

## Spring Hill School District - BlueSaver Qualified High Deductible Health Plan Summary

**Effective Date: 9/01/09**

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

[www.bcbskc.com](http://www.bcbskc.com)

Plan Type	Preferred-Care Blue/BlueSaver
<b>Plan Description</b> <i>(Visit our website at <a href="http://www.bcbskc.com">www.bcbskc.com</a> to receive a complete listing of network hospitals and physicians)</i>	A Preferred Provider Organization (PPO) Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue PPO network.
<b>Deductible (Embedded Deductible)</b>	\$2,500 per single/\$5,000 per family
<b>Coinsurance (1)</b>	Network: 100% / Non-network: 80%
<b>Out-of-Pocket Maximum (2)</b>	Network: \$2,500 single/\$5,000 family; Non-network: \$5,000 single/\$10,000 family
<b>Physician Office Visits</b>	Deductible then coinsurance
<b>Lab Performed in a Physician's Office/Independent Lab</b>	Network: Deductible then 100% Non-network: Deductible then 80%
<b>Lab Performed in a Hospital/Outpatient Facility</b>	Network: Deductible then 100% Non-network: Deductible then 80%
<b>X-ray and Other Radiology Procedures</b>	Network: Deductible then 100% Non-network: Deductible then 80%
<b>Routine Preventive Care</b> <i>(Contract lists covered services)</i>	Network: 100% Non-network: Deductible then coinsurance
<b>Childhood Immunizations</b>	100% (office visit charges apply)
<b>Inpatient Hospital Services/Outpatient Surgery*</b>	Deductible then coinsurance (3)
<b>Emergency Room/Urgent Care</b>	Deductible then coinsurance
<b>Ambulance</b>	Deductible then 100% Ground ambulance limited to \$500 benefit maximum per use.
<b>Durable Medical Equipment*</b>	Deductible then coinsurance \$5,000 calendar year maximum
<b>Allergy Testing, Treatment, Injections</b>	Deductible then coinsurance
<b>Home Health Services*</b>	Deductible then coinsurance 60 visit calendar year maximum
<b>Skilled Nursing Facility*</b>	Deductible then coinsurance 30 day calendar year maximum
<b>Outpatient Therapy**</b> <i>(Speech, Hearing, Physical, Occupational and Skeletal Manipulations)</i>	Deductible then coinsurance Physical, Occupational and Skeletal Manipulations: Combined 40 year calendar year maximum  Speech and Hearing: Combined 20 visit calendar year maximum

<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>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.

**Log on to [www.bcbskc.com](http://www.bcbskc.com) for Provider Directories, claims status and much more!**

	<b>Preferred-Care Blue/BlueSaver</b>
<b>Inpatient Mental Illness/Substance Abuse</b> <i>Specified Diagnoses (4)</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 (4)</i>	Deductible then coinsurance 45 visit calendar year maximum
<b>Inpatient Mental Illness/Substance Abuse Care</b> <i>Other Diagnoses (4)</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 (4)</i>	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>	Deductible then coinsurance 14 day lifetime maximum
<b>Organ Transplant*</b>	Deductible then coinsurance Network: \$500,000 Organ Transplant lifetime maximum Non-Network: \$100,000 Organ Transplant lifetime maximum
<b>Prescription Drugs*</b> <i>(Includes contraceptives – orals, injectables, implants, and devices)</i>	<b>BCBSKC Rx Network:</b> <b>Annual Deductible then 100%</b> Non-network: Deductible, then 50% after: \$10 copay for Type 1 drug; \$50 copay for Type 2 brand drug; \$70 copay for Type 3 brand drug
<b>Prescription Drugs*</b> <b>Mail order drug program – 102 day supply</b>	<b>Annual Deductible then 100%</b>
<b>Lifetime Maximum</b>	\$5,000,000
<b>Dependent Coverage</b>	End of calendar year the children reach age 23, or the end of the month they are no longer an eligible dependent, whichever is first.
<b>Prior Authorization Penalty*</b>	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>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 Exclusions and Limitations</b>	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.
<b>Customer Service</b>	<b>816-395-3558 or <a href="http://www.bcbskc.com">www.bcbskc.com</a></b>

\*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, and chiropractic services received from a non-network chiropractor. This list of services is subject to change. Please refer to your contract for the current list of services, which require Prior Authorization.

**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.

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