

# 2012

## 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 B	Plan C*	Plan A	Plan B	Plan C*
<b>Annual Plan Deductible</b>	\$300 individual/ \$600 family	\$150 individual/ \$300 family	\$1,500 individual/ \$3,000 family	\$500 individual/\$1,500 family		\$2,000 individual/ \$4,000 family
<b>Coinsurance For All Eligible Expenses (unless otherwise noted)</b>	20% coinsurance	35% coinsurance	20% coinsurance	50% coinsurance		
<b>Annual Coinsurance Maximum (does not include deductible or copayment)</b>	\$1,400 individual/ \$2,800 family	\$3,000 individual/ \$6,000 family	N/A	\$3,650 individual/ \$7,300 family		N/A
<b>Annual Out-of-Pocket Maximum (includes deductible and coinsurance)</b>	N/A		\$3,000 individual/ \$6,000 family	N/A		\$3,650 individual/ \$7,300 family
<b>Lifetime Benefit Maximum</b>	none			none		

\***Note applicable to Plan C only:** The individual amounts for Annual Plan Deductible and Annual Out-of-Pocket Maximum are applicable only to single policies. On policies covering more than one person, the family amount must be met before moving on to the next coverage level.

Covered Services	Cost to member when receiving services from network providers			Cost to member when receiving services from non-network providers		
	Plan A	Plan B	Plan C	Plan A	Plan B	Plan C
<b>Preventive Care</b>						
• Well Woman Exam		none		not covered		
• Mammograms		none		deductible plus 50% coinsurance		
• Well Baby and Child Care		none		not covered		
• Well Man Care (annual prostate screening and office visit)		none		not covered		
<b>Preventive Care (continued)</b>						
• Periodic Age Appropriate Physical Exam & Routine Health Screening		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		
• Age Appropriate 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 50% coinsurance		
• Adult		none		not covered		deductible plus 50% coinsurance
<i>Excludes immunizations for foreign travel</i>						
<b>Physician Care</b>						
• Primary Care Physician Office Visits (PCP) for adult	\$25 copayment	\$20 copayment	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
• Primary Care Physician Office Visits for children 18 years of age and younger	\$25 copayment	\$10 copayment	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
<b>Physician Care (continued)</b>						
• Specialist Office Visit for adult	\$45 copayment	\$40 copayment	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
• Specialist Office Visits for children 18 years of age and younger	\$45 copayment	\$25 copayment	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
• Dietitian Consultation	deductible plus 20% coinsurance	deductible plus 35% coinsurance	deductible plus 20% coinsurance	deductible plus 50% 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 20% coinsurance	deductible plus 35% coinsurance	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
<b>Outpatient Surgery</b>						
• Surgery/Anesthesia/Assistant Surgeon	deductible plus 20% coinsurance	deductible plus 35% coinsurance	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
<b>Major Diagnostic Testing</b>						
Includes but not limited to PET scans, CT scans, nuclear cardiology studies, MRI, computerized topography/angiography	deductible plus 20% coinsurance	deductible plus 35% coinsurance	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
<b>Outpatient Services</b>						
Not listed elsewhere	deductible plus 20% coinsurance	deductible plus 35% coinsurance	deductible plus 20% coinsurance	deductible plus 50% 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 B	Plan C	Plan A	Plan B	Plan C
<b>Outpatient Laboratory Services</b>						
• Preferred lab benefit	no coinsurance if using preferred lab vendor		not available	not available		
• Other participating/contracted labs	deductible plus 20% coinsurance	deductible plus 35% coinsurance	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
<b>Urgent Care Facility Visits</b>						
	\$25 copay, deductible plus 20% coinsurance	\$25 copay, deductible plus 35% coinsurance	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
<i>Copay does not apply towards annual coinsurance maximum</i>						
<b>Ambulance/Emergency Transportation (Ground or Air)</b>						
	deductible plus 20% coinsurance	deductible plus 35% coinsurance	deductible plus 20% coinsurance	deductible plus 20% coinsurance	deductible plus 35% coinsurance	deductible plus 20% coinsurance
<b>Emergency Room Services (copayment waived if admitted to any hospital within 24 hours)</b>						
	\$100 copay, deductible plus 20% coinsurance	\$100 copay, deductible plus 35% coinsurance	deductible plus 20% coinsurance	\$100 copay, deductible plus 20% coinsurance	\$100 copay, deductible plus 35% coinsurance	deductible plus 20% coinsurance
<i>Copay does not apply towards annual coinsurance maximum</i>						
<b>Home Health Care (services must be pre-approved by health plan)</b>						
	deductible plus 20% coinsurance	deductible plus 35% coinsurance	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
<b>Hospice Care (services must be pre-approved by health plan) – Inpatient Hospice Care is limited to 6 months</b>						
	deductible plus 20% coinsurance	deductible plus 35% coinsurance	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
<b>Rehabilitation Services (including physical medicine)</b>						
• Inpatient and Outpatient Facility	deductible plus 20% coinsurance	deductible plus 35% coinsurance	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
• Office Services	deductible plus 20% coinsurance	deductible plus 35% coinsurance	deductible plus 20% coinsurance	deductible plus 50% coinsurance	deductible plus 50% coinsurance	
	Manipulations limited to 30 visits per calendar year		Manipulations limited to 26 visits per calendar year	Manipulations limited to 30 visits per calendar year		Manipulations limited to 26 visits per calendar year
<b>Durable Medical Equipment (DME) (DME greater than \$400 must be pre-approved by health plan)</b>						
	deductible plus 20% coinsurance	deductible plus 35% coinsurance	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
	Limited to \$5,000 per calendar year benefit maximum for new purchases, \$2,500 per calendar year benefit maximum for repairs		Limited to \$1,000 per person per year	Limited to \$5,000 per calendar year benefit maximum for new purchases, \$2,500 per calendar year benefit maximum for repairs	Limited to \$1,000 per person per year	
<b>Prosthetic Devices &amp; Orthopedic Devices (prosthetics greater than \$1,000 must be pre-approved by health plan)</b>						
	deductible plus 20% coinsurance	deductible plus 35% coinsurance	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
<b>Allergy Testing</b>						
	deductible plus 20% coinsurance	deductible plus 35% coinsurance	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
<b>Allergy Shots &amp; Antigen Administration (desensitization/treatment)</b>						
	none		deductible plus 20% coinsurance	deductible plus 50% 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	\$25 copayment	\$20 copayment	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
• Office Visits for children 18 years of age and under	\$25 copayment	\$10 copayment	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
• Group Therapy Sessions	\$12.50 copayment	\$10 copayment	deductible plus 20% coinsurance	deductible plus 50% coinsurance		
<b>Autism Services (subject to limitations and pre-approval)</b>						
	deductible plus 20% coinsurance	deductible plus 35% coinsurance	deductible plus 20% coinsurance	deductible plus 50% 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 refer to [www.bcbsks.com/customerservice/members/state/index.htm](http://www.bcbsks.com/customerservice/members/state/index.htm)



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