CMR3A

356288
557

BlueCross BlueShield of Kansas
Blue Choice Network

Kansas Educational Insurance Trust Association
Option KE10 – Non-Grandfathered USD 244 Burlington
Comprehensive Major Medical℠

Effective October 01, 2016 - September 30, 2017

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	
Deductible (Per group anniversary benefit period)	$2,500/$5,000 individual/two-or-more persons
Coinsurance (Member portion for most services)	20% of allowed amounts after deductible has been met
Coinsurance Maximum	$1,000/$2,000 individual/two-or-more persons
Annual Out-of-Pocket Maximum (includes copays, deductible and coinsurance)	$6,350/$12,700 individual/two-or-more persons. After the annual out-of-pocket amount has been reached (copays/deductible/coinsurance), eligible benefits will be paid at 100% of the allowed amount for the remainder of the benefit period.
Doctor's Office Visits	
Home and Office Visits	$25 office visit copay
Preventive Care as defined by the Affordable Care Act	Paid at 100% of the allowable charge. Some of the services include: Routine screenings Immunizations Well-women visits/screenings Contraceptive methods
Drug Coverage	
Prescription Drugs & Mail Order (Pharmacy Submit)	BlueRx Card $100/$200 then 50% coinsurance; Mail order is subject to retail deductible/coinsurance
Medical Services	
Emergency Medical Transportation	Subject to deductible/coinsurance
Inpatient Surgery Physician/Surgical	Subject to deductible/coinsurance
Inpatient Facility Fee	Subject to deductible/coinsurance
Outpatient Surgery Physician/Surgical	Subject to deductible/coinsurance

Outpatient Lab and Radiology	Pays at 100% to a combined maximum of $300 for each covered person, each benefit period, then subject to deductible/coinsurance
Emergency Room	$100 copay then subject to deductible/coinsurance
Accidental Injury Services	Pays 100% up to $1,000 per person each benefit period, then subject to deductible/coinsurance
Recovery/Special Needs	
Outpatient Rehabilitation	Subject to deductible/coinsurance
Hospice	Subject to deductible/coinsurance
Home Health Care	Subject to deductible/coinsurance
Private Duty Nursing	Subject to deductible/coinsurance
Mental Health	
Mental/Behavioral Health **Inpatient Services** Requires pre-admission certification from New Directions Behavioral Health at 1-800-952-5906	Subject to deductible/coinsurance
Outpatient Services	$25 office visit copay
Other	
Maximum Lifetime Benefit	Unlimited
Eligible Dependents	Covered to age 26

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; services or supplies related to sex changes, sexual dysfunctions or inadequacies; 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.