

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

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Buy-Up Plan	Blue-Care	Preferred-Care Blue
<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. Urgent care and an exclusive network of specialists are also covered. <b>Some 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	\$500 per individual/\$1,000 per family
<b>Coinsurance (1)</b>	N/A	Network: 80% / Non-network: 60%
<b>Out-of-Pocket Maximum (2)</b>	Inpatient/Outpatient surgical copays limited to \$500 per member (5 copays per member per calendar year)	Network: \$1,500 individual/\$3,000 family; Non-network: \$4,500 individual/\$9,000 family
<b>Physician Office Visits</b>	PCP office visits: \$15 copay Specialists: \$30 copay	Network: \$10 copay (3) Non-network: Deductible then coinsurance
<b>Routine Preventive Care</b> <i>(Contract lists covered services)</i>	Applicable copay	Mandates Only
<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 (4) Non-network: Deductible then coinsurance
<b>Mammograms, Pap Smears and PSA tests</b>	Applicable copay	Network: 100% after office visit copay Non-network: Deductible then coinsurance
<b>Routine Vision Care (4)</b>	\$30 copay	No Benefit
<b>Childhood Immunizations</b>	100% (office visit copay applies)	100% (office visit charges apply)
<b>Inpatient Hospital Services/Outpatient Surgery*</b>	Inpatient - \$100 copay/day; Outpatient - \$100 copay/occurrence <i>Copays apply to out-of-pocket max.</i>	Deductible then coinsurance (5)
<b>MRI, MRA, CT and PET scans performed in a Physician's Office, Imaging Center or Other Outpatient Setting (including a hospital)</b>	\$50 copay Only one copay will apply for each provider on a specified date of service even if multiple scans are performed	Deductible then coinsurance
<b>Emergency Room/Urgent Care</b> <i>(Copay waived if admitted to a network hospital)</i>	\$50 copay.	\$50 copay then Deductible then coinsurance
<b>Electronic Physician Visit (e-visit)</b>	PCP: \$10 copay Specialist: \$10 copay	Network: \$10 copay Non-network: No Benefit
<b>Urgent Care</b>	\$30 copay if services are received in an <b>urgent care center</b> .	Deductible then coinsurance
<b>Ambulance</b>	No copay Ground ambulance limited to \$500 benefit maximum per use.	Deductible then 80% Ground ambulance limited to \$500 benefit maximum per use.
<b>Durable Medical Equipment*</b>	No copay \$5,000 calendar year maximum	Deductible then coinsurance \$5,000 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>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.

<sup>4</sup>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.

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<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*</b> <i>(Speech, Hearing, Physical &amp; Occupational)</i>	No copay Physical and Occupational: Combined 40 visit calendar year maximum  Speech and Hearing: 20 visit calendar year maximum	Deductible then coinsurance Physical and Occupational: Combined 40 visit calendar year maximum  Speech and Hearing: 20 visit calendar year maximum
<b>Chiropractic Services*</b>	No copay 26 visit calendar year maximum	Deductible & Coinsurance 26 visit calendar year maximum*
<b>Chemical Dependency</b> <i>Outpatient*</i>	\$30 copay 26 visit calendar year maximum	Deductible then coinsurance 26 visit calendar year maximum
<b>Chemical Dependency</b> <i>Residential*</i>	\$100 copay per day up to \$500 per calendar yr 21 day calendar year maximum	Deductible then coinsurance 21 day calendar year maximum
<b>Chemical Dependency</b> <i>Detoxification*</i>	\$100 copay per day up to \$500 per calendar yr 6 day calendar year maximum	Deductible then coinsurance 6 day calendar year maximum
<b>Mental Illness</b> <i>Outpatient*</i>	\$30 copay	Deductible then coinsurance Non-Network: 60 visit calendar year maximum**
<b>Mental Illness</b> <i>Residential*</i>	\$100 copay per day up to \$500 per calendar yr	Deductible then coinsurance Non-network: 30 day calendar year maximum**
<b>Mental Illness*</b> <i>Inpatient*</i>	\$100 copay per day up to \$500 per calendar yr	Deductible then coinsurance
<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>Inpatient Hospice Facility*</b>	\$50 copay per day up to \$500 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>Prescription Drugs</b> <i>(Includes all contraceptives – oral, injectable, devices &amp; implants)</i>	<b>BCBSKC Rx Network</b> \$10 copay for Tier 1 drug; \$30 copay for Tier 2 brand drug; \$50 copay for Tier 3 brand drug.	<b>BCBSKC Rx Network</b> \$10 copay for Tier 1 drug; \$30 copay for Tier 2 brand drug; \$50 copay for Tier 3 brand drug. Non-network: 50% after copay
<b>Express Scripts</b> <i>Mail order drug program – 102 day supply</i>	\$20 copay for Tier 1 drug; \$60 copay for Tier 2 brand drug; \$100 copay for Tier 3 brand drug.	\$20 copay for Tier 1 drug; \$60 copay for Tier 2 brand drug; \$100 copay for Tier 3 brand drug.
<b>Lifetime Maximum</b>	Unlimited	\$5,000,000
<b>Dependent Coverage</b> <i>(Missouri Mandate: Dependent daughters <u>are</u> covered for maternity on <b>Blue-Care only</b>).</i>	End of the calendar year children reach age 23 or the month they are no longer an eligible dependent, whichever is first.	End of the calendar year children reach age 23 or the month they are no longer an eligible dependent, whichever is first.

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<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 6 months 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 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 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 plans.</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 816-395-3558 or <a href="http://www.bcbskc.com">www.bcbskc.com</a></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, 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, and (for Preferred-Care Blue only) 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.

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

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