

- Eliminated two tiered coinsurance maximums. Now just 65/35 for network; and 50/50 for non network.
- Increased preventive services to $450 "per person" (not just adult).
- Rehabilitation Benefit changes from lifetime cap to:
  - Facility based: Medically necessary and appropriate for acute care setting (inpatient or outpatient); requires periodic plan review.
  - Office based: 30 total visits per plan year, regardless of diagnosis.

HMOs:

- Waive copay for one routine physical and one eye exam per person.
- Rehabilitation benefit: same as PPO above.

PPOs/HMOs:

- Increased lifetime medical maximums to $3 million.

Kansas Senior Plan C:

- The benefits of the Kansas Senior Plan C Supplement Plan does not change, however, there is a new option that is available for prescription drugs.
- Keep current drug plan

  or
- Elect new option that does not include prescription drugs.
- NEW! Intended for participants who select a stand alone Medicare Part D plan.
- Take advantage of this new savings opportunity.

Dental:

- **Increased** benefit maximums to $1,700 from $1,600.

New Plan Options:

NEW! **Coventry Advantra Freedom:**

- A Medicare Advantage Plan that includes Medicare Part D prescription drugs.
- Coventry Advantra Freedom contracts directly with Centers for Medicare and Medicaid.
- It is NOT a Medicare Supplement Plan.
- Applies to limited counties (not statewide).
- Provides opportunity for savings through better coordination of your health care.

NEW! **Split Enrollment:**

- There will be an option for retirees with mixed eligibility (one participant is Medicare eligible and the other is not) to split their enrollment. With this option, the Medicare participant could enroll in the Coventry Advantra Freedom Plan or in Kansas Senior Plan C Supplement, while the non-Medicare eligible participant would be allowed to remain in a regular plan. When you enroll, make sure to indicate split enrollment. You will need to complete two separate enrollment forms.

Should Everyone Review Their Health Care Plans?

Yes. The Open Enrollment period from November 1 to November 30, 2005 is your opportunity to begin, verify, or make changes to your benefit elections. This is the only time changes to your current health and dental elections can be made until next year's Open Enrollment period unless you experience a qualifying event (see page 42).

Whether you are enrolling for the first time, changing to a different plan or coverage level, or waiving your health, drug and dental coverage, you must complete an Open Enrollment form.

Two of the PPOs offered in 2005 will not be available in 2006: Kansas Prefer (Harrington) and Preferred Health Systems (PHS). If you were enrolled in either of those two plans, you will receive a notice that your coverage will automatically be moved to the Blue Cross Blue Shield plan called Kansas Choice. If you do not want to be in Kansas Choice, you will need to select a different plan during the Open Enrollment period. Please check the provider list with Kansas Choice or Coventry PPO to make sure your provider is available with them. Another option is to choose an HMO product. Again, read this booklet for all options.

Select Option

Another program not available in 2006 is the Select Option prescription drug program. Select Option was an alternative to the Standard drug plan and designed to reduce costs for Direct Bill participants by requiring mandatory mail-order and mandatory generic drug usage. The Select Option prescription drug program is being eliminated because the new Medicare Part D plans offer significant savings.

When Does Coverage Begin?

Changes and new rates become effective January 1, 2006.

Coverage Period

Health Plan coverage is monthly. New enrollments or changes in enrollment and/or coverage will generally begin on the first day of the month. Terminations of coverage or ineligibility for coverage will be effective on the last day of the month.

Pre-Existing Medical Conditions

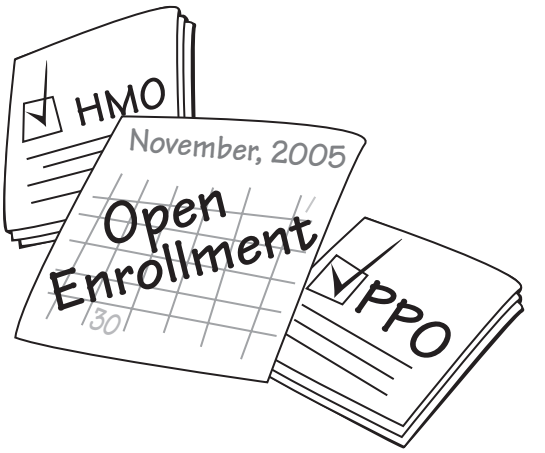
The State of Kansas does not apply a waiting period for coverage of pre-existing medical conditions

Identification Cards

If you make plan changes during Open Enrollment, you will receive a new identification card for plan year 2006. Cards will be mailed to the participant's home address starting in mid-December. If you have not received a new ID card for a plan in which you are expecting one by the first part of January, contact the health plan at the telephone number listed in the front of this booklet to request one. You can request additional cards by contacting your carrier listed in the front of this booklet.

Plan Certificates or Benefit Description.

It is important that you review your Certificate of Coverage or Benefit Description. The information in the Medical Plan Comparisons by Plan Type chart in this booklet is only 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 Certificate of Coverage or Benefit Description, which is the controlling document. Determinations of entitlement to benefits are made based on the Certificate of Coverage or Benefit Description. The Certificates of Coverage or Benefit Description may be viewed on the web at **http://da.state.ks.us/ps/subject/benlink.htm**



BILLING

1-866-214-2978

CONEXIS is a third party administrator which provides the financial billing service for all Direct Bill participants in the State of Kansas Health Plan. CONEXIS' **toll free number (866-214-2978)** was established to provide free access to participants for financial issues. You may also e-mail them at: **CustomerService@conexis.org**

You should also call or e-mail CONEXIS if there are any questions about the automatic monthly deduction for premium payments.

Questions or concerns about plan design changes should be sent to the Health Benefits Staff or the Health Care Commission, at the following address:

Health Care Commission
900 SW Jackson Street, Suite 920-N
Topeka, Kansas 66612

The Health Care Commission's website is at **http://da.state.ks.us/hcc/direct.htm**

Payment of Premiums

The participant may pay their premiums by using one of the following methods:

- Automatic deduction from the participant's monthly KPERS retirement warrant. The participant will need to verify with KPERS that there will be sufficient funds for the deduction. For new retiree participants, as of March 3, 2000, health insurance premium payments can not be made by automatic deduction from the participant's monthly KPERS retirement warrant.
- Authorized monthly payments from the participant's bank account.
- Direct monthly payment by coupon and check made payable to "H and H Clearing Fund." This option is available by special arrangement only if authorized monthly payments from participant's bank account is not available to the participant. Any returned premium payment will be subject to a $25.00 service charge.

If you would like to change the method by which you are currently paying your premiums you should contact CONEXIS at the following number: **CONEXIS 1-866-214-2978**

The premium is due by the first of the month of coverage and past due after the 15th day of the month of coverage. Coverage will be terminated by Health Benefits staff if your account becomes past due.

Steps to Create Your Personal Care Plan

STEP 1 Review your current health care needs, coverage and budget

Life changes, and so do health care needs and costs. While you might prefer to ignore the whole business and just keep the plans you had this year, it's well worth your time to confirm this year's plan still fits, or to choose a different plan. In addition to preparing for sickness, regular medical or dental check-ups or other preventive care may help you keep your personal and family medical costs down in the long term.

Many of our health plans are self insured, meaning the State Health Plan pays our claims for medical, prescription drug and dental costs. Being self-insured helps to keep premiums lower and provides more coverage per dollar spent. It also means that adopting lifestyles which lead to good health can have a direct and positive effect on the bottom line.

STEP 2 Read this booklet and other sources

Once you've thought about what you might need next year in terms of medical coverage – flexibility, network of providers, etc., and what you can afford to pay, use the Table of Contents in this booklet and refer back to these steps to guide you through the decision-making process. This booklet includes information on how to choose health care, as well as benefit and rate comparisons, and other useful aids to help you make your decisions. Take the time to study the plans offered, balancing costs and care options, before you make your benefit elections.

A special section has been added this year concerning Medicare Part D. Read it carefully, as well as materials available through CMS, SHICK, AARP and other organizations.

STEP 3 Attend an Open Enrollment meeting to learn more about your options

A schedule of meetings is included in this booklet behind the opening letter. Still need more information? Go to **http://da.state.ks.us/hcc.direct.htm**, the Benefits Administration website for Direct Bill participants. You may also call the Direct Bill Call Center, toll free 1-888-523-4976 or in Topeka at 785-291-3575, between November 1 and November 30.

STEP 4 Complete the Open Enrollment Process

A Direct Bill change for 2006 should be completed only if you wish to make a change in coverage, such as: changing medical, dental or prescription drug plans or coverage level, or add/drop medical or vision coverage. If changes are desired, please call the Direct Bill Call Center no later than November 30, 2005 at the number listed on the next page.

Direct Bill Call Center

Call Center 1-888-523-4976
(During Open Enrollment Only)

In Topeka 785-291-3575
(During Open Enrollment Only)

Following your call, you may be mailed an Enrollment Form, which you must complete, sign and return to the address listed below:

Direct Bill Membership
Attn: Deb Dumas
900 SW Jackson, Suite 920-N
Topeka, KS 66612-1251

Completed enrollment forms must be received in our office no later than **December 9, 2005** for your Open Enrollment election to be approved.

NOTE: You can make changes as many times as you want during Open Enrollment but not afterward unless you have a qualifying event.

Opportunity for Involvement

Employee Advisory Committee

The Employee Advisory Committee (EAC) was established by the Health Care Commission (HCC) in the mid-1990's. As provided in KSA 75-6510, the EAC is to advise the HCC on matters relating to health care benefits of state officers and employees and to assist the HCC in the development of policy and determination of rates of such benefits. The EAC provides a vehicle for participants to express ideas and concerns about the Kansas State Employees Health Plan to the HCC and its staff.

The EAC is composed of 21 members including active employees and retirees. Each member serves a three-year term. Members are selected on a basis of geographic location, agency, gender, age and plan participation. This is to assure that the membership represents a broad range of employee and retiree interests.

The EAC holds regular meetings at least quarterly. Subcommittees meet between quarterly meetings. Current subcommittees are: Plan Design and Benefits; Retirees; Wellness/Communication and Advocacy. EAC members also have involvement in the carrier selection process.

If you are interested in being involved and giving input into important health plan decisions and making recommendations to the HCC, please write the Health Benefits Office, Attn: EAC, 900 SW Jackson, Suite 920-N, Topeka, Kansas 66612 or e-mail: **Benefits@da.state.ks.us**.

Please feel free to contact any of the EAC members in order provide ideas and suggestions for improvement to the Health Plan. For more information about the committee, see **http://da.state.ks.us/hcc/advisory.htm**

How to Choose Health Care Coverage

Review your current health care needs, coverage and budget

- Decide who is going to be covered. Who qualifies for Part D?
- Do you travel out of state for extended periods?
- Do you have dependents living (going to school) out of state?
- Ask others in the State Health Plan if they have used their health care program and how satisfied they are with their plan.
- Read through the Open Enrollment materials. If you do not understand something, attend an Open Enrollment meeting and/or call the Direct Bill Call Center.

Choice of Providers

- Determine what medical providers (hospital and doctors) you would like to use.
- Do you want to continue with doctors or specialists with whom you are already familiar?
- Do you want the option of going outside a network of health care providers?
- Is your provider's office close to home?
- What procedure is required for an emergency or hospitalization?
- Are providers taking new patients?

Coverage

- What is the current health condition of you and your covered dependents?
- Examine your health care needs. Are there any health conditions that need to be considered? Do you anticipate different health care needs in the coming year?
- What planned changes do you have in the coming year…turning 65, move, etc.?

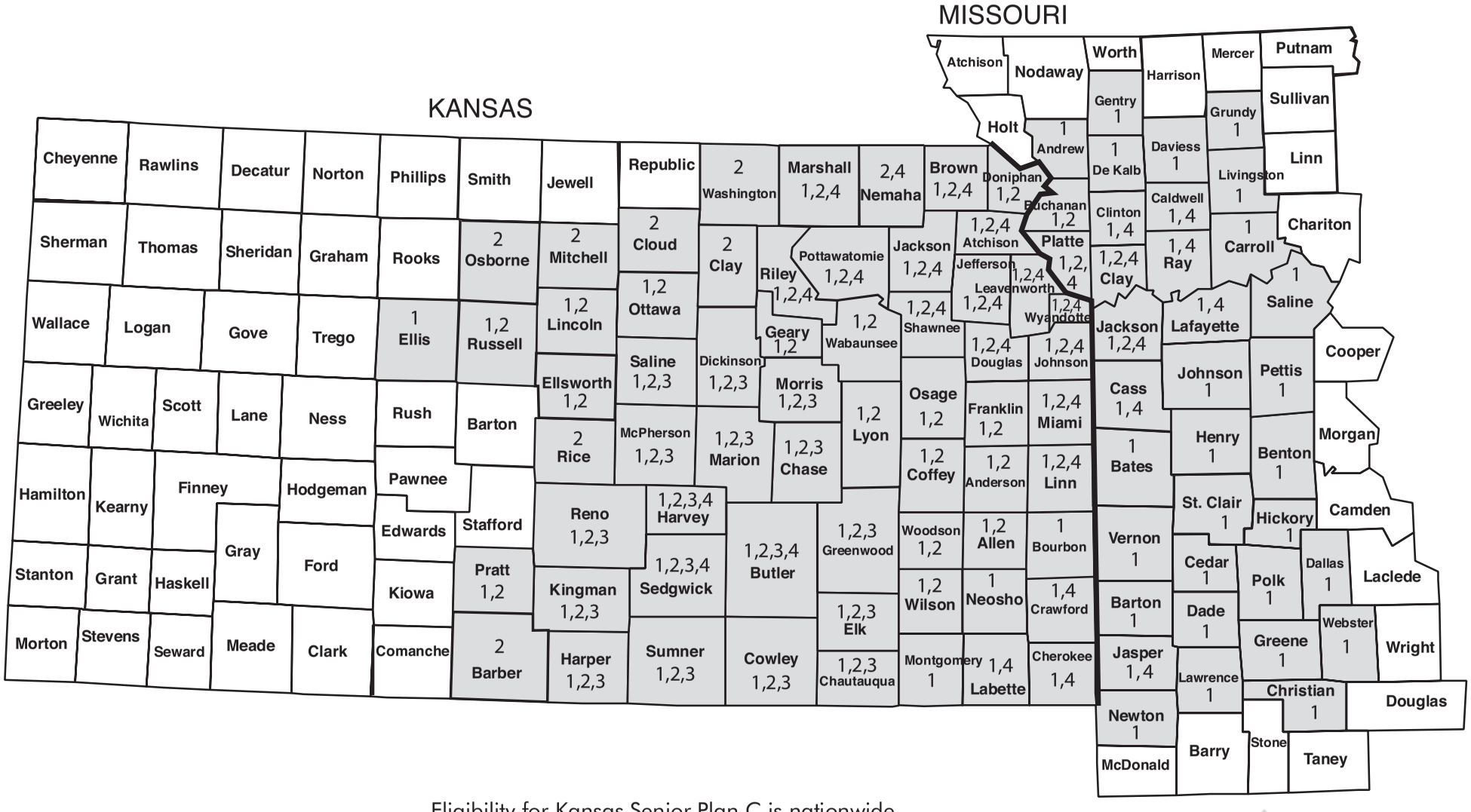
Cost

- Note the cost of each plan (both premium and out-of-pocket expenses).
- How much can you afford to pay?
- Is the freedom of choice of doctors more important than the cost of the plan?
- Are you taking full advantage of Medicare Part D?

FACT

Premiums and deductibles/copays work like a seesaw. Hold one down and the other goes up. Find your balance based on your health care needs and cash flow.

2006 Enrollment Eligibility Plan Options by County



Key

1= Coventry Health Care
2= Premier Blue
3= Preferred Plus of Kansas
4= Coventry Advantra Freedom

Eligibility for Kansas Senior Plan C is nationwide.

Eligibility for enrollment in Kansas Choice and Coventry PPO is in all counties in Kansas and Missouri and in all other states. Check with each of these health plans for locations of contracting physicians and provider networks.

Eligibility for HMO is indicated by the shaded counties on the map above.

Eligibility for Coventry Advantra Freedom is indicated by the number 4.

Choosing an HMO versus PPO

There are two types of traditional health programs offered in the State of Kansas Health Plan - Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO).

HMO

An HMO program offers you a limited number of providers. You must select a Primary Care Physician (PCP) for yourself and your covered dependents. In an HMO program, all services require prior approval or referral by the PCP, except if otherwise noted. If you travel for extended periods of time or have dependents going to school or otherwise living out of the HMO service area, an HMO may not be the best choice.

ALL services require prior approval or referral by the participant's Primary Care Physician (PCP) except where noted otherwise.

Keys to using HMOs

- PCP selection. Verify eligibility with the health plan before a primary care physician (PCP) selection is made. Make sure the PCP is taking new patients. All provider directories are available at: **http://da.state.ks.us/ps/subject/benlink.htm**
- Changes in PCP selection. Changes can only be made by calling the health plan. Changes will become effective the first of the month following notification to the HMO plan.
- When changing PCPs, new referrals must be obtained for scheduled specialists.
- Seeking treatment. Call your PCP before seeking treatment. It is the PCP's responsibility to direct your treatment.
- Treatment by a specialist. All medical services must be coordinated through each covered participant's PCP or HMO plan. This includes any treatment recommended by a specialist to whom the participant has been previously referred.
- Referrals by PCP to a specialist. All referrals from your PCP to a specialist must be obtained PRIOR to the receipt of services. If there is a medical reason for using a specialist that does not contract with the health plan, your PCP must seek authorization from the HMO plan before a referral is made. Services not authorized are not covered.
- Emergency room visits. All emergency room visits for emergency medical conditions must be reported to the HMO plan within a specified period of time-usually 24 to 48 hours. In cases of life or limb threatening emergencies, you should seek help immediately. For non-life or limb threatening situations, you should call your PCP before seeking treatment.
- Emergency services out of area. Any participant temporarily outside the enrollment area will be covered for emergency services only.
- Out of area services. Services are limited to initial treatment of an accident or emergency. Routine or elective care is not covered outside the service area.
- Non-emergency hospitalizations. All non-emergency hospital admissions must be authorized in advance by the HMO plan.
- Urgent care. Care needed on evenings, weekends, or holidays must be coordinated by the PCP.
- Dental accidents/injuries. Claims for treatment of dental accidents/injuries to the teeth must be submitted to the dental plan for payment. Services covered by the dental plan are not eligible for reimbursement through the medical plan.
- Well Woman Exam. Women may visit an OB/GYN physician participating with their HMO plan for an annual well woman exam without a referral from their PCP.
- Well Man Exam. Men may visit a urologist/proctologist who participates with their HMO plan for an annual well man exam without a referral from their PCP.

NOTE: It is the treating physician (and the patient), not the health care plan or the employer, who determines the course of medical treatment. Whether or not the plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

PPO

PPO programs offer you the ability to go to any doctor or hospital (more choice). PPOs have contracted networks. Not all doctors and hospitals are in each network. If you go to a doctor or hospital out of the network, you will still be covered but will pay more for care. Review the network to see if the doctors and hospitals you prefer contract with that health plan. If they do not, that plan option may not be the one for you. Ask yourself if you are willing to change doctors or hospitals in order to have this program. Make note of the non network deductible and coinsurance.

PPOs offer more flexibility, but at a cost.

Keys to using PPOs

- Provider selection. Provider Directories are available at:
  http://da.state.ks.us/ps/subject/benlink.htm
  Verify that your providers are in the health plan you are considering before plan selection is made.
- Claims paid. All claims are paid based on the contracting status of the provider of service at the time the service is performed.
- Other providers involved in your treatment. Ask your physician for the names of any other providers (i.e., anesthesiologist, assistant surgeon, laboratory, etc.) that may be involved in your treatment. This allows you to check their contracting status before any services are performed.
- Preventive Care Service Allowance. The PPO plans feature a Preventive Care Service Allowance of $450 per person per year for specified wellness services. This allowance applies only for routine wellness services provided by network or contracting providers. Services provided to treat an illness or by non network providers will be subject to deductible and coinsurance.
- Using non network provider. You may use a non network provider. The plan will pay the claim based upon their allowed charge for procedures. You will be responsible for any difference between the plan allowance and the actual charge. This difference could result in additional out-of-pocket expenses for you. Ask the provider if they will accept the plan's allowance as payment in full.
- Dental accidents/injuries. Claims for the treatment of dental accidents/injuries to the teeth must be submitted to the dental plan for payment. Services covered by the dental plan are not eligible for reimbursement through the medical plan.

NOTE: It is the treating physician (and the patient), not the health care plan or the employer, who determines the course of medical treatment. Whether or not the plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

2006 Plan Comparison Chart

	Health Maintenance Organization (HMO) Preferred Plus of Kansas Premier Blue Coventry HMO	Preferred Provider Organization (PPO) Coventry PPO Kansas Choice	
BASIC PROVISIONS			
Deductible (not included in coinsurance maximums)	n/a	Network	Non Network
Single Family		$0 $0	$500 $1,500
Coinsurance	10%	65/35%	50/50%
Coinsurance Maximum	$1,000 single/$2,000 family	$2,200/$4,400	$3,650/$7,300
Copayments - (copays are not included in the coinsurance maximum.) Physician Office Visit	$20 PCP / $30 Specialist	Coinsurance	Deductible & Coinsurance
Emergency Room	$75	$100	$200
Urgent Care	$30	Coinsurance	Deductible & Coinsurance
Hospital Admission	$200	$300	$600
Outpatient Mental Health (Not Biologically Based)	$25	$25	$25
Outpatient Surgery*	$100	Coinsurance	Deductible & Coinsurance
Major Diagnostic Tests*	$100 then Coinsurance	Coinsurance	Deductible & Coinsurance
Lifetime Benefit Maximum	$3,000,000 per person	$3,000,000 per person	
Primary Care Physician (PCP)	PCP manages and/or directs all care.	PCP not required.	
Provider Choice	Local Network. Referrals required by Primary Care Physician for care by any other provider.	Freedom to use provider of choice, benefits based on plan description, coverage level based on provider network status.	
Non Network Care	Covered only for initial treatment of medical emergency or if pre-approved by health plan.	Coninsurance	Subject to Deductible, Coinsurance, & Copay
Out of Area Care	Must be Referred by PCP and Pre-Approved by Health Plan.	Coninsurance	Subject to Deductible Coinsurance, & Copay
Amounts Above Plan Allowance	Provider to write off	Provider to write off	Member responsibility
COVERED SERVICES			
Inpatient Services	Copay, then Coinsurance	Subject to Copay and Coinsurance	Subject to Copay and e Coinsurance
Physician Hospital Visits	Subject to Coinsurance	Subject to Coinsurance	Subject to Deductible & Coinsurance
Physician Office Visits PCP	Subject to $20 copay	Subject to Coinsurance	Subject to Deductible and Coinsurance
Specialist	Subject to $30 copay	Subject to Coinsurance	Subject to Deductible and Coinsurance
Urgent Care Center	Subject to $30 copay	Subject to Coinsurance	Subject to Deductible and Coinsurance

* These copayments not included in coinsurance maximums. These services may require coinsurance.

	Health Maintenance Organization (HMO) Preferred Plus of Kansas Premier Blue Coventry HMO	Preferred Provider Organization (PPO) Coventry PPO Kansas Choice	
Covered Services continued		Network	Non Network
Outpatient Surgery	Subject to $100 copayment per surgery, then subject to coinsurance	Subject to Coinsurance	Subject to Deductible and Coinsurance
Emergency Room Visits	Subject to $75 copay (waived if admitted) then subject to coinsurance	Subject to Copay and Coinsurance	Subject to Copay, Deductible and Coinsurance
Other Outpatient Services	Subject to Coinsurance	Subject to Coinsurance	Subject to Deductible and Coinsurance
Ambulance Services	Subject to Coinsurance	Subject to Coinsurance	Subject to Deductible and Coinsurance
Major Diagnostic Tests (includes but not limited to: PET Scans CT Scans, Nuclear Cardiology Studies, Magnetic Resonance Angiography and Computerized Topography Angiography	Subject to $100 copayment per test per day then subject to Coinsurance.	Subject to Coinsurance	Subject to Deductible and Coinsurance
Home Health Care	Services must be pre-approved by Health Plan. Subject to Coinsurance. Limited to $5,000/ benefit period.	Services must be pre-approved by Health Plan. . Limited to $5,000 per benefit period.	
		Subject to Coinsurance	Subject to Deductible & Coinsurance
Hospice	Services must be pre-approved by Health Plan. Limited to $7,500/lifetime. Subject to Coinsurance.	Services must be pre-approved by Health Plan. Limited to $7,500/lifetime. Subject to Coinsurance.	Subject to Deductible and Coinsurance
X-Ray and Laboratory	Subject to Coinsurance.	Subject to Coinsurance. (PET Scans require Pre-Approval by Health Plan)	Subject to Ded & Coins (PET Scans require Pre-Approval by Health Plan)
Physical Rehabilitation Services (including chiropractic care)	Services limited to those medically necessary and appropriate and medical records must show continued improvement in condition.	Services limited to those medically necessary and appropriate and medical records must show continued improvement in condition.	
Facility - Inpatient	Subject to Copay & Coinsurance - subject to continued improvement	Subject to Copay & Coinsurance-subject to continued improvement (Pre-approved by Health Plan)	Subject to Copay. Deductible & Coinsurance - subject to continued improvement (Pre-approved by Health Plan)
Facility - Outpatient	Subject to Coinsurance - subject to continued improvement	Subject to Coinsurance -subject to continued improvement	Subject to Deductible & Coinsurance - subject to continued improvement
Office Based	Subject to Copay & Coinsurance - limited to 30 visits per year	Subject to Coinsurance limited to 30 visits per year	Subject to Deductible & Coinsurance, limited to 30 visits per year

	Health Maintenance Organization (HMO) Preferred Plus of Kansas Premier Blue Coventry HMO	Preferred Provider Organization (PPO) Coventry PPO Kansas Choice	
Covered Services continued		Network	Non Network
Durable Medical Equipment	Services must be pre-approved by Health Plan and subject to 10% Coinsurance, limited to $5,000 per person per year of covered services	Subject to Coinsurance $4,500 per person per year (pre-approved by Health Plan)	Subject to Deductible & Coinsurance, limited to $4,500 per person per year (pre-approved by Health Plan)
Allergy Testing	As approved by Primary Care Physician & precertified by Health Plan, Subject to Office Visit Copayment then Coinsurance	Subject to Coinsurance (pre-approved by Health Plan)	Subject to Deductible & Coinsurance (pre-approved by Health Plan)
Antigen Administration (desensitazation/treatment) Allergy Shots	As approved by Primary Care Physician by Health Plan, subject to office visit copayment and Coinsurance	Subject to Coinsurance (pre-approved by Health Plan)	Subject to Deductible & Coinsurance (pre-approved by Health Plan)
Infertility Treatment (limited to testing & 3 attempts at artificial insemination per year)	As approved by Primary Care Physician. & Precertified by Health Plan. Subject to office visit copayment then Coinsurance	Subject to Coinsurance (pre-approved by Health Plan)	Subject to Deductible & Coinsurance (pre-approved by Health Plan)
Childhood Immunizations to Age 5	Covered in full	Covered in full	Covered in full
MENTAL HEALTH			
Inpatient Nervous & Mental/Drug & Alcohol	Subject to inpatient Copayment, then Coinsurance 60-day Limit/yr	Subject to inpatient Copayment, then Coinsurance 60-day Limit/yr	Subject to Copay and Coinsurance 30-day Limit/yr
Outpatient Nervous & Mental/Drug & Alcohol	First 3 visits @ 100%, next 22 visits - $25 copay; additional visits @ 50%	Both in and out-of-network visits will be counted towards first 25 visits First 3 visits @ 100%, next 22 visits @ $25 copay, additional visits @ 50%	First 3 visits @ 100%, next 22 visits @ 50%, 25 visit limit.
Biologically Based Mental Health Conditions	Benefits same as medical conditions for certain specified mental health conditions	Benefits same as medical conditions for certain specified mental health conditions	
PREVENTIVE CARE			
Preventive Care Services	Limited to one per calendar year	Preventive Care Service Allowance = 1st $450/person covered in full, then subject to Coinsurance	Not Covered
Age Appropriate Routine Physical Exam	Must be provided by PCP Copay waived for one visit per person per year	Preventive Care Service Allowance, then subject to Coinsurance	Not Covered

	Health Maintenance Organization (HMO) Preferred Plus of Kansas Premier Blue Coventry HMO	Preferred Provider Organization (PPO) Coventry PPO Kansas Choice	
Covered Services continued			
Preventive Care Services continued		Network	Non Network
Well-Woman Care (office visit and PAP smear test, & STD testing)	Subject to Office Visit Copayment - No referral required. - Must use Network Provider	Preventive Care Service Allowance, then subject to Coinsurance	Not Covered
Well-Man Care (office visit and PSA blood test)	Subject to Office Visit Copayment - No referral required. - Must use Network Provider	Preventive Care Service Allowance, then subject to Coinsurance	Not Covered
Mammogram (recommended frequency age 35-39 = 1 baseline; age 40-49 = every 2 years; age 50+ = annually)	Covered in Full - no referral required - Must use network provider	Preventive Care Service Allowance, then subject to Coinsurance	Not Covered
Dietitian Consultation (for medical management of a documented disease)	As approved by Primary Care Physician and subject to Office Visit Copayment	Preventive Care Allowance then subject to Coinsurance	Not Covered
Routine Hearing Exam	As approved by Primary Care Physician. Subject to office visit Copayment.	Preventive Care Allowance then subject to Coinsurance	Not Covered
Routine Vision Exam (Refraction Exam for Glasses - Lenses and frames NOT covered)	Limited to one per year. Copay waived for one routine visit per year. No referral required	Preventive Care Allowance then subject to Coinsurance	Not Covered
Age Appropriate Bone Density Screening	As approved by Primary Care Physician and Precertified by Health Plan. Covered in full	Preventive Care Allowance then subject to Coinsurance	Not Covered
PRESCRIPTION DRUG SERVICES	Covered by separate contract with Caremark	Covered by separate contract with Caremark	
DENTAL SERVICES	Covered by separate contract with Delta Dental	Covered by separate contract with Delta Dental	
NON-COVERED SERVICES			
TMJ/Orthognathic Surgery	Not Covered under Medical - see Dental, limited	Not Covered under Medical - see Dental, limited	
Orthotics	Not Covered	Not Covered	
Gastric Surgery and Other **Weight Loss Treatments**	Not Covered	Not Covered	

Coventry HMO is a fully insured Health Maintenance Organization (HMO) available to you and all covered dependents within Coventry's HMO service area.

NEW! *My ePHIT®* is a web-based suite of personalized health improvement programs available to plan participants from Coventry, including online risk assessments, coaching, and more. *My ePHIT* focuses on helping you enhance your health through exercise, nutrition and self-improvement.

Mailing Address

Kansas City/Topeka Area:
Coventry Health Care of Kansas
8320 Ward Parkway
Kansas City, MO 64114

Wichita/South Central Area:
Coventry Health Care of Kansas
8301 East 21st Street North,
Suite 300
Wichita, KS 67206

Customer Service Telephone Numbers

Kansas City/Topeka Area:	800-969-3343
Wichita/South Central Area:	866-320-0697
United Behavioral Health:	866-607-5970
FirstHelp: (24 hr. nurse line)	800-622-9528

Preferred Plus of Kansas, Inc. (PPK) is a fully insured Health Maintenance Organization (HMO). To enroll in coverage with PPK, all participants must maintain primary residence within the PPK enrollment area.

Mental Health/Substance Abuse benefits are coordinated by Behavioral Health Systems. If you are seeking care, call the number below. A separate referral from your PCP is not needed.

Mailing Address

Preferred Plus of Kansas
8535 E. 21st Street North
Wichita, KS 67206

Customer Service Telephone Numbers:

Toll free:	866-618-1691
In Wichita:	316-609-2555

Behavioral Health Services:

in Wichita	316-609-2541
in all other areas	866-338-4281

Premier Blue is a fully insured Health Maintenance Organization (HMO). To enroll in coverage with Premier Blue, all participants must maintain primary residence within the Premier Blue enrollment area.

Mental Health/Substance Abuse benefits are coordinated by Health Management Strategies. If you are seeking care, call the number below. A separate referral from your PCP is not needed.

Mailing Address

Premier Blue
1133 SW Topeka Blvd.
Topeka, KS 66629

PremierBlue

Customer Service Telephone Numbers:

Toll free:	800-332-0028
In Topeka:	785-291-4010

Health Management Strategies

Toll free:	800-952-5906
In Topeka:	785-233-1165

NOTE: Check the map on page 11 for the enrollment area of the HMOs.

Provider Worksheet

Providers I use:	Provider in network		Provider qualifies as PCP	
Coventry HMO				
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
Preferred Plus of Kansas				
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
Premier Blue				
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No

Web site Address for Provider Directory and Benefit Description

http://da.state.ks.us/ps/subject/benlink.htm

NOTE: Provider networks change. Check the web site frequently.

Coventry PPO is a fully insured PPO. You do not need to select a Primary Care Physician (PCP) and are free to see any network specialist you choose; no referrals required. The Coventry network includes almost 5,000 physicians and by using these physicians, you will enjoy the highest level of benefits. **The LabOne lab card benefit is a part of the program.**

NEW! *My ePHIT*® is a web-based suite of personalized health improvement programs available to plan participants from Coventry, including online risk assessments, coaching, and more. *My ePHIT* focuses on helping you enhance your health through exercise, nutrition and self-improvement.

Mailing Address

Kansas City/Topeka Area:
Coventry Health Care of Kansas
8320 Ward Parkway
Kansas City, MO 64114

Wichita/South Central Area:
Coventry Health Care of Kansas
8301 East 21st Street North,
Suite 300
Wichita, KS 67206

Customer Service Telephone Numbers

Kansas City/Topeka Area:	800-969-3343
Wichita/South Central Area:	866-320-0697
United Behavioral Health:	866-607-5970
FirstHelp: (24 hr. nurse line)	800-622-9528

Kansas Choice is a self insured PPO plan administered by Blue Cross Blue Shield of Kansas (BCBSKS). BCBSKS is responsible for claims processing and customer service, network management and utilization review.

You do not need to designate a Primary Care Physician (PCP). A nationwide network is available. For most of Kansas, network providers are in Blue Choice network. For the Kansas City Metropolitan area, including Johnson and Wyandotte counties, network providers are those which contract as Preferred Care Blue Providers with BCBS of Kansas City. In all other locations, network providers are those which contract with the Blue Card PPO network.

The LabOne lab card benefit is part of the program.

Mailing Address

Kansas Choice
1133 SW Topeka Blvd
Topeka, KS 66629-0001

Customer Service Telephone Number

Toll free:	800-332-0307
In Topeka:	785-291-4185

NOTE: You may seek care outside the network benefits by using non network providers, but you will pay a greater share of the cost when using non network providers and facilities.

NOTE: Check the map on page 11 for assistance.

Provider Worksheet

Providers I use:	Provider in network	
Coventry PPO		
_____	**Yes**	**No**
_____	**Yes**	**No**
_____	**Yes**	**No**
_____	**Yes**	**No**
Kansas Choice		
_____	**Yes**	**No**
_____	**Yes**	**No**
_____	**Yes**	**No**
_____	**Yes**	**No**

Web site Address for Provider Directory and Benefit Description
http://da.state.ks.us/ps/subject/benlink.htm

NOTE: Provider networks change. Check the web site frequently.

Coventry Advantra Freedom

What is Coventry Advantra Freedom PPO? Coventry Health Care of Kansas, Inc. (Coventry) offers the Advantra Freedom PPO to State of Kansas retirees who are eligible for Medicare.

Coventry Advantra is a Part C Medicare program for people who have Medicare Part A and Part B. Coventry Advantra contracts directly with Medicare to offer the Advantra plans to Medicare beneficiaries. Coventry Advantra is required to meet all Part C Medicare regulations and requirements. As a Medicare contractor, Coventry Advantra receives funding from Medicare for each Medicare beneficiary who enrolls in Advantra. The funding that Coventry Advantra receives allows it to offer products that have more benefits than Medicare for premiums that may be significantly lower than Medigap policies or individual health plans.

Who can enroll? The Coventry Advantra Freedom PPO is only available to State of Kansas retirees who meet the following requirements:

- Must have Medicare parts A and B
- Must live in a county designated as an enrollment county by the State
- Cannot have End Stage Renal Disease (ESRD)

What counties are in the designated enrollment area?

Kansas: Atchison, Brown, Butler, Cherokee, Crawford, Douglas, Harvey, Jackson, Jefferson, Johnson, Labette, Leavenworth, Linn, Marshall, Miami, Nemaha, Pottawatomie, Riley, Sedgwick, Shawnee, and Wyandotte.

Missouri: Cass, Caldwell, Clay, Clinton, Jackson, Jasper, Lafayette, Platte and Ray.

What are the advantages of the Coventry Advantra Freedom PPO?

- Low premium
- Unlimited hospital days
- Coverage for Preventive Care Services including vision and hearing exams
- Disease and case management programs that help members navigate the health care system when they are sick.
- **The Advantra prescription drug coverage meets all the requirements of Medicare's new Part D prescription drug program. When you enroll in Advantra, you do not need to select an additional Medicare Part D plan.**
- When using network providers, Advantra limits the total out-of-pocket cost that you will pay for health care.
- One ID card for both medical and prescription drug coverage.

What are the disadvantages of the Coventry Advantra Freedom PPO?

- Advantra is a network based program. To get the full advantage and protection of the plan, network hospitals and other providers must be utilized. Not all hospitals, physicians and other service providers are part of the network.
- Most services have copays for which the member is responsible each time that services is used.

Coventry Advantra Rate Chart

Coventry Advantra Freedom PPO[1]

Benefits	Advantra Freedom Copay when using Network Providers
Inpatient Hospital	$100 per day for days 1-5
Inpatient Mental Health	$100 per day for days 1-90
Skilled Nursing Facility (SNF)	$0 for days 1-7 $50 per day for days 8-100
PCP visits	$15 per visit
Specialst visits	$30 per visit
Outpatient Surgery	$150 per visit
Ambulance	$100 per one-way trip
Urgent Care	$30 per visit, world wide coverage
Hearing Services	$30 for each routine hearing test, limited to 1 per year
Routine Physicals	$15 per exam, limited to 1 per year
Out of pocket maximum	$2,000 per person
Non network Coverage	20% coinsurance based on Medicare Allowables

Coventry Advantra Freedom Prescription Drug Coverage (Medicare Part D Plan)

Basic Benefits	Copays
Preferred Generic Drugs	$5
Preferred Brand Drugs	$25
Non=Preferred Generic and Brand Drugs	$50
Limit	Initial coverage limit of $2,250 per person is based on copays + the plan cost. After this amount is reached there is no additional coverage until the member's out-of-pocket costs reach $3,600.
Catastrophic Coverage[2]	**Copays**
Generic and Preferred Brand	$2
All other drugs	$5 or 5% coinsurance, whichever is greater

[1] This is only a partial list of covered services and copays. Coventry Advantra Freedom PPO representatives will be attending the Open Enrollment meetings in the counties where the program is offered in order to allow full review of the plan.

[2] Catastrophic prescription drug coverage becomes effective when the member's annual true out-of-pocket costs for prescription drugs costs reach $3,600.

Kansas Senior Plan C is one of the ten 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. Blue Cross Blue Shield of Kansas administers the program for the State Health Plan. 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.

Overview of Medicare A & B with Kansas Senior Plan C Supplement 2006

Key: Shaded Areas – Medicare Pays White Areas – Kansas Senior Plan C Pays
Dollar amounts listed in charts are 2006 figures.

Medicare A Each Benefit Period*	**Medicare B** $124 Deductible (per calendar year, January 1 to December 31)	**Kansas Senior Plan C Supplement**
	80%	Pays for all the white sections under Medicare A & B plus:
Inpatient Hospital		**Extra Medical Benefits** • Additional 365 hospital days per lifetime • Foreign Travel Emergency $250 deductible, then the plan will pay 80% to a maximum of $50,000 lifetime.
First 60 Days $952 Deductible	Physician's Charges (in or out of hospital)	
Days 61-90 $238/day coinsurance	Durable Medical Equipment & Supplies	
Lifetime Reserve Days 91-150 $476 per day Coinsurance	Ambulance	
Skilled Nursing Facility	Outpatient Hospital Charges	
First 20 days – 100% (No copay)	Blood First 3 Pints	
Days 21-100 $119/day coinsurance	Lab Services	
100% • Home Health • Hospice * Benefit periods ends when patient is out of the hospital or skilled nursing facility for 60 consecutive days.	Preventive Service Mammograms Annual Pap Smears Diabetes Self-Management Bone Mass Measurements Flu Shots (Paid at 100%)	
Usually no premium associated with Part A.	You pay Part B monthly premium at $88.50	

20% Coinsurance

NOTE: If Medicare does not cover the service, there is no benefit under the medical portion of Kansas Senior Plan C.

Health Plan Rate Comparison Chart

For Medicare Eligible Plans

		*Coventry Advantra Freedom	**KS Sr. Plan C with Drugs	***KS Sr. Plan C No Drugs
B	Medicare Participant Only	$68.50	$373.50	$171.50
G	Medicare Participant and Medicare Spouse	$136.50	$746.50	$342.50
X	Medicare Participant, Medicare Spouse and Medicare Dependent	$204.50	$1,119.50	$513.50

* Monthly rates include medical, dental and Medicare Part D prescription drugs
** Monthly rates include medical, dental, and State standard drug plan – creditable coverage
*** Monthly rates include medical, dental and no prescription drug plan

Health Plan Rate Comparison Chart

Standard Drug Option / Participant Dental Only

	Preferred Plus of KS HMO	Premier Blue HMO	Coventry HMO	Coventry PPO	Kansas Choice PPO
All Covered Persons Not Eligible for Medicare					
1 Participant Only	$365.14	$355.72	$372.41	$415.81	$398.20
2 Participant and Spouse	$708.94	$690.10	$723.48	$810.28	$802.10
3 Participant and Child(ren)	$640.18	$623.22	$653.26	$731.38	$668.21
4 Participant, Spouse and Child(ren)	$983.98	$957.60	$1,004.33	$1,125.85	$1,016.22
One or More Covered Persons Eligible for Medicare					
B Medicare Participant Only	$388.70	$383.05	$393.06	$419.10	$315.94
D Participant, Medicare Spouse and all Dependents	$996.47	$973.86	$1,013.92	$1,118.08	$902.63
E Medicare Participant, Spouse and all Dependents	$996.47	$973.86	$1,013.92	$1,118.08	$922.90
G Medicare Participant and Medicare Spouse or Dependent	$756.06	$744.76	$764.79	$816.87	$613.12
H Medicare Participant, Medicare Spouse and all Dependents	$1,026.18	$1,007.34	$1,040.72	$1,127.52	$826.55
R Medicare Participant and Spouse	$726.35	$711.28	$737.98	$807.42	$710.38
T Medicare Participant and Dependent Child(ren)	$658.82	$645.63	$669.00	$729.76	$581.05
U Participant and One Medicare Spouse or Dependent	$726.35	$711.28	$737.98	$807.42	$689.21
X Medicare Participant, Medicare Spouse and Medicare Dependent	$1,123.43	$1,106.47	$1,136.51	$1,214.63	$910.28
Z Medicare Participant, Spouse and Medicare Dependent	$1,093.71	$1,072.99	$1,109.71	$1,205.19	$1,015.20

NOTE: Monthly rates listed are for medical, member only dental and prescription drug coverage.

Health Plan Rate Comparison Chart

Standard Drug Option / Dependent Dental

		Preferred Plus of KS HMO	Premier Blue HMO	Coventry HMO	Coventry PPO	Kansas Choice PPO
All Covered Persons Not Eligible for Medicare						
1	Participant Only	$365.14	$355.72	$372.41	$415.81	$398.20
2	Participant and Spouse	$729.78	$710.94	$744.32	$831.12	$822.94
3	Participant and Child(ren)	$656.85	$639.89	$669.93	$748.05	$684.88
4	Participant, Spouse and Child(ren)	$1,021.49	$995.11	$1,041.84	$1,163.36	$1,053.73
One or More Covered Persons Eligible for Medicare						
B	Medicare Participant Only	$388.70	$383.05	$393.06	$419.10	$315.94
D	Participant, Medicare Spouse and all Dependents	$1,033.98	$1,011.37	$1,051.43	$1,155.59	$940.14
E	Medicare Participant, Spouse and all Dependents	$1,033.98	$1,011.37	$1,051.43	$1,155.59	$960.41
G	Medicare Participant and Medicare Spouse or Dependent	$776.90	$765.60	$785.63	$837.71	$633.96
H	Medicare Participant, Medicare Spouse and all Dependents	$1,063.69	$1,044.85	$1,078.23	$1,165.03	$864.06
R	Medicare Participant and Spouse	$747.19	$732.12	$758.82	$828.26	$731.22
T	Medicare Participant and Dependent Child(ren)	$675.49	$662.30	$685.67	$746.43	$597.72
U	Participant and One Medicare Spouse or Dependent	$747.19	$732.12	$758.82	$828.26	$710.05
X	Medicare Participant, Medicare Spouse and Medicare Dependent	$1,160.94	$1,143.98	$1,174.02	$1,252.14	$947.79
Z	Medicare Participant, Spouse and Medicare Dependent	$1,135.39	$1,114.67	$1,151.39	$1,246.87	$1,056.88

NOTE: Monthly rates listed are for medical, dental and prescription drug coverage.

Decisions for Medicare Beneficiaries, 2006

Enroll in Medicare Part D (Prescription Drug Plan)

Private Market
Companies marketing in Kansas and other states with various benefits and Prescription Drug lists.
Costs range from about $10 to $50.
Select the one just right for you.

Medicare Advantage in State Plan
Coventry Advantra Freedom
Includes Part D drugs.
Limited to certain Kansas or Missouri counties.
See page 22 in booklet.

OR

Kansas Senior Plan C With No Drug Plan
and obtain a Part D plan from the private market.

Kansas Senior Plan C With Standard Drug Plan
Includes standard Caremark drug plan, not Part D.
Receive Creditable Coverage so you will not be charged a late Enrollment fee if you move to Part D after the initial enrollment period.

Regular Health Plans
Coventry HMO and PPO; KS Choice; **Premier Blue and PPK**
Includes standard Caremark drug plan, not Part D.
Receive Creditable Coverage so you will not be charged a late enrollment fee if you move to Part D after the initial enrollment period.

Don' forget! There is extra help for people who need it!

Medicare eligible beneficiaries who have limited income and resources may qualify for extra help paying for their prescription drugs. Annual income is below $14,355 (single) or $19,245 (married couple). Higher income levels may apply if you provide one-half support to other family members living with you. Your assets (including savings and stocks, but not your home or car) are under $11,500 (single) or $23,000 married couple) you may qualify for extra help.

Apply through Social Security Administration. 1-800-772-1213 or www.socialsecurity.gov

Medicare Part D and You

Beginning on November 15, you can choose to enroll in the Medicare Part D prescription drug coverage. Approximately 16 organizations will offer stand-alone prescription drug plans throughout Kansas in 2006. If you live outside Kansas check with Medicare to see which plans are available in your state.

- Monthly premiums can vary between plans depending on the type and level of coverage offered.
- Benefit options also very with some offering options to lower the deductibles in the standard Medicare benefit. There are standard plans and enhanced plans that offer additional benefits beyond Medicare's standard drug coverage.
- All of the prescription drug plans offered in Kansas must offer drugs in six categories of treatments and have access to pharmacies, including convenient neighborhood pharmacies. Mail order services may also be available.

You may already know more than you think to determine if you want to use a stand-alone Part D Plan. You know:

- Your current coverage is with your former employer.
- Your Health Plan's drug coverage is considered "creditable coverage" and can be used to defer any late fee for enrollment in Part D after the initial enrollment period.
- You know what drugs you regularly take. Write down how much it costs you and how much the State pays each month. You can compare preferred drug lists to see whether the drugs you take are covered by the new plan. And check to see the plan's network pharmacies and where they are located.
- You should have received your Medicare & You 2006 handbook and know the companies marketing in your state in order to compare plans.
- You know that if you need financial assistance, you can contact the Social Security Administration at 1-800-722-1213 or www.socialsecurity.gov

Many Ways to Get Help with Enrolling in Medicare Drug Coverage

Many Resources are available to help beneficiaries with specific prescription drug plan options:

- Medicare & You 2006 handbook.
- Visit the Medicare website at www.medicare.gov.
- Call 1-800-MEDICARE (1-800-633-4227), available 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- SHICK (State Health Insurance Counseling of Kansas) 1-800-860-5260.

If you are enrolling in Kansas Senior Plan C with no prescription drug coverage, you must enroll in a Part D plan by December 31, 2005. Otherwise you will not have coverage on January 1, 2006.

Prescription Drug Plan

Caremark is the Pharmacy Benefit Manager (PBM) administering the self-insured prescription benefit plan offered to participants of the State of Kansas Health Plan. Caremark has a network of over 65,000 pharmacies nationwide available to plan participants.

Mailing Address (for paper claims)
Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

Customer Service Telephone Numbers
Toll free: 800-294-6324
TDD: 800-863-5488

Web site Address for Provider Directory and Benefit Description

http://da.state.ks.us/ps/subject/benlink.htm

Prescription benefits are included with all medical plans, **except Coventry Advantra Freedom and the new Kansas Senior Plan C option without drugs**. The cost of this program is incorporated into the medical plan rates.

The Kansas State Employees Prescription Benefit Plan is a five tier program designed to encourage plan participants to partner with their physicians in choosing cost effective medications when needed for the treatment of illness or injury.

The full benefit description and Preferred Drug List are posted at: **http://da.state.ks.us/ps/subject/benlink.htm**

IMPORTANT

The Preferred Drug List will be updated throughout the year. Be sure to check the Preferred Drug List often.

CAREMARK®
It all starts with care®

Plan Coverage	Type of Prescription Mediction	Participant Pays
Tier 1	Generic Drugs	20% coinsurance
Tier 2	Preferred Brand Name Drugs	35% coinsurance
Tier 3	Special Case Medications (1)	$75 copay per fill
Tier 4	Non Preferred Brand Name Drugs	60% coinsurance
Tier 5	Lifestyle Medications (2)	100% of discounted price
Coinsurance Max	Tiers 1, 2, & 3 purchases only	$2,580 per participant/year

(1) Very high-cost medications used to treat generally life-threatening conditions.
(2) Medications used primarily to enhance lifestyle rather than treat an illness or condition.

The coinsurance maximum of $2,580 per participant per year applies to your coinsurance for Tier 1 – Generic, Tier 2 - Preferred Brand Name and the copay for Tier 3 - Special case medications. Once the coinsurance maximum is reached, claims are paid at 100 percent for Tier1, 2, & 3 drugs for the remainder of that calendar year.

The initial fill of any prescription is limited to a 30-day supply or one standard unit of therapy, whichever is less. Prescriptions can be refilled when 75% of the previous fill has been used. Medications may be refilled for up to a 60-day supply, or two standard units of therapy, if the prescription was written to indicate the larger fill and it is within 120 days of the previous fill for the same medication.

Mail Order Options

For your convenience, Caremark offers a mail order option to obtain refills on your prescription medications. This is an especially useful benefit for those drugs you take on a regular basis. In many instances, you will pay less for medications obtained using the Caremark mail order service due to greater discounts and lower dispensing fees. Mail service profile forms are available at: **http://state.ks.us/ps/benefits.htm**

New prescriptions can be filled by mail. Caremark offers a ***"FastStart"*** program that allows your physician to fax your new prescription to Caremark. To contact FastStart call 1-866-772-9503.

Specialty RX

An additional feature of the benefit plan is the SpecialtyRx program. This program focuses on patients who utilize medications identified as being given by injection, are used by small patient populations and are costly. The program offers members a convenient source for these high cost injectibles and improved therapy compliance.

Patients who elect to participate in the Caremark Specialty Rx program will have access to pharmacists or nurses 24 hours per day, 7 days a week. These clinicians specialize in the management of chronic conditions. Of course, you may opt-out of the program if you desire.

Questions to Ask about Prescribed or Recommended Medications

Every day millions of Americans rely on medications to feel better and get well, but it's not always easy to take them correctly. Taking medicine with certain foods, alcohol, dietary/herbal supplements, or other medications might cause a dangerous reaction, or it might stop your medicine from working as well as it should. Here are some questions that can help you get the information you need to use your medicines properly. If the answers seem complicated or confusing, ask again! (Courtesy of the National Council on Patient Information and Education)

1. What is the name of the medicine and what is it supposed to do? Is this the brand name or the generic?
2. How and when do I take it – and for how long? What if I forget to take it?
3. What foods, drinks, other medicines, dietary supplements, or activities should I avoid while taking this medicine?
4. When should I expect the medicine to begin to work, and how will I know if it is working? Are there any tests required with this medicine (for example, to check liver or kidney function)?
5. Are there any side effects, what are they and what do I do if they occur?
6. Will this medicine work safely with other prescription and non-prescription medicines I am taking?
7. Can I get a refill? If so, when?
8. How should I store this medicine?
9. Is there any written information available about the medicine? Is it available in large print or a language other than English?

Your pharmacist will be able to answer these medication questions as well as any others you may have. Choose your pharmacist as carefully as you choose your doctor because he or she is an important part of your health care team. **It is not uncommon to see more than one doctor, and for this reason, it is very important to use just one pharmacy so your medication records will be located in one place.** Your pharmacist can help you keep track of what you are taking – prescription and non-prescription – and make sure that your medications will not interact harmfully with each other.

Dental Plan

The dental plan is self funded administered by Delta Dental of Kansas Inc., which is responsible for claims processing and customer service, network management and utilization review. All participants enrolled in medical coverage are also enrolled in the dental program. You may elect to purchase dental coverage for your dependents who are enrolled in the State Health Plan.

Sometimes more than one procedure is available which would restore the tooth to function, according to accepted standards of dental practice. If a more expensive service or benefit is selected over a less costly method, the plan will pay based upon the fee for the least costly method needed to restore function. **Participants are encouraged to ask their dentist to send in a pre-determination on high cost and major restorative services being considered before work begins.** Delta Dental will review the course of treatment and advise you and your dentist of the benefits available for the proposed treatment. Benefits paid for treatment of an accident do not apply toward the annual benefit maximum for other covered services.

Delta Premier

The DeltaPremier Network is the broad network of providers that participants may utilize. Delta Dental will make payment directly to the dental provider. The participant will only be responsible for paying the specific coinsurance and deductibles for covered services or for any services not covered.

DeltaPreferred

In addition to the DeltaPremier network, Delta Dental also offers the DeltaPreferred PPO network. The PPO network providers have agreed to a reduced fee for providing dental services. The PPO network for our group has been expanded to include all PPO providers in the national DeltaUSA PPO network. All participants of the Delta Dental program may use the PPO providers whenever desired.

Non Network

Participants may use a dental provider who does not contract with Delta Dental. Non participating providers may require payment at the time of service. The participant will then need to file their own claims and the plan payment will be mailed to the participant. Payment will be subject to applicable deductible and coinsurance and paid based upon the lesser of the actual charge or the customary fee for the service as determined by Delta Dental. Patients are responsible for the entire balance of charges not paid by Delta Dental.

Orthodontic Coverage

Procedures for orthodontic appliances and treatment, including both interceptive and corrective, are covered at 50%. Orthodontic treatments are not subject to a deductible and have a $1,000 per person lifetime maximum. The maximum for orthodontic services does not apply to the regular annual maximum for other covered services. To be covered, orthodontic treatment must start after the effective date of dental coverage. For coverage with a non network dentist, orthodontic treatment must start on or after January 1, 2006.

Dental Accidents

Claims for treatment of dental accidents must be processed by the dental plan. Payment for treatment for an accident does not apply to the annual maximum for other services.

Mailing Address

Delta Dental of Kansas, Inc.
P.O. Box 49198
Wichita, KS 67201-9198

Customer Service Telephone Numbers

Toll Free 800-234-3375
In Wichita 316-264-4511

Website Address for Provider Directory and Benefit Description
http://da.state.ks.us/ps/subject/benlink.htm

DELTA DENTAL

The coinsurance percentage listed is the amount paid by Delta Dental. Benefits are subject to the terms of the benefit description.

	PPO	Premier	Non Network*
DIAGNOSTIC AND PREVENTIVE SERVICES: Oral examinations, prophylaxis/cleanings (including periodontal maintenance) twice per plan year Diagnostic x-rays: bitewings twice per plan year for dependents under age 18 and once per plan year for adults age 18 and over. Full mouth x-rays once each five years. Topical fluoride twice per plan year for dependent children under age 19. Space maintainers only for the premature loss of primary molars and only for dependent children under the age of 15. Sealants are covered for dependent children under age 17 and only when applied to permanent molars with no caries (decay) or restorations on the occlusal surface. Sealants are limited to one per four years.	100%	100%	100%
ANCILLARY: Provides for visits to the dentist for the emergency relief of pain.	100%	100%	100%
REGULAR RESTORATIVE DENTISTRY: Provides amalgam (silver) restorations on posterior (back) teeth; composite (white) resin restorations on anterior (front) teeth; and stainless steel crowns for dependents under age 12.	80%	60%	60%
The following procedures are subject to a $45 deductible per person per calendar year not to exceed an annual family deductible of $135:			
ORAL SURGERY: Provides for extractions and related oral surgical procedures performed by the dentist including pre- and post-operative care.	80%	60%	60%
ENDODONTICS: Includes procedures for root canal treatments and root canal fillings.	80%	60%	60%
PERIODONTICS: Includes procedures for the treatment of diseases of the gums and bone supporting the teeth.	80%	60%	60%
SPECIAL RESTORATIVE DENTISTRY: When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for gold restorations and individual crowns.	50%	50%	50%
PROSTHODONTICS: Bridges, partial and complete dentures, including repairs and adjustments.	50%	50%	50%
TMJ: Treatment is limited to specific non-surgical procedures involving Temporomandibular Joint Dysfunction. A treatment plan must be pre-authorized by Delta Dental.	50%	50%	50%

ANNUAL MAXIMUM: The maximum paid by the plan for the above treatments is $1,700 per person per calendar year.

* Non Network Services are subject to the Allowed Amount including the Maximum Plan Allowance for Non-Network Providers. For dental benefits and services provided by a Non Network Dentist, the Plan will determine the amount payable subject to the Allowed amount and applicable Deductible and Coinsurance. Any amounts in excess of the Allowed Amount will be the patient's responsibility.

Vision Plan

Superior Vision Services Basic and Enhanced plans are fully insured voluntary vision programs. Employees may elect to enroll themselves and any eligible dependents in one of the vision programs, whether or not the employee or dependents are enrolled in State's medical coverage. However, if dependent vision coverage is selected and dependent children are also enrolled in the medical plan, the dependent children enrolled in vision must match those enrolled in the medical plan. Enrollment, even on an after-tax basis, cannot be changed during the Plan Year unless due to either a newly eligible dependent or to a dependent becoming ineligible.

Network Providers – How Superior Vision Service Works

To obtain vision care services under the Basic or Enhanced Plans, the participant should contact a Superior Vision network provider. At the appointment, show the ID card or simply indicate enrollment in Superior Vision and provide them the ID number. Superior Vision will pay the network provider for covered services and materials. The patient is responsible for any copayments and any additional costs resulting from cosmetic options, or non-covered services and materials selected.

If the participant has medical coverage through the State, the medical plan will cover one routine eye exam each year. To coordinate benefits with the medical plan, the Superior Vision provider will also need the name of the medical plan and the participant's plan identification number. To maximize benefits, participants need to make sure that their chosen provider is a network provider for both the vision and medical plans.

Non Network Providers – How Superior Vision Works

Before a participant receives services from a non network provider, they should contact Superior Vision Member Services Department at 1-800-507-3800 to receive an authorization number. After receiving services, the participant is responsible for paying the provider in full and submitting itemized receipts along with the authorization to Superior Vision. Reimbursement will be made according to the reimbursement schedule for non network providers listed in the benefit description. It is important to note that the reimbursement schedule does not guarantee full payment.

Superior Vision's Additional Value

Discounts on additional eyewear

Discounts are available for additional eyewear purchases. The discounts range from 10% to 30% 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 participants with a discount of 20% on refractive surgeries.

Web site Address for Provider Directory and Benefit Description

http://da.state.ks.us/ps/subject/benlink.htm

Mailing address

Superior Vision Services, Inc.
P.O. Box 967
Rancho Cordova, CA 95741

Customer Service Telephone Number

Toll free 800-507-3800

		BASIC PLAN	ENHANCED PLAN	BOTH PLANS
Benefit Type	Benefit Frequency	Network Provider	Network Provider	Non Network Provider
Subject to $50 copay				
Eye Exam, M.D.	12 months	Covered in Full after copay	Covered in Full after copay	Up to $38
Eye Exam, O.D.	12 months	Covered in Full after copay	Covered in Full after copay	Up to $38
Subject to $25 materials copay				
Frame	12 months	Up to $100 Retail*	Up to $100 Retail*	Up to $45
Single Vision, Pair	12 months	Covered in Full after copay	Covered in Full after copay	Up to $31
Bifocal, Pair	12 months	Covered in Full after copay	Covered in Full after copay	Up to $51
Trifocal, Pair	12 months	Covered in Full after copay	Covered in Full after copay	Up to $64
Lenticular, Pair	12 months	Covered in Full after copay	Covered in Full after copay	Up to $80
Progressive lens, Pair	12 months	Not Covered	Covered up to $165*	Not Covered
High Index lenses	12 months	Not Covered	Covered up to $116**	Not Covered
Poly-carbonate lenses	12 months	Not Covered	Covered up to $116**	Not Covered
Scratch Coat	12 months	Not Covered	Covered in Full	Not Covered
UV Coat	12 months	Not Covered	Covered in Full	Not Covered
Not subject to materials copay				
Contact Lenses, Medically Necessary	12 months	Covered in Full	Covered in Full	Up to $210 retail
Contact Lenses, Elective-Cosmetic	12 months	Up to $150 retail*	Up to $150 retail*	Up to $105 retail

* Participants are responsible for any charges above the allowance.

** Participants may use only one of the lens allowances per purchase. Participants are responsible for any charges above the allowance.

- Participants can use either the contact lens benefit or the eyeglass benefit, but not both in the same Plan Year.
- Non Network Claims - copay amount(s) is deducted from the benefit allowance at the time of reimbursement.
- Covered lenses are standard glass or plastic (CR-39), clear.

Monthly Rates for Vision Coverage

		Basic Plan	Enhanced Plan
All Covered Persons Not Eligible for Medicare			
1	Participant Only	$4.36	$7.26
2	Participant and Spouse	$8.72	$14.52
3	Participant and Child(ren)	$7.86	$13.06
4	Participant, Spouse and Child(ren)	$12.20	$20.32
One or More Covered Persons Eligible for Medicare			
B	Medicare Participant Only	$6.54	$10.89
D	Participant, Medicare Spouse and all Dependents	$14.39	$23.96
E	Medicare Participant, Spouse and all Dependents	$14.39	$23.96
G	Medicare Participant and Medicare Spouse or Dependent	$13.08	$21.84
H	Medicare Participant, Medicare Spouse and all Dependents	$16.57	$27.59
R	Medicare Participant and Spouse	$10.90	$18.15
T	Medicare Participant and Dependent Child(ren)	$9.89	$16.70
U	Participant and One Medicare Spouse or Dependent	$10.90	$18.15
X	Medicare Participant, Medicare Spouse and Medicare Dependent	$19.62	$32.67
Z	Medicare Participant, Spouse and Medicare Dependent	$17.44	$29.04

Eligibility

Coverage Level

The participant's cost of coverage is based upon the insurance plan, coverage level selected and Medicare eligibility. The participant may choose between the following coverage levels:

1 Participant Only (Not Eligible for Medicare)
2 Participant and Spouse Only (Neither Eligible for Medicare)
3 Participant and Child(ren) Only (None Eligible for Medicare)
4 Participant and Spouse and all Dependents (None Eligible for Medicare)
B Participant Only (Eligible for Medicare)
D Participant (Not Eligible for Medicare) and Spouse (Eligible for Medicare) and all Dependents
E Participant (Eligible for Medicare) and Spouse (Not Eligible for Medicare) and all Dependents
G Participant (Eligible for Medicare) and Spouse or Dependent (Eligible for Medicare)
H Participant and Spouse (Both Eligible for Medicare) and all Dependents
R Participant (Eligible for Medicare) and Spouse (Not Eligible for Medicare)
T Participant (Eligible for Medicare) and Dependent Children (Not Eligible for Medicare)
U Participant (Not Eligible for Medicare) and one Spouse or Dependent (Eligible for Medicare)
X Participant, Spouse and one Dependent (All Eligible for Medicare)
Z Medicare Participant, Non Medicare Spouse, Medicare Dependent Child

Required Information

For each participant and covered dependent, the following information is required:

A. Full Name
B. Birth date
C. Gender
D. Social Security Number
E. PCP Number (required on all HMO's)
F. Relationship (e.g., spouse, child, stepchild, etc.) The State of Kansas may request documenta tion to support proof of relationship or dependency.
G. Medicare Information

Participant Eligibility

An individual is eligible for participation in the State of Kansas Health Plan as a Direct Bill participant if they are:

A. A retired official or participant who is receiving a retirement benefit through the State of Kansas.
B. A totally disabled former State official or participant 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. Any 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 participant or retiree. The spouse or dependents must have been covered under the State plan immediately before the date of death of the participant or retiree.

F. An active State participant 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.

Medicare Eligibility

A Medicare participant is a participant in the State Health Plan who is also eligible for Medicare benefits. For these participants, Medicare is the primary payor of medical benefits. The participant or covered spouse's status will be changed during the year when they are first eligible for Medicare. **This is not just an Open Enrollment change.**

Individuals covered by Medicare will receive, from Medicare and the State Health Plan, the same benefits as active participants, provided their doctor accepts Medicare assignments and participates with the medical plan. Often the State plan is compared to individual medigap policies, such as Plan 65. However, the benefits provided by the State plan are more comprehensive than the benefits provided by these individual policies. The State plan provides medical, optional 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.

If the participant, covered spouse and/or dependent is eligible for Medicare, the participant may enroll in any of the available Health Plans. If all covered persons are eligible for Medicare, the participant may select Kansas Senior Plan C or the Coventry Advantra Freedom plans.

Over Age 65 or otherwise Medicare Eligible—If the participant or covered spouse is age 65 or older, they will be considered an eligible Medicare participant even if they do not elect coverage under Medicare. Their claims will be processed as if they are enrolled in both Parts A and B of Medicare, even if Medicare Part A is not free or if they do not sign up for Medicare Part B. **For this reason, it is very important that they apply 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 their spouse for free Part A coverage, must purchase Part A coverage. It is the participant's responsibility to work with their local Social Security office to enroll for the proper levels of Medicare coverage. The participant and/or covered spouse **must** send a copy of their Medicare card to Direct Bill Membership (see page 9).

Under Age 65 and Disabled—If a participant under age 65 has been approved for total disability by the Social Security Administration, they will be considered a Medicare participant following 24 months from the date of total disability. When under age 65 and covered by Medicare, the participant or covered spouse **must** send a copy of the Medicare card to the State of Kansas (see page 9).

Dental—Medicare does not provide dental benefits; therefore, all dental claims should be sent directly to Delta Dental.

Dependent Definition

A dependent of an eligible participant is eligible for coverage under the State of Kansas Health Plan if they are one of the following:

A. A participant's lawful wife or husband. When the participant has been divorced from the lawful wife or husband, such spouse no longer qualifies as the participant's lawful wife or husband.

B. A participant's unmarried child or stepchild who:

1. Is under 23 years of age;

2. Does not file a joint tax return with another taxpayer;

3. Receives more than half of their support from the participant (Children of parents who are either divorced, legally separated or live apart for the last six months of the calendar year and who live with either or both parents for more than six months of the year may meet this support test if both parents cumulatively provide more than one-half of the child's support); and

4. Is a U.S. citizen, a U.S. national or a resident of the U.S., Canada or Mexico at some time during the tax year; and

5. Either resides with the participant for more than 6 months of the year or does not reside with the child's brother, sister, grandparent, aunt or uncle for more than six months of the year.

C. The child of a participant's covered dependent child if such grandchild resides in the participant's household and meets the criteria of subsection (B)(1) through (B)(5) above.

D. A participant's unmarried child who is over the age of 23, who is not capable of self support because of mental retardation or severe physical handicap which existed prior to attaining age 23, and who has maintained continuous group coverage as a dependent child prior to attaining age 23, and who has maintained continuous group coverage as a dependent child prior to attaining age 23. Such child must be chiefly dependent on the participant for support.

E. The word "child" means, in addition to the participant's own or lawfully adopted child, any stepchild, or a child for whom the covered participant has legal custody. When a covered participant who is a stepparent has been divorced from the natural parent of the stepchild(ren), such child(ren) no longer qualifies as the participant's stepchild(ren) unless the stepparent is granted legal custody. As used in the preceding sentence, the term natural parent includes an adoptive parent.

Additional Dependent Information

Children of divorced parents—A child of parents who are divorced, legally separated, or live apart for the last six months of the calendar year can be enrolled by either parent if one parent meets the support requirement in paragraph B(3).

Grandchild—A participant may cover a grandchild if the participant has legal custody or has adopted the child; or if the grandchild lives in the participant's home, is the child of a covered dependent child, and the participant provides more than one half of the grandchild's support. Special consideration may be given to a grandchild not living with the participant, if the parent is a college student.

Ex-Spouse—When the participant has been divorced from their lawful wife or husband, the ex-spouse is no longer eligible to participate in the State of Kansas Health Plan except as allowed under COBRA continuation coverage.

Dependents who are Employees—A person who is eligible for participant coverage in the State of Kansas Health Plan is not eligible to be a covered dependent in the State of Kansas Health Plan.

Dependents may not be covered in Duplicate—Eligible dependent children may not be covered by more than one participant in the State of Kansas Health Plan.

Dependents residing out-of-country

A spouse who is not a U.S. citizen or who resides in another country is eligible for PPO coverage either when the participant is newly eligible, newly married or at Open Enrollment. The participant will not be allowed to add the spouse to coverage if the spouse moves to the United States during the plan year.

Dependent children who are not U.S. citizens and who reside in another country are not eligible for coverage until they move to the United States. The participant will be not be allowed to add the children to coverage if the children move to the United States during the plan year (if added within 31 days of the move). However, if added to PPO coverage and the dependent children later return to another country during the plan year, coverage may not be dropped for these children until the next Open Enrollment period (unless enrolled on an after-tax basis).

Adopted child—A participant may cover an adopted child if the petition for adoption has been filed with the court, if the participant has a placement agreement from an adoption agency, or if the participant has been granted legal custody of the child. Supporting documentation must be provided in English and must be submitted to Benefits Administration. Adopted children who are not U.S. citizens and who reside in another country, are not eligible for coverage until they reside in the United States.

Note The State of Kansas and the Medical plan reserve the right to request documentation to support proof of dependency and/or residency. When enrolling dependent(s) for coverage with the State of Kansas Health Plan, the participant must certify that the dependent(s) meet the requirements for dependent coverage for the year in which the dependent(s) are being enrolled. The participant 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.

Split Enrollment

To be enrolled as a dependent under a participant's coverage in the State Health Plan, the participant and the dependent must be enrolled with the same insurance plan; however, non Medicare eligible family members may enroll in a separate plan.

Newly Eligible Participants

Effective date of coverage is the first day of the month following enrollment in the State of Kansas Direct Bill Health Plan.

For new retirees and other new participants, the effective date of coverage is the first day of the month following the participant's last day in active pay status.

For new retirees who are age 65, Medicare becomes primary the first day of the month following the last day of **coverage** as an active participant.

Deceased Participants and Spouses

If a Direct Bill participant is deceased, a family member or beneficiary should call the State of Kansas 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 participant's estate; however, premium for the deceased participant is still owed for the entire month in which the death occurs. If premium is paid, health care claims for the deceased participant will be paid up to and including the date of death.

If the Direct Bill participant 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 their own name effective the first day of the month following the date of death. Premium for the remaining family members is generally lower; therefore, prompt notification to the State of Kansas may reduce the premium cost.

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

Please note that KPERS **DOES NOT** notify the State Health Plan in the event of the death of a participant or spouse.

Newly Eligible Dependents

Dependents shall become newly eligible on the later of:

A. The participant's initial date of eligibility; or

B. The date the individual first becomes the participant's eligible dependent. This includes the following:

1. A new spouse due to marriage;
2. New stepchildren due to marriage;
3. A new dependent child due to birth or adoption (the petition for adoption must have been filed with the court or the participant must have a placement agreement);
4. A new dependent child due to new legal custody or new legal guardianship (not power of attorney); or
5. Dependent children identified under a Medical Withholding Order (K.S.A. 23-4, 105).

Coverage for newly eligible dependents may be added mid-year to the participant's current insurance plan, **but only if all of the following requirements are met:**

A. The dependent is added to coverage within 31 calendar days of the event causing new eligibility (by calling the State of Kansas at 1-866-541-7100 or in Topeka at 785-296-1715);

B. The change in coverage is consistent with the event;

C. Written documentation is provided (such as a copy of the birth certificate, petition for adoption, placement agreement, marriage license, custody agreement, etc.); and

D. A completed and signed Enrollment Form is returned within 7 calendar days of receipt.

Coverage will be effective and premium contributions will start the first day of the month following the event.

Coverage for newborn or adopted children will be effective on the date of birth, the date of filing of the petition or the date of the placement agreement. Premium will begin on the first day of the month following the birth/filing. However, no benefits will be provided for the newborn or adopted child until the completed Enrollment Form has been received.

If the petition for adoption or the placement agreement is within 31 days of the birth of the child, the effective date of coverage is the date of birth and the participant will be responsible for premiums as shown in the preceding paragraph.

Non-Newly Eligible Participants and Dependents

Non-newly eligible participants and dependents are defined as participants and/or dependents for whom 31 days have passed since their initial eligibility for coverage.

Non-newly eligible participants 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 one of the events listed below:

B. The change is requested within 31 calendar days of the event (by calling the State of Kansas number listed on the inside front cover);

C. The change in coverage is consistent with the event;

D. Written documentation of the event is provided (such as a divorce decree, death certificate, or custody agreement) or statement from spouse's employer;

E. A completed and signed Enrollment Form is returned within 7 calendar days of receipt.

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 of the month following the event. Qualifying events include:

A. The participant'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 effects cost, benefit level, or benefit coverage for the participant and/or dependents.
E. Termination or commencement of employment (includes retirement) of spouse or dependent which effects benefits coverage for the participant and/or spouse or dependents.
F. Unpaid leave of absence by spouse or dependent which effects the benefits coverage for the participant and/or spouse or dependent.
G. Significant changes during a spouse's Open Enrollment for group health insurance, such as premium increase, benefits level, or enrollment in coverage.
H. A participant, spouse or dependent being called to active military duty.
I. Expiration of COBRA continuation benefits from a previous employer for the participant, spouse or dependent.
J. The participant'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 HMO enrollment area.
M. A dependent turning age 23 or marrying.
N. Spouse or dependent gaining or losing government-sponsored medical card coverage.
O. The participant, spouse or dependent becoming Medicare eligible and electing Medicare coverage as primary.
P. Dependent children identified under a Medical Withholding Order (K.S.A. 23-4,105) 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.

NOTE:

Direct Bill participants may drop medical, dental and prescription coverage on themselves and/or any covered dependents at any time by notifying the State of Kansas at the number listed on the inside front cover. If a participant terminates their coverage, all dependents will also be terminated. **Effective date of change will be the first day of the month following notification.** However, dependent dental coverage may not be dropped unless dependent medical coverage is dropped. Vision coverage may not be dropped during the plan year unless due to an ineligible dependent or unless medical coverage is dropped.

IMPORTANT

YOU must contact Direct Bill Membership for all changes within 31 days of the qualifying event.

Open Enrollment...

Have You

- ✔ Read all of the Open Enrollment materials?
- ✔ Attended your Open Enrollment meeting?
- ✔ Determined whether or not you want to make any changes to your current health plan?
- ✔ Carefully reviewed your prescription drug coverage if Medicare eligible?
- ✔ Called your health care provider's office to ask whether your doctor (or a doctor you wish to see) participates in the plan you have chosen and, if applicable, is accepting new patients?
- ✔ Completed a change form or called the Direct Bill Call Center if you decided to make changes to your health plan?
- ✔ Provided documentation such as birth certificates or marriage license for dependents you are adding for the first time?

When Talking to Your Doctor...

- Make a list before you go to your appointment. Start with the most important items.
- Be honest. It is in your best interest. Your doctor can give you the best treatment only if you are open about what is really going on.
- Stick to the point. Each patient is given a limited amount of time, so make the best use of your time. Give the doctor a brief description of the symptom, when it started, how often it happens, and if it is getting better or worse.
- Share your health history. Tell your doctor your health history and how your health is now. Review with your doctor a prevention plan. Don't forget to discuss health issues that your parents and relatives have as this may provide insight into your health.
- Share your point of view. Your doctor needs to know what is, or is not, working. Voice your feelings in a positive way.
- Ask questions. If you don't ask questions, your doctor may think that you understand why you are being sent for a test or that you don't want more information.
- Always ask for your options or alternative treatments.
- Always ask for possible outcomes or what you can expect.

Improve Your Health...

and Reduce Your Costs

The Health Plan has identified ways that you can reduce the cost of your health care while improving your health.

- **Take Advantage of the Mail Order Pharmacy.** The Mail Order Pharmacy through CaremarkPCS is a convenient and cost effective way to obtain your long-term medications through the mail.

- **Use Generic Prescription Drugs When Possible.** Less expensive, FDA-approved generic equivalents are as effective as brand names - at about one-third of the cost.

- **Manage Stress.** Stress directly and indirectly contributes to the leading causes of death in the United States, and aggravates many other conditions. Managing stress - whether you get more exercise, take deep breaths, or cut back on coffee - can make your life easier and your health costs lower.

- **Stay Active.** Regular exercise - even just walking 30 minutes a day, three days a week - can cut the risk of conditions such as high blood pressure, heart disease, and diabetes.

- **Stop Smoking.** The lifetime medical costs for smokers are nearly one-third higher than those of non-smokers. Kicking the habit may save your life - and save you money too.

- **Use the ER for Emergencies Only.** Whenever someone goes to the emergency room for non-emergency care, we all pay the price. Emergency room visits are substantially more expensive than physician office visits. Don't ever hesitate to go to the ER if it's a true emergency. But if it's not, check with your doctor first.

- **Participate in the Disease Management Programs.** Conditions such as asthma, diabetes, depression and coronary artery disease account for more than $100 billion in health care expenses nationally every year. These programs are available to assist eligible participants in maintaining or enhancing their health through self-care management and effective communications with their physician. The programs are offered by invitation and are free to eligible participants.

- **Lose Weight and Eat Right.** Studies show that obesity adds $7.7 billion to the nation's annual health care bill, and is associated with 63 million additional doctor visits annually. A balanced diet reduces the potential of a wide range of illnesses including type 2 diabetes, hypertension and heart disease.

Allowable Charge - The maximum amount a health plan will pay for a covered service. Network providers and facilities are those who have agreed to accept the Allowable Charge for covered services under the plan.

Billed Charges - The difference between the allowed and actual charge. A network provider will write off this amount (discount). A non network provider will usually not write off this amount and it will become your responsibility to pay.

Coinsurance - Coinsurance is the percentage of covered medical expenses a member must pay in conjunction with the percentage paid by an insurance plan for covered expenses. These amounts are called coinsurance because both the member and the insurance plan share the cost of health care expenses.

Coinsurance Maximum - A set dollar amount identified in the contract of insurance. Once the amount you pay out of your pocket as coinsurance reaches this amount, covered services are paid at 100% of the Allowed Charge with no further Coinsurance being applied for the remainder of the Plan Year. You may be responsible for amounts that exceed the Allowed Charge if you are receiving services from a non network provider. Copayments do not apply to Coinsurance Maximums.

Creditable Coverage - Creditable Coverage under Medicare Part D has to do with prescription drug coverage, not medical coverage. A plan that offers coverage equal to a Part D plan is called "creditable coverage". If you have creditable coverage, you won't be charged a late enrollment fee if you move to a Part D plan after the inital enrollment period (November 15, 2005 to May 15, 2006).

Coordination of Benefits - A system to eliminate duplication of benefits when a person is covered under more than one group health plan. Benefits under the two plans are limited to no more than 100 percent of the claim.

Copayment - A Copayment is a fixed dollar amount of covered medical expenses a member must pay in addition to what is paid by an insurance plan for covered expenses. These amounts are called Copayments because both the member and the insurance plan share the cost of health care expenses.

Covered Medical Expense - The Allowable Charge for a medical procedure that is covered by the contract of insurance and is deemed medically necessary by the health plan in the diagnosis or treatment of an illness or injury.

Deductible - A set dollar amount you must pay out of your pocket each year from Covered Medical Services before the insurance plan begins to pay claims. The Deductible is shown on the Schedule of Benefits of the policy.

Exclusion - A specific condition or circumstance for which an insurance plan or policy will not provide benefits.

Explanation of Benefits (EOB) - A statement sent to a participant by the health plan that indicates the name of the provider, total amount billed, amount paid by the plan, and amount the patient is responsible for paying to the provider. This is not a bill and should be retained to show how the claim was processed.

Health Maintenance Organization (HMO) - A managed care plan that has contractual arrangements with healthcare providers (doctors, hospitals, etc.) who together form a provider network. HMO members are required to see only providers within this network. If a member receives care outside of this network, the HMO will not pay benefits for these services unless the care was pre-authorized or deemed an emergency. Members choose a primary care physician (PCP) who coordinates all aspects of the member's healthcare. To receive benefits, members must receive a referral from their PCP before they can see a specialist.

Late Enrollment Fee in Medicare Part D - Initiative used to encourage as many eligible participants as possible to enroll in a Medicare Part D plan as soon as they are eligible and before the end of the enrollment period (May 15, 2006). The late fee is approximately 12 percent a year that you delay enrolling. The fee won't apply if the insurance plan the participant was enrolled offers creditable coverage to a Part D prescription drug plan.

Medically Necessary - Services or supplies ordered by a physician or provider to identify or treat an illness or injury. Services and supplies must be given in accordance with proper medical practice prevailing in the medical specialty or field at the time the patient receives the service and in the least costly setting required for the patient's condition. The service must be consistent with the patient's illness, injury or condition and be required for reasons other than the patient's convenience. The fact that a physician prescribes a service or supply does not necessarily mean it is medically necessary.

Medicare Advantage Plans - Health plans offered by private insurance companies that contract with Medicare to provide Medicare coverage. These plans are also referred to as Medicare Health Plans. They used to be called the Medicare + Choice plans. They can have either an HMO or PPO design.

Network Provider - (or contracting provider means an Eligible Provider who has entered into a contracting agreement directly with a health insurance company to provide service to plan participants for specific pre-negotiated rates.

Non Network Provider - (or non contracting provider) means an Eligible Provider who has not entered into a contracting agreement with the insurance company. If you visit a physician or other provider within the network, the amount you will be responsible for paying will be less than if you go to a non network Provider. In many cases, the insurance company will either pay less or not pay anything for services you received from non network providers.

Pre-Admission Certification - A plan requirement that you call the health plan prior to admission to the hospital. The phone numbers to call are listed in this health plan summary booklet. Pre-certification is not a guarantee that benefits will be paid.

Preferred Drug List (PDL) - A list of prescription drugs that are covered by the drug plan. In Medicare Part D different plans have different lists of eligible drugs. Not all PDL's are the same. The PDL is also called a formulary or a select drug list.

Primary Care Physician (PCP) - means the Physician selected by the participant of an HMO plan from the list of physicians engaged in general practice, family practice, internal medicine or pediatricians who is participating in the selected HMO program to be the physician who will manage and/or coordinate the patient's health care needs.

Preferred Provider Organization (PPO) - A PPO has arrangements with doctors, hospitals and other providers who have agreed to accept the plan's Allowable Charge for covered medical services as payment in full and will not balance bill you. Participating providers also file claims for you. You can see anyone in the network of providers.

Qualifying Event - An event that allows changes to insurance coverage or an extension of insurance coverage for an employee, spouse or dependent. Such events may be marriage, birth/adoption/placement, loss of group health plan coverage, divorce, death of the covered employee, loss of dependent's eligibility for coverage, etc. When a qualifying event occurs you have 31 days to contact your personnel officer and complete the forms in order to make the change to your membership.

Self Insured - Self insured plans are set up by employers to pay the health claims of its employees. The *employer* assumes the risk of providing the benefits and is obligated to pay all the claims.

Insurance Provider See back for List of Carriers	
Non-State Group	

ENROLLMENT AND CHANGE FORM

STATE OF KANSAS
DIRECT BILL GROUP HEALTH INSURANCE

Coverage Effective Date	

Member ID Number	

Social Security Number	Name (Last, First, MI)	Sex	Date of Birth (Mo/Da/Yr)	HMO Primary Care Physician Number

Home Address (Street)	City	County	State	Zip Code

Home Telephone	Spouse/Dependent of Deceased State Participant? ☐ Yes ☐ No	SSN of Participant	Name of Participant	Date of Death

TYPE OF ACTION

☐ New Enrollment ☐ Termination Request (medical/dental/Rx) ☐ Change Request Date of Event ____/____/____

☐ Death of Spouse or Child* ☐ Divorce* ☐ Drop Spouse and/or Child(ren) ☐ Birth of Dependent*

☐ Adding Spouse and/or Child(ren)* ☐ Child Turning Age 23 ☐ Eligible for Medicare - Member ☐ Split Enrollment

☐ Waive Medical/Dental Coverage ☐ Marriage (including Marriage of Child)* ☐ Eligible for Medicare – Spouse/Dependent

☐ Disability ☐ Drop Family Dental Coverage ☐ Moving In or Out of Service Area ***PROVIDE DOCUMENTATION**

MEDICAL & VISION COVERAGE LEVEL

VISION ☐ **Basic Vision** ☐ **Enhanced Vision** ☐ **Waive Vision**

(Check one box each for medical & vision)

Medical & Drug	Vision (Optional)		Medical & Drug	Vision (Optional)	
☐	☐	1 Participant Only	☐	☐	G Med Participant & Med Spouse or Child
☐	☐	2 Participant and Spouse	☐	☐	H Med Participant, Med Spouse & Child(ren)
☐	☐	3 Participant and Child(ren)	☐	☐	R Med Participant & Spouse
☐	☐	4 Participant, Spouse and Child(ren)	☐	☐	T Medicare Participant and Child(ren)
☐	☐	B Medicare Participant Only	☐	☐	U Participant & Med Spouse or Child
☐	☐	D Participant, Med Spouse & Child(ren)	☐	☐	X Med Participant, Med Spouse & Med Child(ren
☐	☐	E Med Participant, Spouse & Child(ren)	☐	☐	Z Med Participant, Spouse and Med Child

DENTAL COVERAGE LEVEL

☐ **1 Participant Only** ☐ **D Participant and Covered Spouse and/or Child(ren)**

FAMILY INFORMATION (List spouse and/or unmarried dependent children to be covered – subject to dependent definition & REL. codes on reverse).

Action Add	Action Del	Relationship	NAME LAST	First	MI	Social Security Number (Required)	Sex M	Sex F	Date of Birth MO/DAY/YR	HMO Primary Care Physician Number
☐	☐						☐	☐		
☐	☐						☐	☐		
☐	☐						☐	☐		

MEDICARE INSURANCE (Do you or your covered spouse or child(ren) have Medicare coverage?) ☐ Yes ☐ No

Full name of MEDICARE covered persons**	Hospital (Part A) Mo/Day/Yr	Medical (Part B) Mo/Day/Yr	MEDICARE Claim Number

If eligible for Medicare, enrollment in both Part A and Part B of Medicare **are required for the correct level of coverage under the Direct Bill group insurance program. Check with your local **Social Security Office** for your Medicare eligibility. **PROVIDE COPY OF MEDICARE CARD**.

AUTHORIZATION

By my signature, I hereby authorize the change or discontinuation in my Health Plan coverage as indicated above. I understand that all enrollment changes are subject to the State Employee Health Plan enrollment policies and agree to pay the premium for the coverage indicated. If discontinuing direct Bill coverage, I understand that I will not be eligible to re-enroll in the direct Bill Program unless continuous coverage in the Health Plan is maintained.

Date Signed _____ **SIGN YOUR FULL NAME HERE** _____
(DO NOT PRINT)

29-145 Rev. 08/05

TERMS OF ENROLLMENT

I have read and agree to the provisions in the State of Kansas Benefit Information and Options booklet for Retiree and Direct Bill Participants for the plan year in which I am enrolling.

I represent the information on the Enrollment Form to be complete and accurate to the best of my knowledge. I understand that my answers to the questions contained on this Enrollment Form will be used to determine eligibility for coverage. I further understand that if any material information is omitted or incorrect, it could provide the basis to refuse or rescind coverage and to refund any premiums paid as though coverage had never been in force.

If enrolling my dependent(s) for coverage, I certify that they meet the requirements for dependent coverage as listed in the State of Kansas Open Enrollment booklet for Retiree and Direct Bill Participants for the year in which I am enrolling. Any attempt by me to enroll dependents which do not meet the requirements will be considered fraud and will be subject to penalties as prescribed by law.

I agree to the following terms for myself and my dependents: Unless otherwise prevented by law, we authorize health care providers, insurers, claims administrators and employers to provide medical, employment and benefit information, including information relating to drug, alcohol or psychiatric histories and treatment, to the insurance provider or its authorized representatives. Except as otherwise prevented by law, the insurance provider or its authorized representatives may share such information and provide it to the employer, other insurers, claims administrators, re-insurers and other provider organizations only for the purpose of administering the group coverage and claims for benefits, utilization review, risk management, provider peer review and the resolution of grievances relating to health benefit coverage and care. This authorization shall be valid for the duration of coverage. I acknowledge that I have obtained a copy of this authorization. I agree that a reproduced copy of this authorization will be as valid as the original.

Medical Insurance Providers: **(please select your provider by checking the box beside your choice.)**

☐ **Kansas Senior Plan C with Drug Coverage (Medicare Supplemental Plan C)**

☐ **Kansas Senior Plan C without Drug Coverage (Medicare Supplemental Plan C)**

☐ **Kansas Choice (PPO)**

☐ **Coventry Advantra Freedom (Medicare Advantage PPO)**

☐ **Coventry (PPO)**

☐ **Coventry (HMO)**

☐ **Preferred Plus of Kansas – PPK (HMO)**

☐ **Premier Blue (HMO)**

Relationship codes:

SP= spouse;
P = stepson or stepdaughter;
GC = grandson or granddaughter;
XX = court ordered dependent;
D = daughter;
S = son;
L = legal custody dependent;
H = handicapped child over age 23

Mailing Address:
Benefits Administration
Division of Health Policy and Finance
Rm. 920-S, Landon State Office Bldg.
900 SW Jackson
Topeka, Kansas 66612-1251

Resources for Health Information

There are many valuable tools available to assist you in managing your health.

- Health Plan Summary Booklet – provides information on the health plans available to you, costs of the plans and tips to get the most out of the plans you choose.
- Customer service staff for the plan in which you are enrolled
- HealthQuest – newsletters, bulletins, and special programs

http://www.ahrq.gov - Agency for Healthcare Research and Quality. This site includes a pocket guide to good health for adults. It provides information on health conditions/ diseases/ prescriptions/ prevention & wellness.

http://www.stayinginshape.com - How to stay healthy. Here you'll find information on diseases/ conditions/ interactive tools/ calculators/ health quizzes, etc. This site is offered in English and Spanish.

http://www.collaborativecare.net – Includes links to more than 20 good health resources. This site helps patients become informed about their medical options, communicate effectively with their doctors, and achieve better overall health outcomes.

http://www.ama-assn.org - American Medical Association website. Site includes general legislative information and publications on public health.

http://www.nih.gov - National Institutes of Health. A source for general background information on health conditions and research. Here you will find "Talking with your doctor – A guide for older people" which is good information for anyone.

http://www.cdc.gov - Centers for Disease Control. This site includes health and safety topics/ publications and products/ data and statistics.

http://www.npsf.org - National Patient Safety Foundation. A resource that provides a library of information on patient safety.

http://www.ksinsurance.org - This site includes useful information on how to "Take Control" of your health care.

http://www.medicare.gov - This is the official US Government site for people with Medicare.

http://www.aarp.org - Contains current information regarding Medicare legislation as well as research information and health care/prescription drug decision making tools.

STATE OF KANSAS
DEPARTMENT OF ADMINISTRATION
DIVISION OF HEALTH POLICY & FINANCE
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