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

University of Central Missouri
Health Benefit Plan Summary

Effective Date: 1/1/16

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 A) 2015 Benefits	Preferred-Care Blue BlueSaver Plan
Plan Type	A Preferred Provider Organization (PPO)	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.	Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue network.
Deductible	$500 per individual/$1,000 per family	$2,600 per individual/$5,200 per family ***An Individual must meet their INDIVIDUAL deductible before benefits are paid on that individual***
Coinsurance *(1)*	Network: 80% / Non-network: 50%	Network: 100% / Non-network: 80%
Out-of-Pocket Maximum *(2)*	Network: $3,250 individual/$6,500 family; Non-network: $8,125 individual/$16,250 family ***[2]Total of deductible, coinsurance and copays members pay each year toward covered charges before BCBSKC pays 100% of benefits for Medical and Prescription Drug***	Network: $2,600 individual/$5,200 family; Non-network: $5,200 individual/$10,400 family ***[2]Total of deductible, coinsurance and copays members pay each year toward covered charges before BCBSKC pays 100% for Medical and Prescription Drug.***
Physician Office Visits	Network: $20 copay (office visit only) *(3)* Specialist $40 Copay (office visit only) *(3)* Non-network: Deductible then coinsurance	Network: Deductible then 100% coinsurance Non-network: Deductible then 80% coinsurance
Lab Performed in a Physician's Office/Independent Lab	Network: 100% Non-network: Deductible then 50% coinsurance	Network: Deductible then 100% coinsurance Non-network: Deductible then 80% coinsurance
Lab Performed in a Hospital/Outpatient Facility	Network: Deductible then 80% coinsurance Non-network: Deductible then 50% coinsurance	Network: Deductible then 100% coinsurance Non-network: Deductible then 80% coinsurance
X-ray and Other Radiology Procedures	Network: Deductible then 80% coinsurance *(4)* Non-network: Deductible then 50% coinsurance	Network: Deductible then 100% coinsurance *(4)* Non-network: Deductible then 80% coinsurance
Routine Preventive Care *(Contract lists covered services)*	Routine Services: 100% Related OV: 100% Non-network: Deductible then coinsurance	Routine Services: 100% Related OV: 100% Non-network: Deductible then coinsurance
Mammograms, Pap Smears and PSA tests	Network: 100% Non-network: Deductible then 50% coinsurance	Network: 100% Non-network: Deductible then 80% coinsurance
Routine Vision Care	No Benefit	No Benefit
Inpatient Hospital Services/Outpatient Surgery*	Deductible then 80/50% coinsurance *(4)*	Deductible then 100/80% coinsurance *(4)*
Emergency Room *(Copay waived if admitted to a hospital)*	$100 copay then Deductible then 80% coinsurance	Deductible then 100% coinsurance
Electronic Physician Visit (e-visit)	Network (Providers in our Service Area): $10 copay Non-network: No Benefit	No Benefit
Urgent Care	Network: $40 copay (office visit and lab only) *(5)* Non-network: Deductible then 50% coinsurance	Network: Deductible then 100% Coinsurance Non-network: Deductible then 80% coinsurance
Ambulance	Deductible then 80%	Deductible then 100%
Durable Medical Equipment*	Deductible then 80/50% coinsurance	Deductible then 100/80% coinsurance
Allergy Testing, Treatment, Injections	Deductible then 80/50% coinsurance	Deductible then 100/80% coinsurance
Home Health Services*	Deductible then 80/50% coinsurance 60 visit calendar year maximum	Deductible then 100/80% coinsurance 60 visit calendar year maximum

[1]Portion of covered charges paid by BCBSKC after you satisfy your deductible and required copayments.
[3]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.
[4]Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to $200 per day. Inpatient hospital services in a Non-Participating Hospital inside our service area are limited to a $200 maximum per day. 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 $200 per day.
[5]Other services/procedures that are performed by an urgent care provider are subject to the Network Deductible and Coinsurance level.

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

	Preferred-Care Blue (Plan A) 2015 Benefits	Preferred-Care Blue BlueSaver Plan
Skilled Nursing Facility*	Deductible then 80/50% coinsurance 30 day calendar year maximum	Deductible then 100/80% coinsurance 30 day calendar year maximum
Outpatient Therapy *(Speech, Hearing, Physical and Occupational)**	Deductible then 80/50% coinsurance Physical and Occupational: Combined 40 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum	Deductible then 100/80% coinsurance Physical and Occupational: Combined 40 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum
Chiropractic Services*	Network: $40 copay (office visit only*) (6)* Non-network: Deductible then 80/50% coinsurance	Network: Deductible then 100% Coinsurance (office visit only*) (6)* Non-network: Deductible then 100/80% coinsurance
Inpatient Mental Illness/Substance Abuse*	Deductible then coinsurance *(4)* *Prior authorization required from New Directions*	Deductible then 100/80% coinsurance *(4)* *Prior authorization required from New Directions*
Outpatient Mental Illness/Substance Abuse*	Therapy: Deductible then coinsurance *(4)* Office Visit: $20 Copay	Therapy: Deductible then coinsurance *(4)* Office Visit: Deductible then coinsurance
Organ Transplant*	Deductible then 80/50% coinsurance Unlimited Organ Transplant lifetime maximum	Deductible then 100/80% coinsurance Unlimited Organ Transplant lifetime maximum
Inpatient Hospice Facility*	Deductible then 80%/50% 14 day lifetime maximum	Deductible then 100%/80% 14 day lifetime maximum
Women's Contraceptive devices, implants, injections and elective sterilization (includes insertion of devices)	Network: Covered at 100% Non-Network: Deductible then coinsurance	Network: Covered at 100% Non-Network: Deductible then coinsurance
Prescription Drugs*	**BCBSKC Rx Network** $10 copay for Tier 1 drug/contraceptives covered at 100%; $30 copay for Tier 2 brand drug; $50 copay for Tier 3 brand drug Non-network: 50% after copay	**BCBSKC Rx Network** **Annual Deductible then 100%; Tier 1 generic contraceptives covered at 100% (not subject to deductible)** Non-network: Deductible, then 50% after: $10 copay for Tier 1 drug; $30 copay for Tier 2 brand drug; $50 copay for Tier 3 brand drug
Prescription Drugs: Express Scripts: Mail order drug program – 102 day supply	$20 copay for Tier 1 drug/contraceptives covered at 100%; $60 copay for Tier 2 brand drug; $100 copay for Tier 3 brand drug	**Annual Deductible then 100%; Tier 1 generic contraceptives covered at 100% (not subject to deductible)** $20 copay for Tier 1 drug/contraceptives covered at 100%; $60 copay for Tier 2 brand drug; $100 copay for Tier 3 brand drug
Lifetime Maximum	Unlimited	Unlimited
Dependent Coverage	End of the calendar year the children reach age 26	End of the 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.	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.	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.	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.
Customer Service	**816-395-3558 or *www.BlueKC.com***	**816-395-3558 or *www.BlueKC.com***
Blue KC 24 Hour Nurse Line	**877-852-5422 24 hours a day … 365 days a year!**	**877-852-5422 24 hours a day … 365 days a year!**

[6]Other services/procedures including skeletal manipulations performed in a chiropractor's office are subject to the Preferred 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, hi-tech scans, hearing 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*