

This Benefit Summary provides only a highlight of the services covered by Blue Cross and Blue Shield of Kansas City.

www.bluekc.com

Base Plans	Blue-Care	Preferred-Care Blue
Plan Type	A Health Maintenance Organization (HMO)	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 choose a primary care physician. Urgent care and an exclusive network of specialists are also covered. Some 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	\$1,000 per individual/\$2,000 per family
Coinsurance (1)	N/A	Network: 80% / Non-network: 50%
Out-of-Pocket Maximum (2)	Inpatient/Outpatient surgical copays limited to \$1,500 per member (5 copays per member per calendar year)	Network: \$3,000 individual/\$6,000 family; Non-network: \$9,000 individual/\$18,000 family
Physician Office Visits	PCP office visits: \$30 copay Specialists: \$60 copay	Deductible then coinsurance (3)
Lab Performed in Physician's Office/Independent Lab	No copay	Network: No copay Non-network: Deductible then coinsurance
Lab Performed in Hospital/Outpatient Facility	No copay	Network: Deductible then coinsurance Non-network: Deductible then coinsurance
X-ray and Other Radiology Procedures	No copay	Network: Deductible then coinsurance (4) Non-network: Deductible then coinsurance
Routine Preventive Care <i>(Contract lists covered services)</i>	100%	Network: 100% Non-Network: Deductible then coinsurance
Mammograms, Pap Smears and PSA tests	100%	Network: 100% Non-network: Deductible then coinsurance
Childhood Immunizations	100%	100%
Routine Vision Care	\$60 copay	No Benefit
Inpatient Hospital Services/Outpatient Surgery	Inpatient - \$300 copay/day; Outpatient - \$300 copay/occurrence Copays apply to out-of-pocket max.	Deductible then coinsurance (4)
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	Deductible then coinsurance
Emergency Room <i>(Copay waived if admitted to a hospital)</i>	\$150 copay	\$100 copay then Deductible then 80%
Electronic Physician Visit (e-visit)	PCP: \$10 copay Specialist: \$10 copay	Network: \$10 copay Non-network: No Benefit
Urgent Care	\$60 copay if services are received in an urgent care center.	Deductible then coinsurance
Ambulance	No copay Ground ambulance limited to \$500 benefit maximum per use.	Deductible then 80% Ground ambulance limited to \$500 benefit maximum per use.
Durable Medical Equipment*	No copay	Deductible then coinsurance
Allergy Testing, Treatment, Injections	No copay for injections; \$100 copay for testing	Deductible then coinsurance

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

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

³Other 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.

⁴Diagnostic 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. These limited do not pertain to these services outside our service area and will be subject to applicable deductible and coinsurance.

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Base Plan	Blue-Care	Preferred-Care Blue
Home Health Services*	No copay 60 visit calendar year maximum	Deductible then coinsurance 60 visit calendar year maximum
Skilled Nursing Facility*	No copay 30 day calendar year maximum	Deductible then coinsurance 30 day calendar year maximum
Outpatient Therapy* <i>(Speech, Hearing, Physical & Occupational)</i>	No copay Physical and Occupational: Combined 40 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum	Deductible then coinsurance Physical and Occupational: Combined 40 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum
Chiropractic Services	No copay	Deductible & Coinsurance
Inpatient Mental Illness/Substance Abuse	\$300 copay per day up to \$1,500 per calendar yr	Deductible then coinsurance
Outpatient Mental Illness/Substance Abuse	Office Visit: \$30 copay All Other Services: 100%	Deductible then coinsurance
Organ Transplant	Applicable copays Unlimited Organ Transplant lifetime maximum	Deductible then coinsurance Unlimited Organ Transplant lifetime maximum
Inpatient Hospice Facility*	\$150 copay per day up to \$1,500 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
Prescription Drugs <i>(Includes all contraceptives – oral, injectable, devices & implants)</i>	BCBSKC Rx Network \$10 copay for Tier 1 drug; \$30 copay for Tier 2 brand drug; \$50 copay for Tier 3 brand drug.	BCBSKC Rx Network \$10 copay for Tier 1 drug; \$30 copay for Tier 2 brand drug; \$50 copay for Tier 3 brand drug. Non-network: 50% after copay
Express Scripts <i>Mail order drug program – 102 day supply</i>	\$20 copay for Tier 1 drug; \$60 copay for Tier 2 brand drug; \$100 copay for Tier 3 brand drug.	\$20 copay for Tier 1 drug; \$60 copay for Tier 2 brand drug; \$100 copay for Tier 3 brand drug.
Lifetime Maximum	Unlimited	Unlimited
Dependent Coverage <i>(Missouri Mandate: Dependent daughters <u>are</u> covered for maternity on Blue-Care only).</i>	End of the year the children reach age 26 <i>If your child is less than 26 years of age and your child's health coverage ended, or your child was denied health coverage (or was not eligible for health coverage) under a group health plan because under the terms of the plan, the availability of dependent coverage of children ended before the attainment of age 26, your child is eligible to enroll during a 30 day time period that runs coincidentally with your annual Open Enrollment period and ends on the last day of the annual Open Enrollment period. If timely enrolled and subject to the payment of any additional premium, your child's coverage will be effective on January 1, 2011. Please contact your employer or the Customer Service number on the back of your ID card to obtain an application to enroll your child.</i>	
Prior Authorization Penalty (Prior Authorization is required for selected services. See your certificate for a listing of services requiring Prior Authorization).	Prior authorization is the responsibility of the network provider.	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.

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Base Plan	Blue-Care	Preferred-Care Blue
Pre-existing Exclusion Period <i>(does not apply to children under age 19)</i>	Your Employer's group contract provides coverage that contains limitations based on whether a condition is considered preexisting. Any condition (whether physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months from the enrollment date, is considered a preexisting condition (pregnancy is not considered a pre-existing condition). Your Employer's group contract excludes coverage for these specific preexisting conditions for 12 months beginning on the first day of the waiting period (or the date coverage is effective if there is no waiting period). However, your Employer's group contract will provide credit for preexisting conditions if you were previously covered under creditable coverage. The period of any preexisting condition exclusion that would otherwise apply to a person will be reduced by the number of days of creditable coverage the person has as of the enrollment date. In order to receive credit toward the preexisting condition exclusion period, you must provide copies of the Certificates of Creditable Coverage or other acceptable proof of coverage from the prior plan(s) for the verification of prior creditable medical coverage you or any listed dependents currently have, or previously had, including continuation of coverage. You have the right to request a Certificate of Creditable Coverage from your prior plan or insurer. To request assistance in obtaining a Certificate of Creditable Coverage from a prior plan or insurer, please contact Blue Cross and Blue Shield of Kansas City. Should you need additional information or assistance regarding any preexisting condition exclusion, please contact our Member Services Department at (816) 395-2950. There is no exclusion period for the HMO plan.	
Portability	The exclusion period for pre-existing conditions may be reduced by the length of time a person had prior creditable coverage, provided the member does not have a gap in coverage of more than 62 days.	
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	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.	
Exclusions and Limitations	Customer Service 816-395-2270 or www.bluekc.com	

*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, 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, and (for Preferred-Care Blue only) 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.

**Use of in-network benefits reduces out-of-network benefits and use of out-of-network benefits reduces in-network benefits where applicable.

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

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Buy-Up Plan	Blue-Care	Preferred-Care Blue
Plan Type	A Health Maintenance Organization (HMO)	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 choose a primary care physician. Urgent care and an exclusive network of specialists are also covered. Some 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	\$750 per individual/\$1,500 per family
Coinsurance (1)	N/A	Network: 80% / Non-network: 60%
Out-of-Pocket Maximum (2)	Inpatient/Outpatient surgical copays limited to \$1,000 per member (5 copays per member per calendar year)	Network: \$2,000 individual/\$4,000 family; Non-network: \$6,000 individual/\$12,000 family
Physician Office Visits	PCP office visits: \$20 copay Specialists: \$40 copay	Network: \$15 copay (3) Non-network: Deductible then coinsurance
Lab Performed in Physician's Office/Independent Lab	No copay	Network: No copay Non-network: Deductible then coinsurance
Lab Performed in Hospital/Outpatient Facility	No copay	Network: Deductible then coinsurance Non-network: Deductible then coinsurance
X-ray and Other Radiology Procedures	No copay	Network: Deductible then coinsurance (4) Non-network: Deductible then coinsurance
Routine Preventive Care <i>(Contract lists covered services)</i>	100%	Network: 100% Non-network: Deductible then coinsurance
Mammograms, Pap Smears and PSA tests	100%	Network: 100% Non-network: Deductible then coinsurance
Routine Vision Care	\$40 copay	No Benefit
Childhood Immunizations	100%	100%
Inpatient Hospital Services/Outpatient Surgery*	Inpatient - \$200 copay/day; Outpatient - \$200 copay/occurrence Copays apply to out-of-pocket max.	Deductible then coinsurance (4)
MRI, MRA, CT and PET scans performed in a Physician's Office, Imaging Center or Other Outpatient Setting (including a hospital)	\$75 copay Only one copay will apply for each provider on a specified date of service even if multiple scans are performed	Deductible then coinsurance
Emergency Room <i>(Copay waived if admitted to a hospital)</i>	\$75 copay.	\$75 copay then Deductible then 80%
Urgent Care	\$40 copay if services are received in an urgent care center .	\$15 copay if services are received in an urgent care center
Electronic Physician Visit (e-visit)	PCP: \$10 copay Specialist: \$10 copay	Network: \$10 copay Non-network: No Benefit
Ambulance	No copay Ground ambulance limited to \$500 benefit maximum per use.	Deductible then 80% Ground ambulance limited to \$500 benefit maximum per use.
Durable Medical Equipment*	No copay	Deductible then coinsurance
Allergy Testing, Treatment, Injections	No copay for injections; \$100 copay for testing	Deductible then coinsurance

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

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

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Home Health Services*	No copay 60 visit calendar year maximum	Deductible then coinsurance 60 visit calendar year maximum
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Chiropractic Services	No copay	Deductible & coinsurance
Inpatient Mental Illness/Substance Abuse	\$200 copay per day up to \$1,000 per calendar yr	Deductible then coinsurance
Outpatient Mental Illness/Substance Abuse	Office Visit: \$20 copay All Other Services: 100%	Network: Office Visit: \$15 copay; All Other Services: Deductible then coinsurance Non-Network: Deductible then coinsurance
Organ Transplant	Applicable copays Unlimited Organ Transplant lifetime maximum	Deductible then coinsurance Unlimited Transplant lifetime maximum
Inpatient Hospice Facility*	\$100 copay per day up to \$1,000 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
Prescription Drugs <i>(Includes all contraceptives – oral, injectable, devices & implants)</i>	BCBSKC Rx Network \$10 copay for Tier 1 drug; \$30 copay for Tier 2 brand drug; \$50 copay for Tier 3 brand drug.	BCBSKC Rx Network \$10 copay for Tier 1 drug; \$30 copay for Tier 2 brand drug; \$50 copay for Tier 3 brand drug. Non-network: 50% after copay
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Lifetime Maximum	Unlimited	Unlimited
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