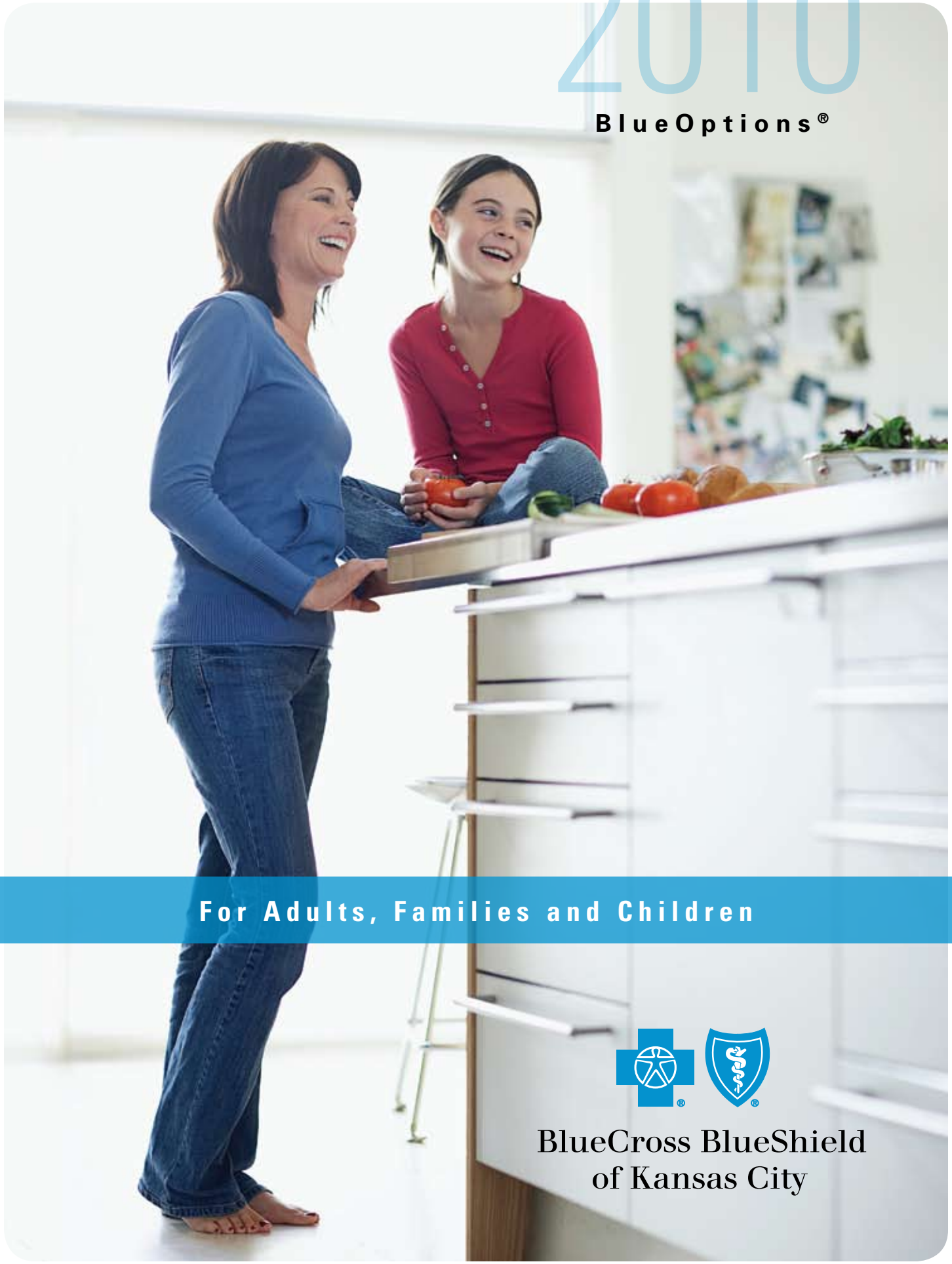
2010

# BlueOptions®

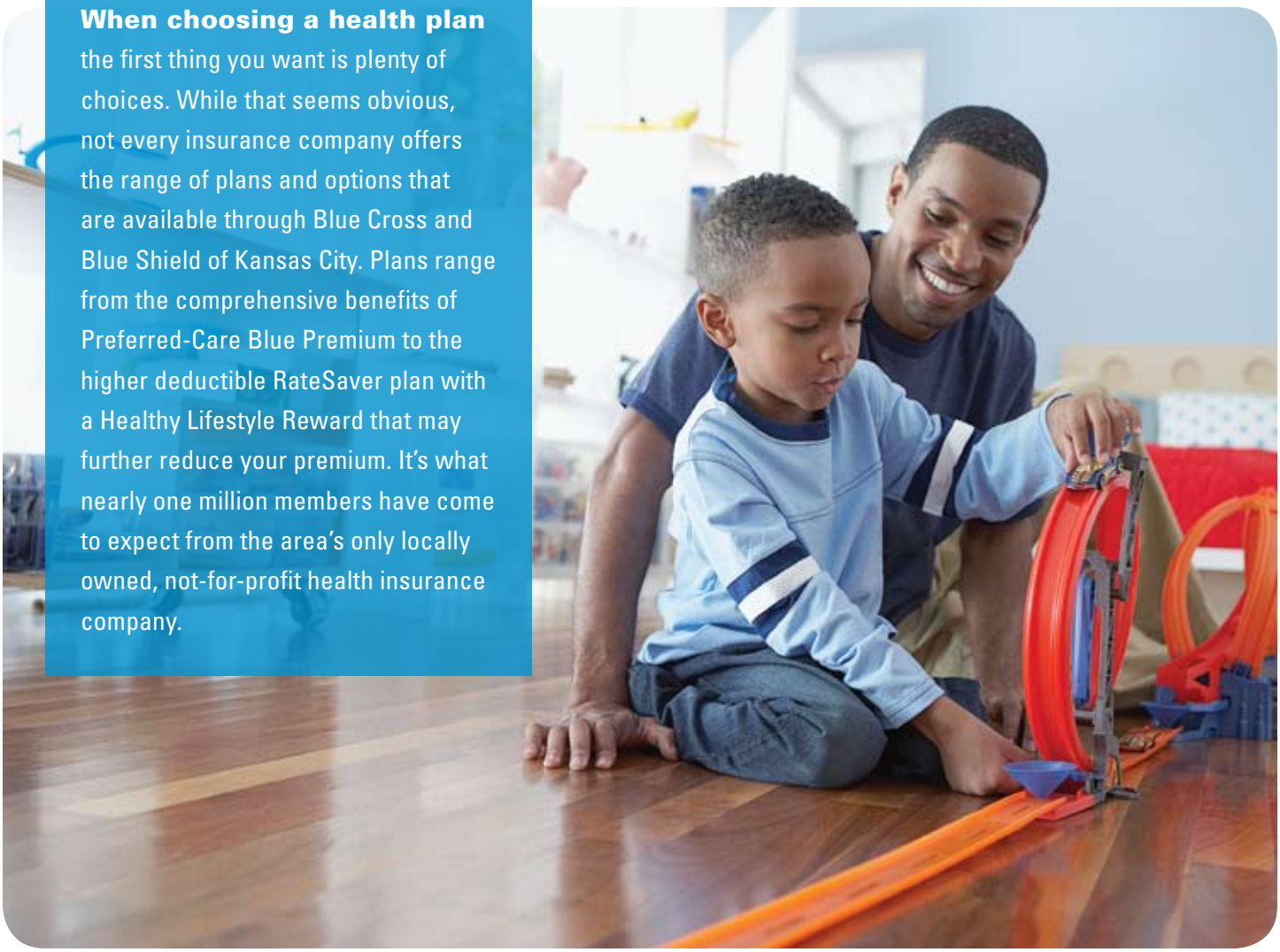


## For Adults, Families and Children

BlueCross BlueShield
of Kansas City

BCP2808BR11/9

**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.



## Benefits at a glance.

| | Preferred-Care Blue Premium | AffordaBlue | RateSaver | BlueSaver® | Short-Term Security |
|---|---|---|---|---|---|
| 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 | • | • | • | • | • |
| Life Insurance* | • | • | • | • | |
| Well-Child Care | • | • | | • | |
| Maternity Care | • | | | | |
| Brand-Name Drug Coverage | • | | | • | |
| Generic Drug Coverage | • | • | | • | |

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



BCP2808BR11/9

# Preferred-Care Blue Premium Benefits

| | | WHAT YOU PAY: IN-NETWORK | | | | OUT-OF-NETWORK |
|---|---|---|---|---|---|---|
| | | **Plan 1** | **Plan 2** | **Plan 3** | **Plan 4** | |
| **Deductible** | Individual | $500 | $1,000 | $2,500 | $5,000 | (Same as In-Network) |
| | Family | $1,500 | $3,000 | $7,500 | $15,000 | |
| **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% (Plans 1-4) | | | | Deductible then 40% |
| **Hospital Services** | Inpatient Services/Outpatient Surgery | Deductible then 20% | | | | Deductible then 40%* |
| | Emergency Room (Copay waived if admitted to an In-Network hospital) | $100 copay then deductible then 20% | | | | $100 copay then deductible then 40% |
| **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% |
| | Other Routine and Well-Child Care ($300 limit per calendar year) | 20% Coinsurance Only | | | | Deductible then 40% |
| | Maternity Care (Subject to 24-month waiting period) | Deductible then 20% | | | | Deductible then 40% |
| | Outpatient Therapy<br>Physical, Occupational and Skeletal Manipulations (40 combined visits per calendar year)<br>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 (Plans 1 & 2) | $40 copay (Plan 3) | Deductible then 20% (Plan 4) | | Deductible then 40% |
| **Drug Coverage** | Tier 1 | $10 copay | | $30 copay | | Applicable copay then 50% |
| | Tier 2 | $50 copay | | $150 copay | | Applicable copay then 50% |
| | Tier 3 | $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 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 plan contract. The covered services described in the benefit schedule are subject to the conditions, limitations and exclusions of the contract.

*This prescription drug benefit design is considered creditable coverage for Medicare Part D purposes.*

**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 plan documents for a complete description of benefits.

| | | KANSAS RESIDENTS | MISSOURI RESIDENTS |
|---|---|---|---|
| **MENTAL HEALTH** | Inpatient Treatment | Deductible then coinsurance<br>Limited to 45 days/year | Deductible then 20%<br>Limited to 90 days/year |
| | Outpatient Treatment | Deductible then coinsurance | Deductible then 20% |
| **SUBSTANCE ABUSE/ CHEMICAL DEPENDENCY** | Residential Treatment | (See Inpatient Treatment Benefit) | Deductible then 20%<br>Limited to 21 days/year |
| | Inpatient Treatment/Detoxification | Deductible then coinsurance<br>Limited to 30 days/year | Deductible then 20%<br>Limited to 6 days/year |
| | Outpatient Treatment | Deductible then coinsurance | Deductible then 20%<br>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 or $200 max per calendar year, and calendar year limitations as noted in benefit description.

LIFETIME BENEFIT MAXIMUM — $5,000,000 PER INDIVIDUAL. **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 contract for details.

**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.BuyBlueKC.com or call 888-800-4478.**

# AffordaBlue Benefits

| | | WHAT YOU PAY: IN-NETWORK | | | OUT-OF-NETWORK |
|---|---|---|---|---|---|
| Deductible | | **Plan 1** | **Plan 2** | **Plan 3** | |
| | Individual | $2,500 | $5,000 | $10,000 | (Same as In-Network) |
| | Family | $7,500 | $15,000 | $30,000 | |
| Physician Services | | **Plan 1** | | **Plans 2 & 3** | |
| | Office visits 1-5 per calendar year* (Office visit charge only) | $30 copay | | $30 copay | 40% Coinsurance |
| | Office visits 6+ per calendar year (Office visit charge only) | Deductible then 20% | | Deductible | Deductible then 40% |
| | Physician Services (Other charges) | Deductible then 20% | | Deductible | Deductible then 40% |
| Hospital Services | Inpatient Services | Deductible then 20% | | Deductible | Deductible then 40%** |
| | Outpatient Surgery | Deductible then 20% | | Deductible | Deductible then 40%** |
| | Emergency Room | Deductible then 20% | | Deductible | Deductible then 40% |
| Medical Services | Allergy Testing | Deductible then 20% | | Deductible | Deductible then 40% |
| | Ambulance ($500 benefit limit per ground use) | Deductible then 20% | | Deductible | Same as Preferred Provider |
| | X-ray, Lab | Deductible then 20% | | Deductible | Deductible then 40%** |
| | Mammograms, Paps, PSAs and Childhood Immunizations (Related office visit charges will apply) | Covered at 100% | | Covered at 100% | Deductible then 40% |
| | Other Routine/Well-Child Care ($300 limit per calendar year) | 20% Coinsurance Only | | Covered at 100% | Deductible then 40% |
| | Outpatient Therapy* | Deductible then 20% | | Deductible | Deductible then 40% |
| | Physical, Occupational and Skeletal Manipulations (40 combined visits per calendar year) | | | | |
| | Speech and Hearing Therapy (Unlimited combined visits per calendar year) | | | | |
| | Urgent Care | | | | |
| | Office visits 1-5 per calendar year* (Office visit charge only) | $30 copay | | $30 copay | 40% Coinsurance |
| | Office visits 6+ per calendar year (Office visit charge only) | Deductible then 20% | | Deductible | Deductible then 40% |
| | Physician Services (Other charges) | Deductible then 20% | | Deductible | Deductible then 40% |
| 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, routine preventive 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 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 plan contract. The covered services described in the benefit schedule are subject to the conditions, limitations and exclusions of the contract. ***This prescription drug benefit is NOT considered creditable coverage for Medicare Part D purposes. See contract for details.

**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 plan documents for a complete description of benefits.

| | | KANSAS RESIDENTS | MISSOURI RESIDENTS |
|---|---|---|---|
| MENTAL HEALTH | Inpatient Treatment | Deductible then coinsurance<br>Limited to 45 days/year | Deductible then 20%<br>Limited to 90 days/year |
| | Outpatient Treatment | Deductible then coinsurance | Deductible then 20% |
| SUBSTANCE ABUSE/ CHEMICAL DEPENDENCY | Residential Treatment | (See Inpatient Treatment Benefit) | Deductible then 20%<br>Limited to 21 days/year |
| | Inpatient Treatment/Detoxification | Deductible then coinsurance<br>Limited to 30 days/year | Deductible then 20%<br>Limited to 6 days/year |
| | Outpatient Treatment | Deductible then coinsurance | Deductible then 20%<br>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 or $200 max per calendar year, and calendar year limitations as noted in benefit description.

LIFETIME BENEFIT MAXIMUM — $5,000,000 PER INDIVIDUAL. **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 AffordaBlue effective date. Benefits for these conditions are available after you've been covered by our plan for 12 consecutive months. See contract for details.

**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.BuyBlueKC.com or call 888-800-4478.**



BCP2808BR11/9

# RateSaver Benefits

| | | WHAT YOU PAY: IN-NETWORK | | | | | OUT-OF-NETWORK |
|---|---|---|---|---|---|---|---|
| | | **Plan 1** | **Plan 2** | **Plan 3** | **Plan 4** | **Plan 5** | |
| 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 | |
| Physician Services | Office Visits<br>(Includes the office visit and the lab services performed in a network physician's office or independent lab) | $30 copay (Plans 1 & 2) | | Deductible then 20% (Plans 3, 4 & 5) | | | 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<br>(Copay waived if admitted to an In-Network hospital) | $100 copay then deductible then 20% | | | | | $100 copay then deductible then 40% |
| Medical Services | Allergy Testing | Deductible then 20% | | | | | Deductible then 40% |
| | Ambulance<br>($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<br>(Related office visit charges will apply) | Covered at 100% | | | | | Deductible then 40% |
| | Outpatient Therapy<br>Physical, Occupational and Skeletal Manipulations<br>(40 combined visits per calendar year)<br>Speech and Hearing Therapy<br>(Unlimited combined visits per calendar year) | Deductible then 20% | | | | | Deductible then 40% |
| | Urgent Care<br>(Includes the office visit and the lab services performed in a network urgent care facility or independent lab) | $30 copay (Plans 1 & 2) | | Deductible then 20% (Plans 3, 4 & 5) | | | Deductible then 40% |
| | Maternity Care | Not Covered | | | | | Not Covered |
| | Routine and Well-Child Care | Not Covered | | | | | Not Covered |
| | Outpatient Prescription Drugs | Not Covered | | | | | Not Covered |

*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 plan contract. 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 plan documents for a complete description of benefits.

| | | KANSAS RESIDENTS | MISSOURI RESIDENTS |
|---|---|---|---|
| MENTAL HEALTH | Inpatient Treatment | Deductible then coinsurance<br>Limited to 45 days/year | Deductible then 20%<br>Limited to 90 days/year |
| | Outpatient Treatment | Deductible then coinsurance | Deductible then 20% |
| SUBSTANCE ABUSE/ CHEMICAL DEPENDENCY | Residential Treatment | (See Inpatient Treatment Benefit) | Deductible then 20%<br>Limited to 21 days/year |
| | Inpatient Treatment/Detoxification | Deductible then coinsurance<br>Limited to 30 days/year | Deductible then 20%<br>Limited to 6 days/year |
| | Outpatient Treatment | Deductible then coinsurance | Deductible then 20%<br>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 or $200 max per calendar year, and calendar year limitations as noted in benefit description.

LIFETIME BENEFIT MAXIMUM — $5,000,000 PER INDIVIDUAL. **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 RateSaver effective date. Benefits for these conditions are available after you've been covered by our plan for 12 consecutive months. See contract for details.

**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. **SCRIPTSAVE.** Receive up to 30% off the cost of prescription drugs with our ScriptSave Prescription Drug Program. Members receive a separate card for this within 15 days of obtaining coverage. (Discounts are not insurance.)

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

# BlueSaver® Benefits

| | | WHAT YOU PAY: IN-NETWORK | | | OUT-OF-NETWORK | | |
|---|---|---|---|---|---|---|---|
| **Deductible** | | **Plan 1**** | **Plan 2** | **Plan 3** | **Plan 1** | **Plan 2** | **Plan 3** |
| | 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% | 20% | 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 coinsurance | Deductible | | Deductible then coinsurance | | |
| | Other Physician Services (Includes X-ray services) | | | | | | |
| **Hospital Services** | Inpatient Services/Outpatient Surgery | Deductible then coinsurance | Deductible | | Deductible then coinsurance* | | |
| | Emergency Room (Copay waived if admitted to an In-Network hospital) | | | | Deductible then coinsurance | | |
| **Medical Services** | Allergy Testing | Deductible then coinsurance | Deductible | | Deductible then coinsurance | | |
| | Ambulance ($500 benefit limit per ground use) | | Deductible | | Deductible then coinsurance | | |
| | Diagnostic X-ray, Lab | | Deductible | | Deductible then coinsurance* | | |
| | Mammograms, Paps, PSAs and Childhood Immunizations (Related office visit charges will apply) | | Covered at 100% | | Deductible then coinsurance | | |
| | Other Routine and Well-Child Care ($300 limit per calendar year) | | Deductible | | Deductible then coinsurance | | |
| | Maternity Care (Subject to 24-month waiting period) | | Deductible | | Deductible then coinsurance | | |
| | Outpatient Therapy, Physical, Occupational and Skeletal Manipulations (40 combined visits per calendar year) | | Deductible | | Deductible then coinsurance | | |
| | Speech and Hearing Therapy (Unlimited combined visits per calendar year) | | | | | | |
| | Urgent Care (Includes the office visit and the lab services performed in a network urgent care facility or independent lab) | | Deductible | | Deductible then coinsurance | | |
| **Drug Coverage** | | **30-Day Supply** | **102-Day Supply** | | | | |
| | Tier 1 | Deductible then $10 copay | Deductible then $30 copay | | Deductible then applicable copay then 50% | | |
| | Tier 2 | Deductible then $50 copay | Deductible then $150 copay | | | | |
| | Tier 3 | Deductible then $80 copay | Deductible then $240 copay | | | | |
| | *This prescription drug benefit design is considered creditable coverage for Medicare Part D purposes.* | | | | | | |

*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 plan contract. The covered services described in the benefit schedule are subject to the conditions, limitations and exclusions of the contract. **Family deductible must be met before coinsurance applies.

**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 plan documents for a complete description of benefits.

| | | KANSAS RESIDENTS | MISSOURI RESIDENTS |
|---|---|---|---|
| **MENTAL HEALTH** | Inpatient Treatment | Deductible then coinsurance<br>Limited to 45 days/year | Deductible then 20%<br>Limited to 90 days/year |
| | Outpatient Treatment | Deductible then coinsurance | Deductible then 20% |
| **SUBSTANCE ABUSE/ CHEMICAL DEPENDENCY** | Residential Treatment | (See Inpatient Treatment Benefit) | Deductible then 20%<br>Limited to 21 days/year |
| | Inpatient Treatment/Detoxification | Deductible then coinsurance<br>Limited to 30 days/year | Deductible then 20%<br>Limited to 6 days/year |
| | Outpatient Treatment | Deductible then coinsurance | Deductible then 20%<br>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 or $200 max per calendar year, and calendar year limitations as noted in benefit description.

LIFETIME BENEFIT MAXIMUM — $5,000,000 PER INDIVIDUAL. **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 BlueSaver® effective date. Benefits for these conditions are available after you've been covered by our plan for 12 consecutive months. See contract for details.

**ADDITIONAL BENEFITS. DENTAL CARE (cleaning and X-rays).** You pay 20% (when you use In-Network dental providers and 50% when you use Out-of-Network dental providers). Biannual routine oral exams (X-rays and cleaning). Fluoride treatments for covered members younger than 19. (Not subject to annual deductible and does not apply to out-of-pocket maximum.) **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.BuyBlueKC.com or call 888-800-4478.**



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# Short-Term Security Benefits

| | | WHAT YOU PAY: IN-NETWORK | | | | OUT-OF-NETWORK |
|---|---|---|---|---|---|---|
| Deductible | **DEDUCTIBLE** | **Plan 1** | **Plan 2** | **Plan 3** | **Plan 4** | |
| | Individual | $500 | $1,000 | $2,500 | $5,000 | (Same as In-Network) |
| | Family | $1,500 | $3,000 | $7,500 | $15,000 | |
| Physician Services | Office Visits<br>(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<br>(Copay waived if admitted to an In-Network hospital) | $100 copay then deductible then 20% | | | | $100 copay then deductible then 40% |
| Medical Services | Allergy Testing | Deductible then 20% | | | | Deductible then 40% |
| | Ambulance<br>($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<br>(Related office visit charges will apply) | Covered at 100% | | | | Deductible then 40% |
| | Outpatient Therapy<br>Physical, Occupational and Skeletal Manipulations<br>(40 combined visits per calendar year)<br>Speech and Hearing Therapy<br>(Unlimited combined visits per calendar year) | Deductible then 20% | | | | Deductible then 40% |
| | Urgent Care<br>(Includes the office visit and the lab services performed in a network urgent care facility or independent lab) | Deductible then 20% | | | | Deductible then 40% |
| | Maternity Care | Not Covered | | | | Not Covered |
| | Routine and Well-Child Care | Not Covered | | | | Not Covered |
| | Outpatient Prescription Drugs | Not Covered | | | | Not Covered |

*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 plan contract. 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 plan documents for a complete description of benefits.

| | | KANSAS RESIDENTS | MISSOURI RESIDENTS |
|---|---|---|---|
| MENTAL HEALTH | Inpatient Treatment | Deductible then coinsurance<br>Limited to 45 days/year | Deductible then 20%<br>Limited to 90 days/year |
| | Outpatient Treatment | Deductible then coinsurance | Deductible then 20% |
| SUBSTANCE ABUSE/ CHEMICAL DEPENDENCY | Residential Treatment | (See Inpatient Treatment Benefit) | Deductible then 20%<br>Limited to 21 days/year |
| | Inpatient Treatment/Detoxification | Deductible then coinsurance<br>Limited to 30 days/year | Deductible then 20%<br>Limited to 6 days/year |
| | Outpatient Treatment | Deductible then coinsurance | Deductible then 20%<br>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 or $200 max per calendar year, and calendar year limitations as noted in benefit description.

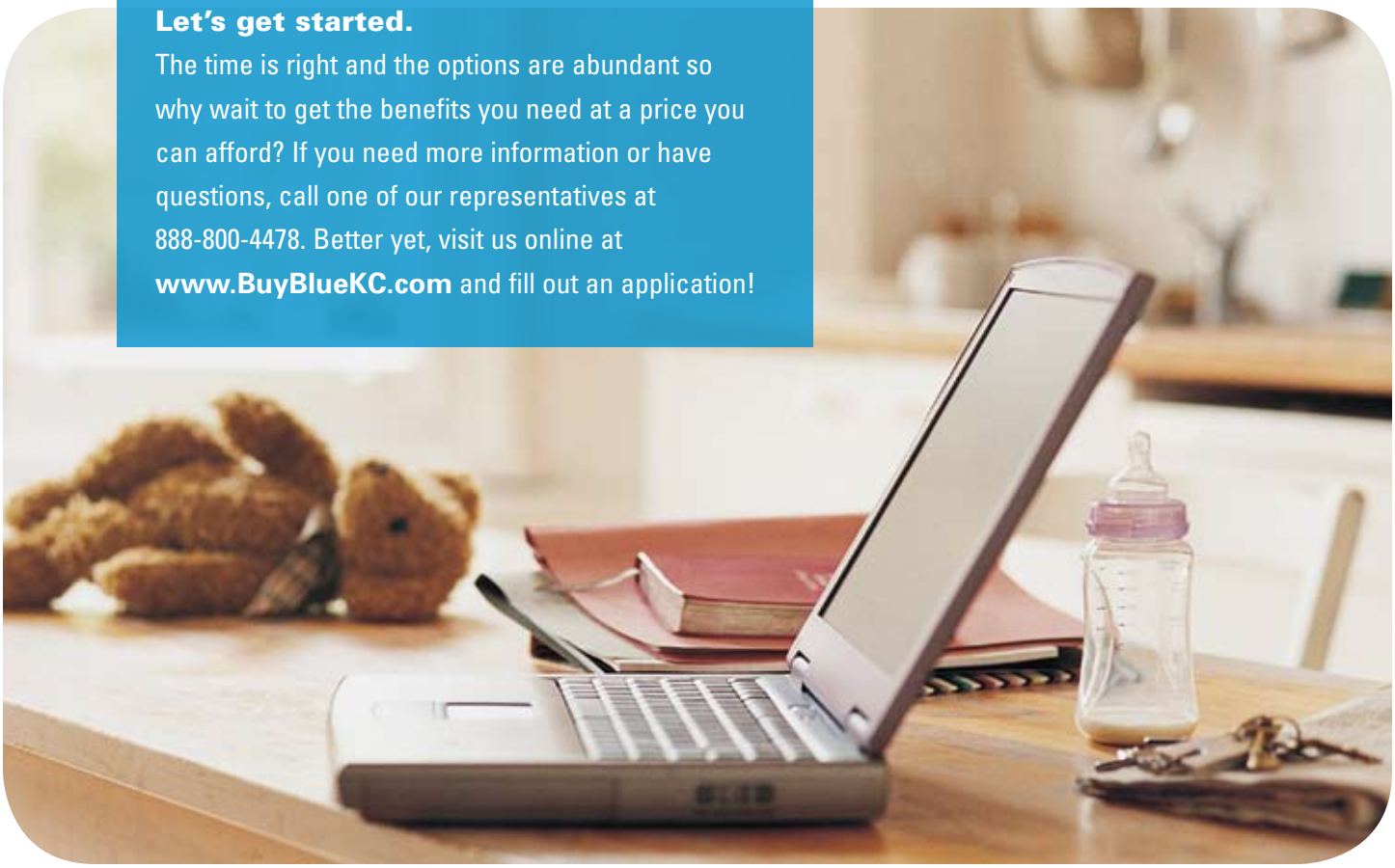
LIFETIME BENEFIT MAXIMUM — $5,000,000 PER INDIVIDUAL. **WHAT YOU SHOULD KNOW ABOUT PRE-EXISTING HEALTH CONDITIONS:** Pre-existing health conditions include any illness, injury or other condition for which medical advice, diagnosis, care or treatment was received or recommended during the six months prior to your Short-Term Security effective date. Pre-existing conditions are excluded under this plan. See contract for details. REFUNDS ARE NOT AVAILABLE.

**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.) **SCRIPTSAVE.** Receive up to 30% off the cost of prescription drugs with our ScriptSave Prescription Drug Program. Members receive a separate card for this within 15 days of obtaining coverage. (Discounts are not insurance.)

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

**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.BuyBlueKC.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® and Short-Term Security 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 up to 30 days per calendar year
- 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 and Short-Term Security 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 calendar year
- 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

BlueCross BlueShield of Kansas City

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What's **your** plan?™

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