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

*Blue*CHOICE – Favorite Healthcare Staffing, Inc.
Health Benefit 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***

	Blue-Card PPO – Base Plan	**Blue-Card PPO – Buy Up Plan**
Plan Type	A Preferred Provider Organization (PPO)	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 Blue-Card PPO network.	Members can receive services from any hospital or physician but receive greater benefits when they use the Blue-Card PPO network.
Deductible	$1,000 per individual/$3,000 per family	$500 per individual/$1,500 per family
Coinsurance *(1)*	Network: 80% / Non-network: 60%	Network: 80% / Non-network: 60%
Out-of-Pocket Maximum *(2)*	Network: $4,000 individual/$8,000 family; Non-network: $8,000 individual/$16,000 family	Network: $3,000 individual/$6,000 family; Non-network: $6,000 individual/$12,000 family
Physician Office Visits	Network: $35 copay *(3)* Non-network: Deductible then coinsurance	Network: $30 copay *(3)* Non-network: Deductible then coinsurance
Lab Performed in a Physician's Office/Independent Lab	Network: No copay Non-network: Deductible then coinsurance	Network: No copay Non-network: Deductible then coinsurance
Lab Performed in a Hospital/Outpatient Facility	Network: Deductible then coinsurance Non-network: Deductible then coinsurance	Network: Deductible then coinsurance Non-network: Deductible then coinsurance
X-ray and Other Radiology Procedures	Network: Deductible then coinsurance *(4)* Non-network: Deductible then coinsurance	Network: Deductible then coinsurance *(4)* Non-network: Deductible then coinsurance
Routine Preventive Care *(Contract lists covered services)*	Network: 80% (not subject to deductible) Related Office Visit: $35 copay Non-network: Deductible then coinsurance $300 calendar year maximum applies to Network and non-network services.	Network: 80% (not subject to deductible) Related Office Visit: $30 copay Non-network: Deductible then coinsurance $300 calendar year maximum applies to Network and non-network services.
Mammograms, Pap Smears and PSA tests	Network: 100% after office visit copay Non-network: Deductible then coinsurance	Network: 100% after office visit copay Non-network: Deductible then coinsurance
Childhood Immunizations	100% (office visit charges apply)	100% (office visit charges apply)
Inpatient Hospital Services/Outpatient Surgery	Deductible then coinsurance	Deductible then coinsurance
Urgent Care	Network: $35 copay (office visit and lab only) (5) Non-network: Deductible then coinsurance	Network: $30 copay (office visit and lab only) (5) Non-network: Deductible then coinsurance
Emergency Room *(Copay waived if admitted to a network hospital)*	$100 copay then Deductible then coinsurance	
Ambulance	Deductible then 80% 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	
Inpatient Hospice Facility**	Deductible then coinsurance 14 day lifetime maximum	
Skilled Nursing Facility**	Deductible then coinsurance 30 day calendar year maximum	
Outpatient Therapy** *(Speech, Hearing, Physical, Occupational and Skeletal Manipulations)*	Deductible then coinsurance Physical, Occupational and Skeletal Manipulations: Combined 40 visit calendar year maximum Speech and Hearing: 20 visit calendar year maximum	

[1]Portion of covered charges paid by BCBSKC after you satisfy your deductible and required copayments.
[2]Total of deductible and coinsurance members pay each year toward covered charges before BCBSKC pays 100% of benefits.
[3]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.
[4]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.
[5]Other services/procedures that are performed by an urgent care provider are subject to the Network Deductible and Coinsurance level

Log on to *www.bcbskc.com* for eligibility and claims status.
Log on to www.bcbskc.com or call 1-800-810-BLUE for providers in your area.

	Blue-Card PPO – Base Plan	Blue-Card PPO – Buy Up Plan
Inpatient Mental Illness/Substance Abuse** *Specified Diagnoses* (6)	Deductible then coinsurance 45 day calendar year maximum *Prior authorization required from New Directions*	
Outpatient Mental Illness/Substance Abuse *Specified Diagnoses* (6)	Deductible then coinsurance 45 visit calendar year maximum	
Inpatient Mental Illness/Substance Abuse Care** *Other Diagnoses*	Deductible then coinsurance 30 day calendar year maximum *Prior authorization required from New Directions*	
Outpatient Mental Illness/ Substance Abuse Care Other Diagnoses	Network: 100% of 1st $100 then 80% to $1,000 then 50%; Non-Network: 100% of 1st $100 then 80% of next $100 then 50%	
Organ Transplant**	Deductible then coinsurance Network: $500,000 Organ Transplant lifetime maximum Non-Network: $100,000 Organ Transplant lifetime maximum	
Prescription Drugs *(Includes contraceptives)*	**BCBSKC Rx Network** $10 copay for Tier 1 drugs; $50 copay for Tier 2 brand drugs; $70 copay for Tier 3 brand drugs. Non-network: 50% after copay	
Prescription Drugs: Mail order drug program – 102 day supply	$30 copay for Tier 1 drugs; $150 copay for Tier 2 brand drugs; $210 copay for Tier 3 brand drugs.	
Lifetime Maximum	$5,000,000	
Prior Authorization Penalty *(Prior Authorization is required for selected services. See your certificate for a listing of services requiring Prior Authorization).*	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.	
Portability	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.	
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	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.	
Exclusions and Limitations	**Customer Service 1-888-989-8842 or *www.bcbskc.com***	

5 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.