

Summary of Benefits

Blue Cross and Blue Shield of Kansas (BCBSKS) is offering a PPO benefit plan. To receive the maximum level of benefits, you must receive services from a Blue Card PPO contracting provider. If an out-of-network provider is selected, you will be responsible for the difference between the non-contracting provider's actual billed charges. In addition, the program allowance will be 20% less than the amount paid to a contracting provider for the same service.

BENEFIT CATEGORY	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE (Per calendar year)	\$300/individual \$600/family	\$600/individual \$1,200/family
COINSURANCE (Member portion for most services)	10% of allowed amounts after deductible	30% of allowed amounts after deductible
ANNUAL OUT-OF-POCKET MAXIMUM (includes deductible and coinsurance) Copays, Outpatient Nervous & Mental and Substance Abuse do not apply to the annual out-of-pocket amount	\$1,500/individual \$3,000/family After the annual out-of-pocket amount has been reached (ded/coins), eligible benefits will increase to 100% of the allowed amount for the remainder of the benefit period.	*\$3,000/individual *\$6,000/family
MAXIMUM LIFETIME BENEFIT	\$2 Million	
PHYSICIAN SERVICES Physicians Visits — home/office	\$15 copay	*Subject to deductible/coinsurance
Surgery — inpatient and outpatient	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
Maternity Care	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
Well Child & Well Baby (for children up to age 72 months)	\$15 copay then covers 100% of allowed amounts	*Subject to deductible/coinsurance
Immunizations & Allergy Injections	100% of allowed amounts	*Subject to deductible/coinsurance
Well Women — Annual Check Up Office Visit Mammogram Pap Smear	\$15 office visit copay 100% to \$300 then subject to deductible/coinsurance† 100% to \$300 then subject to deductible/coinsurance†	*Subject to deductible/coinsurance *Subject to deductible/coinsurance *Subject to deductible/coinsurance
Routine Physicals — Annual Check Up Office Visit Lab & Radiology	\$15 office visit copay 100% to \$300 then subject to deductible/coinsurance†	
Radiology and Lab	100% to \$300 then subject to deductible/coinsurance†	*Subject to deductible/coinsurance
INPATIENT HOSPITAL	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
OUTPATIENT HOSPITAL	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
EMERGENCY SERVICES — EMERGENCY ROOM	\$50 copay per visit then subject to deductible/coinsurance Copay waived if patient admitted.	\$50 per visit then subject to deductible/coinsurance Waived if patient admitted.
AMBULANCE	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
FREESTANDING OUTPATIENT FACILITIES AND OUTPATIENT HOSPITAL SERVICES Radiology & laboratory, surgery, dialysis	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
DURABLE MEDICAL EQUIPMENT Including Foot Orthotics and Prosthetic Devices	Subject to deductible/coinsurance	*Subject to deductible/coinsurance

*The member will also be responsible for the difference between the non-contracting provider's actual billed charges and the BCBSKS payment allowance. Additionally, payment will be 20% less than the amount paid to a contracting provider for the same service.

† All lab and x-ray services including mammograms and pap smears apply to the \$300 lab x-ray benefit.

BENEFIT CATEGORY	IN-NETWORK	OUT-OF-NETWORK
HOME HEALTH CARE	100% of allowable charges subject to annual maximum \$2,500 annual maximum	*Subject to deductible/coinsurance
DIABETIC EQUIPMENT AND SUPPLIES Insulin pumps, insulin pump supplies, glucose monitor	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
HOSPICE CARE	100% of allowable charges subject to annual maximum \$5,000 annual maximum	*Subject to deductible/coinsurance
SHORT-TERM THERAPIES Physical, Speech and Occupational, Respiratory and Cardiac Inpatient Outpatient	Subject to deductible/coinsurance \$15 copay	*Subject to deductible/coinsurance *Subject to deductible/coinsurance
SPINAL MANIPULATIONS	Subject to deductible/coinsurance Combined 20 visits per calendar year	*Subject to deductible/coinsurance
PHYSICAL MEDICINE TMJ (\$5,000 lifetime maximum) Vision Therapy Biofeedback	Subject to deductible/coinsurance Combined 20 visits per calendar year	*Subject to deductible/coinsurance *Subject to deductible/coinsurance *Subject to deductible/coinsurance
BEHAVIORAL HEALTH & SUBSTANCE ABUSE +Inpatient Non-Biological Based — 30 days annually Biological Based — 45 days annually +Requires a pre-admission certification from Health Management Strategies (HMS) HMS 1-800-643-6154 Outpatient Behavioral Health & Substance Abuse Non-Biological Based Outpatient Biological Based Mental Illness (e.g. bipolar, major depression, ADD)	Covers 100% of first \$100; 80% for the next \$100; 50% for remainder of benefit period subject to lifetime health maximum Covers 100% of first \$100; 80% for the next \$100; 50% for remainder of benefit period subject to lifetime health maximum \$15 copay, then 100% of allowed amounts Limited to 45 visits	*Subject to deductible/coinsurance *Subject to deductible/coinsurance *Subject to deductible/coinsurance *Subject to deductible/coinsurance
PRESCRIPTION DRUGS — BlueRx Direct	\$50/person deductible \$100/family deductible 80%/20% coinsurance	If a non-network pharmacy is used, the member is reimbursed the amount that would have been paid to a network pharmacy minus the copay
PRESCRIPTION DRUGS — MAIL ORDER Generic Brand	\$15 copayment per 90-day supply \$45 copayment per 90-day supply	N/A N/A

PLAN EXCLUSION AND LIMITATIONS

The following procedures and all related services and supplies are not covered under this program. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression; duplicate benefits provided under federal, state or local laws, regulations or programs, except Medicaid; cosmetic or reconstructive surgery (except as stated in the certificate); any keratotomy procedures; charges for personal items; convalescent or custodial/maintenance care or rest cures; blood or payments to donors of blood; any service or supply related to the medical management of obesity; charges for services by immediate relatives or by members of your household; acupuncture and admissions for acupuncture; services related to temporomandibular joint dysfunction syndrome over the amount specified in the certificate; dental implants; services or supplies related to sex changes, sexual dysfunctions or inadequacies; any medically-aided insemination procedure; services related to the reversal of sterilization procedures; treatment of nervous or mental conditions over the amount specified in the certificate; hearing aids; eyeglasses or contact lenses (except after the removal of cataracts); unnecessary services and admissions; services or supplies which are experimental or investigative in nature; services not specifically listed as benefits in the certificate; services covered and payable by any medical expense payment provision of any automobile insurance policy.

PRIOR AUTHORIZATION REQUIRED

- BCBSKS — for all inpatient hospital stays and some prescriptions
- HMS — for inpatient nervous and mental and substance abuse stays

This benefit summary is designed to be a brief summary of the benefits. For complete plan details, please see employee certificate.