40-2123. Same; expenses and services covered under plan; exclusions; plan not subject to coverages mandated by other laws. (a) The plan shall offer coverage to every eligible person pursuant to which such person's covered expenses shall be indemnified or reimbursed subject to the provisions of K.S.A. 40-2124, and amendments thereto.

(b) Except for those expenses set forth in subsection (c) of this section, expenses covered under the plan shall include expenses for:

(1) Services of persons licensed to practice medicine and surgery which are medically necessary for the diagnosis or treatment of injuries, illnesses or conditions;

(2) services of advanced registered nurse practitioners who hold a certificate of qualification from the board of nursing to practice in an expanded role or physicians assistants acting under the direction of a supervising physician when such services are provided at the direction of a person licensed to practice medicine and surgery and meet the requirements of paragraph (b)(1) above;

(3) services of licensed dentists when such procedures would otherwise be performed by persons licensed to practice medicine and surgery;

(4) emergency care, surgery and treatment of acute episodes of illness or disease as defined in the plan and provided in a general hospital or ambulatory surgical center as such terms are defined in K.S.A. 65-425, and amendments thereto;

(5) medically necessary diagnostic laboratory and x-ray services;

(6) drugs and controlled substances prescribed by a practitioner, as defined in K.S.A. 65-1626, and amendments thereto, or drugs and controlled substances prescribed by a mid-level practitioner as defined in K.S.A. 65-1626, and amendments thereto. Coverage for outpatient prescriptions shall be subject to a mandatory 50% coinsurance provision, and coverage for prescriptions administered to inpatients shall be subject to a coinsurance provision as established in the plan; and

(7) subject to the approval of the commissioner, the board shall also review and recommend the inclusion of coverage for mental health services and such other primary and preventive health care services as the board determines would not materially impair affordability of the plan.

(c) Expenses not covered under the plan shall include expenses for:

(1) Illness or injury due to an act of war;

(2) services rendered prior to the effective date of coverage under this plan for the person on whose behalf the expense is incurred;

(3) services for which no charge would be made in the absence of insurance or for which the insured bears no legal obligation to pay;

(4) (A) services or charges incurred by the insured which are otherwise covered by:

(i) Medicare or state law or programs;

(ii) medical services provided for members of the United States armed forces and their dependents or for employees of such armed forces;

(iii) military service-connected disability benefits;

(iv) other benefit or entitlement programs provided for by the laws of the United States (except title XIX of the social security act of 1965);

(v) workers compensation or similar programs addressing injuries, diseases, or conditions incurred in the course of employment covered by such programs;

(vi) benefits payable without regard to fault pursuant to any motor vehicle or other liability insurance policy or equivalent self-insurance.

(B) This exclusion shall not apply to services or charges which exceed the benefits payable under the applicable programs listed above and which are otherwise eligible for payment under this section.

(5) Services the provision of which is not within the scope of the license or certificate of the institution or individual rendering such service;

(6) that part of any charge for services or articles rendered or prescribed which exceeds the rate established by K.S.A. 40-2131, and amendments thereto, for such services;

(7) services or articles not medically necessary;

(8) care which is primarily custodial or domiciliary in nature;

(9) cosmetic surgery unless provided as the result of an injury or medically necessary surgical procedure;

(10) eye surgery if corrective lenses would alleviate the problem;

(11) experimental services or supplies not generally recognized as the normal mode of treatment for the illness or injury involved;

(12) service of a blood donor and any fee for failure of the insured to replace the first three pints of blood provided in each calendar year; and

(13) personal supplies or services provided by a health care facility or any other nonmedical or nonprescribed supply or service.

(d) Except as expressly provided for in this act, no law requiring the coverage or the offer of coverage of a health care service or benefit shall apply to the plan.

(e) A plan may incorporate provisions that will direct covered persons to the most appropriate lowest cost health care provider available.

History: L. 1992, ch. 209, § 7; L. 1993, ch. 132, § 5; L. 1997, ch. 184, § 1; L. 1999, ch. 115, § 6; L. 2007, ch. 177, § 28; L. 2014, ch. 131, § 3; July 1, 2015.