

# 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 BCBSKS 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. Note: PCP or referrals are not required under this plan.

BENEFIT CATEGORY	IN-NETWORK	OUT-OF-NETWORK
<b>DEDUCTIBLE</b> (Per calendar year)	\$200/individual \$400/family	\$400/individual \$800/family
<b>COINSURANCE</b> (Member portion for most services)	10% of allowed amounts after deductible	30% of allowed amounts after deductible
<b>ANNUAL OUT-OF-POCKET MAXIMUM (includes deductible and coinsurance)</b>  Copays, Nervous & Mental and Substance Abuse do not apply to the annual out-of-pocket amount	\$600/individual \$1,200/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.	*\$2,100/individual *\$4,200/family
<b>MAXIMUM LIFETIME BENEFIT</b>	\$2.5 million	\$1 million
<b>PHYSICIAN SERVICES</b>  Physicians Visits — home/office  Surgery — inpatient and outpatient  Maternity Care  Well Child & Well Baby (for children up to age 72 months)  Immunizations up to age 72 months Immunizations over 72 months  Well Women — Annual Check Up Office Visit Mammogram Pap Smear  Routine Physicals — Annual Check Up Office Visit Lab & Radiology  Injections  Radiology and Lab	\$20 copay  Subject to deductible/coinsurance  \$20 copay then covers 100% of allowed amounts. Only one copayment will apply for all prenatal care \$20 copay then covers 100% of allowed amounts  100% of allowed amounts Subject to deductible/coinsurance  \$20 office visit copay Covers 100% of allowed amounts Covers 100% of allowed amounts  \$20 office visit copay Covers 100% of allowed amounts  Subject to deductible/coinsurance  Covers 100% of allowed amounts	*Subject to deductible/coinsurance  *Subject to deductible/coinsurance  *Subject to deductible/coinsurance  *Subject to deductible/coinsurance *Subject to deductible/coinsurance  *Subject to deductible/coinsurance *Subject to deductible/coinsurance *Subject to deductible/coinsurance  *Subject to deductible/coinsurance  *Subject to deductible/coinsurance
<b>INPATIENT HOSPITAL</b>	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
<b>OUTPATIENT HOSPITAL</b>	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
<b>EMERGENCY SERVICES — EMERGENCY ROOM</b>	\$100 copay per visit then covers 100% of allowed amounts Copay waived if patient admitted	\$100 per visit then 100% of allowed amounts Waived if patient admitted.
<b>AMBULANCE</b>	\$30 copayment, then 100% of allowed amounts	*Subject to deductible/coinsurance
<b>URGENT CARE</b>	\$20 office visit copay, then 100% of allowed	*Subject to deductible/coinsurance
<b>FREESTANDING OUTPATIENT FACILITIES AND OUTPATIENT HOSPITAL SERVICES</b> Radiology & laboratory, surgery, dialysis	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
<b>DURABLE MEDICAL EQUIPMENT</b> Including Foot Orthotics and Prosthetic Devices	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
<b>HOME HEALTH CARE</b>	Subject to deductible/coinsurance Rehabilitation services are subject to \$20 office visit copay.	*Subject to deductible/coinsurance
<b>DIABETIC EQUIPMENT AND SUPPLIES</b> Insulin pumps, insulin pump supplies, glucose monitor	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
<b>HOSPICE CARE</b>	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.

BENEFIT CATEGORY	IN-NETWORK	OUT-OF-NETWORK
<b>SHORT-TERM THERAPIES</b> Physical, Speech and Occupational, Respiratory and Cardiac <b>Inpatient</b> <b>Outpatient</b>	Subject to deductible/coinsurance \$20 copay	*Subject to deductible/coinsurance *Subject to deductible/coinsurance
<b>SPINAL MANIPULATIONS</b> (including x-rays)	\$20 copay	*Subject to deductible/coinsurance
	Combined 26 visits per calendar year	
<b>PHYSICAL MEDICINE</b> TMJ Vision Therapy Biofeedback Acupressure/Acupuncture	\$20 copay \$20 copay \$20 copay \$20 copay	*Subject to deductible/coinsurance *Subject to deductible/coinsurance *Subject to deductible/coinsurance
	\$20 copay Combined 26 visits per calendar year	
<b>BEHAVIORAL HEALTH &amp; SUBSTANCE ABUSE</b> +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)	Subject to deductible/coinsurance Subject to deductible/coinsurance  Covers up to 100% of first 3 visits, then \$20 copay  \$20 copay, then 100% of allowed amounts	*Subject to deductible/coinsurance *Subject to deductible/coinsurance  Covers up to 100% of allowed amounts for first 3 visits; then 50% for subsequent visits  *Subject to deductible/coinsurance
<b>PRESCRIPTION DRUGS — RETAIL</b> Generic Formulary Brand Non-Formulary Brand	\$7 copay \$20 copay \$40 copay  Diabetic supplies such as insulin syringes and lancets are covered through Raytheon's prescription drug benefit for generic copay. Test strips are covered through Raytheon's prescription benefit for either the formulary or non-formulary copay.  The quantity per prescription shall be the greater of a 34-day supply or 100 unit dosage, or the quantity sufficient for a standard course of treatment as specified by the FDA guidelines. For maintenance drugs, the maximum quantity dispensed shall be up to a three-month supply with a total of three copayments. Other quantity limits will apply for certain prescriptions.	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
<b>PRESCRIPTION DRUGS — MAIL ORDER</b> Generic Formulary Brand Non-Formulary Brand	\$14 copayment per 90-day supply \$40 copayment per 90-day supply \$80 copayment per 90-day supply	N/A 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; 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
- 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*