Kansas City

An independent licensee of the Blue Cross and Blue Shield Association

Effective Date: 01/01/2018

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.

	UCM Custom Plan		PPO Plan	BlueSaver Plan
	Level 1 Employer Designated Network	**Level 2 BlueSelect Plus Network**		
Plan Type	An Exclusive Provider Organization (EPO)		A Preferred Provider Organization (PPO)	A Preferred Provider Organization (PPO)
Plan Description *(Visit our website at BlueKC.com to receive a complete listing of network hospitals and physicians)*	Members must receive all care from in-network preferred providers except for emergency services. Non-emergency services received out-of-network will not be covered.		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.
Embedded Deductible	Network: $500 individual/ $1,000 family	Network: $1,000 individual/ $2,000 family	Network: $1,500 individual/ $3,000 family; Non-network: $1,500 individual/ $3,000 family	Network: $2,700 individual/ $5,400 family; Non-network: $2,700 individual/ $5,400 family *An Individual must meet their INDIVIDUAL deductible before benefits are paid on that individual*
Coinsurance[1]	Network: 80%	Network: 80%	Network: 80% Non-network: 50%	Network: 80% Non-network: 60%
Out-of-Pocket Maximum[2] *Applies to all Medical & Rx Cost Sharing*	Network: $3,000 individual/ $6,000 family	Network: $4,000 individual/ $8,000 family	Network: $4,250 individual/ $8,500 family; Non-network: $8,500 individual/ $17,000 family	Network: $5,000 individual/ $10,000 family; Non-network: $10,000 individual/ $20,000 family
Physician Office Visits	PCP: $0 copay (office visit only) Specialists: $60 copay (office visit only)	PCP: $30 copay (office visit only) Specialists: $60 copay (office visit only)	Network: PCP office visits: $40 copay (office visit only) Network: Specialists: $80 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	Network: No copay	Network: No copay Non-network: Deductible then coinsurance	Deductible then coinsurance
Lab Performed in a Hospital/Outpatient Facility	Network: Deductible then coinsurance	Network: Deductible then coinsurance	Network: Deductible then coinsurance Non-network: Deductible then coinsurance	Deductible then coinsurance

[1] Portion of covered charges paid by Blue KC after you satisfy your deductible and required copayments.
[2] Total of deductible, coinsurance and copays members pay each year toward covered charges before Blue KC pays 100% of benefits.

	UCM Custom Plan		PPO Plan	BlueSaver Plan
	Level 1 Employer Designated Network	**Level 2 BlueSelect Plus Network**		
X-ray and Other Radiology Procedures	Network: Deductible then coinsurance	Network: Deductible then coinsurance	Network: Deductible then coinsurance Non-network: Deductible then coinsurance	Network: Deductible then coinsurance[3] Non-network: Deductible then coinsurance
Routine Preventive Care	Network Routine Services: 100% Office Visit/Wellness Exam: 100% *Unlimited calendar year maximum*	Network Routine Services: 100% Office Visit/Wellness Exam: 100% *Unlimited calendar year maximum*	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%	Network Services: 100% Office Visit: 100%	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	Not Covered	Not Covered
Childhood Immunizations	Network Services: 100% Office Visit: 100%	Network Services: 100% Office Visit: 100%	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	Deductible then coinsurance**Error! Bookmark not defined.**	Deductible then coinsurance**Error! Bookmark not defined.**	Deductible then coinsurance**Error! Bookmark not defined.**	Deductible then coinsurance**Error! Bookmark not defined.**
Inpatient Mental Illness/Substance Abuse[i]	Deductible then coinsurance**Error! Bookmark not defined.** *Prior authorization required from New Directions*	Deductible then coinsurance**Error! Bookmark not defined.** *Prior authorization required from New Directions*	Deductible then coinsurance**Error! Bookmark not defined.** *Prior authorization required from New Directions*	Deductible then coinsurance**Error! Bookmark not defined.** *Prior authorization required from New Directions*
Outpatient Mental Illness/Substance Abuse	Network: Office Visit: $0 copay Therapy/Other Services (including partial hospitalization): Deductible then coinsurance**Error! Bookmark not defined.**	Network: Office Visit: $30 copay Therapy/Other Services (including partial hospitalization): Deductible then coinsurance**Error! Bookmark not defined.**	Network: Office Visit: $40 copay Therapy/Other Services (including partial hospitalization): Deductible then coinsurance**Error! Bookmark not defined.** Non-network: Deductible then coinsurance***Error! Bookmark not defined.***	Deductible then coinsurance**Error! Bookmark not defined.**
Emergency Room	$200 copay then Deductible then 80% (in-network coinsurance)	$200 copay then Deductible then 80% (in-network coinsurance)	$200 copay then Deductible then 80% (in-network coinsurance)	Deductible then 100% (in-network coinsurance)
Urgent Care	Network: $60 copay (office visit and lab only)	Network: $60 copay (office visit and lab only)	Network: $80 copay (office visit and lab only) Non-network: Deductible then coinsurance	Deductible then coinsurance
Ambulance	Deductible then 80% (in-network coinsurance)	Deductible then 80% (in-network coinsurance)	Deductible then 80% (in-network coinsurance)	Deductible then 100% (in-network coinsurance)
Durable Medical Equipment[i]	Deductible then coinsurance	Deductible then coinsurance	Deductible then coinsurance	Deductible then coinsurance

[3] 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 $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.

	UCM Custom Plan		PPO Plan	BlueSaver Plan
	Level 1 **Employer Designated Network**	**Level 2** **BlueSelect Plus Network**		
Allergy Testing, Treatment, Injections	Deductible then coinsurance	Deductible then coinsurance	Deductible then coinsurance	Deductible then coinsurance
Home Health Services[i]	Deductible then coinsurance 60 visit calendar year maximum	Deductible then coinsurance 60 visit calendar year maximum	Deductible then coinsurance 60 visit calendar year maximum	Deductible then coinsurance 60 visit calendar year maximum
Inpatient Hospice Facility[i]	Deductible then coinsurance 14 day lifetime maximum	Deductible then coinsurance 14 day lifetime maximum	Deductible then coinsurance 14 day lifetime maximum	Deductible then coinsurance 14 day lifetime maximum
Skilled Nursing Facility[i]	Deductible then coinsurance 30 day calendar year maximum	Deductible then coinsurance 30 day calendar year maximum	Deductible then coinsurance 30 day calendar year maximum	Deductible then coinsurance 30 day calendar year maximum
Outpatient Therapy[i] *(Speech, Hearing, Physical, Occupational and Skeletal Manipulations)*	Deductible then coinsurance Physical and Occupational: Combined 60 visit calendar year maximum Speech and Hearing: 20 visit calendar year maximum	Deductible then coinsurance Physical and Occupational: Combined 60 visit calendar year maximum Speech and Hearing: 20 visit calendar year maximum	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
Chiropractic Services[i]	Network: $60 copay (office visit only)	Network: $60 copay (office visit only)	Network: $80 copay (office visit only) Non-network: Deductible then coinsurance	Deductible then coinsurance
Contraceptive Devices, Implants, Injections and Elective Sterilization for Women	Network: Covered at 100%	Network: Covered at 100%	Network: Covered at 100% Non-network: Deductible then coinsurance	Network: Covered at 100% Non-network: Not Covered
Prescription Drugs[i] **Retail – up to 34 day supply**	**Network:** $10 copay for Tier 1 drug/contraceptives covered at 100%; $50 for Tier 2 brand drug; $75 for Tier 3 brand drug	**Network:** $10 copay for Tier 1 drug/contraceptives covered at 100%; $50 for Tier 2 brand drug; $75 for Tier 3 brand drug	**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 **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	**Network:** Deductible, then $10 copay for Tier 1 drug/ contraceptives covered at 100% Deductible, then $30 copay for Tier 2 brand drug; Deductible, then $50 copay for Tier 3 brand drug **Non-network:** Deductible then 50% after applicable copay *(Copays apply to out-of-pocket maximum)*
Prescription Drugs[i] **Mail order drug program – up to 102 day supply**	**Network:** $20 copay for Tier 1 drug/contraceptives covered at 100%; $100 for Tier 2 brand drug; $150 for Tier 3 brand drug	**Network:** $20 copay for Tier 1 drug/contraceptives covered at 100%; $100 for Tier 2 brand drug; $150 for Tier 3 brand drug	**Network:** $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	**Network:** Deductible, then $20 copay for Tier 1 drug/ contraceptives covered at 100% Deductible, then $60 copay for Tier 2 brand drug; Deductible, then $100 for Tier 3 brand drug *(Copays apply to out-of-pocket maximum)*

	UCM Custom Plan		PPO Plan	BlueSaver Plan
	Level 1 Employer Designated Network	**Level 2 BlueSelect Plus Network**		
Notice of Religious Rights	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.			
Prior Authorization Penalty[i]	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.			
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	816-395-2270 or BlueKC.com			
Blue KC-24 hour nurse line	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)
- 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, 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:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue KC الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ ، فلديك الحق في الحصول على المساعدة والمعلومات .1-844-395-7126.

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 телефону1-844-395-7126.

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.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue KC, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa1-844-395-7126.

Laotian: ຖ້າ ຫ່ ານ, ຫຼື ຄົນ ່ທ່ ານກ ໍາລັງຊ ່ ວຍເຫຼື ອ, ມ ່ ຄ ໍາຖ ໍາມກ ່ ຽວກັບ Blue KC, ທ ່ ານມ ີສ ດ ່ ທ ່ ຈ ະໄດ ້ ຮ ັ ບການຊ ່ ວຍເຫຼື ອ ແ ລະ ່ ຂ ້ ມ ູ ນຂ ່ າວສານ ່ ທ ເ ປ ັ ນ ພ າສ າ ຂ ອ ງ ທ ່ ານ ່ ບ ມ ຄ ່ າ ໃ ຊ ້ จ ่ าย. ການ ໂ ອ ้ ວ ົ ມ ກ ັ ບ ນ າ ย ພ າ ส า, ใ ห ้ โ ท ห า 1-844-395-7126.

Pennsylvanian Dutch: "Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Blue KC, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-844-395-7126 uffrufe.

Persian: اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue KC داشته باشید حق این را دارید که کمکو اطالعات به زبان خود را به طور رایگان دریافت نمایید 1-844-395-7126. تماس حاصل نمایید.

Cushite: Isin yookan namni biraa isin deeggartan Blue KC irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-844-395-7126 tiin bilbilaa.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue KC, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-395-7126.

For TTY services, please call 1-816-842-5607.

Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association