



St. Joseph School District

Health Benefit Plan Summary - Preferred-Care Blue - 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.

General Plan Information

<p>Plan Type</p>	<p>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.</p>	
<p>Medical Network(s) A complete listing of network hospitals and physicians is available on MyBlueKC.com.</p>	<p>In Area: Preferred-Care Blue Out-of-Area: BlueCard PPO/EPO</p>	
<p>Deductible – Embedded You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services.</p>	<p>In-Network Individual: \$0 Family: \$0</p>	<p>Out-of-Network Not covered</p>
<p>Coinsurance Applies only as specified in your contract. Coinsurance is noted in this summary where applicable.</p>	<p>In-Network Member Pays: 0% Plan Pays: 100%</p>	<p>Out-of-Network Not covered</p>
<p>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</p>	<p>In-Network Individual: \$7,900 Family: \$15,800</p>	<p>Out-of-Network Not covered</p>
<p>Customer Service</p>	<p>PH: 816-395-3558 (local) or 1-888-989-8842 (toll free)</p>	
<p>Plan Benefits - Medical</p>		
<p><i>When you visit a health care provider's office or clinic...</i></p>	<p>In-Network</p>	<p>Out-of-Network</p>
<p>Physician Primary Care Physician (PCP) - An internist, family practitioner, general practitioner, or pediatrician.</p>	<p>\$40 Copay/Visit</p>	<p>Not covered</p>
<p>Specialist - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrists, psychologists and chiropractors.</p>	<p>\$80 Copay/Visit</p>	<p>Not covered</p>
<p>Other Services & Procedures performed in a provider's office and not included with an office visit</p>	<p>No member cost share</p>	<p>Not covered</p>

Urgent Care Center	\$50 Copay/Visit	Not covered
Blue KC Virtual Care - Office Visit Virtual Care provided by Blue KC virtual care partner(s).	\$50 Copay/Visit	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual Care provided by Blue KC virtual care partner(s).	No member cost share	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	Allergy Treatment Included in Office Visit Copay	Not covered
<i>When you need radiology services...</i>	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	No member cost share	Not covered
<i>When you have out-patient surgery...</i>	In-Network	Out-of-Network
Outpatient Surgery Facility Fees Prior Authorization Policy Applies In-Network	\$400 Copay/Day Limited to Inpatient/Outpatient \$1,200 Copay Max per Calendar Year	Not covered
Physician (Surgeon) Services	No member cost share	Not covered
<i>If you need immediate medical attention...</i>	In-Network	Out-of-Network
Urgent Care Center Office Visit	\$50 Copay/Visit	Not covered
Emergency Services Copay Waived if Admitted	\$200 Copay/Visit	\$200 Copay/Visit
Ground Ambulance 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.	No member cost share	No member cost share
Air Ambulance	No member cost share	No member cost share
<i>If you have a hospital stay...</i>	In-Network	Out-of-Network
Hospital Facility Fees Prior Authorization Policy Applies In-Network	\$400 Copay/Day Limited to Inpatient/Outpatient \$1,200 Copay Max per Calendar Year	Not covered
Physician (Surgeon) Services	No member cost share	Not covered

<i>If you need help recovering or have other special health needs...</i>	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	No member cost share	Not covered
Home Health Services Prior Authorization Policy Applies In-Network Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Occupational Therapy Combined with Physical Therapy Limits	No member cost share	Not covered
Skeletal Manipulation performed in a Chiropractic Office	No member cost share	Not covered
Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network	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	\$200 Copay/Day Limited to Inpatient/Outpatient \$1,200 Copay Max per Calendar Year	Not covered
Home Hospice Services	No member cost share	Not covered
<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	\$40 Copay/Visit	Not covered
Therapy	No member cost share	Not covered
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees) Prior Authorization Policy Applies In-Network	\$400 Copay/Day Limited to Inpatient/Outpatient \$1,200 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
<i>Family Planning & Pregnancy...</i>	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 covered for maternity services	Covered	Not covered
Infertility and Impotency Diagnosis and Treatment Infertility and impotency treatment limited to \$10,000 per Lifetime 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 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
Maintenance Medication Program	Mail Service Saver – Member will pay a higher cost-sharing for staying at retail for their maintenance medications after two courtesy fills unless they choose Home Delivery. \$10 Penalty	
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	
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: \$8 Copay/Fill Contraceptives – No member cost share	Not covered
Drug Tier 2: Preferred	RxPremier: \$35 Copay/Fill	Not covered
Drug Tier 3: Non-Preferred / Preferred Specialty	RxPremier: \$55 Copay/Fill	Not covered

Drug Tier 4: Non-Preferred Specialty	RxPremier: \$150 Copay/Fill	Not covered
Retail Pharmacy (Long-term supply: Between 35-102 Days)		
Drug Tier 1: Generic / Generic Specialty	RxPremier: \$16 Copay/Fill Contraceptives – No member cost share	Not covered
Drug Tier 2: Preferred	RxPremier: \$70 Copay/Fill	Not covered
Drug Tier 3: Non-Preferred / Preferred Specialty	RxPremier: \$110 Copay/Fill	Not covered
<i>When you use a mail order pharmacy...</i>	In-Network	Out-of-Network
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days)		
Drug Tier 1: Generic	\$16 Copay/Fill Contraceptives – No member cost share	Not covered
Drug Tier 2: Preferred	\$70 Copay/Fill	Not covered
Drug Tier 3: Non-Preferred	\$110 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.

