

Health insurance the Kansas Way

2023 Open Enrollment Guide for the State of Kansas



2023 State of Kansas benefit summary

Cost to member when receiving services from network providers	Plan A	Plan C ^{1,2}	Plan N ^{1,2}	Plan J ¹
Annual plan deductible	\$800 employee \$1,600 family	\$2,750 employee \$5,500 family	\$2,750 employee \$5,500 family	\$500 employee \$1,000 family
Coinsurance for all eligible expenses (unless otherwise noted)	20%	10%	35%	25%
Annual out-of-pocket maximum (includes deductible, coinsurance and copayment) – Combined medical/drug	\$5,250 individual \$10,500 family	\$4,500 individual \$9,000 family	\$6,650 individual \$13,300 family	\$7,350 individual \$14,700 family
Lifetime benefit maximum	None	None	None	None

Cost to member when receiving services from non network providers	Plan A	Plan C ^{1,2}	Plan N ^{1,2}	Plan J ¹
Annual plan deductible	\$800 employee \$1,600 family	\$2,750 employee \$3,000/\$5,500 employee/family	\$2,750 employee \$3,000/\$5,500 employee/family	\$1,000 employee \$2,000 family
Coinsurance for all eligible expenses (unless otherwise noted)	50%	50%	50%	50%
Annual out-of-pocket maximum (includes deductible, coinsurance and copayment) – Combined medical/drug	\$5,250 individual \$10,500 family	\$4,500 individual \$9,000 family	\$6,650 individual \$13,300 family	\$10,000 individual \$20,000 family
Lifetime benefit maximum	None	None	None	None

Note: When receiving services from non network providers, you may be responsible for additional out-of-pocket expenses for balances over allowed charges.

¹ HRA/HSA eligible

² Plan C and N: The deductible for all “non-single” policies (employee/spouse, employee/children, employee/family) will be \$3,000 for an individual within the family. However, the overall family deductible for these policies will remain at \$5,500.

This information is a general overview of the Medical Benefit. For additional benefits and limitation regarding the Medical Benefit, please refer to the Plan Description.



	Cost to member when receiving services from network providers		Cost to member when receiving services from non network providers	
	Plan A	Plans C, N & J	Plan A	Plans C, N & J
Preventive Care				
Well woman exam		None		Deductible plus coinsurance
Mammograms		None		Deductible plus coinsurance
Well baby and child care		None		Deductible plus coinsurance
Well man care		None		Deductible plus coinsurance
Routine vision exam (refraction for glasses; lenses and frames not covered)		None		Deductible plus coinsurance
Routine hearing exam (hearing aids not covered)		None		Deductible plus coinsurance
Age appropriate bone density screening		None		Deductible plus coinsurance
Colonoscopy screening		None		Deductible plus coinsurance
Preventive lab services		None		Deductible plus coinsurance
Immunizations				
Pediatric		None		Covered in full to age six, otherwise deductible plus coinsurance
Adult		None		Deductible plus coinsurance
Physician Care				
Primary care physician (PCP) office visit	\$20 copayment		Deductible plus coinsurance	Deductible plus coinsurance
Specialist office visit	\$40 copayment		Deductible plus coinsurance	Deductible plus coinsurance
Telemedicine visit - AmWell	\$10 copayment		Deductible plus coinsurance	Deductible plus coinsurance
Inpatient services				
Services must be pre-approved by health plan. Services include: semi-private hospital room and board, physician and surgeon services, lab, x-ray, anesthesiology, and other facility and ancillary charges			Deductible plus coinsurance	Deductible plus coinsurance
Outpatient surgery				
Surgery/anesthesia/assistant surgeon			Deductible plus coinsurance	Deductible plus coinsurance
Outpatient services				
Not listed elsewhere			Deductible plus coinsurance	Deductible plus coinsurance

	Cost to member when receiving services from Network providers		Cost to member when receiving services from Non Network providers	
	Plan A	Plans C, N & J	Plan A	Plans C, N & J
Outpatient laboratory services				
Preferred lab benefit	No cost to member if using preferred lab vendor	Discounts to member if using preferred lab vendor while satisfying deductible; no cost to member if using preferred lab vendor after deductible is satisfied	Not available	
Other labs	Deductible plus coinsurance		Deductible plus coinsurance	
Urgent care facility visits				
	\$50 copayment	Deductible plus coinsurance	Deductible plus coinsurance	
Ambulance/emergency transportation				
Domestic ground or air	Deductible plus coinsurance		Network deductible plus coinsurance	
Emergency room services				
Copayment waived if admitted to any hospital within 24 hours	\$100 copay, deductible plus coinsurance	Deductible plus coinsurance	\$100 copay, deductible plus coinsurance	Network deductible plus coinsurance
Home health care and hospice Care				
Services must be pre-approved by health plan. Inpatient hospice care is limited to 6 months.	Deductible plus coinsurance		Deductible plus coinsurance	
Rehabilitation services (including physical medicine)				
Inpatient and outpatient facility	Deductible plus coinsurance		Deductible plus coinsurance	
Office services – office visit copayment may apply if an office visit is billed. Spinal manipulations are limited to 30 visits per calendar year.	Deductible plus coinsurance		Deductible plus coinsurance	
Durable medical equipment (DME)				
DME greater than \$750 must be pre-approved by health plan	Deductible plus coinsurance		Deductible plus coinsurance	
Prosthetic devices and orthopedic devices				
Prosthetics greater than \$1,000 must be pre-approved by health plan	Deductible plus coinsurance		Deductible plus coinsurance	

	Cost to member when receiving services from network providers		Cost to member when receiving services from non network providers	
	Plan A	Plans C, N & J	Plan A	Plans C, N & J
Mental illness, alcoholism, drug abuse and substance abuse				
Inpatient services	Same as medical		Same as medical	
Outpatient services	Same as medical		Same as medical	
Office visits	\$20 copayment	Deductible plus coinsurance	Deductible plus coinsurance	
Group therapy sessions	\$20 copayment	Deductible plus coinsurance	Deductible plus coinsurance	
Autism services				
Subject to limitations and pre-approval	Deductible plus coinsurance		Deductible plus coinsurance	
Bariatric surgery				
Subject to limitations and pre-approval	Deductible plus coinsurance		Not covered	

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.



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Gall bladder removal	up to \$250
Hip or knee replacement	up to \$500

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