



Health Benefit Plan Summary - First PCB Gold \$1,850 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.

General Plan Information

Plan Type	Preferred Provider Organization (PPO) 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.	
Medical Network(s) A complete listing of network hospitals and physicians is available on MyBlueKC.com .	In Area: Preferred-Care Blue Out-of-Area: BlueCard PPO/EPO	
Deductible – Embedded You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services.	In-Network Individual: \$1,850 Family: \$3,700	Out-of-Network Individual: \$1,850 Family: \$3,700
Coinsurance 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.	In-Network Member Pays: 10% Plan Pays: 90%	Out-of-Network Member Pays: 40% Plan Pays: 60%
Out-of-Pocket Limits – Embedded 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 Applies to: All Medical and Rx Cost Sharing	In-Network Individual: \$5,000 Family: \$10,000	Out-of-Network Individual: \$10,000 Family: \$20,000
Dependent Limiting Age	26	
Customer Service	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>	In-Network	Out-of-Network
Physician <i>Primary Care Physician (PCP)</i> - An internist, family practitioner, general practitioner, or pediatrician.	Initial 4 Visit(s): \$25 Copay/Visit, no Deductible; Subsequent Visit(s): 10% Coinsurance after Deductible	40% Coinsurance after Deductible

Specialist - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrists, psychologists and chiropractors.	Initial 4 Visit(s): \$25 Copay/Visit, no Deductible; Subsequent Visit(s): 10% Coinsurance after Deductible	40% Coinsurance after Deductible
Other Services & Procedures performed in a provider's office and not included with an office visit	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care Center	Initial 4 Visit(s): \$25 Copay/Visit, no Deductible; Subsequent Visit(s): 10% Coinsurance after Deductible	40% Coinsurance after Deductible
Blue KC Virtual Care - Office Visit Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	\$10 Copay/Visit, no Deductible	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	\$10 Copay/Visit, no Deductible	Not applicable
Preventive Screenings & Immunizations (Children & Adults) 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	30% Coinsurance after Deductible
Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility	No member cost share	40% Coinsurance after Deductible
Allergy		
Allergy Testing	Allergy Testing Included in Office Visit Copay	40% Coinsurance after Deductible
Allergy Treatment	Allergy Treatment Included in Office Visit Copay	40% Coinsurance after Deductible
When you need radiology services...	In-Network	Out-of-Network
X-Ray X-rays and other radiology procedures performed in a Physician's Office will not be subject to the applicable Cost-Sharing if you are required to pay your office visit Copayment.	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Other Radiology Procedures (MRI, CT/PET Scans, MRA) Prior Authorization Policy Applies	10% Coinsurance after Deductible	40% Coinsurance after Deductible
When you have out-patient surgery...	In-Network	Out-of-Network
Outpatient Surgery Facility Fees Prior Authorization Policy Applies	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Physician (Surgeon) Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible
If you need immediate medical attention...	In-Network	Out-of-Network
Urgent Care Center Office Visit	Initial 4 Visit(s): \$25 Copay/Visit, no Deductible; Subsequent Visit(s): 10% Coinsurance after Deductible	40% Coinsurance after Deductible

Emergency Services 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.	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
Ground Ambulance 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.	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
Air Ambulance	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
<i>If you have a hospital stay...</i>	In-Network	Out-of-Network
Hospital Facility Fees Prior Authorization Policy Applies	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Physician (Surgeon) Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible
<i>If you need help recovering or have other special health needs...</i>	In-Network	Out-of-Network
Skilled Nursing Care	Not covered	Not covered
Home Health Services Prior Authorization Policy Applies	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Physical Therapy	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Occupational Therapy	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Skeletal Manipulation Prior Authorization Policy Applies Out-of-Network	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Speech Therapy Maximum Rehabilitative Services benefit of 90 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Hearing Therapy	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Durable Medical Equipment Prior Authorization Policy Applies	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Hospice Services Prior Authorization Policy Applies	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Hospice Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible
<i>If you have behavioral health, or substance abuse needs...</i>	In-Network	Out-of-Network
Outpatient Mental Health, Behavioral Health, and Substance Abuse Services Office Visit	Initial 4 Visit(s): \$25 Copay/Visit, no Deductible; Subsequent Visit(s): 10% Coinsurance after Deductible	40% Coinsurance after Deductible
Therapy	10% Coinsurance after Deductible	40% Coinsurance after Deductible

Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees) Prior Authorization Policy Applies	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician) Includes: Therapy & Other Services, partial hospitalizations	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Family Planning & Pregnancy...	In-Network	Out-of-Network
Contraceptive Devices, Implants, and Injections See also pharmacy benefits.	No member cost share	40% Coinsurance after Deductible
Elective Sterilization – Women	No member cost share	40% Coinsurance after Deductible
Elective Sterilization – Men	No member cost share	40% Coinsurance after Deductible
Maternity Dependent daughters are covered for maternity services	Covered	Covered
Infertility Diagnosis and Treatment Pharmacy Coverage: See Member Certificate for more details.	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Routine Pediatric Care...		
Pediatric Dental - Basic Services Maximum benefit of 2 Exam(s) and Cleaning/Calendar Year for In-Network and Out-of-Network	No member cost share	30% Coinsurance after Deductible
Pediatric Dental - Intermediate Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Pediatric Dental - Major Services	50% Coinsurance after Deductible	70% Coinsurance after Deductible
Pediatric Vision Exam - Routine	\$25 Copay/Visit, no Deductible	30% Coinsurance after Deductible
Pediatric Vision Hardware Maximum benefit of 3 Pair of Lenses and 3 Frame(s)/Calendar Year, or Maximum benefit of 1 Annual Supply of Contacts/Calendar Year for In-Network and Out-of-Network	No member cost share	30% Coinsurance after Deductible
General Pharmacy Information		
Retail Pharmacy Network(s)	RxPremier	
Prescription Drug List Learn more about the drugs covered by your plan, drug category/tier, prior authorization and step therapy by reviewing your prescription drug list at MyBlueKC.com	Blue KC - KS Exchange Formulary	
Specialty Pharmacy 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 MyBlueKC.com	OptumRx Specialty Services PH: 1-855-427-4682	
Copay Credit Accumulator Adjustment (CCAA)	Specialty drug copay card dollars will not be included in your deductible and/or out-of-pocket limits. Only your true out-of-pocket costs will be applied to your deductible and/or out-of-pocket totals.	

Outpatient Prescription Drug Deductible You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services.	In-Network Combined with Medical Deductible	Out-of-Network Combined with Medical Deductible
Outpatient Prescription Drug Out-of-Pocket Limits The Out-of-Pocket Limit is the most you could pay during the Calendar Year for your share of the cost of covered services.	In-Network Combined with Medical Out-of-Pocket Limits	Out-of-Network Combined with Medical Out-of-Pocket Limits
Plan Benefits – Pharmacy		
<i>When you use a retail pharmacy...</i>	In-Network	Out-of-Network
Retail Pharmacy (Short-term supply: Up to 34 Days)		
Low Cost Generic	RxPremier: \$5 Copay/Fill, no Deductible	Deductible, then 50% Coinsurance
Drug Tier 1: Generic	RxPremier: \$15 Copay/Fill, no Deductible Contraceptives – No member cost share	Deductible, then 50% Coinsurance
Drug Tier 2: Preferred	RxPremier: \$65 Copay/Fill, no Deductible	Deductible, then 50% Coinsurance
Drug Tier 3: Non-Preferred	RxPremier: 20% Coinsurance, no Deductible	Deductible, then 50% Coinsurance
<i>When you use a specialty pharmacy...</i>	In-Network	Out-of-Network
Specialty Pharmacy (Day supply: Up to 34 Days)		
Specialty Drug Tier 1: Generic Specialty / Preferred Specialty	\$65 Copay/Fill, no Deductible	Deductible, then 50% Coinsurance
Specialty Drug Tier 2: Non-Preferred Specialty	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
<i>When you use a mail order pharmacy...</i>	In-Network	Out-of-Network
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days)		
Low Cost Generic	\$15 Copay/Fill, no Deductible	Deductible, then 50% Coinsurance
Drug Tier 1: Generic	\$45 Copay/Fill, no Deductible Contraceptives – No member cost share	Deductible, then 50% Coinsurance
Drug Tier 2: Preferred	\$195 Copay/Fill, no Deductible	Deductible, then 50% Coinsurance
Drug Tier 3: Non-Preferred	20% Coinsurance, no Deductible	Deductible, 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.

