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

Raymore-Peculiar School District

Effective Date: 7/1/12

Health Benefit Plan Summary – H S A Option

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.bluekc.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.
Embedded Deductible	$2,500 per individual/$5,000 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: $2,500 individual/$5,000 family; Non-network: $5,000 individual/$10,000 family
Physician Office Visits	Deductible then coinsurance
Lab Services	Deductible then coinsurance
X-ray and Other Radiology Procedures	Network: Deductible then coinsurance *(3)* Non-network: Deductible then coinsurance
Routine Preventive Care *(Contract lists covered services)*	Network Routine Services: 100% Office Visit/Wellness Exam: 100% Non-network: deductible then coinsurance
Mammograms, Pap Smears and PSA tests	Network Services: 100% Office Visit: 100% Non-network: Deductible then coinsurance
Routine Vision Care	Network: Deductible then coinsurance Non-network: Deductible then coinsurance One exam per year
Childhood Immunizations	Network Services: 100% Office Visit: 100% Non-network: Deductible then coinsurance
Inpatient Hospital Services/Outpatient Surgery*	Deductible then coinsurance *(3)*
Emergency Room/Urgent Care	Deductible then coinsurance
Ambulance	Deductible then 100% Ground ambulance limited to $500 benefit maximum per use.
Durable Medical Equipment*	Deductible then coinsurance
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

[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]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.bluekc.com* for Provider Directories, claims status and much more!

	Preferred-Care Blue/BlueSaver
Outpatient Therapy* *(Speech, Hearing, Physical and Occupational)*	Deductible then coinsurance Physical and Occupational: Combined 40 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum
Chiropractic Services*	Deductible then coinsurance
Inpatient Mental Illness & Substance Abuse*	Deductible then coinsurance
Outpatient Mental Illness & Substance Abuse*	Deductible then coinsurance
Organ Transplant*	Deductible then coinsurance Unlimited Organ Transplant lifetime maximum
Prescription Drugs* **Retail** *(Includes contraceptives – orals, injectables, implants, and devices)*	**BCBSKC Rx Network** Network: Deductible, then no copay Non-network: Deductible, then 50% after: $12 copay for Type 1 drug; $50 copay for Type 2 brand drug; $70 copay for Type 3 brand drug
Prescription Drugs: **Express Scripts: Mail order drug**	Network: Deductible, then no copay Non-network: Deductible, then 50% after: $24 copay for Type 1 drug; $100 copay for Type 2 brand drug; $140 copay for Type 3 brand drug
Lifetime Maximum	Unlimited
Dependent Coverage Missouri Mandate: Dependent daughters covered for maternity on Blue-Care only.	End of 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.
Pre-existing Exclusion Period **(does not apply to dependents under age 19)**	Your Employer's group contract provides coverage that contains limitations based on whether a condition is considered pre-existing. Any condition (whether physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period from the enrollment date is considered a pre-existing condition (pregnancy is not considered a pre-existing condition). Your Employer's group contract excludes coverage for these specific pre-existing conditions for 12 months 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 pre-existing conditions if you were previously covered under creditable coverage. The period of any pre-existing 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 pre-existing condition exclusion period, you must provide 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 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 pre-existing condition exclusion, please contact our Member Services Department at (816) 395-2950.
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 **Exclusions and Limitations**	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.
Customer Service	816-395-2270 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, prosthetics and appliances, mental health and chemical dependency, some outpatient prescriptions, skilled nursing facility, inpatient hospice 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.

**Use of in-network benefits reduces out-of-network benefits and use of out-of-network benefits reduces in-network benefits where applicable.

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