

State(s) of Issue: Kansas		
Plan: 2011 State Employee Health Plan B		
PLAN B Schedule of Benefits	When Receiving Services from Network Providers	When Receiving Services from Non-Network Providers
Annual Plan Deductible Deductible does not apply to preventive care or office visits	\$150 Individual / \$300 Family	\$500 Individual / \$1,500 Family
Coinsurance For All Eligible Expenses (unless otherwise noted)	35% Coinsurance	50% Coinsurance
Annual Coinsurance Maximum (does not include deductible and copayments)	\$3,000 Individual / \$6,000 Family	\$3,650 Individual / \$7300 Family

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

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

Prenatal Services: <ul style="list-style-type: none"> • Initial screenings for: <ul style="list-style-type: none"> ○ Hepatitis B ○ Bacteruria ○ RH Incompatibility • Counseling for: <ul style="list-style-type: none"> ○ Folic Acid Supplements ○ Tobacco usage ○ Alcohol usage ○ Breast feeding support • Screenings during pregnancy for: <ul style="list-style-type: none"> ○ Iron Deficiency Anemia ○ Sexually Transmitted Infections (STI's) 	Covered In Full	Not Covered
Other Covered Services:		
Age Appropriate Bone Density Screening	Covered In Full	Not Covered
Colonoscopy Screenings (not limited to one)	Covered In Full	Not Covered
Immunizations: <ul style="list-style-type: none"> • Under Age 18 • Over Age 18 	Covered In Full	Covered in full to Age 6, Otherwise Deductible plus 50% Coinsurance
Mammography (not limited to one)	Covered In Full	Deductible plus 50% Coinsurance
Routine Hearing Exam	Covered In Full	Not Covered
Routine Vision Exam	Covered In Full	Not Covered
Ultrasonography for Aortic Aneurysm <ul style="list-style-type: none"> • Men Age 65 to 75 • History of Tobacco use • Once per Lifetime 	Covered In Full	Not Covered
Medical Treatment		
Inpatient Services (Services must be pre-approved by health plan.)	Deductible plus 35% Coinsurance	Deductible plus 50% Coinsurance
Outpatient Services	Deductible plus 35% Coinsurance	Deductible plus 50% Coinsurance

<p>Office Visits - Not subject to Deductible</p> <ul style="list-style-type: none"> • Adult Primary Care Provider (PCP) Office Visits • PCP Office Visits for Children Age 18 and under • Adult Specialist Office Visits • Specialist Office Visits for Children Age 18 and under 	<p>\$20 Copayment</p> <p>\$10 Copayment</p> <p>\$40 Copayment</p> <p>\$25 Copayment</p>	<p>Deductible plus 50% Coinsurance</p> <p>Deductible plus 50% Coinsurance</p> <p>Deductible plus 50% Coinsurance</p> <p>Deductible plus 50% Coinsurance</p>
<p>Allergy Testing</p>	<p>Deductible plus 35% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p>
<p>Allergy Shot & Antigen Administration Desensitization/Treatment</p>	<p>Covered In Full</p>	<p>Deductible plus 50% Coinsurance</p>
<p>Ambulance/Emergency Transportation Ground or Air</p>	<p>Deductible plus 35% Coinsurance</p>	<p>Deductible plus 35% Coinsurance</p>
<p>Autism Services Services must be pre-approved by health plan.</p>	<p>See Separate Rider</p>	<p>See Separate Rider</p>
<p>Dietician Consultation</p>	<p>Deductible plus 35% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p>
<p>Durable Medical Equipment(DME) Any charges exceeding \$400 require pre-approval by health plan Limited to \$5000 per Calendar Year</p>	<p>Deductible plus 35% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p>
<p>Durable Medical Equipment(DME) Repairs Any charges exceeding \$400 require pre-approval by health plan Limited to \$2,500 per Calendar Year</p>	<p>Deductible plus 35% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p>
<p>Emergency Room Services Copayment waived if admitted into any hospital within 24 hours.</p>	<p>\$100 Copayment, Deductible plus 35% Coinsurance</p>	<p>\$100 Copayment, Deductible plus 35% Coinsurance</p>
<p>Home Health Care Services must be pre-approved by health plan.</p>	<p>Deductible plus 35% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p>
<p>Hospice Care Services must be pre-approved by health plan. Limited to 6 months</p>	<p>Deductible plus 35% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p>
<p>Intravenously Administered or Injected Anti-Cancer Medication</p>	<p>See Separate Rider</p>	<p>See Separate Rider</p>
<p>Major Diagnostic Testing (Includes but is not limited to PET Scans, CT Scans, Nuclear Cardiology Studies, MRI, Computerized Topography/Angiography)</p>	<p>Deductible plus 35% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p>
<p>Manipulation Therapies Limited to 30 visits per year</p>	<p>Deductible plus 35% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p>

<p>Mental Health and Substance Abuse</p> <ul style="list-style-type: none"> • Inpatient Services • Outpatient Services • Office Visits – Not subject to the Deductible <ul style="list-style-type: none"> ○ Adult ○ Children Age 18 and under ○ Group Therapy Sessions 	<p>Same as Medical</p> <p>Same as Medical</p> <p>\$20 Copayment</p> <p>\$10 Copayment</p> <p>\$10 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>Deductible plus 50% Coinsurance</p>
<p>Outpatient Laboratory Services</p> <ul style="list-style-type: none"> • Quest Laboratory Services • Other Laboratory Providers 	<p>Covered in Full</p> <p>Deductible plus 35% Coinsurance</p>	<p>Not Applicable</p> <p>Deductible plus 50% Coinsurance</p>
<p>Outpatient Surgery Surgery/Anesthesia/Assistant Surgeon</p>	<p>Deductible plus 35% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p>
<p>Prosthetic Devices Any charges exceeding \$1,000 require prior approval by the health plan</p>	<p>Deductible plus 35% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p>
<p>Rehabilitation Services</p> <ul style="list-style-type: none"> • Inpatient Facility Services • Outpatient Facility Services • Office Services 	<p>Deductible plus 35% Coinsurance</p> <p>Deductible plus 35% Coinsurance</p> <p>Deductible plus 35% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p> <p>Deductible plus 50% Coinsurance</p> <p>Deductible plus 50% Coinsurance</p>
<p>Urgent Care Facility Visits</p>	<p>\$25 Copayment plus Deductible & 35% Coinsurance</p>	<p>Deductible plus 50% Coinsurance</p>