



Favorite Healthcare Staffing Qualified High Deductible Health Plan Summary

Effective: July 1, 2009

This Benefit Summary provides only a highlight of the services covered by Blue Cross and Blue Shield of Kansas City.

www.bcbskc.com

	Preferred-Care Blue/Blue-Saver PPO
Plan Type	A Preferred Provider Organization (PPO)
Plan Description <i>(Visit our website at www.bcbskc.com to receive a complete listing of network hospitals and physicians)</i>	Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue PPO network.
Deductible (Embedded Family Deductible)	\$2,500 per single/\$5,000 per family An Individual must meet their INDIVIDUAL deductible before benefits are paid on that individual
Coinsurance (1)	Network: 100% / Non-network: 80%
Out-of-Pocket Maximum (2)	Network: \$2,500 single/\$5,000 family; Non-network: \$5,000 single/\$10,000 family
Physician Office Visits	Deductible then coinsurance
Lab Performed in a Physician's Office/Independent Lab	Network: Deductible then 100% Non-network: Deductible then 80%
Lab Performed in a Hospital/Outpatient Facility	Network: Deductible then 100% Non-network: Deductible then 80%
X-ray and Other Radiology Procedures	Network: Deductible then 100% Non-network: Deductible then 80%
Routine Preventive Care <i>(Contract lists covered services)</i>	Network: 100% Non-network: Deductible then coinsurance Mandated Routine Services Covered at 100% (not subject to deductible or \$300 Calendar Year Maximum) PSA Tests, Pelvic Exams and Pap Smears, Mammograms, Colorectal Cancer Exams, Newborn Hearing Screening, Childhood Immunizations, Lead Testing Expanded Routine Services Covered at 100% (not subject to deductible) \$300 Calendar Year Maximum applies towards Expanded Routine Benefits – network and non-network services Physician Examinations, Additional Examinations, Testing and Services, Urinalysis, Glucose Screening, Thyroid Stimulating Hormone Screening, Lipid Cholesterol Panel, HPV Screening, HIV Screening, EKG, Chest X-ray
Inpatient Hospital Services/Outpatient Surgery*	Deductible then coinsurance (3)
Emergency Room	Deductible then coinsurance
Ambulance	Deductible then 100% Ground ambulance limited to \$500 benefit maximum per use.
Durable Medical Equipment*	Deductible then coinsurance \$5,000 calendar year maximum
Allergy Testing, Treatment, Injections	Deductible then coinsurance
Home Health Services*	Deductible then coinsurance 60 visit calendar year maximum
Skilled Nursing Facility*	Deductible then coinsurance 100 day calendar year maximum
Outpatient Therapy (Speech, Hearing, Physical, Skeletal Manipulations and Occupational)*	Deductible then coinsurance Physical, Occupational and Skeletal Manipulations: Combined 40 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum

¹Portion of covered charges paid by BCBSKC after you satisfy your deductible and required copayments.

²Total of deductible and coinsurance members pay each year toward covered charges before BCBSKC pays 100% of benefits.

³Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to a \$200 calendar year maximum. Inpatient hospital services in a Non-Participating Hospital inside our service area are limited to a \$200 maximum per day and are limited to 30 days per calendar year. Outpatient services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility (including an ambulatory surgical center) inside our service area are limited to a \$200 calendar year maximum.

Preferred-Care Blue/Blue-Saver PPO	
Inpatient Mental Illness/Substance Abuse <i>Specified Diagnoses (4)</i>	Deductible then coinsurance 45 day calendar year maximum <i>Prior authorization required from New Directions</i>
Outpatient Mental Illness/Substance Abuse <i>Specified Diagnoses (4)</i>	Deductible then coinsurance 45 visit calendar year maximum
Inpatient Mental Illness/Substance Abuse Care <i>Other Diagnoses</i>	Deductible then coinsurance 30 day calendar year maximum <i>Prior authorization required from New Directions</i>
Outpatient Mental Illness/ Substance Abuse Care <i>Other Diagnoses</i>	Network: 100% of 1 st \$100 then 80% to \$1,000 then 50%; Non-Network: 100% of 1 st \$100 then 80% of next \$100 then 50%
Inpatient Hospice Facility*	Deductible then coinsurance 14 day lifetime maximum
Organ Transplant*	Deductible then coinsurance Network: \$500,000 Organ Transplant lifetime maximum Non-Network: \$100,000 Organ Transplant lifetime maximum
Prescription Drugs* <i>(Includes contraceptives – orals, injectables, implants, and devices)</i>	BCBSKC Rx Network Network: Deductible, then covered at 100% Non-network: Deductible, copay and additional 50% of cost: \$10 copay for Type 1 drug; \$50 copay for Type 2 brand drug; \$70 copay for Type 3 brand drug <i>(Copays apply to out-of-pocket maximum)</i>
Prescription Drugs* Mail order drug program – 102 day supply	Network: Deductible, then covered at 100% Non-network: Deductible, copay and additional 50% of cost: \$30 copay for Type 1 drug; \$150 copay for Type 2 brand drug; \$210 copay for Type 3 brand drug <i>(Copays apply to out-of-pocket maximum)</i>
Lifetime Maximum	\$5,000,000
Prior Authorization Penalty*	You are responsible for prior authorization for services received from non-network and out-of-area providers. If prior authorization is not obtained for services which require prior authorization, you are responsible for the cost of the services.
Pre-existing Exclusion Period	There is no exclusion period for the plan.
Late Enrollees	For employees or dependents applying after the eligibility period and not within a special enrollment period, coverage will become effective only on the group's anniversary date.
Detailed Benefit Information Exclusions and Limitations	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.
Customer Service	816-395-3558 or www.bcbskc.com

4 Diagnoses included: schizophrenia, schizoaffective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis, major affective disorders (bipolar and major depression), cyclothymic and dysthymic disorders, obsessive compulsive disorder, panic disorder, and pervasive developmental disorder, including autism, attention deficit disorder and attention deficit hyperactive disorder as such terms are defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV, 1994) of the American Psychiatric Association but do not include conditions not attributable to a mental disorder that are a focus of attention or treatment.

****Prior Authorization will be required for elective inpatient admissions, durable medical equipment (DME), infusion therapy and self injectables, organ and tissue transplants, some outpatient surgeries and services, speech and hearing therapy (including home health for speech therapy), prosthetics and appliances, mental health and chemical dependency, some outpatient prescriptions, skilled nursing facility, dental implants and bone grafts. This list of services is subject to change. Please refer to your contract for the current list of services, which require Prior Authorization.**

The covered services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the contract.