

**Favorite Healthcare Staffing, Inc.**  
**Qualified High Deductible Health Plan Summary**

*Effective: January 1, 2012*

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

*www.bluekc.com*

	<b>Preferred-Care Blue/Blue-Saver PPO</b>
<b>Plan Type</b>	A Preferred Provider Organization (PPO)
<b>Plan Description</b> <i>(Visit our website at www.bluekc.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.
<b>Deductible (Embedded Family Deductible)</b>	\$2,500 per single/\$5,000 per family <b>An Individual must meet their INDIVIDUAL deductible before benefits are paid on that individual</b>
<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% Related Office Visit: 100% Non-network: Deductible then coinsurance
<b>Inpatient Hospital Services/Outpatient Surgery*</b>	Deductible then coinsurance (3)
<b>Emergency Room</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
<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 (Speech, Hearing, Physical, Skeletal Manipulations and Occupational)*</b>	Deductible then coinsurance Physical, Occupational and Skeletal Manipulations: Combined 40 visit 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 \$200 per day. Inpatient hospital services in a Non-Participating Hospital inside our service area are limited to \$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 \$200 per day.

<b>Preferred-Care Blue/Blue-Saver PPO</b>	
<b>Inpatient Mental Illness/Substance Abuse**</b>	Deductible then coinsurance
<b>Outpatient Mental Illness/Substance Abuse</b>	Deductible then coinsurance
<b>Inpatient Hospice Facility*</b>	Deductible then coinsurance 14 day lifetime maximum
<b>Organ Transplant*</b>	Deductible then coinsurance
<b>Prescription Drugs*</b> <i>(Includes contraceptives – orals, injectables, implants, and devices)</i>	<b>BCBSKC Rx Network</b> 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>
<b>Prescription Drugs*</b> <b>Mail order drug program – 102 day supply</b>	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>
<b>Lifetime Maximum</b>	Unlimited
<b>Dependent Coverage</b>	End of calendar year the children reach age 26 or 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>	There is no exclusion period for the plan.
<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>1-888-989-8842 or <a href="http://www.bluekc.com">www.bluekc.com</a></b>
<b>Blue KC 24- Hour Nurse Line</b>	<b>877-852-5422 24 hours a day...365 days a year!</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, hearing 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.**