



An independent licensee of the Blue Cross and Blue Shield Association

University of Central Missouri

Health Benefit Plan Summary

This Benefit Summary provides only highlights of the services covered by Blue Cross and Blue Shield of Kansas City (Blue KC). For Additional details, refer to your member contract available at BlueKC.com.

	Preferred-Care Blue - PPO Plan A	Preferred-Care Blue – BlueSaver Plan
Plan Type	A Preferred Provider Organization (PPO)	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.	Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue PPO network.
Deductible	Network: \$500 individual/ \$1,000 family; Non-network: \$500 individual/ \$1,000 family	Network: \$2,600 individual/ \$5,200 family; Non-network: \$2,600 individual/ \$5,200 family <i>An Individual must meet their INDIVIDUAL deductible before benefits are paid on that individual</i>
Coinsurance¹	Network: 80% Non-network: 50%	Network: 100% Non-network: 80%
Out-of-Pocket Maximum² <i>Applies to all Medical & Rx Cost Sharing</i>	Network: \$3,250 individual/ \$6,500 family; Non-network: \$8,125 individual/ \$16,250 family	Network: \$2,600 individual/ \$5,200 family; Non-network: \$5,200 individual/ \$10,400 family
Physician Office Visits³	Network: PCP office visits: \$20 copay (office visit only) Network: Specialists: \$40 copay (office visit only) Non-network: Deductible then coinsurance	Deductible then coinsurance
Chiropractic Services¹	Network: \$40 copay (office visit only) Non-network: Deductible then coinsurance	Deductible then coinsurance
Lab Performed in a Physician's Office/Independent Lab/Urgent Care Facility	Network: No copay Non-network: Deductible then coinsurance	Deductible then coinsurance
Lab Performed in a Hospital/Outpatient Facility	Network: Deductible then coinsurance Non-network: Deductible then coinsurance	Deductible then coinsurance
X-ray and Other Radiology Procedures²	Network: Deductible then coinsurance Non-network: Deductible then coinsurance	Network: Deductible then coinsurance ⁴ Non-network: Deductible then coinsurance

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

² Diagnostic services performed at a Non-Participating Imaging Center inside the Blue KC Service Area are limited to \$200 per day. Inpatient hospital services in a Non-Participating Hospital inside the Blue KC service area are limited to \$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 the Blue KC service area are limited to \$200 per day.

	Preferred-Care Blue - PPO Plan A	Preferred-Care Blue – BlueSaver Plan
Routine Preventive Care	Network Routine Services: 100% Office Visit/Wellness Exam: 100% Non-network: deductible then coinsurance Unlimited calendar year maximum (applies to network and non-network)	Network Routine Services: 100% Office Visit/Wellness Exam: 100% 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: 100% Non-network: Deductible then coinsurance	Network Services: 100% Office Visit: 100% Non-network: Deductible then coinsurance
Routine Vision Care	Not Covered	Not Covered
Childhood Immunizations	Network Services: 100% Office Visit: 100% Non-network: Deductible then coinsurance	Network Services: 100% Office Visit: 100% Non-network: Deductible then coinsurance
Inpatient Hospital Services/Outpatient Surgery^{2,i}	Deductible then coinsurance ¹	Deductible then coinsurance ¹
Inpatient Mental Illness/Substance Abuse^{2,i}	Deductible then coinsurance ¹ <i>Prior authorization required from New Directions</i>	Deductible then coinsurance ¹ <i>Prior authorization required from New Directions</i>
Outpatient Mental Illness/Substance Abuse	Network: Office Visit: \$20 copay Therapy/Other Services (including partial hospitalization): Deductible then coinsurance ¹ Non-network: Deductible then coinsurance ¹	Deductible then coinsurance ¹
Emergency Room <i>(Copay waived if admitted to a hospital)</i>	\$100 copay then Deductible then 80% (in-network coinsurance)	Deductible then 100% (in-network coinsurance)
Urgent Care <small>Error! Bookmark not defined.</small>	Network: \$40 copay (office visit and lab only) Non-network: Deductible then coinsurance	Deductible then coinsurance
Ambulance	Deductible then 80% (in-network coinsurance)	Deductible then 100% (in-network coinsurance)
Skilled Nursing Facilityⁱ	Deductible then coinsurance 30 day calendar year maximum	Deductible then coinsurance 30 day calendar year maximum
Durable Medical Equipmentⁱ	Deductible then coinsurance	Deductible then coinsurance
Allergy Testing, Treatment, Injections	Deductible then coinsurance	Deductible then coinsurance
Home Health Servicesⁱ	Deductible then coinsurance 60 visit calendar year maximum	Deductible then coinsurance 60 visit calendar year maximum
Inpatient Hospice Facilityⁱ	Deductible then coinsurance 14 day lifetime maximum	Deductible then coinsurance 14 day lifetime maximum
Outpatient Therapyⁱ <i>(Speech, Hearing, Physical and Occupational)</i>	Deductible then coinsurance Physical and Occupational: Combined 60 visit calendar year maximum Speech and Hearing: 20 visit calendar year maximum	Deductible then coinsurance Physical, Occupational and Skeletal Manipulations: Combined 60 visit calendar year maximum Speech and Hearing: 20 visit calendar year maximum
Contraceptive Devices, Implants, Injections and Elective Sterilization for Women	Network: Covered at 100% Non-network: Deductible then coinsurance	Network: Covered at 100% Non-network: Not Covered

	Preferred-Care Blue - PPO Plan A	Preferred-Care Blue – BlueSaver Plan
Prescription Drugsⁱ Retail – up to 34 day supply	<p>Network: \$10 copay for Tier 1 drug/contraceptives covered at 100%; 40% up to \$50 for Tier 2 brand drug; 60% up to \$75 for Tier 3 brand drug</p> <p>Non-network: 50% after copay for Tier 1 drug/contraceptives covered at 100%; 40% coinsurance for Tier 2 brand drug; 60% coinsurance for Tier 3 brand drug</p>	<p>Network: Deductible, then no copay/contraceptives covered at 100%</p> <p>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 <i>(Copays apply to out-of-pocket maximum)</i></p>
Prescription Drugsⁱ Mail order drug program – up to 102 day supply	<p>\$20 copay for Tier 1 drug/contraceptives covered at 100%; 40% up to \$100 for Tier 2 brand drug; 60% up to \$150 for Tier 3 brand drug</p>	<p>Network: Deductible, then no copay/contraceptives covered at 100%</p> <p>Non-Network: Deductible, then 50% after: \$20 copay for Tier 1 drug \$60 copay for Tier 2 brand drug \$100 copay for Tier 3 brand drug <i>(Copays apply to out-of-pocket maximum)</i></p>
Notice of Religious Rights	<p>Your coverage does include elective pregnancy termination coverage. An enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical, or religious beliefs. Please call Customer Service to exclude coverage.</p>	<p>Your coverage does include elective pregnancy termination coverage. An enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical, or religious beliefs. Please call Customer Service to exclude coverage.</p>
Prior Authorization Penaltyⁱ	Prior authorization is the responsibility of the network provider.	Prior authorization is the responsibility of the network provider.
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 BlueKC.com	816-395-3558 or BlueKC.com
Blue KC-24 hour nurse line	877-852-5422, available 24/7	877-852-5422, available 24/7

ⁱ Prior Authorization will be required for elective inpatient admissions, durable medical equipment (DME), high-tech diagnostic testing, infusion therapy and self injectables, organ and tissue transplants, some outpatient surgeries and services, hearing therapy, prosthetics and appliances, mental health and chemical dependency, some outpatient prescriptions, skilled nursing facility, inpatient hospice facility, dental implants and bone grafts, and 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.

Discrimination is Against the Law

Blue KC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue KC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue KC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)

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- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Customer Service, 816-395-6340 (local), 844-395-7126 (Toll free), languagehelp@bluekc.com.

If you believe that Blue KC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Appeals Department, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you, or someone you're helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-844-395-7126.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue KC, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-395-7126.

Chinese: 如果您，或是您正在協助的對象，有關於 Blue KC 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1-844-395-7126。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-395-7126.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-395-7126 an.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 [Blue KC]에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-395-7126 로 전화하십시오.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-844-395-7126.

Arabic:

1-844-395-7126. بد اتصل مترجم مع للتحدث. تكلفة اية دون من بلغتك الضرورية والمعلومات المساعدة على الحصول في الحق فلديك ، Blue KC بخصوص أسئلة تساعده شخص لدى أو لديك كان إن

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue KC, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-395-7126.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue KC, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-395-7126.

