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BlueCross BlueShield of Kansas
Blue Choice Network

USD 263 MULVANE

BlueEdge

Effective October 01, 2019 - September 30, 2020

Maximum benefits are available when services are received from Blue Choice providers. Your financial responsibility is based on the provider network you select. **Non-Blue Choice & Non-CAP**: Difference between the payment allowance and provider charge, additional 20% coinsurance amount, deductible, coinsurance or copay amount **CAP (Non-Blue Choice)**: Additional 20% coinsurance amount,* deductible, coinsurance or copay amount **Blue Choice**: Deductible, coinsurance or copay amount
*Limited to a combined $2,000 per person, $4,000 two-or-more persons each benefit period.

Member Pays			
	Option A	**Option B**	**Option C**
Deductible (Per group anniversary benefit period)	$1,500/$3,000 individual/two-or-more persons.	$2,500/$5,000 individual/two-or-more persons.	$3,500/$7,000 individual/two-or-more persons.
Coinsurance (Member portion for most services)	40% of allowed amounts after deductible has been met.	40% of allowed amounts after deductible has been met.	40% of allowed amounts after deductible has been met.
Coinsurance Maximum	$2,000/$4,000 individual/two-or-more persons.	$2,000/$4,000 individual/two-or-more persons.	$2,000/$4,000 individual/two-or-more persons.
Total Deductible plus Coinsurance	$3,500/$7,000 individual/two-or-more persons.	$4,500/$9,000 individual/two-or-more persons.	$5,500/$11,000 individual/two-or-more persons.
Maximum Out-of-Pocket (includes copays, deductible and coinsurance where applicable)	$6,350/$12,700 individual/two-or-more persons.	$6,350/$12,700 individual/two-or-more persons.	$6,350/$12,700 individual/two-or-more persons.

Doctor's Office Visits	
Home and office visits	$30 copay per visit for the first 5 visits.**
Telemedicine Visits	$30 copay per visit for the first 5 visits.**
Home and office visits - Specialist	$60 copay per visit.**
Preventive care as defined by the Affordable Care Act	Paid at 100% of the allowable charge. Some of the services include: Routine screenings Preventive immunizations Well-women visits/screenings Contraceptive methods
Drug Coverage	
Prescription Drugs & Mail Order	BlueRx Card $15 generic, $100/$200 deductible then preferred brand-40% coinsurance (member pays) with a minimum of $30 or whichever is greater AND non preferred brand-60% coinsurance (member pays) with a minimum of $50 or whichever is greater. Mail Order is 2 1/2 copay ($37.50) for Generic, preferred brand-40% coinsurance with a minimum of $75 or whichever is greater and non-preferred brand-60% coinsurance with a minimum of $125 or whichever is greater with ResultsRx formulary. A 90-day supply is available through the Extended Supply Network. The quantity per prescription is a 30-day pharmacy supply or 90-day mail order supply. **Mail order subject to retail deductible and coinsurance.** Designated Specialty Pharmacy.
Medical Services	
Emergency medical transportation	Subject to deductible/coinsurance.
Inpatient facility fee	Subject to deductible/coinsurance.
Outpatient surgery physician/surgical	Subject to deductible/coinsurance.
Inpatient surgery physician/surgical	Subject to deductible/coinsurance.
Outpatient lab and radiology (Includes Advanced Imaging)	Subject to deductible/coinsurance.
Emergency room	$250 copay then subject to deductible/coinsurance.
Accidental Injury Services	Subject to deductible/coinsurance.
Recovery/Special Needs	
Outpatient rehabilitation	Subject to deductible/coinsurance.
Hospice	Subject to deductible/coinsurance.
Home Social Work Visits	Subject to deductible/coinsurance.
Short-term Therapies-Physical, Speech and Occupational, Respiratory and Cardiac	Subject to office visit copay based on specialty. (Visits count towards the 5 office visit limit per benefit period. Office visits are subject to deductible/coinsurance starting with the 6th visit**) and subject to Outpatient Short Term Therapy visitation limits (regardless of place of service): Outpatient Speech Therapy: 30 visits Outpatient Rehab: 40 visits Spinal Manipulations: 20 visits
Mental Health	
Mental Illness & Substance Use Disorders Inpatient Services Requires pre-admission certification from New Directions Behavioral Health at 1-800-952-5906	Subject to deductible/coinsurance.
Mental Illness & Substance Use Disorders Outpatient Services	$30 copay per visit.
Other	
Maximum Lifetime Benefit	Unlimited.
Eligible Dependents	Covered to age 26.

****Combined benefit period visit maximum, then subject to deductible/coinsurance.**

Monthly Premium

	Type of Coverage	Health
Option A	Employee	$451.14
	Employee/Child	$913.09
	Employee/Spouse	$968.76
	Family	$1430.70
Option B	Employee	$427.73
	Employee/Child	$865.63
	Employee/Spouse	$918.42
	Family	$1356.33
Option C	Employee	$410.17
	Employee/Child	$830.06
	Employee/Spouse	$880.68
	Family	$1300.57

BCBSKS reserves the right to adjust premiums accordingly should enrollment vary from the census.

Exclusions: 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 except for eligible preventive services; 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; any medically-aided insemination procedure; services related to the reversal of sterilization procedures; mental illness or substance use disorder services provided by a non-eligible provider; 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.

This is a brief summary of the coverage available under this program. It is not a legal document.
The exact provisions of the benefits and exclusions are contained in the certificate.