

USD 320
AffordaBlue

Effective October 01, 2011 - September 30, 2012

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 1	Option 2	Option 3
Deductible (Per group anniversary benefit period)	\$500/\$1,500 individual/three-or-more persons	\$1,000/\$3,000 individual/three-or-more persons	\$2,000/\$6,000 individual/three-or-more persons
Coinsurance (Member portion for most services)	20% of allowed amounts after deductible has been met to a maximum of \$1,000/\$3,000 individual/three-or-more persons.	20% of allowed amounts after deductible has been met to a maximum of \$1,000/\$3,000 individual/three-or-more persons.	20% of allowed amounts after deductible has been met to a maximum of \$1,000/\$3,000 individual/three-or-more persons.
Annual Out-of-Pocket Maximum (includes deductible and coinsurance) Copays do not apply to the annual out-of-pocket amount	\$1,500/\$4,500 individual/three-or-more persons	\$2,000/\$6,000 individual/three-or-more persons	\$3,000/\$9,000 individual/three-or-more persons

After the annual out-of-pocket amount has been reached, eligible benefits will be paid at 100% of the allowed amount for the remainder of the benefit period.

At the group's anniversary, an employee can upgrade no more than one deductible level within an option per benefit period. An employee can downgrade to any deductible level within an option per benefit period.

Unlimited Lifetime Benefit. Eligible children covered to age 26.

Covered Services

Doctor Visits - home/office (including hearing and eye exam)	\$25 office visit copay*
Surgery - inpatient and outpatient	Subject to deductible/coinsurance
Maternity Care	Subject to deductible/coinsurance
Injections	Covers 100% of maximum allowance.
Outpatient Radiology & Lab Services	Covered services, including services for accidental injuries, are paid at 100% of allowable charges up to a combined maximum of \$300 for each covered person (\$900 for the three-or-more persons) each benefit period.*
Preventive Care Services	In network 100% coverage; out of network subject to policy provisions including the non-network penalties.
Inpatient Hospital Pre-admission certification required for all planned inpatient admissions at 1-800-782-4437	Subject to deductible/coinsurance
Accidental Injury Services	\$50 copay for first claim received within 60 days of injury. This only applies to the outpatient professional provider visit. All other services subject to deductible and coinsurance.
Outpatient Hospital	Subject to deductible/coinsurance
Emergency Room Services	Subject to deductible/coinsurance; if accident-related, refer to the Accidental Injury provision.
Ambulance Services	Subject to deductible/coinsurance

Covered Services

Home Health Care/Hospice

Pays 100% of allowable charges for Home Health Care; Hospice paid 100% with a \$5,000 lifetime maximum.

Freestanding Outpatient Facilities

(Examples: surgery, renal dialysis)

Subject to deductible/coinsurance

Medical Equipment/Disposable Supplies

Subject to deductible/coinsurance

Short-term Therapies

Physical, Speech and Occupational, Respiratory and Cardiac

Subject to deductible/coinsurance

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

\$25 office visit copay*

* Office visits: maximum of 5 visits for each covered person (15 visits for three-or-more persons) each benefit period. Combined benefit period maximums, then subject to deductible/coinsurance.

Monthly Premium

	<u>Type of Coverage</u>	<u>Health</u>
Option 1	Employee	\$323.71
	Employee/Child	\$635.57
	Employee/Spouse	\$694.93
	Family	\$1000.11
Option 2	Employee	\$300.59
	Employee/Child	\$586.51
	Employee/Spouse	\$645.22
	Family	\$922.88
Option 3	Employee	\$266.55
	Employee/Child	\$517.88
	Employee/Spouse	\$572.04
	Family	\$814.81

— does not include prescription rates

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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; 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.