Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Effective Date: 01/01/2024

Unified School District No. 229, Johnson County, State of Kansas

Health Benefit Plan Summary - EPO PLAN - BlueSelect Plus Network

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	**Exclusive Provider Organization (EPO)** Members receive all care from in-network providers except for emergency services. Non-emergency services received out-of-network will not be covered.	
Medical Network(s) A complete listing of network hospitals and physicians is available on MyBlueKC.com.	**In Area:** BlueSelect Plus **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. **Other Deductible**: Prescription Drugs	**In-Network** Individual: $0 Family: $0	**Out-of-Network** Not covered
Coinsurance Applies only as specified in your contract. Coinsurance is noted in this summary where applicable.	**In-Network** Member Pays: 0% Plan Pays: 100%	**Out-of-Network** Not covered
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: $4,000 Family: $10,000	**Out-of-Network** Not covered
Blue Connect A dedicated team of Blue KC experts delivering superior healthcare customer service, that was designed to help you understand your benefits, find doctors, resolve claims and medical billing issues, and provide coaching for care questions and chronic conditions. Blue Connect Tier Level: Advanced Support	**PH:** 816-395-2244 (local) or 1-888-890-4661 (toll free) **Email:** BlueConnect@bluekc.com	

Plan Benefits - Medical

When you visit a health care provider's office or clinic…	In-Network	Out-of-Network
Physician ***Primary Care Physician (PCP)*** - An internist, family practitioner, general practitioner, or pediatrician.	$35 Copay/Visit	Not covered

Total Care PCP - A primary care provider recognized for delivering high quality, holistic patient care. Participating Total Care network providers can be found in the Provider Directory with the Total Care designation.	$15 Copay/Visit	Not covered
Specialist - 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	Not covered
Other Services & Procedures performed in a provider's office and not included with an office visit	No member cost share	Not covered
Urgent Care Center	$70 Copay/Visit	Not covered
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.	$70 Copay/Visit	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.	$15 Copay/Visit	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	Not covered
Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility	No member cost share	Not covered
Allergy		
Allergy Testing	$100 Copay/Visit	Not covered
Allergy Treatment	No member cost share	Not covered
When you need radiology services…	**In-Network**	**Out-of-Network**
X-Ray	No member cost share	Not covered
Other Radiology Procedures (MRI, CT/PET Scans, MRA) Prior Authorization Policy Applies In-Network	$200 Copay/Provider per Day	Not covered
When you have out-patient surgery…	**In-Network**	**Out-of-Network**
Outpatient Surgery Facility Fees Prior Authorization Policy Applies In-Network	$500 Copay/Day Limited to Inpatient/Outpatient $2,500 Copay Max per Calendar Year	Not covered
Physician (Surgeon) Services	No member cost share	Not covered
If you need immediate medical attention…	**In-Network**	**Out-of-Network**
Urgent Care Center Office Visit	$70 Copay/Visit	Not covered
Emergency Services 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.	$200 Copay/Visit	$200 Copay/Visit

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.	No member cost share	No member cost share
Air Ambulance	No member cost share	No member cost share
If you have a hospital stay…	**In-Network**	**Out-of-Network**
Hospital Facility Fees Prior Authorization Policy Applies In-Network	$500 Copay/Day Limited to Inpatient/Outpatient $2,500 Copay Max per Calendar Year	Not covered
Physician (Surgeon) Services	No member cost share	Not covered
If you need help recovering or have other special health needs…	**In-Network**	**Out-of-Network**
Skilled Nursing Care Prior Authorization Policy Applies In-Network Maximum benefit of 30 Day(s)/Calendar Year for In-Network	$70 Copay/Day Limited to $350 Copay Max per Calendar Year	Not covered
Home Health Services Prior Authorization Policy Applies In-Network Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	$35 Copay/Visit	Not covered
Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	**Physical Therapy in a Provider's Office:** $35 Copay/Visit **Physical Therapy in a Facility:** No member cost share	Not covered
Occupational Therapy Combined with Physical Therapy Limits	**Occupational Therapy in a Provider's Office:** $35 Copay/Visit **Occupational Therapy in a Facility:** No member cost share	Not covered
Skeletal Manipulation Combined with Physical Therapy Limits	No member cost share	Not covered
Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network	**Speech Therapy in a Provider's Office:** $35 Copay/Visit **Speech Therapy in a Facility:** No member cost share	Not covered
Hearing Therapy Combined with Speech Therapy Limits	No member cost share	Not covered
Durable Medical Equipment Prior Authorization Policy Applies In-Network	No member cost share	Not covered
Inpatient Hospice Services Prior Authorization Policy Applies In-Network Maximum benefit of 14 Day(s)/Lifetime for In-Network	$250 Copay/Day Limited to Inpatient/Outpatient $2,500 Copay Max per Calendar Year	Not covered
Home Hospice Services	No member cost share	Not covered
If you have behavioral health, or substance abuse needs…	**In-Network**	**Out-of-Network**

Outpatient Mental Health, Behavioral Health, and Substance Abuse Services **Office Visit**	$15 Copay/Visit	Not covered
Therapy	$15 Copay/Visit	Not covered
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees) Prior Authorization Policy Applies In-Network	$500 Copay/Day Limited to Inpatient/Outpatient $2,500 Copay Max per Calendar Year	Not covered
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician) Includes: Therapy & Other Services, partial hospitalizations	No member cost share	Not covered
Family Planning & Pregnancy…	**In-Network**	**Out-of-Network**
Contraceptive Devices, Implants, and Injections See also pharmacy benefits.	No member cost share	Not covered
Elective Sterilization – Women	No member cost share	Not covered
Elective Sterilization – Men	No member cost share	Not covered
Maternity Dependent Daughters are not covered for maternity services	Covered	Not covered
Infertility and Impotency Diagnosis and Treatment Pharmacy Coverage: See Member Certificate for more details.	No member cost share	Not covered
Routine Vision Care…	**In-Network**	**Out-of-Network**
Routine Eye Exam Maximum benefit of 1 Exam(s)/Calendar Year for In-Network	$10 Copay/Visit	Not covered

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	Premium 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.
Variable Copay Solution (VCS)	When you use a drug copay card, Specialty prescription drugs may be subject to a new plan benefit cost share. This new cost share will not impact you or the price you pay.

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**	**Out-of-Network**
	Individual: $200 Family: $400	Not covered

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**	**Out-of-Network**
	Combined with Medical Out-of-Pocket Limits	Not covered
Rx Savings Solutions 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 MyBlueKC.com and stay up-to-date on cost saving opportunities. **Email:** info@rxsavingsllc.com **PH:** 1-800-268-4476	
Rx Rewards Incentive Program	The Rx Rewards program offers incentives for switching to lower cost prescription alternatives. Log in to MyBlueKC.com to find qualifying prescriptions. Contact Rx Savings Solutions at 1-800-268-4476.	
Plan Benefits – Pharmacy		
When you use a retail or specialty pharmacy...	**In-Network**	**Out-of-Network**
Retail Pharmacy (Short-term supply: Up to 34 Days**)**		
Drug Tier 1: Generic / Generic Specialty	**RxPremier:** Deductible, then $12 Copay/Fill Contraceptives – No member cost share	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then $60 Copay/Fill	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then $80 Copay/Fill	Not covered
Retail Pharmacy (Long-term supply: Between 35-102 Days**)**		
Drug Tier 1: Generic / Generic Specialty	**RxPremier:** Deductible, then $30 Copay/Fill	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then $150 Copay/ Fill	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then $200 Copay/ Fill	Not covered
When you use a mail order pharmacy…	**In-Network**	**Out-of-Network**
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days)		
Drug Tier 1: Generic	Deductible, then $24 Copay/Fill Contraceptives – No member cost share	Not covered
Drug Tier 2: Preferred	Deductible, then $120 Copay/Fill	Not covered
Drug Tier 3: Non-Preferred	Deductible, then $160 Copay/Fill	Not covered

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.

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