2020 State of Kansas Open Enrollment – Benefits Summary

Cost to member when receiving services from **Network** providers	**Plan A**	**Plan C***	**Plan Q**	**Plan N***	**Plan J**
Annual plan deductible	Employee: $1,000 Employee & 1: $2,000 Employee & 2+: $3,000	Employee: $2,750 Employee & Family: $2,800/$5,500	Employee: $500 Family: $1,000	Employee: $2,750 Employee & Family: $2,800/$5,500	Employee: $500 Family: $1,000
Coinsurance for all eligible expenses (unless otherwise noted)	20% coinsurance	10% coinsurance	50% coinsurance	35% coinsurance	25% coinsurance
Annual out-of-pocket maximum (includes deductible, coinsurance and copayment)	Individual: $6,250 Family: $12,500 Combined medical/drug	Individual: $5,500 Family: $11,000 Combined medical/drug	Individual: $6,650 Family: $13,300 Combined medical/drug	Individual: $6,650 Family: $13,300 Combined medical/drug	Individual: $7,350 Family: $14,700 Combined medical/drug
Lifetime benefit maximum	None	None	None	None	None

Cost to member when receiving services from **Non Network** providers	**Plan A**	**Plan C***	**Plan Q**	**Plan N***	**Plan J**
Annual plan deductible	Employee: $1,200 Employee & 1: $2,400 Employee & 2+: $3,600	Employee: $2,750 Employee & Family: $2,800/$5,500	Employee: $700 Employee & Family: $1,400	Employee: $2,750 Employee & Family: $2,800/$5,500	Employee: $1,000 Employee & Family: $2,000
Coinsurance for all eligible expenses (unless otherwise noted)	50% coinsurance	50% coinsurance	60% coinsurance	50% coinsurance	50% coinsurance
Annual out-of-pocket maximum (includes deductible, coinsurance and copayment)	Individual: $6,250 Family: $12,500 Combined medical/drug	Individual: $5,500 Family: $11,000 Combined medical/drug	Individual: $6,650 Family: $13,300 Combined medical/drug	Individual: $6,650 Family: $13,300 Combined medical/drug	Individual: $10,000 Family: $20,000 Combined medical/drug
Lifetime benefit maximum	None	None	None	None	None

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

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	Cost to member when receiving services from **Network** providers		Cost to member when receiving services from **Non Network** providers	
	Plan A	**Plans C, Q, N & J**	**Plan A**	**Plans C, Q, N & J**
Preventive Care				
Well woman exam	None		Deductible plus coinsurance	
Mammograms	None		Deductible plus coinsurance	
Well baby and child care	None		Deductible plus coinsurance	
Well man care	None		Deductible plus coinsurance	
Routine vision exam (refraction for glasses; lenses and frames not covered)	None		Deductible plus coinsurance	
Routine hearing exam (hearing aids not covered)	None		Deductible plus coinsurance	
Age appropriate bone density screening	None		Deductible plus coinsurance	
Colonoscopy screening	None		Deductible plus coinsurance	
Preventive lab services	None		Deductible plus coinsurance	
Immunizations				
Pediatric	None		Covered in full to age six, otherwise deductible plus coinsurance	
Adult	None		Deductible plus coinsurance	
Physician Care				
Primary care physician (PCP) office visit	$40 copayment	Deductible plus coinsurance	Deductible plus coinsurance	
Specialist office visit	$60 copayment	Deductible plus coinsurance	Deductible plus coinsurance	
Telemedicine visit - American Well	$10 copayment	Deductible plus coinsurance	Not covered	
Inpatient services				
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	Deductible plus coinsurance		Deductible plus coinsurance	
Outpatient surgery				
Surgery/anesthesia/assistant surgeon	Deductible plus coinsurance		Deductible plus coinsurance	

	Cost to member when receiving services from **Network** providers		Cost to member when receiving services from **Non Network** providers	
	Plan A	**Plans C, Q, N & J**	**Plan A**	**Plans C, Q, N & J**
Outpatient services				
Not listed elsewhere	Deductible plus coinsurance		Deductible plus coinsurance	
Outpatient laboratory services				
Preferred lab benefit	No cost to member if using preferred lab vendor	Discounts to member if using preferred lab vendor while satisfying deductible; no cost to member if using preferred lab vendor after deductible is satisfied	Not available	
Other labs	Deductible plus coinsurance		Deductible plus coinsurance	
Urgent care facility visits				
	$50 copayment	Deductible plus coinsurance	Deductible plus coinsurance	
Ambulance/emergency transportation				
Domestic ground or air	Deductible plus coinsurance		Network deductible plus coinsurance	
Emergency room services				
Copayment waived if admitted to any hospital within 24 hours	$100 copay, deductible plus coinsurance	Deductible plus coinsurance	$100 copay, network deductible plus coinsurance	Network deductible plus coinsurance
Home health care and hospice Care				
Services must be pre-approved by health plan. Inpatient hospice care is limited to 6 months.	Deductible plus coinsurance		Deductible plus coinsurance	
Rehabilitation services	Including physical medicine		Including physical medicine	
Inpatient and outpatient facility	Deductible plus coinsurance		Deductible plus coinsurance	
Office services – office visit copayment may apply if an office visit is billed. Spinal manipulations are limited to 30 visits per calendar year.	Deductible plus coinsurance		Deductible plus coinsurance	
Durable medical equipment (DME)				
DME greater than $750 must be pre-approved by health plan	Deductible plus coinsurance		Deductible plus coinsurance	

	Cost to member when receiving services from **Network** providers		Cost to member when receiving services from **Non Network** providers	
	Plan A	**Plans C, Q, N & J**	**Plan A**	**Plans C, Q, N & J**
Prosthetic devices and orthopedic devices				
Prosthetics greater than $1,000 must be pre-approved by health plan	Deductible plus coinsurance		Deductible plus coinsurance	
Mental illness, alcoholism, drug abuse and substance abuse				
Inpatient services	Same as medical		Same as medical	
Outpatient services	Same as medical		Same as medical	
Office visits	$40 copayment	Deductible plus coinsurance	Deductible plus coinsurance	
Group therapy sessions	$20 copayment	Deductible plus coinsurance	Deductible plus coinsurance	
Autism services				
Subject to limitations and pre-approval	Deductible plus coinsurance		Deductible plus coinsurance	
Bariatric surgery				
Subject to limitations and pre-approval	Deductible plus coinsurance		Not covered	

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/state

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