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

USD #500 Kansas City, Kansas Public Schools

Effective Date: 1/1/15

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 *(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 network.
First Dollar Coverage*(1)*	Network: $250 per calendar year per member Non-network: No Benefit
Deductible	Network: $2,500 per individual/$7,500 per family Non-network: $5,000 per individual/$15,000 per family
Coinsurance *(2)*	Network: 90% Non-network: 70%
Out-of-Pocket Maximum *(3)*	Network: $5,400 individual/$10,800 family; Non-network: $10,800 individual/$21,600 family
Physician Office Visits	Network: PCP: $25 copay (office visit only) *(4)* Specialist: $50 copay (office visit only) *(4)* 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 *(5)* Non-network: Deductible then coinsurance
Routine Preventive Care *(Contract lists covered services)*	Network Routine Services: 100% Office Visit/Wellness Exam: No copay Non-network: Deductible then coinsurance
Mammograms, Pap Smears and PSA tests	Network Services: 100% Office Visit: No copay Non-network: Deductible then coinsurance
Routine Vision Care	Network: $25 copay Non-network: Deductible then coinsurance
Childhood Immunizations	Network Services: 100% Office Visit: No copay Non-network: Deductible then coinsurance
Inpatient Hospital Services *	Network: $600 copayment per admission, then Deductible, then coinsurance *(5)* Non-network: Deductible then coinsurance

[1]Copayments for all services except Emergency Room, Inpatient Hospital Services, Residential Treatment for Chemical Dependency, Detoxification for Chemical Dependency, Residential Treatment for Mental Illness, Inpatient Mental Illness, and Outpatient Surgery cannot be reimbursed by the Annual First Dollar Coverage.

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

[3]Total of deductible, coinsurance and copays members pay each year toward covered charges before BCBSKC pays 100% of benefits.

[4]Other services/procedures performed in a physician's office are subject to the Network Deductible and Coinsurance level.

[5]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
Outpatient Surgery* *(if in outpatient surgery facility)*	Network: Deductible, then coinsurance *(5)* Non-network: Deductible then coinsurance
Outpatient Non-Surgery**	Deductible then coinsurance *(5)*
Emergency Room *(Copay waived if admitted to a hospital)*	$200 copay then Deductible then 90%
Urgent Care	Network: $50 copay (office visit and lab only) *(6)* Non-network: Deductible then coinsurance
Ambulance	Deductible then 100%
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
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: $600 copayment per admission, Deductible then 90% Non-network: Deductible then coinsurance *Prior authorization required from New Directions*
Outpatient Mental Illness/Substance Abuse*	Network: Office Visit: $25 Copay; Therapy: Deductible then coinsurance; Non-network: Deductible then coinsurance

[6] Other 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 service , hi-tech scans, 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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Organ Transplant*	Deductible then coinsurance Unlimited Organ Transplant lifetime maximum
Contraceptive devices, implants, injections and elective sterilization (includes insertion of devices)	Network: Covered at 100% Non-network: Deductible then coinsurance
Prescription Drugs* **Retail**	$15 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $40 copay for Tier 2 brand drug; $60 copay for Tier 3 brand drug Non-network: Deductible, then 50% after copay
Prescription Drugs: **Express Scripts: Mail order drug program**	$30 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $80 copay for Tier 2 brand drug; $120 copay for Tier 3 brand drug
Lifetime Maximum	Unlimited
Dependent Coverage	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.
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.