

Health Benefit Plan Summary

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
Plan Type	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 network.
Deductible	Network: \$250 per individual/\$750 per family Non-network: \$500 per individual/\$1,500 per family
Coinsurance (1)	Network: 90% Non-network: 70%
Out-of-Pocket Maximum (2)	Network: \$2,250 individual/\$6,750 family; Non-network: \$4,500 individual/\$13,500 family
Physician Office Visits	Network: \$15 copay (office visit only) (3) Non-network: Deductible then coinsurance
Lab Performed in Physician's Office/Independent Lab/Urgent Care Facility	Network: No copay Non-network: Deductible then coinsurance
Lab Performed in Hospital/Outpatient Facility	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
Routine Preventive Care <i>(Contract lists covered services)</i>	Network Routine Services: 100% Office Visit/Wellness Exam: \$15 copay Non-network: Deductible then coinsurance Unlimited calendar year maximum (applies to network and non-network)
Mammograms, Pap Smears and PSA tests	Network Services: 100% Office Visit: \$15 copay Non-network: Deductible then coinsurance
Routine Vision Care	Network: \$15 copay Non-network: Deductible then coinsurance
Childhood Immunizations	Network Services: 100% Office Visit: \$15 copay Non-network: Deductible then coinsurance
Inpatient Hospital Services *	Network: \$400 copayment per admission, then Deductible, then 100% (4) Non-network: Deductible then coinsurance
Outpatient Surgery* <i>(if in outpatient surgery facility)</i>	Network: Deductible then coinsurance(4) Non-network: Deductible then coinsurance
Outpatient Non-Surgery*	Deductible then coinsurance (4)
Emergency Room <i>(Copay waived if admitted to a network hospital)</i>	\$200 copay then Deductible then coinsurance

¹Portion of covered charges paid by BCBSKC after you satisfy your deductible and required copayments.

²Total of deductible and coinsurance members pay each year toward covered charges before BCBSKC pays 100% of benefits.

³Other 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. Office visits for mental health and substance abuse are covered at 100%

⁴Diagnostic 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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Urgent Care	Network: \$15 copay (office visit and lab only) (5) Non-network: Deductible then coinsurance
Electronic Physician Visit (e-visit)	Network: \$10 copay Non-network: No Benefit
Ambulance	Deductible then 90% 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: Combined 20 visit calendar year maximum
Inpatient Mental Illness/Substance Abuse*	Network: \$400 copayment per admission, then Deductible then 100% Non-network: Deductible then coinsurance <i>Prior authorization required from New Directions</i>
Outpatient Mental Illness/Substance Abuse*	Deductible then coinsurance
Organ Transplant**	Deductible then coinsurance Network: \$500,000 Organ Transplant lifetime maximum Non-Network: \$100,000 Organ Transplant lifetime maximum

⁵Other services/procedures that are performed by an urgent care provider are subject to the Network Deductible and Coinsurance level.

*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, inpatient hospice 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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Prescription Drugs** Retail (Includes contraceptives – orals, injectables, implants and devices)	<u>For Individuals Not Completing the HRA & Biometric Screenings</u> Outpatient Prescription Drug Deductible*** \$300 Individual/\$900 Family Deductible, then \$15 copay for Tier 1 drug; Deductible, then \$30 copay for Tier 2 brand drug; Deductible, then \$50 copay for Tier 3 brand drug Non-network: Deductible, then 50% after copay <u>Drug deductible will be waived for those individuals completing the HRA</u>
Prescription Drugs: Express Scripts: Mail order drug program	<u>For Individuals Not Completing the HRA & Biometric Screenings</u> Outpatient Prescription Drug Deductible*** \$300 Individual/\$900 Family Deductible, then \$30 copay for Tier 1 drug; Deductible, then \$60 copay for Tier 2 brand drug; Deductible, then \$100 copay for Tier 3 brand drug <u>Drug deductible will be waived for those individuals completing the HRA</u>
Lifetime Maximum	\$5,000,000
Dependent Coverage	End of calendar year the children reach age 19, 24 if full-time student, or end of month they are no longer an eligible dependent, whichever is first.
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 pre-existing. 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 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 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 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	Local (816) 395-3777 & Toll Free (866) 811-4589 or www.bluekc.com

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**The outpatient prescription drug benefit is separate from the medical deductible. The deductible includes both in-network and out-of-network, retail and mail order.

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