BlueCross BlueShield of Kansas City
An Independent Licensee of the Blue Cross and Blue Shield Association

USD #500 Kansas City, Kansas Public Schools

Qualified High Deductible Health Plan Summary

Effective Date: 1/1/15

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

	Preferred-Care Blue/BlueSaver
Plan Type	A Preferred Provider Organization (PPO)
Plan Description *(Visit our website at www.bcbskc.com to receive a complete listing of network hospitals and physicians)*	Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue PPO network.
Deductible (Aggregate Deductible)	$2,600 per single/$5,200 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: $2,600 single/$5,200 family; Non-network: $5,200 single/$10,400 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 *(Contract lists covered services)*	Network: 100% Non-network: Deductible then coinsurance
Inpatient Hospital Services/Outpatient Surgery*	Deductible then coinsurance *(3)*
Emergency Room/Urgent Care	ER: Deductible then 100% Urgent Care: Deductible then coinsurance
Ambulance	Deductible then 100%
Durable Medical Equipment*	Deductible then coinsurance
Allergy Testing, Treatment, Injections	Deductible then coinsurance
Home Health Services*	Deductible then coinsurance 60 visit calendar year maximum
Outpatient Therapy** *(Speech, Hearing, Physical, Occupational and Skeletal Manipulations)*	Deductible then coinsurance Physical, Occupational and Skeletal Manipulations: Combined 40 year calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum
Inpatient Mental Illness/Substance Abuse	Deductible then coinsurance *Prior authorization required from New Directions*
Outpatient Mental Illness/Substance Abuse	Deductible then coinsurance

[1]Portion of covered charges paid by BCBSKC after you satisfy your deductible and required copayments.
[2]Total of deductible, coinsurance and copays members pay each year toward covered charges before BCBSKC pays 100% of benefits.
[3]Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to a $200 per visit/service. Inpatient hospital services in a Non-Participating Hospital inside our service area are limited to a $200 maximum per day. 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 per visit/service.

Log on to *www.bluekc.com* for Provider Directories, claims status and much more!

	Preferred-Care Blue/BlueSaver
Skilled Nursing Facility*	Deductible then coinsurance 30 day calendar year maximum
Inpatient Hospice Facility*	Deductible then coinsurance 14 day lifetime maximum
Organ Transplant*	Deductible then coinsurance Unlimited Lifetime Maximum
Contraceptive devices, implants, injections and elective sterilization (includes insertion of devices)	Network: Covered at 100% Non-network: Deductible then coinsurance
Prescription Drugs*	**BCBSKC Rx Network:** **Annual Deductible then 100%; Tier 1 generic contraceptives covered at 100%** Non-network: Deductible, then 50% after: $15 copay for Type 1 drug; $40 copay for Type 2 brand drug; $60 copay for Type 3 brand drug
Prescription Drugs* Mail order drug program – 102 day supply	**Annual Deductible then 100%; Tier 1 generic contraceptives covered at 100%**
Lifetime Maximum	Unlimited
Dependent Coverage	End of the calendar year the children reach age 26.
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.
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	**Local (816) 395-3777 & Toll Free (866) 811-4589) or *www.bluekc.com***

*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, hi-tech scans, 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.

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