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 – HMO Plan

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

	Blue-Care
Plan Type	A Health Maintenance Organization (HMO)
Plan Description *(Visit our website at www.bluekc.com to receive a complete listing of network hospitals and physicians)*	Members must receive all care from HMO providers except for emergency services. 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; other services must be ordered by an HMO Physician.
Deductible	N/A
Coinsurance *(1)*	N/A
Out-of-Pocket Maximum *(2)*	Individual $4,000 Family $10,000
Physician Office Visits	PCP office visits: $25 copay Specialists: $50 copay
Lab Performed in Physician's Office/Independent Lab	No copay
Lab Performed in Hospital/Outpatient Facility	No copay
X-ray and Other Radiology Procedures	No copay
Routine Preventive Care *(Contract lists covered services)*	No copay
Mammograms, Pap Smears and PSA tests	100%
Routine Vision Care *(3)*	$10 copay
Childhood Immunizations	100%
Inpatient Hospital Services/Outpatient Surgery**	$300 copay per day up to $1,500 per calendar year
Emergency Room/Urgent Care *(Copay waived if admitted to a hospital)*	$200 copay; $50 copay if services are received in an **urgent care center**.
MRI, MRA, CT and PET scans performed in a Physician's Office, Imaging Center or Other Outpatient Setting (including a hospital)	$200 copay Only one copay will apply for each provider on a specified date of service even if multiple scans are performed
Ambulance	No copay
Durable Medical Equipment*	No copay
Allergy Testing, Treatment, Injections	No copay for injections; $100 copay for testing
Home Health Services*	No copay 60 visit calendar year maximum
Inpatient Hospice Facility*	$150 copay per day up to $1,500 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

[1]Portion of covered charges paid by BCBSKC after you satisfy your deductible and required copayments.
[2]Total of deductible, coinsurance and copays members pay each year toward covered charges before BCBSKC pays 100% of benefits.
[3]Vision Care: You may receive one vision exam per year (PCP referral not required).

Log on to *www.bluekc.com* for Provider Directories, claims status and much more!

	Blue-Care
Skilled Nursing Facility*	No copay 30 day calendar year maximum
Outpatient Therapy* *(Speech, Hearing, Physical, Occupational and Skeletal Manipulations)*	No copay 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*	$300 copay per day up to $1,500 per calendar year. *Prior authorization required from New Directions*
Outpatient Mental Illness/Substance Abuse	Office Visit: $25 Copay; Therapy: No copay *Prior authorization required from New Directions*
Organ Transplant*	Applicable copays Unlimited Organ Transplant lifetime maximum
Contraceptive devices, implants, injections and elective sterilization (includes insertion of devices)	Network: Covered at 100% Non-network: Not Covered
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
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.
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***
Prior Authorization Penalty*	Prior authorization is the responsibility of the network provider.

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

**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, 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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