Kansas City

An independent licensee of the Blue Cross and Blue Shield Association

Effective Date: 01/01/2020

University of Central Missouri

Retiree 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.

	PPO Plan –Plan A
Plan Type	A Preferred Provider Organization (PPO)
Plan Description *(Visit our website at 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.
Embedded Deductible	Network: $1,500 individual/ $3,000 family; Non-network: $1,500 individual/ $3,000 family
Coinsurance[1]	Network: 80% Non-network: 50%
Out-of-Pocket Maximum[2] *Applies to all Medical & Rx Cost Sharing*	Network: $4,250 individual/ $8,500 family; Non-network: $8,500 individual/ $17,000 family
Physician Office Visits	Network: PCP office visits: $40 copay (office visit only) Network: Specialists: $80 copay (office visit only) Non-network: Deductible then coinsurance
Lab Performed in a Physician's Office/Independent Lab/Urgent Care Facility	Network: No copay Non-network: Deductible then coinsurance
Lab Performed in a Hospital/Outpatient Facility	Network: Deductible then coinsurance Non-network: 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.

	PPO Plan-A
X-ray and Other Radiology Procedures	Network: Deductible then coinsurance Non-network: Deductible then coinsurance
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)*
Mammograms, Pap Smears and PSA tests	Network Services: 100% Office Visit: 100% Non-network: Deductible then coinsurance
Childhood Immunizations	Network Services: 100% Office Visit: 100% Non-network: Deductible then coinsurance
Inpatient Hospital Services/Outpatient Surgery	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*
Outpatient Mental Illness/Substance Abuse	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.***
Emergency Room	$200 copay then Deductible then 80% (in-network coinsurance)
Urgent Care	Network: $80 copay (office visit and lab only) Non-network: Deductible then coinsurance
Ambulance	Deductible then 80% (in-network coinsurance)
Durable Medical Equipment[i]	Deductible then coinsurance
Allergy Testing, Treatment, Injections	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.

	PPO Plan-A
Home Health Services[i]	Deductible then coinsurance 60 visit calendar year maximum
Inpatient Hospice Facility[i]	Deductible then coinsurance 14 day lifetime maximum
Skilled Nursing Facility[i]	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
Chiropractic Services[i]	Network: $80 copay (office visit only) Non-network: Deductible then coinsurance
Contraceptive Devices, Implants, Injections and Elective Sterilization for Women	Network: Covered at 100% Non-network: Deductible then coinsurance
Prescription Drugs[i] **Retail – up to 34 day supply**	**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
Prescription Drugs[i] **Mail order drug program – up to 102 day supply**	**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

	PPO Plan-A
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	Local: 816-395-2270 Toll Free: 800-654-0155 Online: 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.