

# 2016

## Open Enrollment Benefits Summary for the State of Kansas



	Cost to member when receiving services from Network providers		Cost to member when receiving services from Non Network providers	
	Plan A	Plan C	Plan A	Plan C
<b>Annual Plan Deductible</b>	\$400 individual/ \$800 family	\$2,750 individual/ \$5,500 family	\$600 individual/\$1,800 family	\$2,750 individual/ \$5,500 family
<b>Coinsurance For All Eligible Expenses (unless otherwise noted)</b>	20% coinsurance	N/A	50% coinsurance	20% coinsurance
<b>Annual Out-of-Pocket Maximum (includes deductible, coinsurance and copayment)</b>	\$4,750 individual/ \$9,500 family combined medical and drug	\$2,750 individual/ \$5,500 family combined medical and drug	\$4,750 individual/ \$9,500 family	\$4,100 individual/ \$8,200 family
<b>Lifetime Benefit Maximum</b>	none		none	

For a complete benefit description, please visit [www.bcbsks.com/customerservice/members/state/index.htm](http://www.bcbsks.com/customerservice/members/state/index.htm)

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

Covered Services	Cost to member when receiving services from Network providers		Cost to member when receiving services from Non Network providers	
	Plan A	Plan C	Plan A	Plan C
<b>Preventive Care</b>				
• Well Woman Exam		none		not covered
• Mammograms		none		not covered
• Well Baby and Child Care		none		not covered
• Well Man Care		none		not covered
• Routine Vision Exam (refraction for glasses – lenses and frames NOT covered)		none		not covered
• Routine Hearing Exam (hearing aids NOT covered)		none		not covered
• Age Appropriate Bone Density Screening		none		not covered
• Colonoscopy Screening		none		not covered
• Preventive Lab Services		none		not covered
<b>Immunizations</b>				
• Pediatric		none		Covered in full to age six, otherwise deductible plus coinsurance
• Adult		none		not covered
<b>Physician Care</b>				
• Primary Care Physician Office Visits (PCP)	\$30 copayment		deductible	deductible plus coinsurance
• Specialist Office Visit	\$50 copayment		deductible	deductible plus coinsurance
<b>Inpatient Services (services must be pre-approved by health plan)</b>				
Services include semi-private hospital room & board, physician and surgeon services, lab, x-ray, anesthesiology and other facility and ancillary charges		deductible plus coinsurance	deductible	deductible plus coinsurance

Covered Services	Cost to member when receiving services from Network providers		Cost to member when receiving services from Non Network providers	
	Plan A	Plan C	Plan A	Plan C
<b>Outpatient Surgery</b>				
• Surgery/Anesthesia/Assistant Surgeon	deductible plus coinsurance	deductible	deductible plus coinsurance	
<b>Outpatient Services</b>				
Not listed elsewhere	deductible plus coinsurance	deductible	deductible plus coinsurance	
<b>Outpatient Laboratory Services</b>				
• Preferred lab benefit	no cost to member if using preferred lab vendor	Discounts to member if using preferred lab vendor	not available	
• Other labs	deductible plus coinsurance	deductible	deductible plus coinsurance	
<b>Urgent Care Facility Visits</b>				
	\$50 copay	deductible	deductible plus coinsurance	
<b>Ambulance/Emergency Transportation (Ground or Air)</b>				
	deductible plus coinsurance	deductible	Network deductible plus coinsurance	Network deductible
<b>Emergency Room Services (copayment waived if admitted to any hospital within 24 hours)</b>				
	\$100 copay, deductible plus coinsurance	deductible	\$100 copay, network deductible plus coinsurance	Network deductible
<b>Home Health Care and Hospice Care (services must be pre-approved by health plan – inpatient hospice care is limited to 6 months)</b>				
	deductible plus coinsurance	deductible	deductible plus coinsurance	
<b>Rehabilitation Services (including physical medicine)</b>				
• Inpatient and Outpatient Facility	deductible plus coinsurance	deductible	deductible plus coinsurance	
• Office Services (Office visit copay may apply if an office visit is billed)	deductible plus coinsurance	deductible	deductible plus coinsurance	
	Spinal manipulations limited to 30 visits per calendar year			
<b>Durable Medical Equipment (DME) (DME greater than \$750 must be pre-approved by health plan)</b>				
	deductible plus coinsurance	deductible	deductible plus coinsurance	
<b>Prosthetic Devices &amp; Orthopedic Devices (prosthetics greater than \$1,000 must be pre-approved by health plan)</b>				
	deductible plus coinsurance	deductible	deductible plus coinsurance	
<b>Mental Illness, Alcoholism, Drug Abuse or Substance Abuse</b>				
• Inpatient Services	same as medical		same as medical	
• Outpatient Services	same as medical		same as medical	
• Office Visits	\$30 copayment	deductible	deductible plus coinsurance	
• Group Therapy Sessions	\$15 copayment	deductible	deductible plus coinsurance	
<b>Autism Services (subject to limitations and pre-approval)</b>				
	deductible plus coinsurance	deductible	deductible plus coinsurance	
<b>Bariatric Surgery (subject to limitations and pre-approval)</b>				
	deductible plus coinsurance	deductible	deductible plus coinsurance	

**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.

For more information or if you have any questions about a covered service or limitation, please call:  
**291-4185** (in Topeka)      **1-800-332-0307** (toll free)

For a complete benefit description, please visit [bcbsks.com/customerservice/members/state/index.htm](https://bcbsks.com/customerservice/members/state/index.htm)