

# State of Kansas Employees 2010

<b>State(s) of Issue:</b> Kansas		
<b>Plan:</b> State of Kansas 2010 Plan A		
	<b>When Receiving Services from Network Providers</b>	<b>When Receiving Services from Non Network Providers</b>
<b>Annual Plan Deductible</b> Reminder: Deductible does not apply to preventive care or office visits	\$150 Individual / \$300 Family	\$500 Individual / \$1,500 Family
<b>Coinsurance For All Eligible Expenses</b>	20% Coinsurance	50% Coinsurance
<b>Annual Coinsurance Maximum</b> (does not include deductible and copayments)	\$1,200 Individual / \$2,400 Family	\$3,650 Individual / \$7,300 Family
<b>Lifetime Benefit Maximum</b>	None	None

Covered Services	Cost to Member When Receiving Services from Network Providers	Cost to Member When Receiving Services from Non Network Providers
<b>Preventive Care</b>		
▪ Well Woman Exam	Covered in full	Not Covered
▪ Mammograms	Covered in full	Not Covered
▪ Well Baby and Child Care	Covered in full	Not Covered
▪ Well Man Care (Annual Prostate Screening and Office Visit)	Covered in full	Not Covered
▪ Periodic Age Appropriate Physical Exam and Routine Health Screening	Covered in full	Not Covered
▪ Routine Vision Exam	Covered in full	Not Covered
▪ Routine Hearing Exam	Covered in full	Not Covered
▪ Age Appropriate Bone Density Screening	Covered in full	Not Covered
▪ Colonoscopy Screenings	Covered in full	Not Covered

Covered Services	Cost to Member When Receiving Services from Network Providers	Cost to Member When Receiving Services from Non Network Providers
<b>Immunizations</b> <ul style="list-style-type: none"> <li>▪ Pediatric</li> <li>▪ Adult</li> </ul>	<p>Covered in full</p> <p>Covered in full</p>	<p>Covered in full to Age 6, Otherwise Deductible plus 50% Coinsurance</p> <p>Deductible plus 50% Coinsurance</p>
<b>Physician Care</b> <ul style="list-style-type: none"> <li>▪ Primary Care Provider Office Visits</li> <li>▪ Specialist Office Visits</li> </ul>	<p>\$20 Copayment</p> <p>\$40 Copayment</p>	<p>Deductible plus 50% Coinsurance</p> <p>Deductible plus 50% Coinsurance</p>
<b>Dietician Consultation</b>	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
<b>Inpatient Services</b> (Services must be pre-approved by health plan.)	Deductible plus 20% Coinsurance	\$600 Copayment per Admission plus Deductible and 50% Coinsurance
<b>Outpatient Surgery</b> <ul style="list-style-type: none"> <li>▪ Surgery/Anesthesia/Assistant Surgeon</li> </ul>	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
<b>Major Diagnostic Testing</b> (includes but not limited to PET Scans, CT Scans, Nuclear Cardiology Studies, MRI, Computerized Topography/Angiography)	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
<b>Outpatient Laboratory Services</b> <ul style="list-style-type: none"> <li>▪ Quest Diagnostics – LabCard</li> <li>▪ Other participating/contracted labs</li> </ul>	<p>Covered in Full</p> <p>Deductible plus 20% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p> <p>Deductible plus 50% Coinsurance</p>

Effective 1/1/2010

Covered Services	Cost to Member When Receiving Services from Network Providers	Cost to Member When Receiving Services from Non Network Providers
<b>Outpatient Services</b>  <ul style="list-style-type: none"> <li>▪ Telemedicine</li> </ul>	Deductible plus 20% Coinsurance  Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance  Deductible plus 50% Coinsurance
<b>Urgent Care Facility Visits</b>	\$20 Copayment, Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
<b>Ambulance/Emergency Transportation</b> (Ground or Air)	Deductible plus 20% Coinsurance	Deductible plus 20% Coinsurance
<b>Emergency Room Services</b> Copayment is waived if admitted into any hospital within 24 hours.	\$100 Copayment, Deductible plus 20% Coinsurance	\$200 Copayment, plus Deductible and 50% Coinsurance
<b>Home Health Care</b> (Services must be pre-approved by health plan.)	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
<b>Hospice Care</b> (Services must be pre-approved by health plan.) <i>Limited to 6 Months</i>	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
<b>Rehabilitation Services</b> (including physical medicine) <ul style="list-style-type: none"> <li>▪ Inpatient Facility</li> <li>▪ Outpatient Facility</li> <li>▪ Office Services <i>Limited to 30 visits per Calendar Year</i></li> </ul>	Deductible plus 20% Coinsurance  Deductible plus 20% Coinsurance  Deductible plus 20% Coinsurance	\$600 Copayment per Admission plus Deductible and 50% Coinsurance  Deductible plus 50% Coinsurance  Deductible plus 50% Coinsurance
<b>Durable Medical Equipment (DME)</b> <i>Limited to \$5,000 per Calendar Year.</i> Any charges exceeding \$400 require pre-approval by health plan.	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance

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<b>Prosthetic Devices</b> Any charges exceeding \$1,000 require pre-approval by health plan.	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
<b>Orthotic Devices</b>	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
<b>Allergy Testing</b>	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
<b>Allergy Shots &amp; Antigen Administration</b> (desensitization/treatment)	Covered in full	Deductible plus 50% Coinsurance
<b>Mental Illness, Alcoholism, Drug Abuse or Substance Use</b> <ul style="list-style-type: none"> <li>▪ Inpatient Services</li> <li>▪ Outpatient Services</li> <li>▪ Office Visits</li> <li>▪ Group Therapy Sessions</li> </ul>	Same as Medical  Same as Medical  \$20 Copayment  \$10 Copayment	Same as Medical  Same as Medical  Deductible plus 50% Coinsurance  Deductible plus 50% Coinsurance