

<b>State(s) of Issue: Kansas</b>		
<b>Plan: 2011 State Employee Health Plan A</b>		
<b>Plan A Schedule of Benefits</b>	<b>When Receiving Services from Network Providers</b>	<b>When Receiving Services from Non-Network Providers</b>
<b>Annual Plan Deductible</b> Deductible does not apply to preventive care or office visits	\$300 Individual / \$600 Family	\$500 Individual / \$1,500 Family
<b>Coinsurance For All Eligible Expenses</b> (unless otherwise noted)	20% Coinsurance	50% Coinsurance
<b>Annual Coinsurance Maximum</b> (does not include deductible and copayments)	\$1,400 Individual / \$2,800 Family	\$3,650 Individual / \$7300 Family

<b>Covered Services</b>	<b>Cost to Members When Receiving Services from Network Providers</b>	<b>Cost to Members When Receiving Services from Non Network Providers</b>
<b>PREVENTIVE CARE</b>		
<b>Age Appropriate Physical Exam and Routine Health Screening</b>	Limited to one visit or service per year unless otherwise noted	
<b>Well Baby Exams</b> - (includes multiple office visits as specified in benefit description) <ul style="list-style-type: none"> <li>• Includes newborn screenings for: <ul style="list-style-type: none"> <li>○ Congenital hypothyroidism</li> <li>○ Sickle cell disease</li> <li>○ Gonococcal ophthalmia neonatorum</li> <li>○ Phenylketonuria (PKU)</li> <li>○ Hearing Check</li> </ul> </li> </ul>	Covered In Full	Not Covered
<b>Well Child Annual Exam</b> <ul style="list-style-type: none"> <li>• Includes screenings for: <ul style="list-style-type: none"> <li>○ Adolescent Depression</li> <li>○ HIV</li> <li>○ Obesity</li> </ul> </li> <li>• Counseling for: <ul style="list-style-type: none"> <li>○ Healthy Diet</li> <li>○ Obesity/Weight management</li> <li>○ Sexually Transmitted Infections(STI's)</li> <li>○ Chemoprevention for dental caries</li> <li>○ Iron Deficiency</li> </ul> </li> </ul>	Covered In Full	Not Covered

<p><b>Well Woman Annual Exam</b></p> <ul style="list-style-type: none"> <li>• Includes screening for: <ul style="list-style-type: none"> <li>○ Sexually Transmitted Infections (STI's)</li> <li>○ HIV</li> <li>○ Cervical Cancer</li> <li>○ High blood pressure</li> <li>○ Cholesterol</li> <li>○ Diabetes</li> <li>○ Depression</li> <li>○ Osteoporosis</li> <li>○ Colorectal Cancer</li> </ul> </li> <li>• <b>Counseling for:</b> <ul style="list-style-type: none"> <li>○ Alcohol usage</li> <li>○ Aspirin usage</li> <li>○ Breast Cancer Risks/BRCS screening</li> <li>○ Healthy diet</li> <li>○ Obesity/Weight management</li> <li>○ Tobacco usage</li> <li>○ STI's</li> <li>○ Folic Acid intake</li> </ul> </li> </ul>	<p>Covered In Full</p>	<p>Not Covered</p>
<p><b>Well Man Annual Exam</b></p> <ul style="list-style-type: none"> <li>• Includes screenings for: <ul style="list-style-type: none"> <li>○ Prostate exam</li> <li>○ Sexually Transmitted Infections (STI's)</li> <li>○ HIV</li> <li>○ High blood pressure</li> <li>○ Cholesterol</li> <li>○ Diabetes</li> <li>○ Depression</li> <li>○ Colorectal Cancer</li> </ul> </li> <li>• <b>Counseling for:</b> <ul style="list-style-type: none"> <li>○ Alcohol usage</li> <li>○ Aspirin usage</li> <li>○ Healthy diet</li> <li>○ Obesity/Weight management</li> <li>○ Tobacco usage</li> <li>○ STI's</li> </ul> </li> </ul>	<p>Covered In Full</p>	<p>Not Covered</p>

<b>Prenatal Services:</b> <ul style="list-style-type: none"> <li>• Initial screenings for: <ul style="list-style-type: none"> <li>○ Hepatitis B</li> <li>○ Bacteruria</li> <li>○ RH Incompatibility</li> </ul> </li> <li>• Counseling for: <ul style="list-style-type: none"> <li>○ Folic Acid Supplements</li> <li>○ Tobacco usage</li> <li>○ Alcohol usage</li> <li>○ Breast feeding support</li> </ul> </li> <li>• Screenings during pregnancy for: <ul style="list-style-type: none"> <li>○ Iron Deficiency Anemia</li> <li>○ Sexually Transmitted Infections (STI's)</li> </ul> </li> </ul>	Covered In Full	Not Covered
<b>Other Covered Services:</b>		
<b>Age Appropriate Bone Density Screening</b>	Covered In Full	Not Covered
<b>Colonoscopy Screenings</b> (not limited to one)	Covered In Full	Not Covered
<b>Immunizations:</b> <ul style="list-style-type: none"> <li>• Under Age 18</li>   <li>• Over Age 18</li> </ul>	Covered In Full	Covered in full to Age 6, Otherwise Deductible plus 50% Coinsurance
<b>Mammography</b> ( not limited to one)	Covered In Full	Deductible plus 50% Coinsurance
<b>Routine Hearing Exam</b>	Covered In Full	Not Covered
<b>Routine Vision Exam</b>	Covered In Full	Not Covered
<b>Ultrasonography for Aortic Aneurysm</b> <ul style="list-style-type: none"> <li>• Men Age 65 to 75</li> <li>• History of Tobacco use</li> <li>• Once per Lifetime</li> </ul>	Covered In Full	Not Covered
<b>Medical Treatment</b>		
<b>Inpatient Services</b> (Services must be pre-approved by health plan.)	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
<b>Outpatient Services</b>	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance

<b>Office Visits</b> - Not subject to Deductible <ul style="list-style-type: none"> <li>• <b>Primary Care Provider (PCP) Office Visits</b></li> <li>• <b>Specialist Office Visits</b></li> </ul>	\$25 Copayment  \$45 Copayment	Deductible plus 50% Coinsurance  Deductible plus 50% Coinsurance
<b>Allergy Testing</b>	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
<b>Allergy Shot &amp; Antigen Administration</b> Desensitization/Treatment	Covered In Full	Deductible plus 50% Coinsurance
<b>Ambulance/Emergency Transportation</b> Ground or Air	Deductible plus 20% Coinsurance	Deductible plus 20% Coinsurance
<b>Autism Services</b> Services must be pre-approved by health plan.	See Separate Rider	See Separate Rider
<b>Dietician Consultation</b>	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
<b>Durable Medical Equipment(DME)</b> Any charges exceeding \$400 require pre-approval by health plan Limited to \$5000 per Calendar Year	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
<b>Durable Medical Equipment(DME) Repairs</b> Any charges exceeding \$400 require pre-approval by health plan Limited to \$2,500 per Calendar Year	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
<b>Emergency Room Services</b> Copayment waived if admitted into any hospital within 24 hours.	\$100 Copayment Deductible plus 20% Coinsurance	\$100 Copayment Deductible plus 20% 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. Limited to 6 months	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
<b>Intravenously Administered or Injected Anti-Cancer Medication</b>	See Separate Rider	See Separate Rider
<b>Major Diagnostic Testing</b> (Includes but is not limited to PET Scans, CT Scans, Nuclear Cardiology Studies, MRI, Computerized Topography/Angiography)	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance
<b>Manipulation Therapies</b> Limited to 30 visits per year	Deductible plus 20% Coinsurance	Deductible plus 50% Coinsurance

<p><b>Mental Health and Substance Abuse</b></p> <ul style="list-style-type: none"> <li>• Inpatient Services</li> <li>• Outpatient Services</li> <li>• Office Visits – Not subject to the Deductible</li> <li>• Group Therapy Sessions</li> </ul>	<p>Same as Medical</p> <p>Same as Medical</p> <p>\$25 Copayment</p> <p>\$12.50 Copayment</p>	<p>Same as Medical</p> <p>Same as Medical</p> <p>Deductible plus 50% Coinsurance</p> <p>Deductible plus 50% Coinsurance</p>
<p><b>Outpatient Laboratory Services</b></p> <ul style="list-style-type: none"> <li>• Quest Laboratory Services</li> <li>• Other Laboratory Providers</li> </ul>	<p>Covered in Full</p> <p>Deductible plus 20% Coinsurance</p>	<p>Not Applicable</p> <p>Deductible plus 50% Coinsurance</p>
<p><b>Outpatient Surgery</b> Surgery/Anesthesia/Assistant Surgeon</p>	<p>Deductible plus 20% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p>
<p><b>Prosthetic Devices</b> Any charges exceeding \$1,000 require prior approval by the health plan</p>	<p>Deductible plus 20% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p>
<p><b>Rehabilitation Services</b></p> <ul style="list-style-type: none"> <li>• Inpatient Facility Services</li> <li>• Outpatient Facility Services</li> <li>• Office Services</li> </ul>	<p>Deductible plus 20% Coinsurance</p> <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>Deductible plus 50% Coinsurance</p>
<p><b>Urgent Care Facility Visits</b></p>	<p>\$25 Copayment plus Deductible &amp; 20% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p>