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Open Enrollment
Benefits Summary for the State of Kansas

	Cost to member when receiving services from network providers		Cost to member when receiving services from non-network providers	
	Plan A	Plan B	Plan A	Plan B
Annual Plan Deductible	$150 individual/ $300 family	none	$500 individual/$1,500 family	
Coinsurance For All Eligible Expenses (unless otherwise noted)	20% coinsurance	30% coinsurance	50% coinsurance	
Annual Coinsurance Maximum (does not include deductible or copayment)	$1,200 individual/ $2,400 family	$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	
	Plan A	Plan B	Plan A	Plan B
Preventive Care				
• Well Woman Exam	none		not covered	
• Mammograms	none		not covered	
• Well Baby and Child Care	none		not covered	
• Well Man Care (annual prostate screening and office visit)	none		not covered	
• Periodic Age Appropriate Physical Exam & Routine Health Screening	none		not covered	
• Routine Vision Exam (refraction for glasses – lenses and frames NOT covered)	none		not covered	
• Routine Hearing Exam (hearing aids NOT covered)	none		not covered	
• Age Appropriate Bone Density Screening	none		not covered	
• Age Appropriate Colonoscopy Screening	none		not covered	

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Covered Services	Cost to member when receiving services from network providers		Cost to member when receiving services from non-network providers	
	Plan A	Plan B	Plan A	Plan B
Immunizations				
• Pediatric	none		covered in full to age six, otherwise deductible plus 50% coinsurance	
• Adult	none		deductible plus 50% coinsurance	
Excludes immunizations for foreign travel				
Physician Care				
• Primary Care Physician Office Visits (PCP) for adult	$20 copayment		deductible plus 50% coinsurance	
• Primary Care Physician Office Visits for children 18 years of age and younger	$20 copayment	$10 copayment	deductible plus 50% coinsurance	
• Specialist Office Visit for adult	$40 copayment		deductible plus 50% coinsurance	
• Specialist Office Visits for children 18 years of age and younger	$40 copayment	$25 copayment	deductible plus 50% coinsurance	
• Dietitian Consultation	deductible plus 20% coinsurance	30% coinsurance	deductible plus 50% coinsurance	
Inpatient Services (services must be pre-approved by health plan)				
Services include semi-private hospital room & board, physician and surgeon services, lab, x-ray, anesthesiology and other facility and ancillary charges	deductible plus 20% coinsurance	30% coinsurance	$600 copayment per admission plus deductible and 50% coinsurance *Copayment does not apply towards annual coinsurance maximum*	
Outpatient Surgery				
• Surgery/Anesthesia/ Assistant Surgeon	deductible plus 20% coinsurance	30% coinsurance	deductible plus 50% coinsurance	
Major Diagnostic Testing				
Includes but not limited to PET scans, CT scans, nuclear cardiology studies, MRI, computerized topography/angiography	deductible plus 20% coinsurance	30% coinsurance	deductible plus 50% coinsurance	
Outpatient Services				
Not listed elsewhere	deductible plus 20% coinsurance	30% coinsurance	deductible plus 50% coinsurance	
• Telemedicine	deductible plus 20% coinsurance	30% 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	
	Plan A	Plan B	Plan A	Plan B
Outpatient Laboratory Services				
• Preferred LabCard provider	no coinsurance if using the preferred LabCard benefit through Quest Diagnostics		not available	
• Other participating/contracted labs	deductible plus 20% coinsurance	30% coinsurance	deductible plus 50% coinsurance	
Urgent Care Facility Visits				
	$20 copay, deductible plus 20% coinsurance	$20 copay plus 30% coinsurance	deductible plus 50% coinsurance	
	Copay does not apply towards annual coinsurance maximum			
Ambulance/Emergency Transportation (Ground or Air)				
	deductible plus 20% coinsurance	30% coinsurance	deductible plus 20% coinsurance	30% coinsurance
Emergency Room Services (copayment waived if admitted to any hospital within 24 hours)				
	$100 copay, deductible plus 20% coinsurance	$100 copay plus 30% coinsurance	$200 copay plus deductible and 50% coinsurance	
	Copay does not apply towards annual coinsurance maximum			
Home Health Care (services must be pre-approved by health plan)				
	deductible plus 20% coinsurance	30% coinsurance	deductible plus 50% coinsurance	
Hospice Care (services must be pre-approved by health plan) – *Limited to 6 months*				
	deductible plus 20% coinsurance	30% coinsurance	deductible plus 50% coinsurance	
Rehabilitation Services (including physical medicine)				
• Inpatient and Outpatient Facility	deductible plus 20% coinsurance	30% coinsurance	$600 copayment per admission plus deductible and 50% coinsurance *Copayment does not apply towards annual coinsurance maximum*	
• Office Services	deductible plus 20% coinsurance	30% coinsurance	deductible plus 50% coinsurance	
	Limited to 30 visits per calendar year benefit maximum			
Durable Medical Equipment (DME) (DME greater than $400 must be pre-approved by health plan)				
	deductible plus 20% coinsurance	30% coinsurance	deductible plus 50% coinsurance	
	Limited to $5,000 per calendar year benefit maximum			

Covered Services	Cost to member when receiving services from network providers		Cost to member when receiving services from non-network providers	
	Plan A	Plan B	Plan A	Plan B
Prosthetic Devices & Orthopedic Devices (prosthetics greater than $1,000 must be pre-approved by health plan)				
	deductible plus 20% coinsurance	30% coinsurance	deductible plus 50% coinsurance	
Allergy Testing				
	deductible plus 20% coinsurance	30% coinsurance	deductible plus 50% coinsurance	
Allergy Shots & Antigen Administration (desensitization/treatment)				
	none		deductible plus 50% coinsurance	
Mental Illness, Alcoholism, Drug Abuse or Substance Abuse				
Inpatient Services	same as medical		same as medical	
Outpatient Services	same as medical		same as medical	
Office Visits	$20 copayment		deductible plus 50% coinsurance	
Office Visits for children 18 years of age and under	$20 copayment	$10 copayment	deductible plus 50% coinsurance	
Group Therapy Sessions	$10 copayment		deductible plus 50% coinsurance	

Please note: Maximum benefit limits do not guarantee that all services will be approved to the maximum number allowed under this plan. Payments that are on a percentage basis will be applied to the contracted allowed amount reimbursed to the provider, if applicable.

For more information or if you have any questions about a covered service or limitation, please call:
291-4185 (in Topeka) **1-800-332-0307** (toll free)

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