BlueCross BlueShield Kansas
Blue Choice Network

KICF Pooled Employee Health Insurance Program

Comprehensive Major Medical℠

Effective January 01, 2024 - December 31, 2024

Your financial responsibility is based on your provider's network: PPO (Blue Choice) or Traditional (CAP). Maximum benefits are available when services are received from Blue Choice providers. Non-Blue Choice & Non-CAP: The difference between the payment allowance and provider charge, additional 20% non-PPO network coinsurance amount*, deductible, coinsurance or copay amount. CAP (Non-Blue Choice): Additional 20% non-PPO network coinsurance amount*, deductible, coinsurance or copay amount. Blue Choice: Deductible, coinsurance or copay amount.
*Non-PPO Coinsurance limited to a combined $2,000 per person, $4,000 two-or more persons each benefit period.

Member Pays			
	Option A	**Option B**	**Option C**
Deductible (Per group anniversary benefit period)	$1,000/$2,000 individual/two-or-more persons.	$1,500/$3,000 individual/two-or-more persons.	$2,500/$5,000 individual/two-or-more persons.
Coinsurance (Member portion for most services)	20% of allowed amounts after deductible has been met.	20% of allowed amounts after deductible has been met.	20% of allowed amounts after deductible has been met.
Coinsurance Maximum	$2,500/$5,000 individual/two-or-more persons.	$2,500/$5,000 individual/two-or-more persons.	$2,500/$5,000 individual/two-or-more persons.
Total Deductible plus Coinsurance	$3,000/$6,000 individual/two-or-more persons.	$3,500/$7,000 individual/two-or-more persons.	$4,000/$8,000 individual/two-or-more persons.
Maximum Out-of-Pocket (includes copays, deductible and coinsurance where applicable)	$6,350/$12,700 individual/two-or-more.	$6,350/$12,700 individual/two-or-more.	$6,350/$12,700 individual/two-or-more.

Doctor's Office Visits	
Home and office visits	$35 copay per visit.
Telemedicine Visits	AmWell providers same as primary office visit. Non AmWell providers same as face-to-face visit.
Preventive care as defined by the Affordable Care Act	Paid at 100% of the allowable charge. Some of the services include: Routine screenings Preventive immunizations Well-women visits/screenings

Drug Coverage	
Prescription Drugs & Mail Order	BlueRx Card $15/$50/$75/**20% up to $250** with Mail order is $40/$125/$187.50 with **ResultsRx formulary. A 90-day supply is available through the Extended Supply Network. The quantity per prescription is a 30-day pharmacy supply** or 90-day mail order supply. Designated Specialty Pharmacy.

Medical Services	
Emergency medical transportation	Subject to deductible/coinsurance.
Inpatient facility fee	Subject to deductible/coinsurance.
Outpatient surgery physician/surgical	Subject to deductible/coinsurance.
Outpatient lab and radiology (Includes Advanced Imaging)	Subject to deductible/coinsurance.
Emergency room	$150 copay then subject to deductible/coinsurance.
Accidental Injury Services	Subject to deductible/coinsurance.
Inpatient surgery physician/surgical	Subject to deductible/coinsurance.

Recovery/Special Needs	
Outpatient rehabilitation	Subject to deductible/coinsurance.
Hospice	Subject to deductible/coinsurance.
Home Social Work Visits	Subject to deductible/coinsurance.

Mental Health	
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	$35 copay per visit.
Other	
Maximum Lifetime Benefit	Unlimited.
Eligible Dependents	Covered to age 26.

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; 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; 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.