

**Benefit Summary for Washburn University**  
**Blue Choice Comprehensive Major Medical Program**  
**Effective November 1, 2012 – October 31, 2013**  
**Non - Grandfathered**

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.

<b>Member Pays</b>	
<b>Deductible</b> (Per group anniversary benefit period)	Base - \$1,000/\$3,000 individual/three-or-more persons Buy-Up - \$500/\$1,500 individual/three-or-more persons
<b>Coinsurance</b> (Member portion for most services)	Base - 20% of allowed amounts after deductible has been met; Buy-up - 20% of allowed amounts after deductible has been met; up to \$1,000/\$3,000 (Base and Buy-Up) individual/three-or-more persons maximum
<b>Annual Out-of-Pocket Maximum (includes deductible and coinsurance)</b> Copays do not apply to the annual out-of-pocket amount	Base - \$2,000/\$6,000 individual/three-or-more persons Buy-up- \$1,500/\$4,500 individual/three-or-more persons After the annual out-of-pocket amount has been reached (deductible/coinsurance), eligible benefits will be paid at 100% of the allowed amount for the remainder of the benefit period.
<b>Unlimited Lifetime Benefit. Eligible children covered to age 26.</b>	

<b>Covered Services</b>	
<b>Medical Services</b> <ul style="list-style-type: none"> <li>• Doctor Visits — home/office (including hearing and eye exam)</li> <li>• Surgery — inpatient and outpatient</li> <li>• Maternity Care</li> <li>• Injections</li> <li>• Outpatient Radiology and Lab Services</li> </ul> <p>* Combined benefit period maximum.</p>	Base - \$30 / Buy-Up \$30 office visit copay  Subject to deductible/coinsurance Subject to deductible/coinsurance Covers 100% of maximum allowance Pays 100% of the allowable charge to a maximum of \$500 per person each benefit period, then subject to deductible and coinsurance*
<b>Preventive Care Services</b>	In network 100% coverage; out of network subject to policy provisions including the non-network penalties.
<b>Inpatient Hospital</b> Pre-admission certification required for all planned inpatient admissions at 1-800-782-4437	Subject to deductible/coinsurance
<b>Accidental Injury Services</b>	Subject to deductible/coinsurance
<b>Ambulance Services</b>	Subject to deductible/coinsurance
<b>Outpatient Hospital</b>	Subject to deductible/coinsurance

## Covered Services

<b>Emergency Room Services</b>	Subject to deductible/coinsurance
<b>Private Duty Nursing</b>	Unlimited
<b>Freestanding Outpatient Facilities</b> (Examples: surgery, renal dialysis)	Subject to deductible/coinsurance
<b>Medical Equipment/Disposable Supplies</b>	Subject to deductible/coinsurance
<b>Short-term Therapies</b> — Physical, Speech and Occupational, Respiratory and Cardiac	Subject to deductible/coinsurance
<b>Mental Illness &amp; Substance Use Disorders</b> <ul style="list-style-type: none"> <li>• <b>Inpatient Services</b> Requires pre-admission certification from New Directions Behavioral Health at 1-800-952-5906</li> <li>• <b>Outpatient Services</b></li> </ul>	Subject to deductible/coinsurance  Base -\$30 / Buy Up - \$30 office visit copay
<b>Prescription Drugs</b> <ul style="list-style-type: none"> <li>• <b>BlueRx Card - Retail</b> Generic/brand formulary/brand non-formulary Diabetic supplies are covered</li> <li>• <b>BlueRx Mail</b> (90-day supply)</li> </ul>	The quantity per prescription shall be the greater of a 34-day supply or 100 unit dosage, if defined as a maintenance drug Base: \$5/\$50/\$100 copay Buy Up - \$5/\$40/\$80 copay  2 times retail copay  (Note: prior authorization and quantity limits may apply)

**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.