

State of Kansas Employees 2010

State(s) of Issue: Kansas		
Plan: State of Kansas 2010 Plan B		
	When Receiving Services from Network Providers	When Receiving Services from Non Network Providers
Annual Plan Deductible Reminder: Deductible does not apply to preventive care or office visits	None	\$500 Individual / \$1,500 Family
Coinsurance For All Eligible Expenses (unless otherwise noted)	30% Coinsurance	50% Coinsurance
Annual Coinsurance Maximum (does not include deductible and copayments)	\$2,200 Individual / \$4,400 Family	\$3,650 Individual / \$7,300 Family
Lifetime Benefit Maximum	None	None

Covered Services	Cost to Member When Receiving Services from Network Providers	Cost to Member When Receiving Services from Non Network Providers
Preventive Care		
▪ 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
Immunizations <ul style="list-style-type: none"> ▪ Pediatric ▪ Adult 	<p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p>	<p style="text-align: center;">Covered in full to Age 6, Otherwise Deductible plus 50% Coinsurance</p> <p style="text-align: center;">Deductible plus 50% Coinsurance</p>
Physician Care <ul style="list-style-type: none"> ▪ Adult Primary Care Provider (PCP) Office Visits ▪ Primary Care Provider Office Visits for Children Age 18 and Under ▪ Adult Specialist Office Visits ▪ Specialist Office Visits for Children Age 18 and Under 	<p style="text-align: center;">\$20 Copayment</p> <p style="text-align: center;">\$10 Copayment</p> <p style="text-align: center;">\$40 Copayment</p> <p style="text-align: center;">\$25 Copayment</p>	<p style="text-align: center;">Deductible plus 50% Coinsurance</p> <p style="text-align: center;">Deductible plus 50% Coinsurance</p> <p style="text-align: center;">Deductible plus 50% Coinsurance</p> <p style="text-align: center;">Deductible plus 50% Coinsurance</p>
Dietician Consultation	<p style="text-align: center;">30% Coinsurance</p>	<p style="text-align: center;">Deductible plus 50% Coinsurance</p>
Inpatient Services (Services must be pre-approved by health plan.)	<p style="text-align: center;">30% Coinsurance</p>	<p style="text-align: center;">\$600 Copayment per Admission plus Deductible and 50% Coinsurance</p>
Outpatient Surgery <ul style="list-style-type: none"> ▪ Surgery/Anesthesia/Assistant Surgeon 	<p style="text-align: center;">30% Coinsurance</p>	<p style="text-align: center;">Deductible plus 50% Coinsurance</p>
Major Diagnostic Testing (includes but not limited to PET Scans, CT Scans, Nuclear Cardiology Studies, MRI, Computerized Topography/Angiography)	<p style="text-align: center;">30% Coinsurance</p>	<p style="text-align: center;">Deductible plus 50% Coinsurance</p>

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Outpatient Laboratory Services <ul style="list-style-type: none"> ▪ Quest Diagnostics – LabCard ▪ Other participating/contracted labs 	<p style="text-align: center;">Covered in full</p> <p style="text-align: center;">30% Coinsurance</p>	<p style="text-align: center;">Deductible plus 50% Coinsurance</p> <p style="text-align: center;">Deductible plus 50% Coinsurance</p>
Outpatient Services <ul style="list-style-type: none"> ▪ Telemedicine 	<p style="text-align: center;">30% Coinsurance</p> <p style="text-align: center;">30% Coinsurance</p>	<p style="text-align: center;">Deductible plus 50% Coinsurance</p> <p style="text-align: center;">Deductible plus 50% Coinsurance</p>
Urgent Care Facility Visits	<p style="text-align: center;">\$20 Copayment plus 30% Coinsurance</p>	<p style="text-align: center;">Deductible plus 50% Coinsurance</p>
Ambulance/Emergency Transportation (Ground or Air)	<p style="text-align: center;">30% Coinsurance</p>	<p style="text-align: center;">30% Coinsurance</p>
Emergency Room Services Copayment is waived if admitted into any hospital within 24 hours.	<p style="text-align: center;">\$100 Copayment plus 30% Coinsurance</p>	<p style="text-align: center;">\$200 Copayment plus Deductible and 50% Coinsurance</p>
Home Health Care (Services must be pre-approved by health plan.)	<p style="text-align: center;">30% Coinsurance</p>	<p style="text-align: center;">Deductible plus 50% Coinsurance</p>
Hospice Care (Services must be pre-approved by health plan.) <i>Limited to 6 Months</i>	<p style="text-align: center;">30% Coinsurance</p>	<p style="text-align: center;">Deductible plus 50% Coinsurance</p>
Rehabilitation Services (including physical medicine) <ul style="list-style-type: none"> ▪ Inpatient Facility ▪ Outpatient Facility ▪ Office Services <i>Limited to 30 visits per Calendar Year</i> 	<p style="text-align: center;">30% Coinsurance</p> <p style="text-align: center;">30% Coinsurance</p> <p style="text-align: center;">30% Coinsurance</p>	<p style="text-align: center;">\$600 Copayment per Admission plus Deductible and 50% Coinsurance</p> <p style="text-align: center;">Deductible plus 50% Coinsurance</p> <p style="text-align: center;">Deductible plus 50% Coinsurance</p>

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Durable Medical Equipment (DME) <i>Limited to \$5,000 per Calendar Year.</i> Any charges exceeding \$400 require pre-approval by health plan.	30% Coinsurance	Deductible plus 50% Coinsurance
Prosthetic Devices Any charges exceeding \$1,000 require pre-approval by health plan.	30% Coinsurance	Deductible plus 50% Coinsurance
Orthotic Devices	30% Coinsurance	Deductible plus 50% Coinsurance
Allergy Testing	30% Coinsurance	Deductible plus 50% Coinsurance
Allergy Shots & Antigen Administration (desensitization/ treatment)	Covered in full	Deductible plus 50% Coinsurance
Mental Illness, Alcoholism, Drug Abuse or Substance Use <ul style="list-style-type: none"> ▪ Inpatient Services ▪ Outpatient Services ▪ Adult Office Visits ▪ Office Visits for Children Age 18 and Under ▪ Group Therapy Sessions 	Same as Medical Same as Medical \$20 Copayment \$10 Copayment \$10 Copayment	Same as Medical Same as Medical Deductible plus 50% Coinsurance Deductible plus 50% Coinsurance Deductible plus 50% Coinsurance