Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Effective Date: 01/01/2025

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.

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:** 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. **Other Deductible**: Prescription Drugs	**In-Network** Individual: $1,000 Family: $2,000	**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: 20% Plan Pays: 80%	**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: $6,500 Family: $13,000	**Out-of-Network** Not covered
Customer Service	**PH:** 816-395-2270 (local) or 1-800-654-0155 (toll free)	

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.	$40 Copay/Visit, no Deductible	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.	$80 Copay/Visit, no Deductible	Not covered
Other Services & Procedures performed in a provider's office and not included with an office visit	20% Coinsurance after Deductible	Not covered

Urgent Care Center	$80 Copay/Visit, no Deductible	$80 Copay/Visit, no Deductible
Blue KC Virtual Care - Office Visit Virtual Care provided by Blue KC virtual care partner(s).	$80 Copay/Visit, no Deductible	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual Care provided by Blue KC virtual care partner(s).	20% Coinsurance after Deductible	Not applicable
Designated Health Clinic **Name of Clinic:** Complete Health & Wellness Center	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, no Deductible	Not covered
Allergy Treatment	20% Coinsurance after Deductible	Not covered
When you need radiology services…	**In-Network**	**Out-of-Network**
X-Ray	20% Coinsurance after Deductible	Not covered
Other Radiology Procedures (MRI, CT/PET Scans, MRA) Prior Authorization Policy Applies In-Network	$200 Copay/Provider per Day, then 20% Coinsurance, no Deductible	Not covered
When you have out-patient surgery…	**In-Network**	**Out-of-Network**
Outpatient Surgery Facility Fees Prior Authorization Policy Applies In-Network	20% Coinsurance after Deductible	Not covered
Physician (Surgeon) Services	20% Coinsurance after Deductible	Not covered
If you need immediate medical attention…	**In-Network**	**Out-of-Network**
Urgent Care Center Office Visit	$80 Copay/Visit, no Deductible	$80 Copay/Visit, no Deductible
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.	$500 Copay/Visit, then Deductible, then 20% Coinsurance	$500 Copay/Visit, then In-Network Deductible, then 20% Coinsurance
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.	20% Coinsurance after Deductible	20% Coinsurance after In-Network Deductible
Air Ambulance	20% Coinsurance after Deductible	20% Coinsurance after In-Network Deductible
If you have a hospital stay…	**In-Network**	**Out-of-Network**
Hospital Facility Fees Prior Authorization Policy Applies In-Network	20% Coinsurance after Deductible	Not covered

Physician (Surgeon) Services	20% Coinsurance after Deductible	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	20% Coinsurance after Deductible	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	20% Coinsurance after Deductible	Not covered
Occupational Therapy Combined with Physical Therapy Limits	20% Coinsurance after Deductible	Not covered
Skeletal Manipulation performed in a Chiropractic Office	$40 Copay/Visit, no Deductible	Not covered
Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network	20% Coinsurance after Deductible	Not covered
Hearing Therapy Combined with Speech Therapy Limits	20% Coinsurance after Deductible	Not covered
Durable Medical Equipment Prior Authorization Policy Applies In-Network	20% Coinsurance after Deductible	Not covered
Inpatient Hospice Services Prior Authorization Policy Applies In-Network Maximum benefit of 14 Day(s)/Lifetime for In-Network	20% Coinsurance after Deductible	Not covered
Home Hospice Services	20% Coinsurance after Deductible	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**	$40 Copay/Visit, no Deductible	Not covered
Therapy	20% Coinsurance after Deductible	Not covered
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees) Prior Authorization Policy Applies In-Network	20% Coinsurance after Deductible	Not covered
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician) Includes: Therapy & Other Services, partial hospitalizations	20% Coinsurance after Deductible	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 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.	20% Coinsurance after Deductible	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, no Deductible	Not covered

General Pharmacy Information

Retail Pharmacy Network(s)	RxPreferred 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** Individual: $150 Family: $450	**Out-of-Network** 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** Combined with Medical Out-of-Pocket Limits	**Out-of-Network** Not covered
Maintenance Medication Program	**Mail Service Member Select** – 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 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	**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.

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