

## Johnson County Government Employees Health Benefit Plan Summary

*Effective Date: 1/1/09*

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

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Plan Type	Blue-Care (Open Access)	Preferred-Care Blue (BlueCard)
<b>Plan Type</b>	A Health Maintenance Organization (HMO)	A Preferred Provider Organization (PPO)
<b>Plan Description</b> <i>(Visit our website at <a href="http://www.bcbskc.com">www.bcbskc.com</a> to receive a complete listing of network hospitals and physicians)</i>	Members choose a primary care physician. Members may self-refer to physician specialists in the Blue-Care network. Urgent care and an exclusive network of specialists are also covered; <b>other services must be ordered by an HMO Physician.</b>	Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue network.
<b>Deductible</b>	N/A	\$300 per individual/\$600 per family
<b>Coinsurance *</b>	N/A	Network: 80% / Non-network: 60%
<b>Out-of-Pocket Maximum **</b>	Inpatient/Outpatient surgical copays limited to 5 copays per member per calendar year	Network: \$1,500 individual/\$3,000 family; Non-network: \$3,000 individual/\$6,000 family
<b>Physician Office Visits</b>	PCP office visits: \$15 copay Specialists: \$30 copay	Network: \$15 copay *** Non-network: Deductible then coinsurance
<b>Lab Performed in Physician's Office/Independent Lab</b>	No copay	Network: No copay Non-network: Deductible then coinsurance
<b>Lab Performed in Hospital/Outpatient Facility</b>	No copay	Network: Deductible then coinsurance Non-network: Deductible then coinsurance
<b>X-ray and Other Radiology Procedures</b>	No copay	Network: Deductible then coinsurance **** Non-network: Deductible then coinsurance
<b>Routine Preventive Care</b> <i>(Contract lists covered services)</i>	PCP office visits: \$15 copay Specialists: \$30 copay	Network Routine Services: 100% Office Visit/Wellness Exam: \$15 copay Non-network: Deductible then coinsurance Unlimited Calendar Year Maximum
<b>Mammograms, Pap Smears and PSA Tests</b>	100% (office visit copay applies)	Network: 100% (office visit copay applies) Non-network: Deductible then coinsurance
<b>Routine Hearing Care</b>	PCP office visits: \$15 copay Specialists: \$30 copay	Deductible then coinsurance
<b>Childhood Immunizations</b> <i>(Contract lists covered services)</i>	100% (office visit copay applies)	Network: 100% (office visit copay applies) Non-network: Deductible then coinsurance
<b>Inpatient Hospital Services/Outpatient Surgery</b>	\$200 copay per day up to \$1,000 per calendar year. <i>(Inpatient/Outpatient surgical copays limited to 5 copays per member per calendar year)</i>	Deductible then coinsurance ****
<b>Emergency Room</b> <i>(Copay waived if admitted to a network hospital)</i>	\$100 copay	Network: \$100 copay then Deductible then 80% Non-network: \$100 copay then deductible then 60%
<b>Urgent Care</b>	\$30 copay	Network: \$30 copay (office visit and lab only) ***** Non-network: Deductible then coinsurance
<b>Ambulance</b>	No copay Subject to maximum allowable charge	Deductible then coinsurance Subject to maximum allowable charge

\* 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.

\*\*\* 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.

\*\*\*\* 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.

\*\*\*\*\* Other services/procedures that are performed by an urgent care provider are subject to the Network Deductible and Coinsurance level.

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	<b>Blue-Care (Open Access)</b>	<b>Preferred-Care Blue (BlueCard)</b>
<b>Electronic Physician Visit (e-visit)</b>	PCP: \$10 copay Specialist: \$10 copay	Network: \$10 copay Non-network: No Benefit
<b>Durable Medical Equipment♦</b>	No copay \$10,000 calendar year maximum	Deductible then coinsurance \$10,000 calendar year maximum
<b>Allergy Testing, Treatment, Injections</b>	No copay for injections; \$100 copay for testing	Deductible then coinsurance
<b>Home Health Services♦</b>	No copay 60 visit calendar year maximum	Deductible then coinsurance 60 visit calendar year maximum
<b>Skilled Nursing Facility♦</b>	No copay 30 day calendar year maximum	Deductible then coinsurance 30 day calendar year maximum
<b>Outpatient Therapy (Speech, Hearing, Physical, Occupational and Skeletal Manipulations) ♦</b>	No copay Physical, Occupational and Skeletal Manipulations: Combined 40 visit calendar year maximum  Speech and Hearing: Combined 20 visit calendar year maximum	Deductible then coinsurance Physical, Occupational and Skeletal Manipulations: Combined 40 year calendar year maximum  Speech and Hearing: Combined 20 visit calendar year maximum
<b>Inpatient Mental Illness/Substance Abuse ♦</b> <i>Specified Diagnoses *****</i>	\$200 copay per day up to \$1,000 per calendar year. ( <i>Inpatient/Outpatient surgical copays limited to 5 copays per member per calendar year.</i> ) 45 day calendar year maximum. <i>Prior authorization required from New Directions</i>	Deductible then coinsurance 45 day calendar year maximum <i>Prior authorization required from New Directions</i>
<b>Outpatient Mental Illness/Substance Abuse♦</b> <i>Specified Diagnoses *****</i>	\$30 copay 45 visit calendar year maximum <i>Prior authorization required from New Directions</i>	Deductible then coinsurance 45 visit calendar year maximum
<b>Inpatient Mental Illness/Substance Abuse Care ♦</b> <i>Other Diagnoses</i>	\$200 copay per day up to \$1,000 per calendar year. ( <i>Inpatient/Outpatient surgical copays limited to 5 copays per member per calendar year.</i> ) 30 day calendar year maximum. <i>Prior authorization required from New Directions</i>	Deductible then coinsurance 30 day calendar year maximum <i>Prior authorization required from New Directions</i>
<b>Outpatient Mental Illness/ Substance Abuse Care ♦</b> <i>Other Diagnoses</i>	No copay for visits 1-3; \$25 copay for visits 4-20; \$50 copay for visits 21+ <i>Prior authorization required from New Directions</i>	Network: 100% of 1 <sup>st</sup> \$100 then 80% to \$1,000 then 50%; Non-Network: 100% of 1 <sup>st</sup> \$100 then 80% of next \$100 then 50%
<b>Organ Transplant ♦</b>	Applicable copays \$500,000 Organ Transplant lifetime maximum	Deductible then coinsurance Network: \$500,000 Organ Transplant lifetime maximum Non-Network: \$100,000 Organ Transplant lifetime maximum
<b>Foot Orthotics</b>	No copay \$500 Calendar Year Maximum	Network: Deductible then Coinsurance Non-network: Not covered \$500 Calendar year Maximum
<b>Hearing Aids</b>	Cost of Initial/Replacement/Repair of Existing Hearing Aid  \$2,000 Calendar Year Maximum	Cost of Initial/Replacement/Repair of Existing Hearing Aid Deductible then Coinsurance \$2,000 Calendar Year Maximum
<b>Bariatric Surgery for Morbid Obesity♦</b>	\$200 Copay per day <i>Copays limited to five copays per member per calendar year</i> \$20,000 Lifetime Maximum	Network: Deductible & Coinsurance Non-network: Not Covered \$20,000 Lifetime Maximum
<b>Inpatient Hospice Facility ♦</b>	\$100 copay per day up to \$1,000 per calendar year Copayments paid for Inpatient Hospice apply to the maximum amount you pay for inpatient services and outpatient surgery in any calendar year 14 day lifetime maximum	Deductible then coinsurance 14 day lifetime maximum

	<b>Blue-Care (Open Access)</b>	<b>Preferred-Care Blue (BlueCard)</b>
<b>Prescription Drugs ♦</b> <i>Includes contraceptives - oral, injectable, implants and devices. Smoking Cessation and some Over-the-Counter drugs are also covered. Please see attached list of Over-the-Counter drugs that are included. Note: \$500 Annual Maximum on Smoking Cessation Drugs</i>	<b>BCBSKC Rx Network</b> \$4 copay for Tier 1 drugs; \$18 copay for Tier 2 brand drugs; \$40 copay for Tier 3 brand drugs. <b>Non-network: No Benefit</b>	<b>BCBSKC Rx Network</b> \$4 copay for Tier 1 drugs; \$18 copay for Tier 2 brand drugs; \$40 copay for Tier 3 brand drugs. <b>Non-network: 50% after copay</b>
<b>Prescription Drugs: Mail order drug program – 102 day supply</b>	\$8 copay for Tier 1 drugs; \$36 copay for Tier 2 brand drugs; \$80 copay for Tier 3 brand drugs. <b>Non-network: No Benefit</b>	\$8 copay for Tier 1 drugs; \$36 copay for Tier 2 brand drugs; \$80 copay for Tier 3 brand drugs <b>Non-network: 50% after copay</b>
<b>Lifetime Maximum</b>	\$2,000,000	\$2,000,000
<b>Dependent Coverage</b>	End of calendar year the children reach age 25 or the date they are no longer an eligible dependent, whichever is first.	End of calendar year the children reach age 25 or the date they are no longer an eligible dependent, whichever is first.
<b>Prior Authorization Penalty</b> <i>(Prior Authorization is required for selected services. See your certificate for a listing of services requiring Prior Authorization).</i>	Prior authorization is the responsibility of the network provider.	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>	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 ( <b>pregnancy is not considered a pre-existing condition</b> ). 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 <b>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</b> 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. <b>There is no exclusion period for the HMO plan.</b>	
<b>Portability</b>	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.	
<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</b>	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.	
<b>Exclusions and Limitations</b>	<b>Customer Service (816) 395-3364 or Toll Free - 1-866-242-1487 or <a href="http://www.bcbskc.com">www.bcbskc.com</a></b>	

\*\*\*\*\* **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.

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