

## Spring Hill School District Health Benefit Plan Summary

*Effective: 9/1/09*

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

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	<b>Blue-Care</b>	<b>Preferred-Care Blue</b>
<b>Plan Type</b>	A Health Maintenance Organization (HMO)	A Preferred Provider Organization (PPO)
<b>Plan Description</b> <i>(Visit our website at www.bcbskc.com to receive a complete listing of network hospitals and physicians)</i>	Members choose a primary care physician. Members may self-refer to physician specialists in the Blue-Care network. Urgent care and an exclusive network of specialists are also covered; <b>other services must be ordered by an HMO Physician.</b>	Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue network.
<b>Deductible</b>	N/A	\$500 per individual/\$1,000 per family
<b>Coinsurance (1)</b>	N/A	Network: 80% / Non-network: 60%
<b>Out-of-Pocket Maximum (2)</b>	<i>Inpatient/Outpatient surgical copays limited to 5 copays per member per calendar year.</i>	Network: \$1,500 individual/\$3,000 family; Non-network: \$3,000 individual/\$6,000 family
<b>Physician Office Visits</b>	PCP office visits: \$30 copay Specialists: \$60 copay	Network: Deductible then coinsurance Non-network: Deductible then coinsurance
<b>Lab Performed in Physician's Office/Independent Lab</b>	No copay	Deductible then coinsurance
<b>Lab Performed in Hospital/Outpatient Facility</b>	No copay	Network: Deductible then coinsurance Non-network: Deductible then coinsurance
<b>X-ray and Other Radiology Procedures</b>	No copay	Network: Deductible then coinsurance (4) Non-network: Deductible then coinsurance
<b>Routine Preventive Care</b> <i>(Contract lists covered services)</i>	PCP office visits: \$30 copay Specialists: \$60 copay	Mandated Network Routine Services: 80% <i>(not subject to deductible)</i> Non-network: Deductible then coinsurance
<b>Mammograms, Pap Smears and PSA tests, Childhood Immunizations</b>	PCP office visits: \$30 copay Specialists: \$60 copay	Network: 100% after office charge Non-network: Deductible then coinsurance
<b>Routine Vision Care (5)</b>	\$10 copay	No Benefit
<b>Inpatient Hospital Services/Outpatient Surgery*</b>	\$500 copay per day up to \$2,500 per calendar year	Deductible then coinsurance (4)
<b>MRI, MRA, CT and PET scans performed in a Physician's Office, Imaging Center or Other Outpatient Setting (including a hospital)</b>	\$200 copay <i>Only one copay will apply for each provider on a specified date of service even if multiple scans are performed</i>	Deductible then coinsurance
<b>Emergency Room/Urgent Care</b> <i>(Copay waived if admitted to a network hospital)</i>	\$200 copay; \$60 copay if services are received in an <b>urgent care center</b> .	<b>ER:</b> \$75 copay then Deductible & coinsurance <b>Urgent Care:</b> Deductible then coinsurance (4) Non-network: Deductible then coinsurance

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

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

<sup>3</sup>Other services/procedures not specified on this benefit schedule that are performed in a physician's office are subject to the Network Deductible and Coinsurance level.

<sup>4</sup>Diagnostic 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.

<sup>5</sup>Vision Care: You may receive one vision exam per year through Vision Providers (PCP referral not required).

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	<b>Blue-Care</b>	<b>Preferred-Care Blue</b>
<b>Ambulance</b>	No copay Ground ambulance limited to \$500 benefit maximum per use.	Deductible then 80% Ground ambulance limited to \$500 benefit maximum per use.
<b>Durable Medical Equipment*</b>	No copay \$5,000 calendar year maximum	Deductible then coinsurance \$5,000 calendar year maximum
<b>Allergy Testing, Treatment, Injections</b>	No copay for injections; \$100 copay for testing	Deductible then coinsurance
<b>Home Health Services*</b>	No copay 60 visit calendar year maximum	Deductible then coinsurance 60 visit calendar year maximum
<b>Skilled Nursing Facility*</b>	No copay 30 day calendar year maximum	Deductible then coinsurance 30 day calendar year maximum
<b>Outpatient Therapy</b> ( <i>Speech, Hearing, Physical, Occupational and Skeletal Manipulations</i> )	No copay Physical, Occupational and Skeletal Manipulations: Combined 40 visit calendar year maximum  Speech and Hearing: Combined 20 visit calendar year maximum	Deductible then coinsurance Physical, Occupational and Skeletal Manipulations: Combined 40 visit calendar year maximum  Speech and Hearing: Combined 20 visit calendar year maximum
<b>Inpatient Mental Illness/Substance Abuse*</b> <i>Specified Diagnoses (6)</i>	\$500 copay per day up to \$2,500 per calendar year 45 day calendar year maximum. <i>Prior authorization required from New Directions</i>	Deductible then coinsurance 45 day calendar year maximum <i>Prior authorization required from New Directions</i>
<b>Outpatient Mental Illness/Substance Abuse</b> <i>Specified Diagnoses (6)</i>	\$60 copay 45 visit calendar year maximum <i>Prior authorization required from New Directions</i>	Deductible then coinsurance 45 visit calendar year maximum
<b>Inpatient Mental Illness/Substance Abuse Care*</b> <i>Other Diagnoses</i>	\$500 copay per day up to \$2,500 per calendar year 30 day calendar year maximum. <i>Prior authorization required from New Directions</i>	Deductible then coinsurance 30 day calendar year maximum <i>Prior authorization required from New Directions</i>
<b>Outpatient Mental Illness/ Substance Abuse Care</b> <i>Other Diagnoses</i>	No copay for visits 1-3; \$25 copay for visits 4-20; \$50 copay for visits 21+ Prior authorization required from New Directions	Network: 100% of 1 <sup>st</sup> \$100 then 80% to \$1,000 then 50%; Non-Network: 100% of 1 <sup>st</sup> \$100 then 80% of next \$100 then 50%
<b>Inpatient Hospice Facility*</b>	\$250 copay per day up to \$2,500 per calendar year Copayments paid for Inpatient Hospice apply to the maximum amount you pay for inpatient services and outpatient surgery in any calendar year 14 day lifetime maximum	Deductible then coinsurance 14 day lifetime maximum
<b>Organ Transplant*</b>	Applicable copays \$500,000 Organ Transplant lifetime maximum	Deductible then coinsurance Network: \$500,000 Organ Transplant lifetime maximum Non-Network: \$100,000 Organ Transplant lifetime maximum
<b>Prescription Drugs</b> <i>(Includes all contraceptives- oral, injectable, devices and implants)</i>	<b>BCBSKC Rx Network:</b> \$10 copay for Tier 1 drug; \$50 copay for Tier 2 brand drug; \$70 copay for Tier 3 brand drug. <i>(Covered only if written by a network physician)</i>	<b>BCBSKC Rx Network:</b> \$10 copay for Tier 1 drug; \$50 copay for Tier 2 brand drug; \$70 copay for Tier 3 brand drug. Non-network: 50% after copay
<b>Prescription Drugs: Mail order drug program – 102 day supply</b>	\$20 copay for Tier 1 drug; \$100 copay for Tier 2 brand drug; \$140 copay for Tier 3 brand drug.	\$20 copay for Tier 1 drug; \$100 copay for Tier 2 brand drug; \$140 copay for Tier 3 brand drug.

	<b>Blue-Care</b>	<b>Preferred-Care Blue</b>
<b>Lifetime Maximum</b>	\$5,000,000	\$5,000,000
<b>Dependent Coverage</b>	End of calendar year the children reach age 23 or the month they are no longer an eligible dependent, whichever is first.	End of calendar year the children reach age 23 or the month they are no longer an eligible dependent, whichever is first.
<b>Prior Authorization Penalty</b> <i>(Prior Authorization is required for selected services. See your certificate for a listing of services requiring Prior Authorization).</i>	Prior authorization is the responsibility of the network provider.	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.
<b>Pre-existing Exclusion Period</b>	Your Employer's group contract provides coverage that contains limitations based on whether a condition is considered preexisting. Any condition (whether physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 90 day period from the enrollment date, is considered a preexisting condition ( <b>pregnancy is not considered a pre-existing condition</b> ). Your Employer's group contract excludes coverage for these specific preexisting conditions for 90 days beginning on the first day of the waiting period (or the date coverage is effective if there is no waiting period). However, your Employer's group contract will provide credit for preexisting conditions if you were previously covered under creditable coverage. The period of any preexisting condition exclusion that would otherwise apply to a person will be reduced by the number of days of creditable coverage the person has as of the enrollment date. In order to receive credit toward the preexisting condition exclusion period, you must provide <b>copies of the Certificates of Creditable Coverage or other acceptable proof of coverage from the prior plan(s) for the verification of prior creditable medical coverage</b> you or any listed dependents currently have, or previously had, including continuation of coverage. You have the right to request a Certificate of Creditable Coverage from your prior plan or insurer. To request assistance in obtaining a Certificate of Creditable Coverage from a prior plan or insurer, please contact Blue Cross and Blue Shield of Kansas City. Should you need additional information or assistance regarding any preexisting condition exclusion, please contact our Member Services Department at (816) 395-2950. <b>There is no exclusion period for the HMO plan.</b>	
<b>Portability</b>	The exclusion period for pre-existing conditions may be reduced by the length of time a person had prior creditable coverage, provided the member does not have a gap in coverage of more than 62 days.	
<b>Late Enrollees</b>	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.	
<b>Detailed Benefit Information</b>	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.	
<b>Exclusions and Limitations</b>	<b>Customer Service 816-395-3558 or <a href="http://www.bcbskc.com">www.bcbskc.com</a></b>	

<sup>6</sup> **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.**

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