



## Metropolitan Community College

### Health Benefit Plan Summary - Preferred-Care Blue PPO 2700 BlueSaver Plan

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 [BlueKC.com](http://BlueKC.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. This plan is an HSA Qualified High Deductible Health Plan.	
<b>Medical Network(s)</b> A complete listing of network hospitals and physicians is available on <a href="http://BlueKC.com">BlueKC.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: \$2,700 Family: \$5,400	<b>Out-of-Network</b> Individual: \$2,700 Family: \$5,400
<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: 0% Plan Pays: 100%	<b>Out-of-Network</b> Member Pays: 20% Plan Pays: 80%
<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: \$2,700 Family: \$5,400	<b>Out-of-Network</b> Individual: \$5,400 Family: \$10,800
<b>Blue KC 24-Hour Nurse Line</b> Available 7 days a week, 365 days a year to help you with symptoms or answer health-related questions.	<b>PH:</b> (877) 852-5422	
<b>Customer Service</b>	<b>PH:</b> (888) 989-8842	
<b>Plan Benefits - Medical</b>		
<b>When you visit a health care provider's office or clinic...</b> <b>Physician</b> <b>Primary Care Physician (PCP)</b> - An internist, family practitioner, general practitioner, or pediatrician.  <b>Specialist</b> - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrist, psychologists and chiropractors.	<b>In-Network</b>  <b>PCP Office Visit:</b> Deductible, then no charge  <b>Specialist Office Visit:</b> Deductible, then no charge	<b>Out-of-Network</b>  20% Coinsurance after Deductible  20% Coinsurance after Deductible

<b>Other Services &amp; Procedures performed in a provider's office and not included with an office visit</b>	<b>Other Services:</b> Deductible, then no charge	20% Coinsurance after Deductible
<b>Urgent Care Center</b>	<b>Office Visit:</b> Deductible, then no charge	20% Coinsurance after Deductible
<b>Designated Telehealth Office Visit</b>	<b>Office Visit:</b> Deductible, then no charge	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	20% Coinsurance after Deductible
<b>Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility</b>	Deductible, then no charge	20% Coinsurance after Deductible
<b>Allergy</b>		
<b>Allergy Testing</b>	Deductible, then no charge	20% Coinsurance after Deductible
<b>Allergy Treatment (Injection)</b>	Deductible, then no charge	20% Coinsurance after Deductible
<b>Allergy Treatment (Serum)</b>	Deductible, then no charge	20% Coinsurance after Deductible
<b>When you need radiology services...</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>X-Ray</b> Maximum benefit of \$200/Day for Out-of-Network/Non-Participating/In-Area Provider	Deductible, then no charge	20% Coinsurance after Deductible
<b>Other Radiology Procedures (MRI, CT/PET Scans, MRA)</b> Prior Authorization Policy Applies Maximum benefit of \$200/Day for Out-of-Network/Non-Participating/In-Area Provider	Deductible, then no charge	20% 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 Maximum benefit of \$200/Day for Out-of-Network/Non-Participating/In-Area Provider	Deductible, then no charge	20% Coinsurance after Deductible
<b>Physician (Surgeon) Services</b>	Deductible, then no charge	20% 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>	Deductible, then no charge	20% Coinsurance after Deductible
<b>Emergency Services</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.	Deductible, then no charge	In-Network Deductible, then no charge
<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.	Deductible, then no charge	In-Network Deductible, then no charge
<b>Air Ambulance</b>	Deductible, then no charge	In-Network Deductible, then no charge

<i>If you have a hospital stay...</i>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Hospital Facility Fees</b> Prior Authorization Policy Applies Maximum benefit of \$200/Day for Out-of-Network/Non-Participating/In-Area Provider	Deductible, then no charge	20% Coinsurance after Deductible
<b>Physician (Surgeon) Services</b>	Deductible, then no charge	20% 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	Deductible, then no charge	20% 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	Deductible, then no charge	20% Coinsurance after Deductible
<b>Physical Therapy</b> Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
<b>Occupational Therapy</b> Combined with Physical Therapy Limits	Deductible, then no charge	20% Coinsurance after Deductible
<b>Other Services Performed in Chiropractic Office Visit (including Skeletal Manipulation)</b> Prior Authorization Policy Applies Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
<b>Speech Therapy</b> Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
<b>Hearing Therapy</b> Combined with Speech Therapy Limits	Deductible, then no charge	20% Coinsurance after Deductible
<b>Durable Medical Equipment</b> Prior Authorization Policy Applies	Deductible, then no charge	20% 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	Deductible, then no charge	20% Coinsurance after Deductible
<b>Home Hospice Services</b>	Deductible, then no charge	20% 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>	Deductible, then no charge	20% Coinsurance after Deductible

<b>Facility Fees</b> Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
<b>Therapy</b>	Deductible, then no charge	20% Coinsurance after Deductible
<b>Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees)</b> Prior Authorization Policy Applies Maximum benefit of \$200/Day for Out-of-Network/Non-Participating/In-Area Provider	Deductible, then no charge	20% Coinsurance after Deductible
<b>Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician)</b> Includes: Therapy & Other Services, partial hospitalizations	Deductible, then no charge	20% Coinsurance after Deductible
<b>Family Planning &amp; Pregnancy...</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Contraceptive Devices, Implants, and Injections</b> See also pharmacy benefits.	Covered at 100%	20% Coinsurance after Deductible
<b>Elective Sterilization – Women</b>	Covered at 100%	20% Coinsurance after Deductible
<b>Elective Sterilization – Men</b>	Covered at 100%	20% Coinsurance after Deductible
<b>Maternity</b> Dependent daughters are covered for maternity services	Covered	Covered
<b>Infertility and/or Impotency Treatment</b>	Not covered	Not covered
<b>Routine Vision Care...</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	Deductible, then no charge	20% Coinsurance after Deductible
<b>General Pharmacy Information</b>		
<b>Pharmacy Network(s)</b>	<b>Network 1: National Plus</b>	
<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>	National Preferred	
<b>Outpatient Prescription Drug Deductible</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>	<b>Out-of-Network</b>
	Combined with Medical Deductible	Combined with Medical Deductible
<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>Rx Savings Solutions</b> A team of pharmacists and pharmacy technician will help you make sure you're getting the best possible pricing for your medicines. Member support is available Monday – Friday, 7 a.m. to 7 p.m. CST.	Register online at <a href="http://MyBlueKC.com">MyBlueKC.com</a> and stay up-to-date on cost saving opportunities. <b>Email:</b> <a href="mailto:info@rxsavingsllc.com">info@rxsavingsllc.com</a> <b>PH:</b> 1-800-268-4476	
<b>Plan Benefits – Pharmacy</b>		

<i>When you visit a retail pharmacy...</i>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Retail Pharmacy (Short-term supply: Up to 34 Days)</b>		
<b>Drug Tier 1:</b> Generic / Generic Specialty	<b>National Plus:</b> Deductible, then no charge	Deductible, then \$10 Copay/Fill, then 50% Coinsurance
<b>Drug Tier 2:</b> Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	<b>National Plus:</b> Deductible, then no charge	Deductible, then \$30 Copay/Fill, then 50% Coinsurance
<b>Drug Tier 3:</b> Non-Preferred Brand / Non-Preferred Brand Specialty	<b>National Plus:</b> Deductible, then no charge	Deductible, then \$50 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</b>		
<b>Drug Tier 1:</b> Generic / Generic Specialty	Deductible, then no charge	Deductible, then \$20 Copay/Fill, then 50% Coinsurance
<b>Drug Tier 2:</b> Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	Deductible, then no charge	Deductible, then \$60 Copay/Fill, then 50% Coinsurance
<b>Drug Tier 3:</b> Non-Preferred Brand / Non-Preferred Brand Specialty	Deductible, then no charge	Deductible, then \$100 Copay/Fill, then 50% Coinsurance

## 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](mailto: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](mailto: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 [ocrportal.hhs.gov/ocr/portal/lobby.jsf](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 [www.hhs.gov/ocr/office/file/index.html](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 1-877-410-6716.

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 1-877-410-6716.

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 1-877-410-6716。

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 1-877-410-6716.

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 1-877-410-6716 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 1-877-410-6716 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 1-877-410-6716.

