

Kansas City Public School Retirement System - Humana Group Medicare Plans

Description of Service	PPO In Network	PPO Out of Network	PFFS	HMO
<u>Inpatient Hospital Services - All Authorized Admissions</u>				
Medical / Surgical Facility	\$175/day (DAYS 1-5)	\$950 per admission without pre-notification \$900 per admission with pre-notification	\$180/day 1-5	Hospital \$250 / day (Days 1 - 5)
Psychiatric Services (190 Day Lifetime Limit on all Inpatient Psychiatric Care)	\$175/day (DAYS 1-5)	\$950 per admission	\$180/day 1-5	Hospital \$250 / day (Days 1 - 5)
<u>Skilled Nursing Facility</u>				
3 Day Prior Hospital Stay	Not Required	Not Required	Not Required	Not Required
Days 1 - 100	\$75/DAY (DAYS 14-100)	15% Coinsurance	\$90/day 4-100	\$75 Copay per day (days 21 - 100)
<u>Outpatient Therapies</u>				
Cardiac, Occupational, Physical, Respiratory, Audiology & Speech Therapies	\$35 copay Specialist or Independent Therapist \$40 copay CORF \$15 copay Cardiac Rehab - Outpatient Hospital \$50 copay Outpatient Hospital	15% coinsurance Specialist or Independent Therapist 15% coinsurance CORF 15% coinsurance Cardiac Rehab - Outpatient Hospital 15% coinsurance Outpatient Hospital	20% coinsurance	\$25 Copay - Specialist or Independent Therapist \$25 Copay-CORF \$100 copay - Outpatient Hospital
<u>Emergency Care / Post Stabilization / Urgent Care</u>				
Emergency Room (Worldwide Coverage)	\$50 Copay (waived if admitted w/in 24 hours)	\$50 Copay (waived if admitted w/in 24 hours)	20% coinsurance up to a \$50 max	\$50 Copay (waived if admitted w/in 24 hours)
Immediate Care Facility (In Network) No Referral Required	\$35 Copay	15% Coinsurance	20% coinsurance	\$25 Copay
Urgently Needed Care (Out of Area)	\$10 PCP Office Visit Copay \$35 Specialist Office Visit Copay \$35 Immediate Care Facility Copay	15% Coinsurance PCP Office Visit 15% Coinsurance Specialist Office Visit 15% Coinsurance Immediate Care Facility	20% coinsurance \$15 PCP Office Visit Copay \$30 SPC Office Visit Copay	\$25 Copay - Specialist
Worldwide Coverage (Foreign Travel Benefit) (Combined for all Emergency/Urgent Care)	\$250 deductible, 20% coinsurance, \$25,000 maximum annual benefit or 60 consecutive days, whichever is reached first	\$250 deductible, 20% coinsurance, \$25,000 maximum annual benefit or 60 consecutive days, whichever is reached first	\$250 deductible, 20% coinsurance, \$25,000 maximum annual benefit or 60 consecutive days, whichever is reached first	Coverage for Emergency Care
<u>Mental & Nervous Services</u>				
Physician Services, Outpatient Services, Partial Hospitalization, Outpatient Substance Abuse, Specialty Services Non-Physician, Hospital Outpatient	\$35 Office Visit Copay Specialist \$35 Partial Hospitalization Copay \$50 Outpatient Hospital Copay	15% Coinsurance Specialist Office Visit 15% Coinsurance Partial Hospitalization 15% Outpatient Hospital	\$15 PCP Office Visit Copay \$30 SPC Office Visit Copay 20% coinsurance 20% Outpatient Hospital Coinsurance	\$25 Copay Specialist \$25 Copay Partial Hospitalization \$100 Copay Hospital Outpatient
<u>Home Health</u>				
Home Health Services	\$10	15% Coinsurance	No Copay (per date of service)	\$0 Copay (per date of service)
Personal Home Care	No Benefit	No Benefit	Not Covered	No Coverage
<u>Outpatient Facility Services</u>				
Ambulatory Surgical Center (ASC)	\$100 Copay	15% Coinsurance	20% coinsurance	\$150 Copay
Freestanding Laboratory	\$0 Copay	15% Coinsurance	20% coinsurance	\$0 Copay
Freestanding Radiology Facility	\$100 copay Advanced Imaging \$100 copay Nuclear Medicine \$30 copay Screening Mammogram \$30 copay Diagnostic Mammogram \$30 copay Other	15% Coinsurance	20% coinsurance	\$0 Copay

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Outpatient Hospital	\$150 copay Surgical \$50 copay Observation \$100 copay Advanced Imaging \$100 copay Nuclear Medicine \$50 copay Screening Mammogram \$15 copay Cardiac Rehab \$50 copay Diabetic Education \$50 copay Nutritional Therapy \$50 copay Other	15% Coinsurance	20% coinsurance	\$200 Copay - Surgical \$100 Copay - Non-Surgical/Advanced Imaging / Other \$0 Copay - Basic Radiological Services and Lab Services
<u>Outpatient Clinical / Diagnostic / Therapeutic Radiological Lab</u>				
Outpatient Clinical / Diagnostic / Therapeutic Radiological Lab Services	\$10 copay Office Visit PCP \$35 copay Office Visit Specialist \$0 copay Freestanding Laboratory \$30 copay Freestanding Radiology Facility \$50 copay Outpatient Hospital	15% Coinsurance	\$15 PCP Office Visit Copay \$30 SPC Office Visit Copay 20% Freestanding Radiology Facility 20% Outpatient Hospital Coinsurance	\$10 Copay - PCP \$25 Copay - Specialist \$25 Copay - CORF \$0 copay - Outpatient Hospital
Outpatient X-Rays	\$10 Office Visit Copay PCP \$35 Office Visit Copay Specialist \$100 copay Freestanding Radiology - Advanced Imaging \$100 copay Freestanding Radiology - Nuclear Medicine \$30 copay Freestanding Radiology - Screening Mammogram \$30 copay Freestanding Radiology - Other \$100 Outpatient Hospital - Advanced Imaging \$100 Outpatient Hospital - Nuclear Medicine	15% Coinsurance	\$15 PCP Office Visit Copay \$30 SPC Office Visit Copay 20% Freestanding Radiology/Facility Coinsurance 20% Outpatient Hospital Coinsurance	\$10 Copay - PCP \$25 Copay - Specialist \$0 copay - Freestanding Radiology Facility \$100 copay - Non-Surgical / Advanced Imaging / Other \$0 copay - Basic Radiological Services and Lab Services
<u>Health Care Professional Services - Physician Office</u>				
Primary Care Physician (PCP)	\$10 Office Visit Copay	15% Coinsurance	\$15 PCP Office Visit Copay	\$10 Office Visit Copay
Specialist	\$35 Office Visit Copay	15% Coinsurance	\$30 SPC Office Visit Copay	\$25 Office Visit Copay
Chiropractic Services (Medicare-Covered Services Only)	\$35 Office Visit Copay	15% Coinsurance	\$30 Office Visit Copay	\$25 Office Visit Copay
Chiropractic Services - Routine	No Benefit	No Benefit	No Benefit	No Coverage
Podiatry Services (Medicare-Covered Services Only)	\$35 Office Visit Copay	15% Coinsurance	\$30 Office Visit Copay	\$25 Office Visit Copay
Podiatry Services - Routine	No Benefit	No Benefit	No Benefit	No Coverage
<u>Health Care Professional Services</u>				
Other Health Care Professional Services, Outpatient Blood & Blood Component	\$10 Office Visit Copay PCP \$35 Office Visit Copay Specialist \$50 Copay Outpatient Hospital	15% Coinsurance	\$15 PCP Office Visit Copay \$30 SPC Office Visit Copay 20% Freestanding Radiology Facility Coinsurance 20% Outpatient Hospital Coinsurance	\$10 Copay - PCP \$25 Copay - Specialist \$25 Copay - CORF No Copay - Freestanding Radiology Facility \$100 Copay - Outpatient Hospital
Drugs Administered in Physicians Office (4)	15% Coinsurance in addition to applicable office visit copay	15% Coinsurance in addition to applicable office visit copay	20% Coinsurance	0% Coinsurance. \$0 Copay.

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Renal Dialysis Services	\$0 Copay Renal Dialysis Center \$50 Copay Outpatient Hospital	\$0 Copay Renal Dialysis Center \$50 Copay Outpatient Hospital	20% coinsurance Place of treatment copay does not apply	\$0 Copay - Dialysis Center \$25 Copay - Specialist \$100 Copay - Outpatient Hospital
Preventive / Training Services				
Bone Mass Measurement (1 per year), Colorectal Screening (1 per year)	\$10 Office Visit Copay PCP \$35 Office Visit Copay Specialist \$30 Copay Freestanding Radiology Facility \$50 Copay Outpatient Hospital \$150 Copay Outpatient Hospital Surgical	15% Coinsurance	\$0 Copay for exam/screening service	\$10 Copay - PCP \$25 Copay - Specialist \$25 Copay - CORF \$0 Copay - Freestanding Radiology Facility \$100 Copay - Outpatient Hospital-Other Services \$200 Copay - Outpatient Hospital Surgical \$0 Copay - Basic Radiological Services and Lab Services
Diabetes Self Mgmt. (1 per year), Nutritional Therapy (Diabetic or ESRD Patients)	\$10 Office Visit Copay PCP \$35 Office Visit Copay Specialist \$30 Copay Freestanding Radiology Facility \$50 Copay Outpatient Hospital \$150 Copay Outpatient Hospital Surgical	15% Coinsurance	\$0 Copay for exam/screening service	\$10 Copay - PCP \$25 Copay - Specialist \$25 Copay - CORF \$0 Copay - Freestanding Radiology Facility \$100 Copay - Outpatient Hospital-Other Services \$200 Copay - Outpatient Hospital Surgical \$0 Copay - Basic Radiological Services and Lab Services
Pap Smears & Pelvic Exams Screenings (1 per year),	\$10 Office Visit Copay PCP \$35 Office Visit Copay Specialist \$30 Copay Freestanding Radiology Facility \$50 Copay Outpatient Hospital \$150 Copay Outpatient Hospital Surgical	15% Coinsurance	\$0 Copay for exam/screening service	\$10 Copay - PCP \$25 Copay - Specialist \$25 Copay - CORF \$0 Copay - Freestanding Radiology Facility \$100 Copay - Outpatient Hospital-Other Services \$200 Copay - Outpatient Hospital Surgical \$0 Copay - Basic Radiological Services and Lab Services
Prostrate Cancer Screening (1 per year)	\$10 Office Visit Copay PCP \$35 Office Visit Copay Specialist \$30 Copay Freestanding Radiology Facility \$50 Copay Outpatient Hospital \$150 Copay Outpatient Hospital Surgical	15% Coinsurance	\$0 Copay for exam/screening service	\$10 Copay - PCP \$25 Copay - Specialist \$25 Copay - CORF \$0 Copay - Freestanding Radiology Facility \$100 Copay - Outpatient Hospital-Other Services \$200 Copay - Outpatient Hospital Surgical \$0 Copay - Basic Radiological Services and Lab Services

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Immunizations (1 per year) PCP/Specialist Office Visit Copay applies only if other services are provided	\$10 Office Visit Copay PCP \$35 Office Visit Copay Specialist	15% Coinsurance	\$0 Copay	\$0 Copay
Routine Physical Exams (One per Year)	\$10 Office Visit Copay PCP \$35 Office Visit Copay Specialist \$30 Copay Freestanding Radiology Facility \$50 Copay Outpatient Hospital \$150 Copay Outpatient Hospital Surgical	15% Coinsurance	\$0 Copay for routine physical exam	\$10 Copay - PCP \$25 Copay - Specialist \$25 Copay - CORF \$0 Copay - Freestanding Radiology Facility \$100 Copay - Outpatient Hospital-Other Services \$200 Copay - Outpatient Hospital Surgical \$0 Copay - Basic Radiological Services and Lab Services
<u>Ambulance Services (Medicare-Covered Services)</u>				
Ambulance - Emergency Transport	\$100 Copay (per date of service)	\$100 Copay (per date of service)	20% coinsurance	\$75 Copay per Date of Service
Transportation (Non-Medicare Covered)	No Benefit	No Benefit	No Coverage	No Coverage
<u>Durable Medical Equipment, Prosthetics, Orthotics & Other Medical Supplies</u>				
DME	20% Coinsurance	40% Coinsurance	20% Coinsurance	Member Pays 20% Coinsurance. No Copay
Medical Supplies	20% Coinsurance	40% Coinsurance	20% Coinsurance	Member Pays 20% Coinsurance. No Copay
Prosthetics	20% Coinsurance	40% Coinsurance	20% Coinsurance	Member Pays 20% Coinsurance. No Copay
Diabetic Monitoring Supplies (2)	20% Coinsurance	20% Coinsurance Non network Pharmacy 40% Coinsurance Non network DME provider	20% Coinsurance	See Group Rx Options
<u>Outpatient Drugs & Biologicals / Prescription Drug</u>				
Retail Pharmacy - Up to a 30 Day Supply Co-pays from \$0 to \$2,400.00	Level 1-\$10 Level 2-\$20 Level 3-\$40 Level 4-25%	Level 1-\$10 Level 2-\$20 Level 3-\$40 Level 4-25%	Level 1-\$5 Level 2-\$30 Level 3-\$60 Level 4-25%	Level 1-\$5 Level 2-\$30 Level 3-\$60 Level 4-25%
Retail Pharmacy - Up to a 30 Day Supply Co-pays from \$2,401 to \$3,850	Level 1-\$10 Level 2-\$20 Level 3-\$40 Level 4-25%	Level 1-\$10 Level 2-\$20 Level 3-\$40 Level 4-25%	Level 1-4 100%	Level 1-4 100%
Retail Pharmacy - Up to a 30 Day Supply Co-pays from \$3,850 to unlimited	Level 1 & 2-\$2.15 Level 3 & 4- \$5.15 or 5%	Level 1 & 2-\$2.15 Level 3 & 4- \$5.15 or 5%	Level 1 & 2-\$2.15 Level 3 & 4- \$5.15 or 5%	Level 1 & 2-\$2.15 Level 3 & 4- \$5.15 or 5%
Mail Order - Up to a 90 Day Supply	2X-Levels 1-3	2X-Levels 1-3	2X-Levels 1-3	2X-Levels 1-3
<u>Dental</u>				
Medicare-Covered Services	\$35 Specialist Copay for exam	15% Coinsurance Specialist Office Visit	\$30 Specialist Copay for exam	\$25 Copay - Exam by Specialist
Routine Services	No Benefit	No Benefit	No Benefit	No Benefit
<u>Eye Exams / Eyewear</u>				
Medicare-Covered Services	\$35 Specialist Copay for exam (No copay for eyewear following cataract surgery)	15% Coinsurance Specialist Office Visit (No copay for eyewear following cataract surgery)	\$30 Copay for each Medicare covered exam & eyewear only	\$25 Copay - Exam by Specialist
Routine Services	No Benefit	No Benefit	No Benefit	No Coverage
<u>Hearing Exams / Hearing Aids</u>				

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Medicare-Covered Services	\$35 Specialist Copay for exam	15% Coinsurance Specialist Office Visit	\$30 Specialist Copay for exam	\$25 Copay - Exam by Specialist
Routine Services & Hearing Aids	No Benefit	No Benefit	No Benefit	No Coverage
<u>Value Added Items & Services</u>				
EyeMed Vision Discount	Available	Not Available	Available	Available
Rx Discount Program	Available	Not Available	Available	Available
<u>Annual Out of Pocket Maximum</u>	None	None	\$5,000	\$2,500