BlueCross BlueShield of Kansas

Greenbush Health Insurance Trust

Comprehensive Major Medical℠

Non-Grandfathered **Effective October 01, 2024 - September 30, 2025**

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 A Option B Option C Option D	***No Deductible carry over on any option*** $1,500 individual /$3,000 two persons /$4,500 three or more persons $2,000 individual / $4,000 two persons / $6,000 three or more persons $2,500 individual /$5,000 two persons / $7,500 three or more persons $5,000 individual/$10,000 two or more persons
Coinsurance (Member portion for most services) Option A, B, C Option D	 20% of allowed amounts after deductible has been met 0% of allowed amounts after deductible has been met
Coinsurance Maximum Option A Option B Option C Option D	 $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 $2,000 individual / $4,000 two persons / $6,000 three or more persons Not Applicable
Annual Out-of-Pocket Maximum (includes copays, deductible and coinsurance) All Options	$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 A, B & C Option D	$35/$70 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, Contraceptives

Prescription Drugs & Mail Order	
Option A, B and C	ResultsRx BlueRx Card Generic $15 per 30 days, *ESN $30 per 31-90 Days Preferred Brand - $50 per 30 days, *ESN $100 per 31-60 days, $150 per 61-90 days Non-Preferred Brand - $75 per 30 days, *ESN $150 per 31-60 days, $225 per 61-90 days Mail Order 2.5 Times Co-pays Preferred Specialty -25% up to $250 per 30 days, Prime Therapeutics Exclusive Specialty Network Non-Preferred Specialty - 25% to $1,000 per 30 days, Prime Therapeutics Exclusive Specialty Network *ESN (Extended Supply Network Pharmacy)
Option D	ResultsRx BlueRx Card, AFTER Deductible Generic $15 per 30 days, *ESN $30 per 31-90 Days Preferred Brand - $50 per 30 days, *ESN $100 per 31-60 days, $150 per 61-90 days Non-Preferred Brand - $75 per 30 days, *ESN $150 per 31-60 days, $225 per 61-90 days Mail Order 2.5 Times Co-pays Preferred Specialty - 25% up to $250 per 30 days, Prime Therapeutics Exclusive Specialty Network Non-Preferred Specialty - 25% to $1,000 per 30 days, Prime Therapeutics Exclusive Specialty Network *ESN (Extended Supply Network Pharmacy)

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 A, B and **C** Option D	 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 Option A, B & C	$250 Copay, then subject to deductible/coinsurance
Emergency Room Option D	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 A, B & **C** Option D	 $35 office visit copay Deductible/Coinsurance

Other	
Maximum Lifetime Benefit	Unlimited
Eligible Dependents	Covered to age 26

*Combined out of pocket maximum

	Employee	Employee/Child(ren)	Employee/Spouse	Employee/Dependents
Option A	$942.00	$1,651.00	$1,677.00	$2,391.00
Option B	$825.00	$1,446.00	$1,470.00	$2,098.00
Option C	$774.00	$1,356.00	$1,376.00	$1,965.00
Option D	$604.00	$1,063.00	$1,074.00	$1,539.00

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 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.