## 2018 State of Kansas Open Enrollment – Benefits Summary

<table>
<thead>
<tr>
<th>Cost to member when receiving services from <strong>Network</strong> providers</th>
<th><strong>Plan A</strong></th>
<th><strong>Plan C</strong></th>
<th><strong>Plan Q</strong></th>
<th><strong>Plan N</strong></th>
<th><strong>Plan J</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual plan deductible</td>
<td>Employee: $1,000</td>
<td>Individual: $2,750</td>
<td>Individual: $500</td>
<td>Individual: $2,750</td>
<td>Individual: $500</td>
</tr>
<tr>
<td></td>
<td>Employee &amp; 1: $2,000</td>
<td>Family: $5,500</td>
<td>Family: $1,000</td>
<td>Family: $5,500</td>
<td>Family: $1,000</td>
</tr>
<tr>
<td></td>
<td>Employee &amp; 2+: $3,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance for all eligible expenses (unless otherwise noted)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>35% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Family: $12,500</td>
<td>Family: $11,000</td>
<td>Family: $13,300</td>
<td>Family: $13,300</td>
<td>Family: $14,700</td>
</tr>
<tr>
<td></td>
<td>Combined medical/drug</td>
<td>Combined medical/drug</td>
<td>Combined medical/drug</td>
<td>Combined medical/drug</td>
<td>Combined medical/drug</td>
</tr>
<tr>
<td>Lifetime benefit maximum</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cost to member when receiving services from <strong>Non Network</strong> providers</th>
<th><strong>Plan A</strong></th>
<th><strong>Plan C</strong></th>
<th><strong>Plan Q</strong></th>
<th><strong>Plan N</strong></th>
<th><strong>Plan J</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual plan deductible</td>
<td>Employee: $1,200</td>
<td>Individual: $2,750</td>
<td>Individual: $700</td>
<td>Individual: $2,750</td>
<td>Individual: $1,000</td>
</tr>
<tr>
<td></td>
<td>Employee &amp; 1: $2,400</td>
<td>Family: $5,500</td>
<td>Family: $1,400</td>
<td>Family: $5,500</td>
<td>Family: $2,000</td>
</tr>
<tr>
<td></td>
<td>Employee &amp; 2+: $3,600</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance for all eligible expenses (unless otherwise noted)</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td>60% coinsurance</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Annual out-of-pocket maximum (includes deductible, coinsurance and copayment)</td>
<td>Individual: $6,250</td>
<td>Individual: $5,500</td>
<td>Individual: $6,650</td>
<td>Individual: $6,650</td>
<td>Individual: $10,000</td>
</tr>
<tr>
<td></td>
<td>Family: $12,500</td>
<td>Family: $11,000</td>
<td>Family: $13,300</td>
<td>Family: $13,300</td>
<td>Family: $20,000</td>
</tr>
<tr>
<td></td>
<td>Combined medical/drug</td>
<td>Combined medical/drug</td>
<td>Combined medical/drug</td>
<td>Combined medical/drug</td>
<td>Combined medical/drug</td>
</tr>
<tr>
<td>Lifetime benefit maximum</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

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

* HRA/HSA eligible

[bcbsks.com/state](http://bcbsks.com/state)
<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>Cost to member when receiving services from <strong>Network</strong> providers</th>
<th>Cost to member when receiving services from <strong>Non Network</strong> providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td>Plan A</td>
<td>Plans C, Q, N &amp; J</td>
</tr>
<tr>
<td>Well woman exam</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Mammograms</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Well baby and child care</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Well man care</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Routine vision exam (refraction for glasses; lenses and frames not covered)</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Routine hearing exam (hearing aids not covered)</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Age appropriate bone density screening</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Colonoscopy screening</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Preventive lab services</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Immunizations</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Immunizations</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Pediatric</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Adult</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Physician Care</td>
<td></td>
<td>$40 copayment</td>
</tr>
<tr>
<td>Physician Care</td>
<td></td>
<td>$60 copayment</td>
</tr>
<tr>
<td>Physician Care</td>
<td></td>
<td>$10 copayment</td>
</tr>
<tr>
<td>Primary care physician (PCP) office visit</td>
<td>$40 copayment</td>
<td>Deductible plus coinsurance</td>
</tr>
<tr>
<td>Specialist office visit</td>
<td></td>
<td>$60 copayment</td>
</tr>
<tr>
<td>Telehealth visit</td>
<td></td>
<td>$10 copayment</td>
</tr>
<tr>
<td>Telehealth visit</td>
<td></td>
<td>$10 copayment</td>
</tr>
<tr>
<td>Inpatient services</td>
<td></td>
<td>$10 copayment</td>
</tr>
<tr>
<td>Inpatient services</td>
<td></td>
<td>$10 copayment</td>
</tr>
<tr>
<td>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</td>
<td></td>
<td>$10 copayment</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td></td>
<td>$10 copayment</td>
</tr>
<tr>
<td>Surgery/anesthesia/assistant surgeon</td>
<td></td>
<td>$10 copayment</td>
</tr>
<tr>
<td>Cost to member when receiving services from <strong>Network</strong> providers</td>
<td>Cost to member when receiving services from <strong>Non Network</strong> providers</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient services</strong></td>
<td><strong>Outpatient services</strong></td>
<td></td>
</tr>
<tr>
<td>Not listed elsewhere</td>
<td><strong>Outpatient services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient laboratory services</strong></td>
<td><strong>Outpatient laboratory services</strong></td>
<td></td>
</tr>
<tr>
<td>Preferred lab benefit</td>
<td>Preferred lab benefit</td>
<td></td>
</tr>
<tr>
<td>No cost to member if using preferred lab vendor</td>
<td>Discounts to member if using preferred lab vendor while satisfying deductible; no cost to member if using preferred lab vendor after deductible is satisfied</td>
<td></td>
</tr>
<tr>
<td>Other labs</td>
<td><strong>Other labs</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent care facility visits</strong></td>
<td><strong>Urgent care facility visits</strong></td>
<td></td>
</tr>
<tr>
<td>$50 copayment</td>
<td>Deductible plus coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance/emergency transportation</strong></td>
<td><strong>Ambulance/emergency transportation</strong></td>
<td></td>
</tr>
<tr>
<td>Domestic ground or air</td>
<td>Domestic ground or air</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency room services</strong></td>
<td><strong>Emergency room services</strong></td>
<td></td>
</tr>
<tr>
<td>Copayment waived if admitted to any hospital within 24 hours</td>
<td>Copayment waived if admitted to any hospital within 24 hours</td>
<td></td>
</tr>
<tr>
<td>$100 copay, deductible plus coinsurance</td>
<td>$100 copay, network deductible plus coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>Home health care and hospice Care</strong></td>
<td><strong>Home health care and hospice Care</strong></td>
<td></td>
</tr>
<tr>
<td>Services must be pre-approved by health plan. Inpatient hospice care is limited to 6 months.</td>
<td>Services must be pre-approved by health plan. Inpatient hospice care is limited to 6 months.</td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitation services</strong></td>
<td><strong>Rehabilitation services</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient and outpatient facility</td>
<td>Inpatient and outpatient facility</td>
<td></td>
</tr>
<tr>
<td>Office services – office visit copayment may apply if an office visit is billed. Spinal manipulations are limited to 30 visits per calendar year.</td>
<td>Office services – office visit copayment may apply if an office visit is billed. Spinal manipulations are limited to 30 visits per calendar year.</td>
<td></td>
</tr>
<tr>
<td><strong>Durable medical equipment (DME)</strong></td>
<td><strong>Durable medical equipment (DME)</strong></td>
<td></td>
</tr>
<tr>
<td>DME greater than $750 must be pre-approved by health plan</td>
<td>DME greater than $750 must be pre-approved by health plan</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Network</td>
<td>Non Network</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>--------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td><strong>Prosthetic devices and orthopedic devices</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetics greater than $1,000 must be pre-approved by health plan</td>
<td>Deductible plus coinsurance</td>
<td>Deductible plus coinsurance</td>
</tr>
<tr>
<td><strong>Mental illness, alcoholism, drug abuse and substance abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient services</td>
<td>Same as medical</td>
<td>Same as medical</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>Same as medical</td>
<td>Same as medical</td>
</tr>
<tr>
<td>Office visits</td>
<td>$40 copayment</td>
<td>Deductible plus coinsurance</td>
</tr>
<tr>
<td>Group therapy sessions</td>
<td>$20 copayment</td>
<td>Deductible plus coinsurance</td>
</tr>
<tr>
<td><strong>Autism services</strong></td>
<td>Deductible plus coinsurance</td>
<td>Deductible plus coinsurance</td>
</tr>
<tr>
<td>Subject to limitations and pre-approval</td>
<td></td>
<td>Deductible plus coinsurance</td>
</tr>
<tr>
<td><strong>Bariatric surgery</strong></td>
<td>Deductible plus coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Subject to limitations and pre-approval</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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:

**In Topeka:** 291-4185
**Toll Free:** 1-800-332-0307

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