

**Johnson County Government Employees
Qualified High Deductible Health Plan Summary**

Effective Date: 1/1/10

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

www.BlueKC.com

| | BlueSaver – Employee Only | BlueSaver – Employee + 1/Family |
|---|--|---|
| Plan Type | A Preferred Provider Organization (PPO) | A Preferred Provider Organization (PPO) |
| Plan Description <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. | Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue PPO network. |
| Deductible | \$1,500 per individual | \$2,400 per individual/\$3,000 per family <i>An Individual must meet their INDIVIDUAL deductible before benefits are paid on that individual</i> |
| Coinsurance * | Network: 90% Non-network: 60% | Network: 90% / Non-network: 60% |
| Out-of-Pocket Maximum ** | Network: \$3,000 individual Non-network: \$6,000 individual | Network: \$3,000 individual/\$6,000 family; Non-network: \$6,000 Individual/\$12,000 family |
| Physician Office Visits | Network: Deductible then 90% Non-network: Deductible then 60% | |
| Lab Performed in a Physician's Office/Independent Lab | Network: Deductible then 90% Non-network: Deductible then 60% | |
| Lab Performed in a Hospital/Outpatient Facility | Network: Deductible then 90% Non-network: Deductible then 60% | |
| X-ray and Other Radiology Procedures | Network: Deductible then 90% Non-network: Deductible then 60% | |
| Routine Preventive Care <i>(Contract lists covered services)</i> | Network: 100% Non-network: Deductible then coinsurance Mandated Routine Services PSA Tests, Pelvic Exams and Pap Smears, Mammograms, Colorectal Cancer Exams, Newborn Hearing Screening, Childhood Immunizations, Lead Testing Expanded Routine Services Physician Examinations, Additional Examinations, Testing and Services, Urinalysis, Glucose Screening, Thyroid Stimulating Hormone Screening, Lipid Cholesterol Panel, HPV Screening, HIV Screening, EKG, Chest X-ray | |
| Inpatient Hospital Services/Outpatient Surgery♦ | Network: Deductible then 90% *** Non-network: Deductible then 60% | |
| Emergency Room/Urgent Care | Network: Deductible then 90% Non-network: Deductible then 60% | |
| Ambulance | Deductible then 90% Subject to maximum allowable charge | |
| Durable Medical Equipment♦ | Network: Deductible then 90% Non-network: Deductible then 60% \$10,000 calendar year maximum | |
| Allergy Testing, Treatment, Injections | Network: Deductible then 90% Non-network: Deductible then 60% | |
| Home Health Services♦ | Network: Deductible then 90% Non-network: Deductible then 60% 60 visit calendar year maximum | |

* Portion of covered charges paid by BCBSKC after you satisfy your deductible and required copayments.

** Total of deductible and coinsurance members pay each year toward covered charges before BCBSKC pays 100% of benefits.

*** 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!

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| Outpatient Therapy ♦ <i>(Speech, Hearing, Physical, Occupational and Skeletal Manipulations)</i> | | Network: Deductible then 90% Non-network: Deductible then 60% Physical, Occupational and Skeletal Manipulations: Combined 40 year calendar year maximum Speech and Hearing: 20 visit calendar year maximum |
| Inpatient Mental Illness/Substance Abuse ♦ | | Deductible then coinsurance *** <i>Prior authorization required from New Directions</i> |
| Outpatient Mental Illness/Substance Abuse ♦ | | Deductible then coinsurance *** |
| Skilled Nursing Facility ♦ | | Network: Deductible then 90% Non-network: Deductible then 60% 30 day calendar year maximum |
| Inpatient Hospice Facility ♦ | | Network: Deductible then 90% Non-network: Deductible then 60% 14 day lifetime maximum |
| Organ Transplant ♦ | | Network: Deductible then 90% Non-network: Deductible then 60% Network: \$500,000 Organ Transplant lifetime maximum Non-Network: \$100,000 Organ Transplant lifetime maximum |
| Foot Orthotics | | Network: Deductible then Coinsurance Non-network: Not covered \$500 Calendar year Maximum |
| Hearing Aids | | Cost of Initial/Replacement/Repair of Existing Hearing Aid Deductible then Coinsurance \$2,000 Calendar Year Maximum |
| Bariatric Surgery for Morbid Obesity ♦ | | Network: Deductible & Coinsurance Non-network: Not Covered \$20,000 Lifetime Maximum |
| Prescription Drugs ♦ <i>Includes contraceptives - oral, injectable, implants and devices. Smoking Cessation and some Over-the-Counter drugs are also covered. Please see list of Over-the-Counter drugs.</i> | | BCBSKC Rx: Network: Annual Deductible then 90% Non-network: Annual Deductible then 60% |
| Prescription Drugs ♦ Mail order drug program – 102 day supply | | Network: Annual Deductible then 90% Non-network: Annual Deductible then 60% |
| Preventive Prescription Drugs ♦ <i>Preventive medications are covered at the appropriate copay level (not subject to deductible). The covered medications are based on Express Scripts' list of preventive medications in accordance with IRS guidelines. Please see list of preventive drugs.</i> | | BCBSKC Rx Network \$5 copay for Tier 1 drugs; \$25 copay for Tier 2 brand drugs; \$45 copay for Tier 3 brand drugs. Non-network: 50% after copay |
| Preventive Prescription Drugs ♦ Mail order drug program – 102 day supply | | \$10 copay for Tier 1 drugs; \$50 copay for Tier 2 brand drugs; \$90 copay for Tier 3 brand drugs Non-network: 50% after copay |
| Lifetime Maximum | | \$2,000,000 |

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| Dependent Coverage | Dependents are covered through the end of calendar month in which they turn nineteen (19), or through the end of the calendar year in which they turn twenty-five (25) if a full-time student. | |
| 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 | 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 (pregnancy is not considered a pre-existing condition). 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 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 preexisting 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 | Customer Service (816) 395-3364 or Toll Free - 1-866-242-1487 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, 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.