

State of Kansas Employees 2010

State(s) of Issue: Kansas

Plan: State of Kansas 2010 Plan C – QHDHP

	When Receiving Services from Network Providers	When Receiving Services from Non Network Providers¹
Annual Plan Deductible Reminder: Deductible does not apply to preventive care or office visits	\$1,500 Individual / \$3,000 Family	\$2,000 Individual / \$4,000 Family
Coinsurance For All Eligible Expenses	20% Coinsurance	50% Coinsurance
Annual Out-of-Pocket Maximum Includes Deductible, Coinsurance and Copayment	\$3,000 Individual / \$6,000 Family	\$3,650 Individual / \$7,300 Family
Lifetime Benefit Maximum	None	None

HSA Worksheet	Employer Contribution	Employee Contributions
Full-Time Employees Employee Only	\$37.50 (\$900.00 per year)	\$25.00 to \$89.58
Employee + Dependents	\$56.25 (\$1,350.00 per year)	\$25.00 to \$200.00
Part-Time Employees Employee Only	\$28.13 (\$675.12 per year)	\$25.00 to \$98.95
Employee + Dependents*	\$42.19 (\$1,012.56 per year)	\$25.00 to \$214.06

*The HSA contribution maximums for Employee + Spouse, Employee + Children, and Family are the same.

Note: All columns represent 24 semi-monthly payments. The HSA total State contribution for nine-month regents employees are distributed evenly over 16 pay periods each year.

Covered Services	Cost to Member When Receiving Services from Network Providers	Cost to Member When Receiving Services from Non Network Providers ¹
<p>Preventive Care</p> <ul style="list-style-type: none"> ▪ Well Woman Exam ▪ Mammograms ▪ Well Baby and Child Care ▪ Well Man Care (Annual Prostate Screening and Office Visit) ▪ Periodic Age Appropriate Physical Exam and Routine Health Screening ▪ Age Appropriate Bone Density Screening ▪ Colonoscopy Screenings ▪ Routine Vision Exam ▪ Routine Hearing Exam 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>	<p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p>
<p>Immunizations</p> <ul style="list-style-type: none"> ▪ Pediatric ▪ Adult 	<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>
<p>Physician Care</p> <ul style="list-style-type: none"> ▪ Primary Care Provider Office Visits ▪ Specialist Office Visits 	<p>Deductible plus 20% Coinsurance</p> <p>Deductible plus 20% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p> <p>Deductible plus 50% Coinsurance</p>
<p>Inpatient Services² (Services must be pre-approved by health plan.)</p>	<p>Deductible plus 20% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p>
<p>Outpatient Surgery</p> <ul style="list-style-type: none"> ▪ Surgery/Anesthesia/Assistant Surgeon 	<p>Deductible plus 20% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p>

Covered Services	Cost to Member When Receiving Services from Network Providers	Cost to Member When Receiving Services from Non Network Providers ¹
Major Diagnostic Testing (Includes but not limited to PET Scans, CT Scans, Nuclear Cardiology Studies, MRI, Computerized Topography/Angiography)	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
Outpatient Laboratory Services	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
Outpatient Services	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
Urgent Care Facility Visits	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
Ambulance/Emergency Transportation (Ground or Air)	Deductible plus 20% Coinsurance	Deductible plus 20% Coinsurance
Emergency Room Services	Deductible plus 20% Coinsurance	Deductible plus 20% Coinsurance
Home Health Care² (Services must be pre-approved by health plan.)	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
Hospice Care² (Services must be pre-approved by health plan.)	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
Outpatient Short-Term Therapy <ul style="list-style-type: none"> ▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy <p><i>Limited to 20 visits per Condition</i></p>	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance

Covered Services	Cost to Member When Receiving Services from Network Providers	Cost to Member When Receiving Services from Non Network Providers ¹
Rehabilitation Services <ul style="list-style-type: none"> ▪ Inpatient <i>Limited to 20 days per Calendar Year</i> ▪ Partial Day Programs (4 hours or greater) <i>Limited to 20 visits per Calendar Year</i> ▪ Outpatient (Pulmonary, Cardiac) <i>Limited to 20 visits per Condition</i> 	Deductible plus 20% Coinsurance Deductible plus 20% Coinsurance Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance Deductible plus 50% Coinsurance Deductible plus 50% Coinsurance
Chiropractic Services / Spinal Manipulation <i>Limited to 26 visits per Calendar Year</i>	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
Durable Medical Equipment (DME) <i>Limited to \$1,000 per Calendar Year</i>	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
Prosthetic Devices <i>Limited to \$1,000 per Calendar Year</i>	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
Orthotic Devices <i>Limited to \$1,000 per Calendar Year</i>	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
Allergy Testing, Shots & Antigen Administration (desensitization/ treatment)	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
Infertility (includes diagnosis and diagnostic surgical treatment only) <i>Limited to \$2,000 per Calendar Year</i>	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance

Covered Services	Cost to Member When Receiving Services from Network Providers	Cost to Member When Receiving Services from Non Network Providers ¹
Mental Illness, Alcoholism, Drug Abuse or Substance Use <ul style="list-style-type: none"> ▪ Inpatient Services ▪ Outpatient Services ▪ Office Visits ▪ Group Therapy Sessions 	Same as Medical	Same as Medical
Formula & Low Protein Modified Foods for PKU & Amino Acid Disease <i>Limited to \$5,000 per Calendar Year</i>	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
Human Leukocyte Antigen Testing <i>Limited to \$75 per Calendar Year</i>	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
Dietician Consultation	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
Prescription Drugs	See Separate Benefit Description	See Separate Benefit Description