



Lee's Summit School District

**Health Benefit Plan Summary - PCB EPO 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 [MyBlueKC.com](http://MyBlueKC.com).

**General Plan Information**

<p><b>Plan Type</b></p>	<p><b>Exclusive Provider Organization (EPO)</b> Members receive all care from in-network providers except for emergency services. Non-emergency services received out-of-network will not be covered.</p>	
<p><b>Medical Network(s)</b> A complete listing of network hospitals and physicians is available on <a href="http://MyBlueKC.com">MyBlueKC.com</a>.</p>	<p><b>In Area:</b> Preferred-Care Blue <b>Out-of-Area:</b> BlueCard PPO/EPO</p>	
<p><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>Other Deductible:</b> Prescription Drugs</p>	<p><b>In-Network</b> Individual: \$1,000 Family: \$2,000</p>	<p><b>Out-of-Network</b> Not covered</p>
<p><b>Coinsurance</b> Applies only as specified in your contract. Coinsurance is noted in this summary where applicable.</p>	<p><b>In-Network</b> Member Pays: 20% Plan Pays: 80%</p>	<p><b>Out-of-Network</b> Not covered</p>
<p><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</p>	<p><b>In-Network</b> Individual: \$6,500 Family: \$13,000</p>	<p><b>Out-of-Network</b> Not covered</p>
<p><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.</p>	<p><b>PH:</b> 1-877-852-5422</p>	
<p><b>Customer Service</b></p>	<p><b>PH:</b> 816-395-2270 (local) or 1-800-654-0155 (toll free)</p>	

**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>
<p><b>Physician</b> <b>Primary Care Physician (PCP)</b> - An internist, family practitioner, general practitioner, or pediatrician.</p>	<p>\$40 Copay/Visit, no Deductible</p>	<p>Not covered</p>

<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.	\$80 Copay/Visit, no Deductible	Not covered
<b>Other Services &amp; Procedures performed in a provider's office and not included with an office visit</b>	20% Coinsurance after Deductible	Not covered
<b>Urgent Care Center</b>	\$80 Copay/Visit, no Deductible	Not covered
<b>Blue KC Virtual Care - Office Visit</b> Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	\$80 Copay/Visit, no Deductible	Not applicable
<b>Blue KC Virtual Care - Behavioral Health Therapy</b> Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	20% Coinsurance after Deductible	Not applicable
<b>Designated Health Clinic</b> <b>Name of Clinic:</b> Complete Health & Wellness Center	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	Not covered
<b>Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility</b>	No member cost share	Not covered
<b>Allergy</b>		
<b>Allergy Testing</b>	\$100 Copay/Visit, no Deductible	Not covered
<b>Allergy Treatment</b>	20% Coinsurance after Deductible	Not covered
<b>When you need radiology services...</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>X-Ray</b>	20% Coinsurance after Deductible	Not covered
<b>Other Radiology Procedures (MRI, CT/PET Scans, MRA)</b> Prior Authorization Policy Applies In-Network	\$200 Copay/Provider per Day, then 20% Coinsurance, no Deductible	Not covered
<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 In-Network	20% Coinsurance after Deductible	Not covered
<b>Physician (Surgeon) Services</b>	20% Coinsurance after Deductible	Not covered
<b>If you need immediate medical attention...</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Urgent Care Center Office Visit</b>	\$80 Copay/Visit, no Deductible	Not covered
<b>Emergency Services</b> Copay Waived if Admitted	\$500 Copay/Visit, then Deductible, then 20% Coinsurance	\$500 Copay/Visit, then In-Network Deductible, then 20% Coinsurance
<b>Ground Ambulance</b> Out-of-Network Benefits: In-Area benefits are subject to billed charges. Out-of-Area benefits are subject to the host plan's allowable charges, and 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
<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 In-Network	20% Coinsurance after Deductible	Not covered
<b>Physician (Surgeon) Services</b>	20% Coinsurance after Deductible	Not covered
<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 In-Network Maximum benefit of 30 Day(s)/Calendar Year for In-Network	20% Coinsurance after Deductible	Not covered
<b>Home Health Services</b> Prior Authorization Policy Applies In-Network Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
<b>Physical Therapy</b> Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	20% Coinsurance after Deductible	Not covered
<b>Occupational Therapy</b> Combined with Physical Therapy Limits	20% Coinsurance after Deductible	Not covered
<b>Skeletal Manipulation performed in a Chiropractic Office</b>	\$40 Copay/Visit, no Deductible	Not covered
<b>Speech Therapy</b> Maximum benefit of 20 Visit(s)/Calendar Year for In-Network	20% Coinsurance after Deductible	Not covered
<b>Hearing Therapy</b> Combined with Speech Therapy Limits	20% Coinsurance after Deductible	Not covered
<b>Durable Medical Equipment</b> Prior Authorization Policy Applies In-Network	20% Coinsurance after Deductible	Not covered
<b>Inpatient Hospice Services</b> Prior Authorization Policy Applies In-Network Maximum benefit of 14 Day(s)/Lifetime for In-Network	20% Coinsurance after Deductible	Not covered
<b>Home Hospice Services</b>	20% Coinsurance after Deductible	Not covered
<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>	\$40 Copay/Visit, no Deductible	Not covered
<b>Therapy</b>	20% Coinsurance after Deductible	Not covered
<b>Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees)</b> Prior Authorization Policy Applies In-Network	20% Coinsurance after Deductible	Not covered
<b>Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician)</b> Includes: Therapy & Other Services, partial hospitalizations	20% Coinsurance after Deductible	Not covered

<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	Not covered
<b>Elective Sterilization – Women</b>	No member cost share	Not covered
<b>Elective Sterilization – Men</b>	No member cost share	Not covered
<b>Maternity</b> Dependent daughters are covered for maternity services	Covered	Not covered
<b>Infertility and Impotency Diagnosis and Treatment</b> Pharmacy Coverage: Not Covered	Not covered	Not covered
<i>Routine Vision Care...</i>	<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	\$10 Copay/Visit, no Deductible	Not covered
<b>General Pharmacy Information</b>		
<b>Retail Pharmacy Network(s)</b>	RxPreferred 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:</b> 1-855-427-4682	
<b>Copay Credit Accumulator Adjustment (CCAA)</b>	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.	
<b>Variable Copay Solution (VCS)</b>	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.	
<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>
	Individual: \$150 Family: \$450	Not covered
<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	Not covered
<b>Maintenance Medication Program</b>	<b>Mail Service Member Select</b> – Member must make a choice of where to obtain their maintenance medications after two courtesy fills: long-term supply through Home Delivery or a short-term supply from a retail pharmacy.	

**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](http://MyBlueKC.com) and stay up-to-date on cost saving opportunities.

**Email:** [info@rxsavingsllc.com](mailto: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](http://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

**RxPreferred:** Deductible, then \$15 Copay/Fill  
**RxPremier:** Deductible, then \$25 Copay/Fill  
 Contraceptives – No member cost share

Not covered

**Drug Tier 2:** Preferred / Preferred Specialty

**RxPreferred:** Deductible, then \$40 Copay/Fill  
**RxPremier:** Deductible, then \$50 Copay/Fill

Not covered

**Drug Tier 3:** Non-Preferred / Non-Preferred Specialty

**RxPreferred:** Deductible, then \$65 Copay/Fill  
**RxPremier:** Deductible, then \$75 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 \$30 Copay/Fill  
 Contraceptives – No member cost share

Not covered

**Drug Tier 2:** Preferred

Deductible, then \$80 Copay/Fill

Not covered

**Drug Tier 3:** Non-Preferred

Deductible, then \$130 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](mailto:languagehelp@bluekc.com).

