

**Blue Cross Blue Shield of Kansas
Blue Choice
Comprehensive Major Medical Program**

ESSDACK HEALTH INSURANCE GROUP



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ESSDACK Health Insurance Plan

Blue Choice Comprehensive Major Medical - Triple Option

October 1, 2011 – September 30, 2012

“EXISTING MEMBER DISTRICTS - GRANDFATHERED”

	\$500 Deductible	\$1,000 Deductible	\$1,500 Deductible
Deductible	\$500 per person \$1,000 per family	\$1,000 per person \$2,000 per family	\$1,500 per person \$3,000 per family
Coinsurance	80 / 20 (Plan pays 80%; individual pays 20% to coinsurance maximum)	80 / 20 (Plan pays 80%; individual pays 20% to coinsurance maximum)	80 / 20 (Plan pays 80%; individual pays 20% to coinsurance maximum)
Coinsurance Maximum	\$1,000 per person \$2,000 per family	\$2,000 per person \$4,000 per family	\$2,500 per person \$5,000 per family
Deductible plus Coinsurance Out of Pocket Totals*	\$1,500 per person \$3,000 per family	\$3,000 per person \$6,000 per family	\$4,000 per person \$8,000 per family
Chiropractic	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Accidental Injuries	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Blue Rx Card <i>Patient uses local BC/BS pharmacy and receives medication immediately.</i>	\$15 Generic Copay \$40 Name Brand Copay when no Generic is available, \$40 Plus Cost Difference for Name Brand when Generic is available. Maximum supply: 30 days	\$15 Generic Copay \$40 Name Brand Copay when no Generic is available, \$40 Plus Cost Difference for Name Brand when Generic is available. Maximum supply: 30 days	\$15 Generic Copay \$40 Name Brand Copay when no Generic is available, \$40 Plus Cost Difference for Name Brand when Generic is available. Maximum supply: 30 days
Blue Rx Mail Order– (PrimeMail) <i>PrimeMail Pharmacy mails medications to your home.</i>	\$35 Generic Copay \$90 Name Brand Copay when no Generic is available, \$90 Plus Cost Difference for Name Brand when Generic is available. Maximum supply: 90 days	\$35 Generic Copay \$90 Name Brand Copay when no Generic is available, \$90 Plus Cost Difference for Name Brand when Generic is available. Maximum supply: 90 days	\$35 Generic Copay \$90 Name Brand Copay when no Generic is available, \$90 Plus Cost Difference for Name Brand when Generic is available. Maximum supply: 90 days
Dependent Coverage	Eligible children covered to age 26, unless eligible through own employer	Eligible children covered to age 26, unless eligible through own employer	Eligible children covered to age 26, unless eligible through own employer
Lifetime Maximum	Unlimited	Unlimited	Unlimited

Pre-admission certification is required on all planned inpatient admissions.

* “Deductible Plus Coinsurance Out of Pocket Totals” do not include excess charges of non-contracting providers, additional coinsurance for using non-Blue Choice providers, outpatient prescription drug costs or copays, etc. Some step therapy, quantity limits and prior authorization may be required on certain drugs. Refer to carriers Summary Plan Descriptions for more benefit details.

MONTHLY PREMIUMS – with ‘Grandfathered’ Contingency

	\$500 Deductible		\$1,000 Deductible		\$1,500 Deductible	
	Single	Family	Single	Family	Single	Family
Current Rates 10/1/10-9/30/11	\$443.00	\$1,002.00	\$400.00	\$910.00	\$375.00	\$856.00
Renewal Rates 10/1/11-9/30/12	\$443.00	\$1,002.00	\$400.00	\$910.00	\$375.00	\$856.00
Monthly \$ INCREASE	\$0	\$0	\$0	\$0	\$0	\$0
Monthly % INCREASE	0%	0%	0%	0%	0%	0%

Employees can move one deductible level at open enrollment. For example:

If you are enrolled in the \$500 Option today, you can move to the \$1,000 on 10/1/11.

If you are enrolled in the \$1,000 Option today, you can move to either the \$500 or \$1,500 on 10/1/11.

If you are on the \$1,500 Option today, you can move to the \$1,000 on 10/1/11.

CONTINGENCY ON RATES: On June 17, 2010, the Interim Final Rules regarding "Grandfathered" Group Health Plans under The Patient Protection and Affordable Care Act (PPACA) were issued. These rates are firm for districts that attest to maintaining their Grandfathered status. Grandfathered Plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points as compared to the contribution percent at March 23, 2010. All Member Districts will be required to provide the data necessary to make this determination. If a member district is not in compliance, the ESSDACK Health Insurance Group will work with the district to come under compliance. If a member district is not able to come under compliance, a one-time exception to the Statement of Assurances will be made to allow a non-compliant district to withdraw from the ESSDACK Health Insurance Plan effective September 30, 2011 and pursue a contract directly with BC/BS or another insurance company.

We reserve the right to re-rate should enrollment effective 10/1/2011 vary by + or – 10% within each option.

4/19/2011 GBS kr

**Benefit Summary for ESSDACK Health Insurance Plan
Triple Option Comprehensive Major Medical Program
Effective October 1, 2011 — September 30, 2012**

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.

Member Pays	
Triple Option \$500 Deductible \$1000 Deductible \$1500 Deductible	\$500/\$1,000 individual/two-or-more persons \$1,000/\$2,000 individual/two-or-more persons \$1,500/\$3,000 individual/two-or-more persons
Coinsurance (Member portion for most services) \$500 Deductible \$1000 Deductible \$1500 Deductible	20% of allowed amounts after deductible has been met; up to \$1,000/\$2,000 individual/two-or-more persons \$2,000/\$4,000 individual/two-or-more persons \$2,500/\$5,000 individual/two-or-more persons
Annual Out-of-Pocket Maximum (includes deductible and coinsurance) Non-biologically based outpatient nervous & mental and substance abuse services do not apply to the annual out-of-pocket amount. <u>Employees can move one deductible level at open enrollment.</u>	\$500 Deductible: \$1,500/\$3,000 individual/two-or-more persons \$1000 Deductible: \$3,000/\$6,000 individual/two-or-more persons \$1500 Deductible: \$4,000/\$8,000 individual/two-or-more persons After the annual out-of-pocket amount has been reached (ded/coins), eligible benefits will be paid at 100% of the allowed amount for the remainder of the benefit period.
Unlimited Lifetime Maximum Benefit. Eligible children covered to age 26.	

Covered Services	
Medical Services <ul style="list-style-type: none"> • Doctor Visits — home/office (including hearing and eye exam) • Surgery — inpatient and outpatient • Maternity Care • Well Child & Well Baby Office Visit • Immunizations up to age 72 months • Immunizations over 72 months • Well Women — Annual Check Up <ul style="list-style-type: none"> Office Visit Mammogram Pap Smear • Routine Physicals — Annual Check Up <ul style="list-style-type: none"> Office Visit • Injections • Outpatient Radiology and Lab Services 	Subject to deductible/coinsurance Subject to deductible/coinsurance Subject to deductible/coinsurance Subject to deductible/coinsurance Covers 100% of maximum allowance Subject to deductible/coinsurance Subject to deductible/coinsurance Subject to deductible/coinsurance Subject to deductible/coinsurance
Inpatient Hospital Pre-admission certification required for all planned inpatient admissions at 1-800-782-4437	Subject to deductible/coinsurance
Accidental Injury Services	Subject to deductible/coinsurance
Ambulance Services	Subject to deductible/coinsurance
Outpatient Hospital	Subject to deductible/coinsurance

Covered Services	
Emergency Room Services	Subject to deductible/coinsurance
Private Duty Nursing	Subject to the deductible and/or coinsurance Eligible covered nursing services in the home would be subject to pre-certification for medical necessity.
Freestanding Outpatient Facilities (Examples: surgery, renal dialysis)	Subject to deductible/coinsurance
Medical Equipment/Disposable Supplies	Subject to deductible/coinsurance
Chiropractic	Subject to deductible/coinsurance
Short-term Therapies — Physical, Speech and Occupational, Respiratory and Cardiac	Subject to deductible/coinsurance
Mental Illness & Substance Use Disorders	
<ul style="list-style-type: none"> • Inpatient Services Requires pre-admission certification from New Directions Behavioral Health at 1-800-952-5906 • Outpatient Services 	Subject to deductible/coinsurance Subject to deductible/coinsurance
Prescription Drugs	
<ul style="list-style-type: none"> • BlueRx Card - Retail • BlueRx Mail (90-day supply) 	\$15 Generic Copay \$40 Name Brand Copay when no Generic is available, \$40 Plus Cost Difference for Name Brand when Generic is available. Maximum supply: 30 days \$35 Generic Copay \$90 Name Brand Copay when no Generic is available, \$90 Plus Cost Difference for Name Brand when Generic is available. Maximum supply: 90 days (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; 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; dental implants; services or supplies related to sex changes, sexual dysfunctions or inadequacies; any medically-aided insemination procedure; services related to the reversal of sterilization procedures; treatment of nervous or mental conditions over the amount specified in the certificate; 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.

Electronic Contract/Certificates

Now Online!

Blue Cross and Blue Shield of Kansas now provides members a more convenient method of viewing their contract/certificate. By simply going online, members can securely access their contract/certificate at www.bcbsks.com.

Our new approach for viewing this important document provides members several advantages while allowing BCBSKS to continue identifying the most responsible use of resources.

Convenience and accessibility

- Contracts/certificates will always be available online – members will always know where to find their document.
- Contracts/certificates will always be up-to-date because they are automatically updated online.
- Members can reduce paper mail volume yet still receive all of their plan's benefit information in one convenient location.
- Members may print all or part of their contract/certificate using their personal printer.

How to access the online contract/certificate

Members that haven't done so already need to set up a "BlueAccess" profile to access their online contract/certificate by following these instructions:

- Clicking on "Log In" in the BlueAccess box
- Following the prompts on the screen to create a user ID and receiving a password.
- Clicking on the "Contract/Certificate" icon



Hard copy format

Members seeking to obtain a printed copy of their contract/certificate may do so by completing a specially-marked postcard in their contract/certificate packet.



ResourceBlue.

BlueAccess®

User ID

Password



Log In

[Spouse or Dependent](#)

[Forgot ID /Password](#)

[Sign-up](#)

[BlueAccess Tour](#)





1133 SW Topeka Boulevard
Topeka, Kansas 66629-0001

In Topeka - (785) 291-7000
In Kansas - (800) 432-0216

Web site: www.bcbsks.com

Important New Information About Your BlueRx CardSM Prescription Drug Benefit Effective Jan. 1, 2011

New Prior Authorization Programs

Reducing drug benefit costs and encouraging safe and effective drug use are important for Blue Cross and Blue Shield of Kansas (BCBSKS). We continue monitoring trends in prescription benefit management. This helps identify opportunities for improving patient compliance and overall health, promoting treatment guidelines, and reducing costs for our customers.

Effective Jan. 1, 2011, BCBSKS will be implementing utilization management programs for a number of high cost specialty drug classes.

Prior Authorization of Oral Oncology Agents

The prior authorization requirement would only apply to new starts. The criterion allows approval for any FDA approved indication and any indication listed in one of the recognized drug compendia. This program is designed to offer member education and to promote adherence to therapy. An oncology cycle management program will be used for drugs with a high discontinuation rate. For the first fill, a 16 day initial supply will be dispensed to the patient. The patient will be contacted on day 10-12 to determine if the drug is being tolerated. If the drug has not been discontinued, the balance of the first month's supply will be dispensed. The member is only responsible for one copayment.

Prior Authorization for Biologics used for Autoimmune Disease

These biologic agents are used to treat autoimmune diseases such as rheumatoid arthritis, Crohn's disease and psoriasis. The prior authorization requirement would apply to new starts and would require the drug to be used for an approved indication. Step therapy would also be required. The member would have to start therapy on a formulary agent prior to being approved for a non-formulary product. This program is designed to offer member education and adherence to therapy.

Prior Authorization for Ampyra[®]

Ampyra[®] is approved to increase walking speed for patients with multiple sclerosis. Approval will only be granted for patients who are ambulatory.

Existing Utilization Management Programs

Existing step therapy/prior authorization programs, quantity limits and non-coverage of selected non-formulary brand drugs will continue. These programs include:

- Step therapy/prior authorization for certain high blood cholesterol, antihypertensive and antidepressant drugs, requiring the use of generic drugs prior to covering brand name drugs.
- Prior authorization for adult and pediatric growth hormone. Members will be required to use our preferred growth hormone product, Omnitrope. The prior authorization criteria will allow the use of other brands of growth hormone after a trial and treatment failure of Omnitrope.

- Prior authorization for Celebrex.
- Quantity limits on Oxycontin and drugs used to treat migraine headaches and erectile dysfunction.
- Non-coverage of brand non-sedating antihistamine (NSA) drugs.
- Non-coverage of brand proton pump inhibitors (PPIs). **Aciphex® will no longer be covered.** Members currently using Aciphex® will be notified of this change. Coverage will be limited to generic PPIs which include omeprazole, lansoprazole and pantoprazole.

Formulary/Preferred Medication List

The formulary, or Preferred Medication List (PML), mailed to members on an annual basis will identify specialty drugs, drugs requiring prior authorization, drugs with quantity limits or those that are not covered. The PML may also be found at www.bcbsks.com or by calling the customer service center at the number listed on the back of your identification card.

Should you have any questions regarding this important new information about your prescription drug benefit, please contact your sales representative.

Mandatory Generic Option

How the Option Works

- When a brand name drug is dispensed and there is an appropriate generic substitute available, the insured's responsibility will be the difference between the allowance for the brand drug and the generic substitute, plus the brand deductible. Generic allowances are determined by the maximum allowable cost (MAC) for the generic drug.
- In some situations, the difference between the brand and the generic substitute, plus brand deductible, will be greater than the allowed charge for the brand drug. In this situation, the insured will only be responsible for the allowed charge of the brand drug.
- The availability of a generic substitute is determined by the FDA. The generic must be determined to be bio-equivalent to the brand drug. There are some drugs which are available in the same strength and dosage form as the brand, but are not considered bio-equivalent. The insured will only be responsible for the brand drug deductible when the brand is dispensed for these drugs.
- If the pharmacy indicates that the generic is not available in the marketplace, or if state law prohibits generic substitution, the brand drug will be treated as a single source brand. The insured's responsibility will be the brand deductible.
- If the pharmacy indicates that the brand drug is being used as a generic, the brand will be reimbursed at the generic allowance and the insured will only be responsible for the generic deductible.
- If the brand drug is required by the doctor and cannot be substituted with a generic equivalent, the insured will be required to pay the difference between the brand allowance and the generic allowance, plus the brand deductible.
- If the pharmacy does not stock the generic and the brand drug is dispensed, the insured will be required to pay the difference between the brand allowance and the generic allowance, plus the brand deductible.
- Sometimes your doctor may prescribe a medication to be dispensed as written when there is a formulary preferred brand or generic alternative drug. To help your benefit plan save money, the pharmacist may, on occasion, discuss with your doctor whether an alternative drug might be appropriate for you. Let your doctor know if you have a question about a change in prescription or prefer the original prescription. Your doctor always makes the final decision on your drug.

General Notice of Pre-existing Condition Exclusion



Note: *The Affordable Care Act of 2010 eliminates pre-existing requirements and is being phased in during two separate time periods. Children under the age of 19 with a pre-existing condition can not be denied insurance at plan anniversaries on or after Sept. 23, 2010. This protection is extended to all other people with pre-existing conditions at plan anniversaries on or after Jan. 1, 2014.*

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait ___ days before this plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the ___-day period prior to your date of employment. The pre-existing condition exclusion does not apply to pregnancy, **children under the age of 19** or a child enrolled in the plan within 63 days of adoption or placement for adoption.

The length of this pre-existing condition exclusion will be reduced by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition waiting period if you have not experienced a gap in coverage of 63 or more days.

Certificate of Creditable Coverage

To reduce the pre-existing condition exclusion by your creditable coverage, you should give your employer a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you have had prior health coverage, you may obtain one from your prior plan or issuer.

Questions?

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Blue Cross and Blue Shield of Kansas, Customer Service Department, 1133 Topeka Blvd., Topeka, KS 66629-0001. You may also call BCBSKS at 291-4180, in Topeka or 1-800-432-3990, toll-free.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

For employees eligible for coverage under the **Unified School District #405 Insurance Plan** (the Plan), this notice contains important information about your right to COBRA continuation coverage which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Group Leader.

COBRA continuation coverage for the Plan is administered by:

Marsha S. Huggans, Group Leader
Frisbie Education Center
800 South Workman
Lyons, KS 67554 (620)257-5196

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage **must pay** for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced, or
- (2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Unified School District #405, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Group Leader has been notified that a qualifying event has occurred. **When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B or both), the employer must notify the Group Leader of the qualifying event within 30 days of any of these events.**

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Group Leader. The Plan requires you to notify the Group Leader within 60 days after the qualifying event occurs.

Once the Group Leader receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts up for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Group Leader in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Group Leader is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all these cases, you must make sure that the Group Leader is notified of the second qualifying event within 60 days of the second qualifying event.**

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact Marsha S. Huggans, Group Leader or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Group Leader informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Group Leader.

ResourceBlueSM

www.bcbsks.com/resourceblue



Now featuring ...

Timely and credible health information from

WebMD[®]

Exclusive discounts on
health and wellness
products & services from

Blue365[®]
Your resource for living healthier.[®]

An easier and more affordable path to wellness

Resource Blue, already an easy-to-use online resource, now makes it easier than ever to help you live a healthy lifestyle. We've partnered with WebMD[®] and Blue365[®] to provide you exclusive access to health information, resources, discounts and savings. With this feature-rich expansion, you have a new way to get even more from your Blue Cross and Blue Shield of Kansas (BCBSKS) membership every day.

WebMD – interactive, simple and credible health information

Resource Blue, powered by WebMD, provides you and your family access to:

- Board-certified physicians
- Award-winning journalists
- Trained community moderators

The WebMD content staff also includes individuals that hold advanced degrees in medical illustration, health communications, nursing and medicine. WebMD provides you the tools you need to make smart choices – from critical information about preventing a serious disease to developing a personalized health improvement plan.

Powerful tools and solutions

Resource Blue's WebMD connection opens up your world to a variety of *solution suites* dedicated to helping you find the health and medical information, support and services you need. Below you'll find a brief summary of a few of the programs supporting each solution suite.

Health Management Suite

- WebMD Health Assessment – gives you the information you need to stay one step ahead of potentially serious or chronic health problems.
- Child Health Manager – allows you to track, manage and monitor your children's health.

Benefits and Financial Suite

- WebMD Coverage AdvisorsSM – provides personalized cost comparison across available health plan options.

Health Record Suite

- WebMD Health RecordsSM – empowers you to gather, store, manage and share life-long health information with other authorized individuals.
- Health Trackers – provides you graphic tools to track important health measurements over time.

Blue365 – exclusive discounts on health and wellness products & services

Improving and maintaining your health 24/7, 365 days a year is what you'll discover with Blue365. Enjoy value-added discounts and offers on programs and services from leading national companies – just for BCBSKS members. Blue365 supports your total wellness with online resources, including:

Health and wellness

- Discounts on weight loss and nutrition program
- Savings on elective procedures like laser vision correction
- Access to a personal walking/fitness program
- Savings on hearing aids

Family care

- Support tools for family care, including how to choose a caregiver
- Access emotional support to deal with care of a family member

Financial well-being

- Financial consulting for a healthier future
- Access to Medicare information

Healthy travel

- Savings on spa vacations and wellness getaways

Explore all the Blue365 healthy choices* at bcbsks.com/resourceblue.

SPORTLINE



DAVIS VISION

EVERLAST

QualSight
Regional U.S.-W. Pricing

eDiets

Men'sHealth

Reebok

NutriSystem

Jenny Craig

Beltone
Challenging the World's Best Hearing

Women'sHealth

POLAR
LISTEN TO YOUR BODY

LasikPlus

Healthyroads

TruHearing
Where You Choose to Hear

Disease & Care Management

BCBSKS offers its members *Healthy Options*, a series of care management initiatives focused on asthma, diabetes, heart disease, high blood pressure and high cholesterol. With Healthy Options care management, our goal is to improve the overall health of our members with chronic health conditions by providing members with education, tools and one-on-one support.

Participation in this HIPAA-compliant program is strictly voluntary and the member may opt out at any time. The primary goal of Healthy Options is to improve the quality of life for our members while achieving efficient use of health care services.

ResourceBlue

www.bcbsks.com/resourceblue



**BlueCross
BlueShield
of Kansas**

*Independent companies that do not provide Blue Cross and/or Blue Shield products or services and are solely responsible of the services provided.

Blue Cross and Blue Shield of Kansas is an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSSSM, BLUE SHIELDSM and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. WebMD provides health information and services to consumers and health care professionals and is responsible for privacy policies governing its site. WebMD is not affiliated with Blue Cross and Blue Shield of Kansas.

Blue365SM offers access to savings on items that Members may purchase directly from independent vendors, which are different from items that are covered under your policies with your local Blue company, its contracts with Medicare, or any other applicable federal healthcare program. To find out what is covered under your policies, call your local Blue company. The products and services described herein are neither offered nor guaranteed under your local Blue company's contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to your local Blue company's grievance process. Blue Cross and Blue Shield Association (BCBSA) and local Blue companies may receive payments from Blue365 vendors. Neither any local Blue company nor BCBSA recommends, endorses, warrants or guarantees any specific Blue365 vendor or item.