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BlueCross BlueShield of Kansas
Blue Choice Network

Grandfathered
USD 456 - MELVERN
AffordaBlue

Benefits include but are not limited to: **2473501** **Effective Date: October 01, 2020**

Deductible	$500 per person ($1,500 three-or-more persons).
Coinsurance	80/20 -- Plan pays 80%; individual pays 20% up to $1,000 per person ($3,000 three-or-more persons) maximum.
Office Visits	$25 copay per visit.**
Telemedicine Visits	$25 copay per visit.**
Prescription Drugs & Mail Order	$100/$300 then 50% coinsurance; Mail order is subject to retail deductible/coinsurance.
Outpatient Immunizations and Injections	Pays 100% of allowable charges.
Outpatient Radiology and Laboratory Services (Includes Advanced Imaging)	100% of the allowable charges to a maximum of $300 per person ($900 three-or-more persons), then subject to deductible/coinsurance.
Accidental Injuries	$50 copay for initial visit when within 60 days of injury. (Copay is waived if admitted to the hospital within 24 hours).
Home Social Work Visits/Hospice	Pays 100% of allowable charges.
Mental Illness and Substance Use Disorders	Inpatient subject to deductible/coinsurance; Outpatient subject to $25 copay per visit.**
Lifetime Maximum	Unlimited for each covered person.
Eligible Dependents	Covered to age 26.

****Combined benefit period maximum of 5 visits for each covered person (15 visits for three-or-more persons).**

Monthly Premium

Type of Coverage	Health	Dental	Total
Employee	$455.24	$36.15	$491.39
Employee/Child	$905.59	$70.60	$976.19
Employee/Spouse	$977.58	$77.72	$1055.30
Family	$1420.62	$111.34	$1531.96

Dental: ☐ Yes ☐ No

Printed Name: _____ Signature: _____
Plan Administrator Rep., Plan Sponsor Rep. or Officer of the Company

Title: _____ Date: _____

For Office Use Only

Effective Date: _____ Completed Date: _____

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Blue Cross Blue Shield of Kansas
Blue Choice Network

Grandfathered
USD 456 - MELVERN
AffordaBlue

Benefits include but are not limited to: **2473501** **Effective Date: October 01, 2020**

Deductible	$1,000 per person ($3,000 three-or-more persons).
Coinsurance	80/20 -- Plan pays 80%; individual pays 20% up to $1,000 per person ($3,000 three-or-more persons) maximum.
Office Visits	$25 copay per visit.**
Telemedicine Visits	$25 copay per visit.**
Prescription Drugs & Mail Order	$100/$300 then 50% coinsurance; Mail order is subject to retail deductible/coinsurance.
Outpatient Immunizations and Injections	Pays 100% of allowable charges.
Outpatient Radiology and Laboratory Services (Includes Advanced Imaging)	100% of the allowable charges to a maximum of $300 per person ($900 three-or-more persons), then subject to deductible/coinsurance.
Accidental Injuries	$50 copay for initial visit when within 60 days of injury. (Copay is waived if admitted to the hospital within 24 hours).
Home Social Work Visits/Hospice	Pays 100% of allowable charges.
Mental Illness and Substance Use Disorders	Inpatient subject to deductible/coinsurance; Outpatient subject to $25 copay per visit.**
Lifetime Maximum	Unlimited for each covered person.
Eligible Dependents	Covered to age 26.

****Combined benefit period maximum of 5 visits for each covered person (15 visits for three-or-more persons).**

Monthly Premium

Type of Coverage	Health	Dental	Total
Employee	$430.65	$36.15	$466.80
Employee/Child	$852.57	$70.60	$923.17
Employee/Spouse	$924.70	$77.72	$1002.42
Family	$1337.51	$111.34	$1448.85

Dental: ☐ Yes ☐ No

Printed Name: _____ Signature: _____

Plan Administrator Rep., Plan Sponsor Rep. or Officer of the Company

Title: _____ Date: _____

For Office Use Only

Effective Date: _____ Completed Date: _____

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BlueCross BlueShield of Kansas
Blue Choice Network

Grandfathered
USD 456 - MELVERN
AffordaBlue

Benefits include but are not limited to: **2473501** **Effective Date: October 01, 2020**

Deductible	$2000 per person ($6000 three-or-more persons).
Coinsurance	80/20 -- Plan pays 80%; individual pays 20% up to $1,000 per person ($3,000 three-or-more persons) maximum.
Office Visits	$25 copay per visit.**
Telemedicine Visits	$25 copay per visit.**
Outpatient Immunizations and Injections	Pays 100% of allowable charges.
Prescription Drugs & Mail Order	$100/$300 then 50% coinsurance; Mail order is subject to retail deductible/coinsurance.
Outpatient Radiology and Laboratory Services (Includes Advanced Imaging)	100% of the allowable charges to a maximum of $300 per person ($900 three-or-more persons), then subject to deductible/coinsurance.
Accidental Injuries	$50 copay for initial visit when within 60 days of injury. (Copay is waived if admitted to the hospital within 24 hours).
Home Social Work Visits/Hospice	Pays 100% of allowable charges.
Mental Illness and Substance Use Disorders	Inpatient subject to deductible/coinsurance; Outpatient subject to $25 copay per visit.**
Lifetime Maximum	Unlimited for each covered person.
Eligible Dependents	Covered to age 26.

****Combined benefit period maximum of 5 visits for each covered person (15 visits for three-or-more persons).**

Monthly Premium

Type of Coverage	Health	Dental	Total
Employee	$394.64	$36.15	$430.79
Employee/Child	$778.92	$70.60	$849.52
Employee/Spouse	$847.28	$77.72	$925.00
Family	$1222.06	$111.34	$1333.40

Dental: ☐ Yes ☐ No

Printed Name: _____ Signature: _____
Plan Administrator Rep., Plan Sponsor Rep. or Officer of the Company

Title: _____ Date: _____

For Office Use Only

Effective Date: _____ Completed Date: _____