



## Health Benefit Plan Summary - PCB PPO \$2000 (OOPM \$5000) KS

This Benefit Summary provides only highlights of the services covered by Blue Cross and Blue Shield of Kansas City (Blue KC). For Additional details, exclusions and limitations refer to your member certificate available at [MyBlueKC.com](http://MyBlueKC.com).

General Plan Information		
<b>Plan Type</b>	<b>Preferred Provider Organization (PPO)</b> Members can receive services from any hospital or physician, but receive greater benefits when using in-network providers.  Services rendered at Out-of-Network providers are subject to Out-of-Network allowables as stated in your contract, and balance billing may occur.	
<b>Medical Network(s)</b> A complete listing of network hospitals and physicians is available on <a href="http://MyBlueKC.com">MyBlueKC.com</a> .	<b>In Area:</b> Preferred-Care Blue <b>Out-of-Area:</b> BlueCard PPO/EPO	
<b>Deductible – Embedded</b> You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services.	<b>In-Network</b> Individual: \$2,000 Family: \$6,000	<b>Out-of-Network</b> Individual: \$2,000 Family: \$6,000
<b>Coinsurance</b> The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.	<b>In-Network</b> Member Pays: 20% Plan Pays: 80%	<b>Out-of-Network</b> Member Pays: 40% Plan Pays: 60%
<b>Out-of-Pocket Limits – Embedded</b> The Out-of-Pocket Limit is the most you could pay during the Calendar Year for your share of the cost of covered services. These cost shares apply to the Out-of-Pocket Limit: Coinsurance, Deductibles, Copays <b>Applies to:</b> All Medical and Rx Cost Sharing	<b>In-Network</b> Individual: \$5,000 Family: \$10,000	<b>Out-of-Network</b> Individual: \$10,000 Family: \$20,000
<b>Dependent Limiting Age</b>	26	
<b>Customer Service</b>	PH: 816-395-3558 (local) or 1-888-989-8842 (toll free)	
Plan Benefits - Medical		
<i>When you visit a health care provider's office or clinic...</i>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Physician</b> <b>Primary Care Physician (PCP)</b> - An internist, family practitioner, general practitioner, or pediatrician.	\$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
<b>Specialist</b> - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrists, psychologists and chiropractors.	\$70 Copay/Visit, no Deductible	40% Coinsurance after Deductible

<b>Other Services &amp; Procedures performed in a provider's office and not included with an office visit</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Urgent Care Center</b>	\$70 Copay/Visit, no Deductible	40% Coinsurance after Deductible
<b>Blue KC Virtual Care - Office Visit</b> Virtual Care provided by Blue KC virtual care partner(s).	No member cost share	Not applicable
<b>Blue KC Virtual Care - Behavioral Health Therapy</b> Virtual Care provided by Blue KC virtual care partner(s).	No member cost share	Not applicable
<b>Preventive Screenings &amp; Immunizations (Children &amp; Adults)</b> Blue KC health plans include routine preventive benefits that are consistent with the guidelines developed by the United States Preventive Services Task Force (USPSTF), Health Resources and Services Administration (HRSA), and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Services must be billed with a primary diagnosis of preventive to be covered at 100%. Refer to your member certificate for additional details.	No member cost share	40% Coinsurance after Deductible
<b>Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility</b>	No member cost share	40% Coinsurance after Deductible
<b>Allergy</b>		
<b>Allergy Testing</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Allergy Treatment</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>When you need radiology services...</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>X-Ray</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Other Radiology Procedures (MRI, CT/PET Scans, MRA)</b> Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>When you have out-patient surgery...</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Outpatient Surgery Facility Fees</b> Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Physician (Surgeon) Services</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>If you need immediate medical attention...</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Urgent Care Center Office Visit</b>	\$70 Copay/Visit, no Deductible	40% Coinsurance after Deductible
<b>Emergency Services</b> Copay Waived if Admitted Out-of-Network benefits are subject to the plan's allowable charge. Out-of-Network providers may bill the member for the remaining balance. See Certificate for details.	\$100 Copay/Visit, then Deductible, then 20% Coinsurance	\$100 Copay/Visit, then In-Network Deductible, then 20% Coinsurance
<b>Ground Ambulance</b> Out-of-Network benefits are subject to the plan's allowable charge. Out-of-Network providers may bill the member for the remaining balance. See Certificate for details.	20% Coinsurance after Deductible	20% Coinsurance after In-Network Deductible
<b>Air Ambulance</b>	20% Coinsurance after Deductible	20% Coinsurance after In-Network Deductible
<b>If you have a hospital stay...</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Hospital Facility Fees</b> Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible

<b>Physician (Surgeon) Services</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<i>If you need help recovering or have other special health needs...</i>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Skilled Nursing Care</b> Prior Authorization Policy Applies Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Home Health Services</b> Prior Authorization Policy Applies Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Physical Therapy</b> Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Occupational Therapy</b> Combined with Physical Therapy Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Skeletal Manipulation</b> Prior Authorization Policy Applies Out-of-Network Combined with Physical Therapy Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Speech Therapy</b> Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Hearing Therapy</b> Combined with Speech Therapy Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Durable Medical Equipment</b> Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Inpatient Hospice Services</b> Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Home Hospice Services</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<i>If you have behavioral health, or substance abuse needs...</i>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Outpatient Mental Health, Behavioral Health, and Substance Abuse Services Office Visit</b>	\$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
<b>Therapy</b>	\$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
<b>Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees)</b> Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician)</b> Includes: Therapy & Other Services, partial hospitalizations	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<i>Family Planning &amp; Pregnancy...</i>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Contraceptive Devices, Implants, and Injections</b> See also pharmacy benefits.	No member cost share	40% Coinsurance after Deductible

<b>Elective Sterilization – Women</b>	No member cost share	40% Coinsurance after Deductible
<b>Elective Sterilization – Men</b>	No member cost share	40% Coinsurance after Deductible
<b>Maternity</b> Dependent daughters are covered for maternity services	Covered	Covered
<b>Infertility and Impotency Diagnosis and Treatment</b> Pharmacy Coverage: Not Covered	Not covered	Not covered
<b><i>Routine Vision Care...</i></b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Routine Eye Exam</b> Maximum benefit of 1 Exam(s)/Calendar Year for In-Network and Out-of-Network Provided by Vision Service Plan (VSP)	\$20 Copay/Visit, no Deductible	\$20 Copay/Visit, no Deductible Limited to \$45 Benefit Max per Calendar Year.
<b>General Pharmacy Information</b>		
<b>Retail Pharmacy Network(s)</b>	RxPremier	
<b>Prescription Drug List</b> Learn more about the drugs covered by your plan, drug category/tier, prior authorization and step therapy by reviewing your prescription drug list at <a href="http://MyBlueKC.com">MyBlueKC.com</a>	Premium Formulary	
<b>Specialty Pharmacy</b> A Specialty Pharmacy is one that provides specialized care for patients with complex chronic health conditions. Learn more about the drugs covered by your plan, drug category/tier, prior authorization and step therapy by reviewing your prescription drug list at <a href="http://MyBlueKC.com">MyBlueKC.com</a>	OptumRx Specialty Services <b>PH: 1-855-427-4682</b>	
<b>High-Cost Drug Discount Program</b>	The program can help you secure financial assistance which may substantially reduce or completely cover your out-of-pocket costs for your qualifying medication(s). Only your true-out-of-pocket costs will be applied to your deductible and/or out-of-pocket totals.	
<b>Outpatient Prescription Drug Out-of-Pocket Limits</b> The Out-of-Pocket Limit is the most you could pay during the Calendar Year for your share of the cost of covered services.	<b>In-Network</b>	<b>Out-of-Network</b>
	Combined with Medical Out-of-Pocket Limits	Combined with Medical Out-of-Pocket Limits
<b>Plan Benefits – Pharmacy</b>		
<b><i>When you use a retail pharmacy...</i></b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Retail Pharmacy (Short-term supply: Up to 34 Days)</b>		
<b>Drug Tier 1: Generic</b>	<b>RxPremier:</b> \$15 Copay/Fill Contraceptives – No member cost share	\$15 Copay/Fill, then 50% Coinsurance
<b>Drug Tier 2: Preferred</b>	<b>RxPremier:</b> \$70 Copay/Fill	\$70 Copay/Fill, then 50% Coinsurance
<b>Drug Tier 3: Non-Preferred</b>	<b>RxPremier:</b> \$110 Copay/Fill	\$110 Copay/Fill, then 50% Coinsurance
<b><i>When you use a specialty pharmacy...</i></b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Specialty Pharmacy (Day supply: Up to 34 Days)</b>		
<b>Specialty Drug Tier 1: Generic Specialty</b>	\$15 Copay/Fill	\$15 Copay/Fill, then 50% Coinsurance
<b>Specialty Drug Tier 2: Preferred Specialty</b>	\$110 Copay/Fill	\$110 Copay/Fill, then 50% Coinsurance
<b>Specialty Drug Tier 3: Non-Preferred Specialty</b>	\$200 Copay/Fill	\$200 Copay/Fill, then 50% Coinsurance

<i>When you use a mail order pharmacy...</i>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Mail Order Pharmacy (Mail Order supply: Between 35-102 Days)</b>		
<b>Drug Tier 1: Generic</b>	\$37.50 Copay/Fill Contraceptives – No member cost share	\$37.50 Copay/Fill, then 50% Coinsurance
<b>Drug Tier 2: Preferred</b>	\$175 Copay/Fill	\$175 Copay/Fill, then 50% Coinsurance
<b>Drug Tier 3: Non-Preferred</b>	\$275 Copay/Fill	\$275 Copay/Fill, then 50% Coinsurance

## Discrimination is Against the Law

Blue Cross and Blue Shield of Kansas City (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.

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.

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。

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](mailto:languagehelp@bluekc.com).

