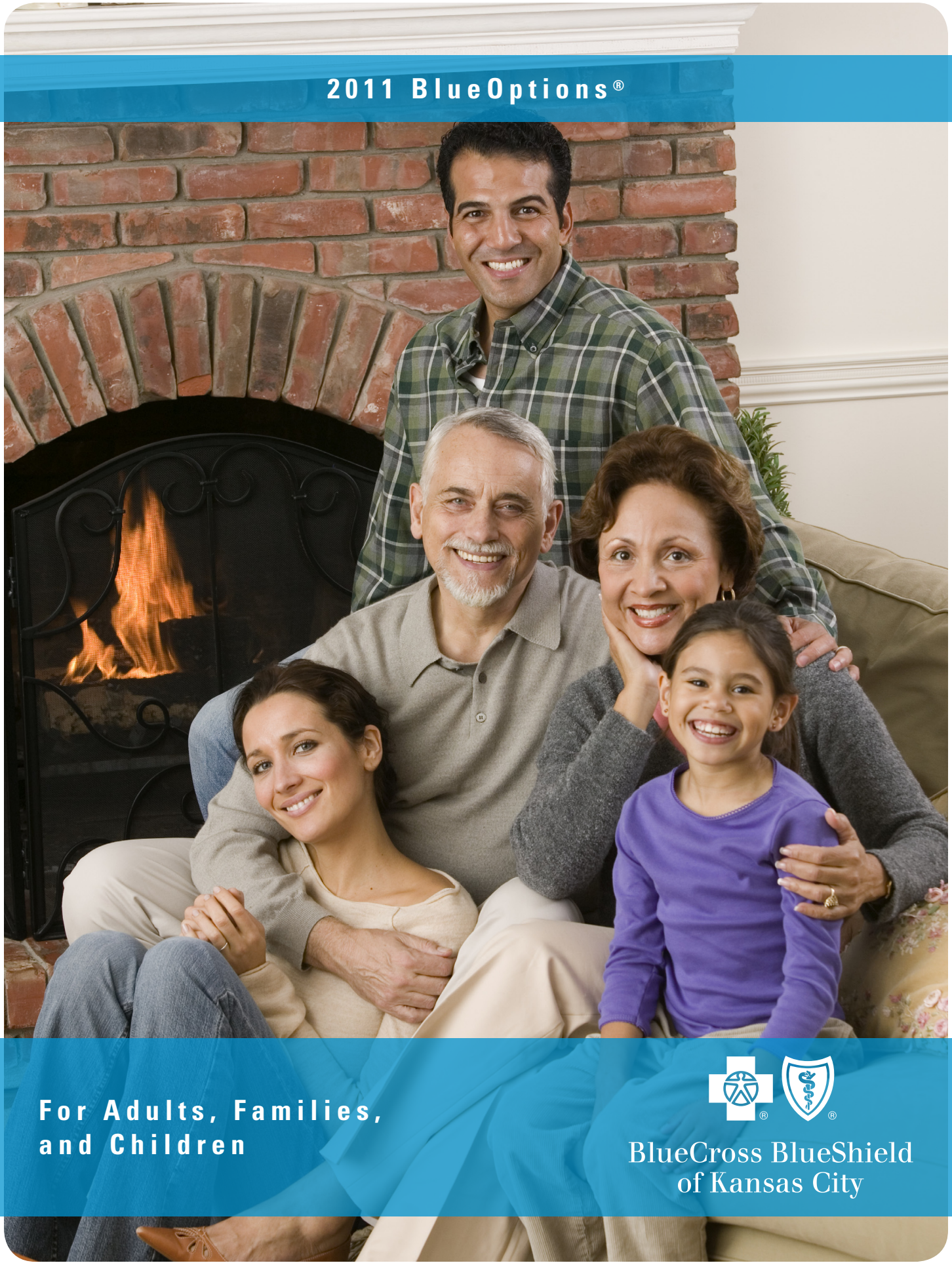
2011 BlueOptions®



For Adults, Families, and Children

BlueCross BlueShield of Kansas City

BCP2808BR12/10

When choosing a health plan the first thing you want is plenty of choices. While that seems obvious, not every insurance company offers the range of plans and options that are available through Blue Cross and Blue Shield of Kansas City. Plans range from the comprehensive benefits of Preferred-Care Blue Premium to the higher deductible RateSaver plan with a Healthy Lifestyle Reward that may further reduce your premium. It's what nearly one million members have come to expect from the area's only locally owned, not-for-profit health insurance company.

	Preferred-Care Blue Premium	AffordaBlue	RateSaver	BlueSaver®	Short-Term Security	Blue4U
Deductible	•	•	•	•	•	•
Office Visits	•	•	•	•	•	•
Inpatient Services	•	•	•	•	•	•
Outpatient Surgery	•	•	•	•	•	•
Emergency Room	•	•	•	•	•	•
Allergy Testing	•	•	•	•	•	•
Ambulance	•	•	•	•	•	•
Diagnostic X-ray	•	•	•	•	•	•
Lab	•	•	•	•	•	•
Well-Woman Care	•	•	•	•	•	•
PSA	•	•	•	•	•	•
Outpatient Therapy	•	•	•	•	•	•
Urgent Care	•	•	•	•	•	•
Mental Health	•	•	•	•	•	•
Substance Abuse	•	•	•	•	•	•
Chemical Dependency	•	•	•	•	•	•
Eye Exams	•	•	•	•		•
Life Insurance*	•	•	•	•		•
Well-Child Care	•	•	•	•		•
Maternity Care	•			•		
Brand-Name Drug Coverage	•			•		•
Generic Drug Coverage	•	•		•		•
Preferred Care Blue Network	•	•	•	•	•	
Blue Access Network						•

*Life insurance underwritten by Missouri Valley Life and Health Insurance Company, a subsidiary of Blue Cross and Blue Shield of Kansas City.

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Preferred-Care Blue Premium Benefits

		WHAT YOU PAY: IN-NETWORK				OUT-OF-NETWORK			
Deductible	Individual	$500	$1,000	$2,500	$5,000	$500	$1,000	$2,500	$5,000
	Family	$1,500	$3,000	$7,500	$15,000	$1,500	$3,000	$7,500	$15,000
	COINSURANCE	20%	20%	20%	20%	40%	40%	40%	40%
Physician Services	Office Visits (Includes the office visit and the lab services performed in a network physician's office or independent lab)	$20 copay	$20 copay	$40 copay	Deductible then 20%	Deductible then 40%			
	Other Physician Services (Includes X-ray services)	Deductible then 20%				Deductible then 40%			
	Eye Exam (Annual) †	$20 copay				$20 copay ($45 maximum benefit)			
Hospital Services	Inpatient Services/Outpatient Surgery	Deductible then 20%				Deductible then 40%*			
	Emergency Room (Copay waived if admitted to a hospital)	$100 copay then deductible then 20%				Same as In-Network			
Medical Services	Allergy Testing	Deductible then 20%				Deductible then 40%			
	Ambulance ($500 benefit limit per ground use)	Deductible then 20%				Same as In-Network			
	Diagnostic X-ray, Lab	Deductible then 20%				Deductible then 40%*			
	Mammograms, Paps, PSAs and Childhood Immunizations	Covered at 100%				Deductible then 40%			
	Other Routine and Well-Child Care	Covered at 100%				Deductible then 40%			
	Maternity Care (Subject to 24-month waiting period)	Deductible then 20%				Deductible then 40%			
	Outpatient Therapy Physical, Occupational and Skeletal Manipulations (40 combined visits per calendar year) Speech and Hearing Therapy (Unlimited combined visits per calendar year)	Deductible then 20%				Deductible then 40%			
	Urgent Care (Includes the office visit and the lab services performed in a network urgent care or independent lab)	$20 copay	$20 copay	$40 copay	Deductible then 20%	Deductible then 40%			
	Annual Out-of-Pocket Maximum (Individual/Family)	$2,500/$7,500	$3,000/$9,000	$4,500/$13,500	$7,000/$21,000	$5,000/$15,000	$6,000/$18,000	$9,000/$27,000	$14,000/$42,000
Drug Coverage			**34-day supply**	**102-day supply**					
	Tier 1 This prescription drug benefit design		$10 copay	$30 copay		Applicable copay then 50%			
	Tier 2 is considered creditable coverage		$50 copay	$150 copay		Applicable copay then 50%			
	Tier 3 for Medicare Part D purposes		$80 copay	$240 copay		Applicable copay then 50%			

*Services performed at non-participating imaging centers, hospitals or outpatient facilities in our service area are limited to $200 max per day. † Eye exam provided by Vision Service Plan (VSP). Once you have chosen one of our health insurance plans, you will receive further plan details in your policy. The covered services described in the benefit schedule are subject to the conditions, limitations and exclusions of the policy.

Mental Health and Substance Abuse/Chemical Dependency.
Kansas residents receive benefits when using either in-network or out-of-network providers. Missouri residents receive benefits when using in-network providers ONLY. All benefits are subject to Kansas and Missouri state mandates. Please refer to the contract for a complete description of benefits.

		KANSAS RESIDENTS	MISSOURI RESIDENTS
Mental Health	Inpatient Treatment	Deductible then coinsurance Limited to 45 days/year	Deductible then in-network coinsurance Limited to 90 days/year
	Outpatient Treatment	Deductible then coinsurance	Deductible then in-network coinsurance
Substance Abuse/ Chemical Dependency	Residential Treatment	(See Inpatient Treatment Benefit)	Deductible then in-network coinsurance Limited to 21 days/year
	Inpatient Treatment/Detoxification	Deductible then coinsurance Limited to 30 days/year	Deductible then in-network coinsurance Limited to 6 days/year
	Outpatient Treatment	Deductible then coinsurance	Deductible then in-network coinsurance Limited to 26 days/year and limited to lifetime of 10 episodes of treatment for chemical dependency

Services performed at non-participating hospitals or outpatient facilities in our service area are limited to $200 max per day.

WHAT YOU SHOULD KNOW ABOUT PRE-EXISTING HEALTH CONDITIONS: Pre-existing health conditions include any illness, injury or other condition for which medical advice, diagnosis, care or treatment was received or recommended during the six months prior to your Preferred-Care Blue Premium effective date. Benefits for these conditions are available after you've been covered by our plan for 12 consecutive months. See policy for details. (Pre-existing health conditions not applicable to those under age 19.)

ADDITIONAL BENEFITS. EYEWEAR DISCOUNTS. Get discounts on prescription and non-prescription eyewear products from participating network providers listed in your provider directory. Lasik, eyeglass frames, lenses and contact lenses, sunglasses and eye care kits are eligible for discounts. (Discounts are not insurance.) **LIFE INSURANCE.** $10,000 term life insurance on the contract holder.

Need rates?
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AffordaBlue Benefits

		WHAT YOU PAY: IN-NETWORK			OUT-OF-NETWORK		
Deductible	Individual	$2,500	$5,000	$10,000	$2,500	$5,000	$10,000
	Family	$7,500	$15,000	$30,000	$7,500	$15,000	$30,000
	COINSURANCE	20%	0%	0%	40%	30%	30%
Physician Services	Office visits 1-5 per calendar year* (Office visit charge only)	$30 copay	$30 copay		40% Coinsurance	30% Coinsurance	
	Office visits 6+ per calendar year* (Office visit charge only)	Deductible then 20%	Deductible		Deductible then 40%	Deductible then 30%	
	Physician Services (Other charges)	Deductible then 20%	Deductible		Deductible then 40%	Deductible then 30%	
	Eye Exam (Annual) †	$20 copay	$20 copay		$20 copay ($45 maximum benefit)	$20 copay ($45 maximum benefit)	
Hospital Services	Inpatient Services	Deductible then 20%	Deductible		Deductible then 40%**	Deductible then 30%**	
	Outpatient Surgery	Deductible then 20%	Deductible		Deductible then 40%**	Deductible then 30%**	
	Emergency Room	Deductible then 20%	Deductible		Same as In-Network	Same as In-Network	
Medical Services	Allergy Testing	Deductible then 20%	Deductible		Deductible then 40%	Deductible then 30%	
	Ambulance ($500 benefit limit per ground use)	Deductible then 20%	Deductible		Same as In-Network	Same as In-Network	
	Diagnostic X-ray, Lab	Deductible then 20%	Deductible		Deductible then 40%**	Deductible then 30%**	
	Mammograms, Paps, PSAs and Childhood Immunizations	Covered at 100%	Covered at 100%		Deductible then 40%	Deductible then 30%	
	Other Routine and Well-Child Care	Covered at 100%	Covered at 100%		Deductible then 40%	Deductible then 30%	
	Outpatient Therapy* Physical, Occupational and Skeletal Manipulations (40 combined visits per calendar year) Speech and Hearing Therapy (Unlimited combined visits per calendar year)	Deductible then 20%	Deductible		Deductible then 40%	Deductible then 30%	
	Urgent Care						
	Office visits 1-5 per calendar year* (Office visit charge only)	$30 copay	$30 copay		40% Coinsurance	30% Coinsurance	
	Office visits 6+ per calendar year* (Office visit charge only)	Deductible then 20%	Deductible		Deductible then 40%	Deductible then 30%	
	Physician Services (Other charges)	Deductible then 20%	Deductible		Deductible then 40%	Deductible then 30%	
	Annual Out-of-Pocket Maximum (Individual/Family)	$4,500/$13,500	$5,000/$15,000	$10,000/$30,000	$9,000/$27,000	$10,000/$30,000	$20,000/$60,000
Drug Coverage	Prescription Drugs***	Generics Covered Only			Generics Covered Only		
	Short-Term Supplies	$12 copay			$12 copay then 50%		
	Long-Term Supplies (Mail order)	$36 copay			$36 copay then 50%		

*Preferred and non-preferred office visits charged in conjunction with physician services, urgent care, or outpatient therapy will be subject to office visit copayment up to 5 per calendar year. Additional services subject to deductible, then coinsurance. **Services performed at non-participating imaging centers, hospitals or outpatient facilities in our service area are limited to $200 max per day. ***This prescription drug benefit is NOT considered creditable coverage for Medicare Part D purposes. See policy for details. † Eye exam provided by Vision Service Plan (VSP). Once you have chosen one of our health insurance plans, you will receive further plan details in your policy. The covered services described in the benefit schedule are subject to the conditions, limitations and exclusions of the contract.

Mental Health and Substance Abuse/Chemical Dependency.
Kansas residents receive benefits when using either in-network or out-of-network providers. Missouri residents receive benefits when using in-network providers ONLY. All benefits are subject to Kansas and Missouri state mandates. Please refer to the contract for a complete description of benefits.

		KANSAS RESIDENTS	MISSOURI RESIDENTS
Mental Health	Inpatient Treatment	Deductible then coinsurance Limited to 45 days/year	Deductible then in-network coinsurance Limited to 90 days/year
	Outpatient Treatment	Deductible then coinsurance	Deductible then in-network coinsurance
Substance Abuse/ Chemical Dependency	Residential Treatment	(See Inpatient Treatment Benefit)	Deductible then in-network coinsurance Limited to 21 days/year
	Inpatient Treatment/Detoxification	Deductible then coinsurance Limited to 30 days/year	Deductible then in-network coinsurance Limited to 6 days/year
	Outpatient Treatment	Deductible then coinsurance	Deductible then in-network coinsurance Limited to 26 days/year and limited to lifetime of 10 episodes of treatment for chemical dependency

Services performed at non-participating hospitals or outpatient facilities in our service area are limited to $200 max per day.

WHAT YOU SHOULD KNOW ABOUT PRE-EXISTING HEALTH CONDITIONS: Pre-existing health conditions include any illness, injury or other condition for which medical advice, diagnosis, care or treatment was received or recommended during the six months prior to your Preferred-Care Blue Premium effective date. Benefits for these conditions are available after you've been covered by our plan for 12 consecutive months. See policy for details. (Pre-existing health conditions not applicable to those under age 19.)

ADDITIONAL BENEFITS. EYEWEAR DISCOUNTS. Get discounts on prescription and non-prescription eyewear products from participating network providers listed in your provider directory. Lasik, eyeglass frames, lenses and contact lenses, sunglasses and eye care kits are eligible for discounts. (Discounts are not insurance.) **LIFE INSURANCE.** $10,000 term life insurance on the contract holder.

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RateSaver Benefits

		WHAT YOU PAY: IN-NETWORK					OUT-OF-NETWORK
Deductible	Individual	$500	$1,000	$2,500	$5,000	$10,000	(Same as In-Network)
	Family	$1,500	$3,000	$7,500	$15,000	$30,000	
	COINSURANCE	20%	20%	20%	20%	20%	40%
Physician Services	Office Visits (Includes the office visit and the lab services performed in a network physician's office or independent lab)	$30 copay		Deductible then 20%			Deductible then 40%
	Other Physician Services (Includes X-ray services)	Deductible then 20%		Deductible then 20%			Deductible then 40%
	Eye Exam (Annual) †	$20 copay		$20 copay			$20 copay ($45 maximum benefit)
Hospital Services	Inpatient Services/Outpatient Surgery	Deductible then 20%		Deductible then 20%			Deductible then 40%*
	Emergency Room (Copay waived if admitted to a hospital)	$100 copay then deductible then 20%		$100 copay then deductible then 20%			Same as In-Network
Medical Services	Allergy Testing	Deductible then 20%		Deductible then 20%			Deductible then 40%
	Ambulance ($500 benefit limit per ground use)	Deductible then 20%		Deductible then 20%			Same as In-Network
	Diagnostic X-ray, Lab	Deductible then 20%		Deductible then 20%			Deductible then 40%*
	Mammograms, Paps, PSAs and Childhood Immunizations	Covered at 100%		Covered at 100%			Deductible then 40%
	Other Routine and Well-Child Care	Covered at 100%		Covered at 100%			Deductible then 40%
	Outpatient Therapy Physical, Occupational and Skeletal Manipulations (40 combined visits per calendar year) Speech and Hearing Therapy (Unlimited combined visits per calendar year)	Deductible then 20%		Deductible then 20%			Deductible then 40%
	Urgent Care (Includes the office visit and the lab services performed in a network physician's office or independent lab)	$30 copay		Deductible then 20%			Deductible then 40%
	Maternity Care	Not Covered		Not Covered			Not Covered
	Outpatient Prescription Drugs	Not Covered		Not Covered			Not Covered
	Annual Out-of-Pocket Maximum (Individual/Family)	$2,500/$7,500	$3,000/$9,000	$4,500/$13,500	$7,000/$21,000	$11,000/$33,000	See below‡

*Services performed at non-participating imaging centers, hospitals or outpatient facilities in our service area are limited to $200 max per day. † Eye exam provided by Vision Service Plan (VSP). ‡ Out of pocket maximums for RateSaver out-of-network plans are as follows (Individual/Family): $500 deductible $5,000/$15,000; $1,000 deductible $6,000/$18,000; $2,500 deductible $9,000/$27,000; $5,000 deductible $14,000/$42,000; and $10,000 deductible $22,000/$66,000. Once you have chosen one of our health insurance plans, you will receive further plan details in your policy. The covered services described in the benefit schedule are subject to the conditions, limitations and exclusions of the policy.

Mental Health and Substance Abuse/Chemical Dependency.
Kansas residents receive benefits when using either in-network or out-of-network providers. Missouri residents receive benefits when using in-network providers ONLY. All benefits are subject to Kansas and Missouri state mandates. Please refer to the contract for a complete description of benefits.

		KANSAS RESIDENTS	MISSOURI RESIDENTS
Mental Health	Inpatient Treatment	Deductible then coinsurance Limited to 45 days/year	Deductible then in-network coinsurance Limited to 90 days/year
	Outpatient Treatment	Deductible then coinsurance	Deductible then in-network coinsurance
Substance Abuse/ Chemical Dependency	Residential Treatment	(See Inpatient Treatment Benefit)	Deductible then in-network coinsurance Limited to 21 days/year
	Inpatient Treatment/Detoxification	Deductible then coinsurance Limited to 30 days/year	Deductible then in-network coinsurance Limited to 6 days/year
	Outpatient Treatment	Deductible then coinsurance	Deductible then in-network coinsurance Limited to 26 days/year and limited to lifetime of 10 episodes of treatment for chemical dependency

Services performed at non-participating hospitals or outpatient facilities in our service area are limited to $200 max per day.

WHAT YOU SHOULD KNOW ABOUT PRE-EXISTING HEALTH CONDITIONS: Pre-existing health conditions include any illness, injury or other condition for which medical advice, diagnosis, care or treatment was received or recommended during the six months prior to your Preferred-Care Blue Premium effective date. Benefits for these conditions are available after you've been covered by our plan for 12 consecutive months. See policy for details. (Pre-existing health conditions not applicable to those under age 19.)

ADDITIONAL BENEFITS. EYEWEAR DISCOUNTS. Get discounts on prescription and non-prescription eyewear products from participating network providers listed in your provider directory. Lasik, eyeglass frames, lenses and contact lenses, sunglasses and eye care kits are eligible for discounts. (Discounts are not insurance.) **LIFE INSURANCE.** $10,000 term life insurance on the contract holder.

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BlueSaver® Benefits

		WHAT YOU PAY: IN-NETWORK			OUT-OF-NETWORK		
Deductible	Individual	$1,500	$3,000	$5,000	$1,500	$3,000	$5,000
	Family**	$3,000	$6,000	$10,000	$3,000	$6,000	$10,000
	COINSURANCE	10%	0%	0%	30%	30%	20%
Physician Services	Office Visits (Includes the office visit and the lab services performed in a network physician's office or independent lab)	Deductible then 10%	Deductible		Deductible then coinsurance		
	Other Physician Services (Includes X-ray services)	Deductible then 10%	Deductible		Deductible then coinsurance		
	Eye Exam (Annual)	$20 copay	$20 copay		$20 copay ($45 maximum benefit)		
Hospital Services	Inpatient Services/Outpatient Surgery	Deductible then 10%	Deductible		Deductible then coinsurance*		
	Emergency Room (Copay waived if admitted to a hospital)	Deductible then 10%	Deductible		Same as In-Network		
Medical Services	Allergy Testing	Deductible then 10%	Deductible		Deductible then coinsurance		
	Ambulance ($500 benefit limit per ground use)	Deductible then 10%	Deductible		Same as In-Network		
	Diagnostic X-ray, Lab	Deductible then 10%	Deductible		Deductible then coinsurance*		
	Mammograms, Paps, PSAs and Childhood Immunizations	Covered at 100%	Covered at 100%		Deductible then coinsurance		
	Other Routine and Well-Child Care	Covered at 100%	Covered at 100%		Deductible then coinsurance		
	Maternity Care (Subject to 24-month waiting period)	Deductible then 10%	Deductible		Deductible then coinsurance		
	Outpatient Therapy Physical, Occupational and Skeletal Manipulations (40 combined visits per calendar year) Speech and Hearing Therapy (Unlimited combined visits per calendar year)	Deductible then 10%	Deductible		Deductible then coinsurance		
	Urgent Care (Includes the office visit and the lab services performed in a network urgent care or independent lab)	Deductible then 10%	Deductible		Deductible then coinsurance		
	Annual Out-of-Pocket Maximum (Individual/Family)	$2,500/$5,000	$3,000/$6,000	$5,000/$10,000	$5,000/$10,000	$6,000/$12,000	$10,000/$20,000
Drug Coverage		**34-day supply**	**102-day supply**		Deductible then applicable copay then 50%		
	Tier 1 — This prescription drug benefit design	Deductible then $10 copay	Deductible then $30 copay				
	Tier 2 — is considered creditable coverage	Deductible then $50 copay	Deductible then $150 copay				
	Tier 3 — for Medicare Part D purposes	Deductible then $80 copay	Deductible then $240 copay				

*Services performed at non-participating imaging centers, hospitals or outpatient facilities in our service area are limited to $200 max per day. **Family deductible must be met before coinsurance applies. † Eye exam provided by Vision Service Plan (VSP). Once you have chosen one of our health insurance plans, you will receive further plan details in your policy. The covered services described in the benefit schedule are subject to the conditions, limitations and exclusions of the policy.

Mental Health and Substance Abuse/Chemical Dependency.
Kansas residents receive benefits when using either in-network or out-of-network providers. Missouri residents receive benefits when using in-network providers ONLY. All benefits are subject to Kansas and Missouri state mandates. Please refer to the contract for a complete description of benefits.

		KANSAS RESIDENTS	MISSOURI RESIDENTS
Mental Health	Inpatient Treatment	Deductible then coinsurance Limited to 45 days/year	Deductible then in-network coinsurance Limited to 90 days/year
	Outpatient Treatment	Deductible then coinsurance	Deductible then in-network coinsurance
Substance Abuse/ Chemical Dependency	Residential Treatment	(See Inpatient Treatment Benefit)	Deductible then in-network coinsurance Limited to 21 days/year
	Inpatient Treatment/Detoxification	Deductible then coinsurance Limited to 30 days/year	Deductible then in-network coinsurance Limited to 6 days/year
	Outpatient Treatment	Deductible then coinsurance	Deductible then in-network coinsurance Limited to 26 days/year and limited to lifetime of 10 episodes of treatment for chemical dependency

Services performed at non-participating hospitals or outpatient facilities in our service area are limited to $200 max per day.

WHAT YOU SHOULD KNOW ABOUT PRE-EXISTING HEALTH CONDITIONS: Pre-existing health conditions include any illness, injury or other condition for which medical advice, diagnosis, care or treatment was received or recommended during the six months prior to your Preferred-Care Blue Premium effective date. Benefits for these conditions are available after you've been covered by our plan for 12 consecutive months. See policy for details. (Pre-existing health conditions not applicable to those under age 19.)

ADDITIONAL BENEFITS. EYEWEAR DISCOUNTS. Get discounts on prescription and non-prescription eyewear products from participating network providers listed in your provider directory. Lasik, eyeglass frames, lenses and contact lenses, sunglasses and eye care kits are eligible for discounts. (Discounts are not insurance.) **LIFE INSURANCE.** $10,000 term life insurance on the contract holder.

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Short-Term Security Benefits

		WHAT YOU PAY: IN-NETWORK				OUT-OF-NETWORK			
Deductible	Individual	$500	$1,000	$2,500	$5,000	$500	$1,000	$2,500	$5,000
	Family	$1,500	$3,000	$7,500	$15,000	$1,500	$3,000	$7,500	$15,000
	COINSURANCE	20%	20%	20%	20%	40%	40%	40%	40%
Physician Services	Office Visits (Includes the office visit and the lab services performed in a network physician's office or independent lab)	Deductible then 20%				Deductible then 40%			
	Other Physician Services (Includes X-ray services)	Deductible then 20%				Deductible then 40%			
Hospital Services	Inpatient Services/Outpatient Surgery	Deductible then 20%				Deductible then 40%*			
	Emergency Room (Copay waived if admitted to a hospital)	$100 copay then deductible then 20%				Same as In-Network			
Medical Services	Allergy Testing	Deductible then 20%				Deductible then 40%			
	Ambulance ($500 benefit limit per ground use)	Deductible then 20%				Same as In-Network			
	Diagnostic X-ray, Lab	Deductible then 20%				Deductible then 40%*			
	Mammograms, Paps, PSAs and Childhood Immunizations (Related office visit charges will apply)	Covered at 100%				Deductible then 40%			
	Outpatient Therapy Physical, Occupational and Skeletal Manipulations (40 combined visits per calendar year) Speech and Hearing Therapy (Unlimited combined visits per calendar year)	Deductible then 20%				Deductible then 40%			
	Urgent Care (Includes the office visit and the lab services performed in a network physician's office or independent lab)	Deductible then 20%				Deductible then 40%			
	Maternity Care	Not Covered				Not Covered			
	Other State Mandated Routine and Well Child Care	20% coinsurance				Deductible then 40%			
	Outpatient Prescription Drugs	Not Covered				Not Covered			
	Annual Out-of-Pocket Maximum (Individual/Family)	$2,500/$7,500	$3,000/$9,000	$4,500/$13,500	$7,000/$21,000	$5,000/$15,000	$6,000/$18,000	$9,000/$27,000	$14,000/$42,000

*Services performed at non-participating imaging centers, hospitals or outpatient facilities in our service area are limited to $200 max per day or $200 max per calendar year, and additional calendar year limitations may apply. Once you have chosen one of our health insurance plans, you will receive further plan details in your policy. The covered services described in the benefit schedule are subject to the conditions, limitations and exclusions of the policy.

Mental Health and Substance Abuse/Chemical Dependency.
Kansas residents receive benefits when using either in-network or out-of-network providers. Missouri residents receive benefits when using in-network providers ONLY. All benefits are subject to Kansas and Missouri state mandates. Please refer to the contract for a complete description of benefits.

		KANSAS RESIDENTS	MISSOURI RESIDENTS
Mental Health	Inpatient Treatment	Deductible then coinsurance Limited to 45 days/year	Deductible then in-network coinsurance Limited to 90 days/year
	Outpatient Treatment	Deductible then coinsurance	Deductible then in-network coinsurance
Substance Abuse/ Chemical Dependency	Residential Treatment	(See Inpatient Treatment Benefit)	Deductible then in-network coinsurance Limited to 21 days/year
	Inpatient Treatment/Detoxification	Deductible then coinsurance Limited to 30 days/year	Deductible then in-network coinsurance Limited to 6 days/year
	Outpatient Treatment	Deductible then coinsurance	Deductible then in-network coinsurance Limited to 26 days/year and limited to lifetime of 10 episodes of treatment for chemical dependency

Services performed at non-participating hospitals or outpatient facilities in our service area are limited to $200 max per day.

WHAT YOU SHOULD KNOW ABOUT PRE-EXISTING HEALTH CONDITIONS: Pre-existing health conditions include any illness, injury or other condition for which medical advice, diagnosis, care or treatment was received or recommended during the six months prior to your Preferred-Care Blue Premium effective date. Benefits for these conditions are available after you've been covered by our plan for 12 consecutive months. See policy for details. (Pre-existing health conditions not applicable to those under age 19.)

ADDITIONAL BENEFITS. EYEWEAR DISCOUNTS. Get discounts on prescription and non-prescription eyewear products from participating network providers listed in your provider directory. Lasik, eyeglass frames, lenses and contact lenses, sunglasses and eye care kits are eligible for discounts. (Discounts are not insurance.) **LIFE INSURANCE.** $10,000 term life insurance on the contract holder.

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Blue4U Benefits

		WHAT YOU PAY: IN-NETWORK				OUT-OF-NETWORK			
Deductible	Individual Policy Only	$500	$1,000	$2,500	$5,000	$500	$1,000	$2,500	$5,000
	COINSURANCE	20%	20%	20%	0%	40%	40%	40%	30%
Physician Services	Office visits 1-5 per calendar year* (Office visit charge only)	$40 copay			$40 copay	40% coinsurance			30% coinsurance
	Office visits 6+ per calendar year* (Office visit charge only)	Deductible then 20%			Deductible	Deductible then 40%			Deductible then 30%
	Physician Services (Other charges)	Deductible then 20%			Deductible	Deductible then 40%			Deductible then 30%
	Eye Exam (Annual) †	$20 copay			$20 copay	$20 copay ($45 maximum benefit)			$20 copay ($45 maximum benefit)
Hospital Services	Inpatient Services	Deductible then 20%			Deductible	Deductible then 40%**			Deductible then 30%**
	Outpatient Surgery	Deductible then 20%			Deductible	Deductible then 40%**			Deductible then 30%**
	Emergency Room	Deductible then 20%			Deductible	Same as In-Network			Same as In-Network
Medical Services	Allergy Testing	Deductible then 20%			Deductible	Deductible then 40%			Deductible then 30%
	Ambulance ($500 benefit limit per ground use)	Deductible then 20%			Deductible	Same as In-Network			Same as In-Network
	X-ray, Lab	Deductible then 20%			Deductible	Deductible then 40%**			Deductible then 30%**
	Mammograms, Paps, PSAs and Childhood Immunizations	Covered at 100%			Covered at 100%	Deductible then 40%			Deductible then 30%
	Other Routine and Well-Child Care	Covered at 100%			Covered at 100%	Deductible then 40%			Deductible then 30%
	Outpatient Therapy Physical, Occupational and Skeletal Manipulations (40 combined visits per calendar year) Speech and Hearing Therapy (Unlimited combined visits per calendar year)	Deductible then 20%			Deductible	Deductible then 40%			Deductible then 30%
	Urgent Care								
	Office visits 1-5 per calendar year* (Office visit charge only)	$40 copay			$40 copay	40% coinsurance			30% coinsurance
	Office visits 6+ per calendar year* (Office visit charge only)	Deductible then 20%			Deductible	Deductible then 40%			Deductible then 30%
	Physician Services (Other charges)	Deductible then 20%			Deductible	Deductible then 40%			Deductible then 30%
	Annual Out-of-Pocket Maximum	$2,500	$3,000	$4,500	$5,000	$5,000	$6,000	$9,000	$10,000
Drug Coverage	Prescription Drugs *Short-Term/Long-Term (mail order)***								
	Tier 1 This prescription drug benefit design	$12 copay/$36 copay				Copay ($12/$36) then 50%			
	Tier 2 is considered creditable coverage	$500 deductible then 50%				$500 deductible then 50% plus copay ($50/$150)			
	Tier 3 for Medicare Part D purposes	$500 deductible then 50%				$500 deductible then 50% plus copay ($80/$240)			

*Preferred and non-preferred office visits charged in conjunction with physician services, urgent care, or outpatient therapy will be subject to office visit copayment up to 5 per calendar year. Additional services subject to deductible, then coinsurance. **Services performed at non-participating imaging centers, hospitals or outpatient facilities in our service area are limited to $200 max per day. See contract for details. † Eye exam provided by Vision Service Plan (VSP). Once you have chosen one of our health insurance plans, you will receive further plan details in your policy. The covered services described in the benefit schedule are subject to the conditions, limitations and exclusions of the policy.

Mental Health and Substance Abuse/Chemical Dependency.
Kansas residents receive benefits when using either in-network or out-of-network providers. Missouri residents receive benefits when using in-network providers ONLY. All benefits are subject to Kansas and Missouri state mandates. Please refer to the contract for a complete description of benefits.

		KANSAS RESIDENTS	MISSOURI RESIDENTS
Mental Health	Inpatient Treatment	Deductible then coinsurance Limited to 45 days/year	Deductible then in-network coinsurance Limited to 90 days/year
	Outpatient Treatment	Deductible then coinsurance	Deductible then in-network coinsurance
Substance Abuse/ Chemical Dependency	Residential Treatment	(See Inpatient Treatment Benefit)	Deductible then in-network coinsurance Limited to 21 days/year
	Inpatient Treatment/Detoxification	Deductible then coinsurance Limited to 30 days/year	Deductible then in-network coinsurance Limited to 6 days/year
	Outpatient Treatment	Deductible then coinsurance	Deductible then in-network coinsurance Limited to 26 days/year and limited to lifetime of 10 episodes of treatment for chemical dependency

Services performed at non-participating hospitals or outpatient facilities in our service area are limited to $200 max per day.

WHAT YOU SHOULD KNOW ABOUT PRE-EXISTING HEALTH CONDITIONS: Pre-existing health conditions include any illness, injury or other condition for which medical advice, diagnosis, care or treatment was received or recommended during the six months prior to your Preferred-Care Blue Premium effective date. Benefits for these conditions are available after you've been covered by our plan for 12 consecutive months. See policy for details. (Pre-existing health conditions not applicable to those under age 19.)

ADDITIONAL BENEFITS. EYEWEAR DISCOUNTS. Get discounts on prescription and non-prescription eyewear products from participating network providers listed in your provider directory. Lasik, eyeglass frames, lenses and contact lenses, sunglasses and eye care kits are eligible for discounts. (Discounts are not insurance.) **LIFE INSURANCE.** $10,000 term life insurance on the contract holder.

Need rates?
Visit us online @ www.BlueKC.com or call 888-800-4478.

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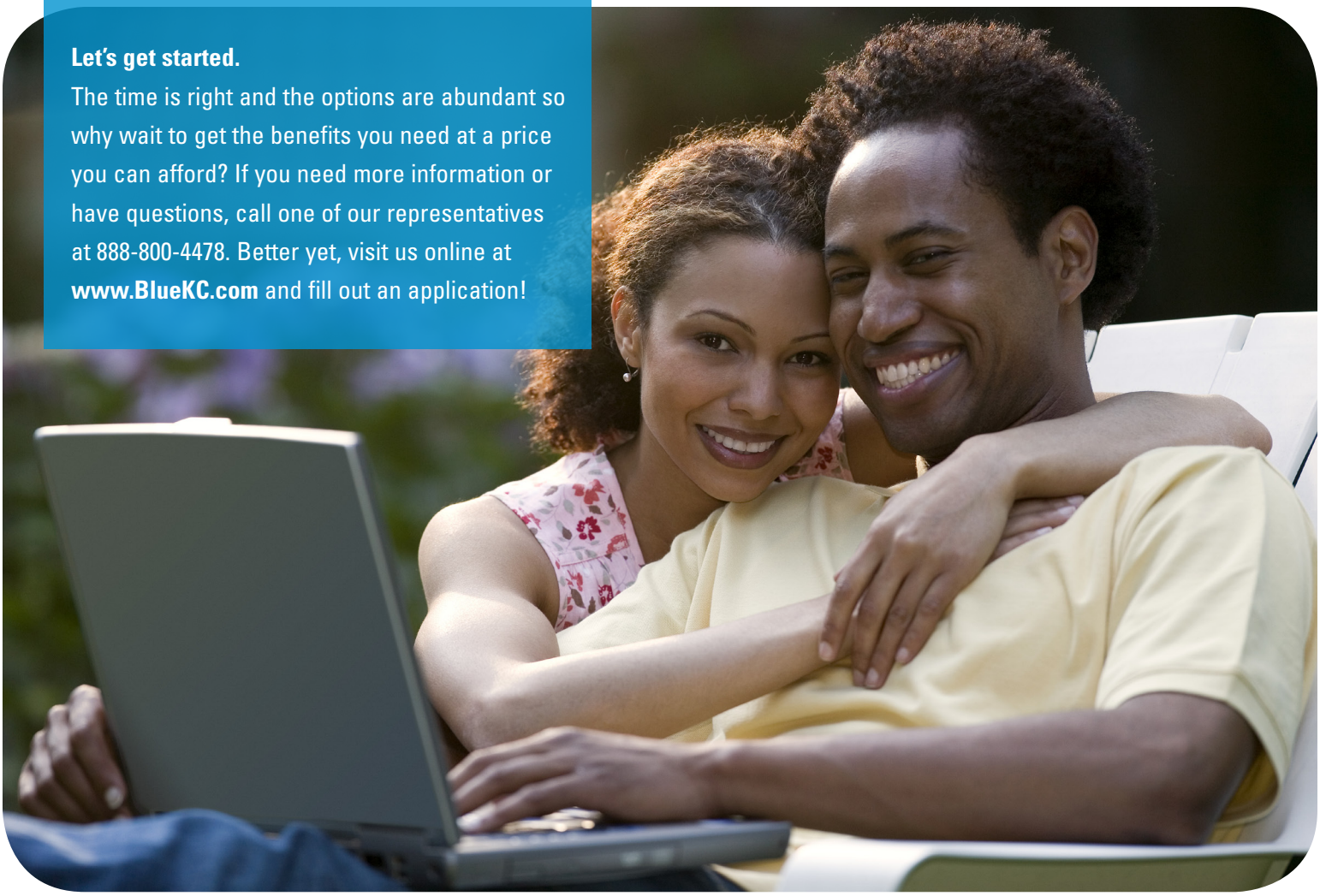

Let's get started.

The time is right and the options are abundant so why wait to get the benefits you need at a price you can afford? If you need more information or have questions, call one of our representatives at 888-800-4478. Better yet, visit us online at **www.BlueKC.com** and fill out an application!

Exclusions and Limitations

The following services and supplies are NOT covered under the Preferred-Care Blue Premium, AffordaBlue, RateSaver, BlueSaver®, Short-Term Security and Blue4U plans:

- Blood donor expenses
- Brand-name medications (AffordaBlue)
- Outpatient prescription drugs (RateSaver and Short-Term Security only)
- Care for any injury or illness incurred while on active or reserve military duty, or resulting from war or any act of war
- Contraceptives (RateSaver and Short-Term Security only)
- Custodial, convalescent or respite care
- Drugs and medicines that do not require a prescription
- Diagnostic services performed at a non-participating imaging center inside our service area are limited to a $200 calendar year maximum
- Experimental or investigational services
- Hairplasty, regardless of the reason or diagnosis
- Hearing aids, eyeglasses and contact lenses or examinations for their prescription and fitting
- Hypnotism, hypnotic anesthesia, acupuncture and acupressure
- Inpatient hospital services received from a non-participating provider hospital inside our service area are limited to $200 per day with the exception of Short-Term Security
- In-vitro fertilization and all other artificial methods of conception
- Injuries and illnesses related to member's job
- Marital counseling
- Maternity coverage for dependent daughter
- Maternity (AffordaBlue, RateSaver, Short-Term Security, and Blue4U only)
- Medical weight-reduction programs and nutrients
- Musical therapy, remedial reading, recreational therapy, other forms of special education
- Nonhuman, mechanical, experimental or investigative transplants; see contract for further coverage limitations
- Nonmedical equipment, including but not limited to equipment and supplies for conditioning the air, arch supports, corrective shoes, hot water bottles and personal care items
- Orthognathic surgery (services and supplies for correcting deformities of the jaw)
- Penile prosthesis and its implantation or any related complications
- Outpatient services received from a non-participating provider hospital or facility inside our service area are limited to $200 per day with the exception of Short-Term Security
- Pre-existing conditions during the Exclusion Period
- All pre-existing conditions (Short-Term Security only)
- Radial keratotomy and other refractive keratotomy procedures
- Reversal of sterilization procedures
- Services and supplies not medically necessary
- Services and supplies for cosmetic purposes
- Services and supplies received free of charge from a government agency
- Services and supplies for the medical or dental management (nonsurgical treatment) of conditions of the temporomandibular joint
- Services performed by an individual's immediate family members or household members
- Services related to the diagnosis or treatment (including drugs) of impotency
- Services related to the diagnosis or treatment (including drugs) of infertility or related conditions
- Sex transformations and related charges
- Treatment for morbid obesity including prescription drugs
- Surgical treatment of scarring secondary to acne or chicken pox
- Travel, whether or not recommended or prescribed by physician

Notes and Information

BlueCross BlueShield of Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

What's your plan?™

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