BlueKC Plans

	Blue-Care (Rate-Saver)	Blue-Care	Preferred-Care Blue
Plan Type	A Health Maintenance Organization (HMO)		A Preferred Provider Organization (PPO)
Plan Description	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.**		Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue network.
Deductible	N/A	N/A	Network: $200 per individual/$400 per family; Non-network: $600 per individual/$1,200 per family
Coinsurance *(1)*	90% Coinsurance (applies only to inpatient services at a hospital and outpatient surgeries at a hospital or an outpatient facility)	N/A	Network: 90% / Non-network: 70%
Out-of-Pocket Maximum *(2)*	$2,000 individual/$4,000 family	N/A	Network: $1,000 individual/$2,000 family; Non-network: $2,000 individual/$4,000 family
Physician Office Visits	Medical Home PCP office visits: $10 copay *(3)* PCP office visits: $20 copay Specialists: $35 copay	Medical Home PCP office visits: $10 copay *(3)* PCP office visits: $20 copay Specialists: $35 copay	Network: Medical Home PCP $15 Copay* (office visit only) *(3)(6)* All Other Physicians $25 copay (office visit only) *(6)* Non-network: Deductible then coinsurance
Lab Performed in Physician's Office/Independent Lab	No copay	No copay	Network: No copay Non-network: Deductible then coinsurance
Lab Performed in Hospital/Outpatient Facility	No copay	No copay	Network: Deductible then coinsurance Non-network: Deductible then coinsurance
X-ray and Other Radiology Procedures	No copay	No copay	Network: Deductible then coinsurance *(8)* Non-network: Deductible then coinsurance
Routine Preventive Care *(Contract lists covered services)*	100%	100%	Network: 100% Related Office Visit: No copay Non-network: Deductible then coinsurance Unlimited Calendar year maximum
Mammograms, Pap Smears and PSA tests	100%	100%	Network: No copay Non-network: Deductible then coinsurance
Routine Vision Care *(4)*	$20 copay	$20 copay	Network: $25 copay Non-network: Deductible then coinsurance One exam per year
Childhood Immunizations	100%	100%	Network: 100% Non-network: Deductible then coinsurance
Inpatient Hospital Services/ Outpatient Surgery *(5)*	90% Coinsurance	$100 copay per day up to $500 per calendar year	Deductible then coinsurance *(8)*

MRI, MRA, CT and PET scans performed in a Physician's Office, Imaging Center or Other Outpatient Setting (including a hospital)	$150 copay Only one copay will apply for each provider on a specified date of service even if multiple scans are performed	$150 copay Only one copay will apply for each provider on a specified date of service even if multiple scans are performed	Deductible then coinsurance *(5)*
Emergency Room/Urgent Care *(Copay waived if admitted to a hospital)*	$150 copay; $35 copay if services are received in an **urgent care center**.	$150 copay; $35 copay if services are received in an **urgent care center**.	ER: $150 copay then Deductible then 90% Urgent Care: Network: $25 Copay (office visit and lab only) *(9)* Non-network: Deductible then coinsurance
Ambulance	No copay Ground ambulance No limit per use.		Deductible then 90%
Durable Medical Equipment *(5)*	No copay	No copay	Deductible then coinsurance
Allergy Testing, Treatment, Injections	No copay for injections; $100 copay for testing	No copay for injections; $100 copay for testing	Deductible then coinsurance
Home Health Services *(5)*	No copay 60 visit calendar year maximum	No copay 60 visit calendar year maximum	Deductible then coinsurance 60 visit calendar year maximum
Skilled Nursing Facility *(5)*	No copay 30 day calendar year maximum	No copay 30 day calendar year maximum	Deductible then coinsurance 30 day calendar year maximum
Outpatient Therapy *(Speech, Hearing, Physical and Occupational) (5)*	No copay Physical and Occupational: Combined 60 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum	No copay Physical and Occupational: Combined 60 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum	Deductible then coinsurance Physical and Occupational: Combined 60 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum
Chiropractic Services	No copay	No copay	Network: $25 copay (office visit only) (7) Non-network: Deductible then coinsurance
Inpatient Mental Illness/Substance Abuse *(5)*	90% Coinsurance	$100 copay per day up to $500 per calendar year	Deductible then coinsurance *(8)* Prior authorization required from New Directions
Outpatient Mental Illness/Substance Abuse *(5)*	Office Visit & Therapy: $10 copay	Office Visit & Therapy: $10 copay	Network Office Visit $15 Copay (office visit only) All Other Services Deductible then coinsurance *(8)* Non-network: Deductible then coinsurance
Organ Transplant *(5)*	Applicable copays Unlimited Organ Transplant lifetime maximum	Applicable copays Unlimited Organ Transplant lifetime maximum	Deductible then coinsurance Unlimited Organ Transplant lifetime maximum
Inpatient Hospice Facility *(5)*	90% up to $2,000/$4,000 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	$50 copay per day up to $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	Deductible then coinsurance 14 day lifetime maximum
Contraceptive devices, implants, injections and elective sterilization (includes insertion of devices)	Network: Covered at 100% Non-Network: Not Covered	Network: Covered at 100% Non-Network: Not Covered	Network: Covered at 100% Non-network: Deductible then 70%

Prescription Drugs *(5)*	**BCBSKC Rx Network:** $12 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $30 copay for Tier 2 brand drug; $60 copay for Tier 3 brand drug	**BCBSKC Rx Network:** $12 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $30 copay for Tier 2 brand drug; $60 copay for Tier 3 brand drug	**BCBSKC Rx Network** $12 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $30 copay for Tier 2 brand drug; $60 copay for Tier 3 brand drug Non-network: 50% after copay
Prescription Drugs: Express Scripts: Mail order drug program – 102 day supply	$24 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $60 copay for Tier 2 drug; $120 copay for Tier 3 brand drug	$24 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $60 copay for Tier 2 drug; $120 copay for Tier 3 brand drug	$24 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $60 copay for Tier 2 brand drug; $120 copay for Tier 3 brand drug
Lifetime Maximum	Unlimited	Unlimited	Unlimited
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 as 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.		
Dependent Coverage Missouri Mandate: Dependent daughters covered for maternity on **Blue-Care**.	End of the year the children reach age 26		
Prior Authorization Penalty *(5)*	Prior authorization is the responsibility of the network provider.		You are responsible for prior authorization for services received. 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.		
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	**816-395-3558 or *www.bluekc.com***		

[1] *Portion of covered charges paid by BCBSKC after you satisfy your deductible and required copayments.*

[2] *Total of deductible and coinsurance members pay each year toward covered charges before BCBSKC pays 100% of benefits.*

[3] *Medical Home PCP – Participating Medical Home physicians can be found in the Provider Directory with the Blue Distinction Total Care (BDTC) designation.*

[4] *Vision Care: You may receive one vision exam per year (PCP referral not required).*

[5] *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, speech and hearing therapy (including home health for speech therapy), prosthetics and appliances, mental health and chemical dependency, some outpatient prescriptions, skilled nursing 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.*

[6] *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.*

[7] *Other services/procedures including skeletal manipulations performed in a chiropractor's office are subject to the Preferred Deductible and Coinsurance level.*

[8] *Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to a $200 calendar year maximum. Inpatient hospital services in a Non-Participating Hospital inside our service area are limited to a $200 maximum per day and are limited to 30 days per calendar year. 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 a $200 calendar year maximum.*

[9] *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!

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