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BlueCross BlueShield of Kansas
Blue Choice Network

Greenbush Health Insurance Trust

Comprehensive Major Medical℠

Non-Grandfathered **Effective October 01, 2015 - September 30, 2016**

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) Option 1 Option 2 Option 3	 $500 individual /$1,000 two persons /$1,500 three or more persons $1,000 individual / $2,000 two persons / $3,000 three or more persons $1,500 individual /$3,000 two persons / $4,500 three or more persons
Coinsurance (Member portion for most services) Option 1 Option 2 Option 3	 0% of allowed amounts after deductible has been met 10% of allowed amounts after deductible has been met 20% of allowed amounts after deductible has been met
Coinsurance Maximum Option 1 Option 2 Option 3	 Not Applicable $1,000 individual /$2,000 two persons / $2,500 three or more persons $2,000 individual / $4,000 two persons / $5,000 three or more persons
Annual Out-of-Pocket Maximum (includes copays, deductible and coinsurance)	Option 1 - $6,350 individual / $12,700 two-or-more persons Option 2 - $6,350 individual / $12,700 two-or-more persons Option 3 - $6,350 individual / $12,700 two-or-more persons After the annual out-of-pocket amount has been reached (deductible/coinsurance/copays), 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 Option 1 Option 2 Option 3	 $20 office visit copay $20 office visit copay Deductible/Coinsurance
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	BlueRx Card $15/$30/$45; Mail order is 2 1/2 x copay The quantity per prescription shall be the greater of a 34-day supply or 100 unit dosage, if defined as a maintenance drug.
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 Option 1 Option 2 Option 3	 Pays at 100% to a combined maximum of $300 for each covered person, each benefit period then subject to deductible/coinsurance Pays at 100% to a combined maximum of $300 for each covered person, each benefit period then subject to deductible/coinsurance Subject to deductible/coinsurance
Emergency Room	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 Health Care	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 Option 1 Option 2 Option 3	 $20 office visit copay $20 office visit copay Deductible/Coinsurance
Other	
Maximum Lifetime Benefit	Unlimited
Eligible Dependents	Covered to age 26

* Combined benefit period maximum

Monthly Premium

2014 Health/Rx	Employee	Employee/Child	Employee/Spouse	Family
Option 1	$603.00	$1,052.00	$1,073.00	$1,519.00
Option 2	$554.00	$964.00	$984.00	$1,393.00
Option 3	$492.00	$858.00	$876.00	$1,242.00

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 kenotomy 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.