



## Lees Summit R VII School District

### Health Benefit Plan Summary - PCB PPO BlueSaver HSA 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](https://www.mylbluekc.com).

#### General Plan Information

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| <b>Plan Type</b>                                                                                                                                                                                                                                                                                                   | <b>Preferred Provider Organization (PPO)</b><br>Members can receive services from any hospital or physician, but receive greater benefits when using in-network providers.<br>This plan is an HSA Qualified High Deductible Health Plan.<br>Services rendered at Out-of-Network providers are subject to Out-of-Network allowables as stated in your contract, and balance billing may occur. |                                                                  |
| <b>Medical Network(s)</b><br>A complete listing of network hospitals and physicians is available on <a href="https://www.mylbluekc.com">MyBlueKC.com</a> .                                                                                                                                                         | <b>In Area:</b> Preferred-Care Blue<br><b>Out-of-Area:</b> BlueCard PPO/EPO                                                                                                                                                                                                                                                                                                                   |                                                                  |
| <b>Deductible – Embedded</b><br>You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services.                                                                                                                                                                        | <b>In-Network</b><br>Individual: \$4,000<br>Family: \$8,000                                                                                                                                                                                                                                                                                                                                   | <b>Out-of-Network</b><br>Individual: \$4,000<br>Family: \$8,000  |
| <b>Coinsurance</b><br>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.                                                                                                        | <b>In-Network</b><br>Member Pays: 0%<br>Plan Pays: 100%                                                                                                                                                                                                                                                                                                                                       | <b>Out-of-Network</b><br>Member Pays: 20%<br>Plan Pays: 80%      |
| <b>Out-of-Pocket Limits – Embedded</b><br>The Out-of-Pocket Limit is the most you could pay during the Calendar Year for your share of the cost of covered services.<br>These cost shares apply to the Out-of-Pocket Limit: Coinsurance, Deductibles, Copays<br><b>Applies to:</b> All Medical and Rx Cost Sharing | <b>In-Network</b><br>Individual: \$4,000<br>Family: \$8,000                                                                                                                                                                                                                                                                                                                                   | <b>Out-of-Network</b><br>Individual: \$8,000<br>Family: \$16,000 |
| <b>Customer Service</b>                                                                                                                                                                                                                                                                                            | <b>PH:</b> 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>                                                                  | <b>In-Network</b>          | <b>Out-of-Network</b>            |
|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------|
| <b>Physician</b><br><b>Primary Care Physician (PCP)</b> - An internist, family practitioner, general practitioner, or pediatrician. | Deductible, then no charge | 20% Coinsurance after Deductible |
| <b>Telehealth Providers other than Blue KC Virtual Care - Office Visit - Primary Care</b>                                           | Deductible, then no charge | 20% Coinsurance after Deductible |

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| <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.                                                                                                                                                                                                                                                                                                                                                                 | Deductible, then no charge | 20% Coinsurance after Deductible      |
| <b>Other Services &amp; Procedures performed in a provider's office and not included with an office visit</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Deductible, then no charge | 20% Coinsurance after Deductible      |
| <b>Urgent Care Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Deductible, then no charge | 20% Coinsurance after Deductible      |
| <b>Blue KC Virtual Care - Office Visit</b><br>Virtual Care provided by Blue KC virtual care partner(s).                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Deductible, then no charge | Not applicable                        |
| <b>Blue KC Virtual Care - Behavioral Health Therapy</b><br>Virtual Care provided by Blue KC virtual care partner(s).                                                                                                                                                                                                                                                                                                                                                                                                                                             | Deductible, then no charge | Not applicable                        |
| <b>Designated Health Clinic</b><br><b>Name of Clinic:</b> Complete Health & Wellness Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Deductible, then no charge | Not Applicable                        |
| <b>Preventive Screenings &amp; Immunizations (Children &amp; Adults)</b><br>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       | 20% Coinsurance after Deductible      |
| <b>Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Deductible, then no charge | 20% Coinsurance after Deductible      |
| <b>Allergy</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                            |                                       |
| <b>Allergy Testing</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Deductible, then no charge | 20% Coinsurance after Deductible      |
| <b>Allergy Treatment</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Deductible, then no charge | 20% Coinsurance after Deductible      |
| <b><i>When you need radiology services...</i></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>In-Network</b>          | <b>Out-of-Network</b>                 |
| <b>X-Ray</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Deductible, then no charge | 20% Coinsurance after Deductible      |
| <b>Other Radiology Procedures (MRI, CT/PET Scans, MRA)</b><br>Prior Authorization Policy Applies                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Deductible, then no charge | 20% Coinsurance after Deductible      |
| <b><i>When you have out-patient surgery...</i></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>In-Network</b>          | <b>Out-of-Network</b>                 |
| <b>Outpatient Surgery Facility Fees</b><br>Prior Authorization Policy Applies                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Deductible, then no charge | 20% Coinsurance after Deductible      |
| <b>Physician (Surgeon) Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Deductible, then no charge | 20% Coinsurance after Deductible      |
| <b><i>If you need immediate medical attention...</i></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>In-Network</b>          | <b>Out-of-Network</b>                 |
| <b>Urgent Care Center Office Visit</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Deductible, then no charge | 20% Coinsurance after Deductible      |
| <b>Emergency Services</b><br>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.                                                                                                                                                                                                                                                                                                                                                            | Deductible, then no charge | In-Network Deductible, then no charge |
| <b>Ground Ambulance</b><br>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.                                                                                                                                                                                                                                                                                                                                                              | Deductible, then no charge | In-Network Deductible, then no charge |
| <b>Air Ambulance</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Deductible, then no charge | In-Network Deductible, then no charge |

| <i>If you have a hospital stay...</i>                                                                                                               | <b>In-Network</b>          | <b>Out-of-Network</b>            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------|
| <b>Hospital Facility Fees</b><br>Prior Authorization Policy Applies                                                                                 | Deductible, then no charge | 20% Coinsurance after Deductible |
| <b>Physician (Surgeon) Services</b>                                                                                                                 | Deductible, then no charge | 20% Coinsurance after Deductible |
| <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><br>Prior Authorization Policy Applies<br>Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network   | Deductible, then no charge | 20% Coinsurance after Deductible |
| <b>Home Health Services</b><br>Prior Authorization Policy Applies<br>Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network | Deductible, then no charge | 20% Coinsurance after Deductible |
| <b>Physical Therapy</b><br>Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network                                           | Deductible, then no charge | 20% Coinsurance after Deductible |
| <b>Occupational Therapy</b><br>Combined with Physical Therapy Limits                                                                                | Deductible, then no charge | 20% Coinsurance after Deductible |
| <b>Skeletal Manipulation performed in a Chiropractic Office</b>                                                                                     | Deductible, then no charge | 20% Coinsurance after Deductible |
| <b>Speech Therapy</b><br>Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network                                             | Deductible, then no charge | 20% Coinsurance after Deductible |
| <b>Hearing Therapy</b><br>Combined with Speech Therapy Limits                                                                                       | Deductible, then no charge | 20% Coinsurance after Deductible |
| <b>Durable Medical Equipment</b><br>Prior Authorization Policy Applies                                                                              | Deductible, then no charge | 20% Coinsurance after Deductible |
| <b>Inpatient Hospice Services</b><br>Prior Authorization Policy Applies<br>Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network  | Deductible, then no charge | 20% Coinsurance after Deductible |
| <b>Home Hospice Services</b>                                                                                                                        | Deductible, then no charge | 20% Coinsurance after Deductible |
| <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>                                                       | Deductible, then no charge | 20% Coinsurance after Deductible |
| <b>Therapy in Provider's Office</b>                                                                                                                 | Deductible, then no charge | 20% Coinsurance after Deductible |
| <b>Therapy in Facility</b>                                                                                                                          | Deductible, then no charge | 20% Coinsurance after Deductible |
| <b>Telehealth Providers other than Blue KC Virtual Care - Office Visit - Behavioral Health</b>                                                      | Deductible, then no charge | 20% Coinsurance after Deductible |
| <b>Telehealth Providers other than Blue KC Virtual Care - Behavioral Health Therapy</b>                                                             | Deductible, then no charge | 20% Coinsurance after Deductible |
| <b>Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees)</b><br>Prior Authorization Policy Applies               | Deductible, then no charge | 20% Coinsurance after Deductible |

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| <b>Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician)</b><br>Includes: Therapy & Other Services, partial hospitalizations                                                                                                                                                                                             | Deductible, then no charge                                                                                                                                                                                                     | 20% Coinsurance after Deductible           |
| <b>Family Planning &amp; Pregnancy...</b>                                                                                                                                                                                                                                                                                                               | <b>In-Network</b>                                                                                                                                                                                                              | <b>Out-of-Network</b>                      |
| <b>Contraceptive Devices, Implants, and Injections</b><br>See also pharmacy benefits.                                                                                                                                                                                                                                                                   | No member cost share                                                                                                                                                                                                           | 20% Coinsurance after Deductible           |
| <b>Elective Sterilization – Women</b>                                                                                                                                                                                                                                                                                                                   | No member cost share                                                                                                                                                                                                           | 20% Coinsurance after Deductible           |
| <b>Elective Sterilization – Men</b>                                                                                                                                                                                                                                                                                                                     | Deductible, then no charge                                                                                                                                                                                                     | 20% Coinsurance after Deductible           |
| <b>Maternity</b><br>Dependent daughters are covered for maternity services                                                                                                                                                                                                                                                                              | Covered                                                                                                                                                                                                                        | Covered                                    |
| <b>Infertility and Impotency Diagnosis and Treatment</b><br>Infertility and impotency treatment limited to \$10,000 per Lifetime<br>Pharmacy Coverage: See Member Certificate for more details.                                                                                                                                                         | Subject to Applicable Cost Shares                                                                                                                                                                                              | Subject to Applicable Cost Shares          |
| <b>Routine Vision Care...</b>                                                                                                                                                                                                                                                                                                                           | <b>In-Network</b>                                                                                                                                                                                                              | <b>Out-of-Network</b>                      |
| <b>Routine Eye Exam</b>                                                                                                                                                                                                                                                                                                                                 | Not covered                                                                                                                                                                                                                    | Not covered                                |
| <b>General Pharmacy Information</b>                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                |                                            |
| <b>Retail Pharmacy Network(s)</b>                                                                                                                                                                                                                                                                                                                       | RxPreferred<br>RxPremier                                                                                                                                                                                                       |                                            |
| <b>Prescription Drug List</b><br>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="https://www.mylbluekc.com">MyBlueKC.com</a>                                                                                                             | Premium Formulary                                                                                                                                                                                                              |                                            |
| <b>Specialty Pharmacy</b><br>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="https://www.mylbluekc.com">MyBlueKC.com</a> | OptumRx Specialty Services<br><b>PH: 1-855-427-4682</b>                                                                                                                                                                        |                                            |
| <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>Outpatient Prescription Drug Deductible</b><br>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>                      |
|                                                                                                                                                                                                                                                                                                                                                         | Combined with Medical Deductible                                                                                                                                                                                               | Combined with Medical Deductible           |
| <b>Outpatient Prescription Drug Out-of-Pocket Limits</b><br>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                                                                                                                                                                                     | Combined with Medical Out-of-Pocket Limits |
| <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. |                                            |

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| <b>Rx Savings Solutions</b><br>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 <a href="https://www.MyBlueKC.com">MyBlueKC.com</a> and stay up-to-date on cost saving opportunities.<br><b>Email:</b> <a href="mailto:info@rxsavingsllc.com">info@rxsavingsllc.com</a><br><b>PH:</b> 1-800-268-4476         |                                                         |
| <b>Rx Rewards Incentive Program</b>                                                                                                                                                                                                  | The Rx Rewards program offers incentives for switching to lower cost prescription alternatives. Log in to <a href="https://www.MyBlueKC.com">MyBlueKC.com</a> to find qualifying prescriptions. Contact Rx Savings Solutions at 1-800-268-4476. |                                                         |
| <b>Plan Benefits – Pharmacy</b>                                                                                                                                                                                                      |                                                                                                                                                                                                                                                 |                                                         |
| <i>When you use a retail or specialty pharmacy...</i>                                                                                                                                                                                | <b>In-Network</b>                                                                                                                                                                                                                               | <b>Out-of-Network</b>                                   |
| <b>Retail Pharmacy (Short-term supply: Up to 34 Days)</b>                                                                                                                                                                            |                                                                                                                                                                                                                                                 |                                                         |
| <b>Drug Tier 1:</b> Generic / Generic Specialty                                                                                                                                                                                      | <b>RxPreferred:</b> Deductible, then no charge<br><b>RxPremier:</b> Deductible, then no charge<br>Contraceptives – No member cost share                                                                                                         | Deductible, then \$15 Copay/Fill, then 50% Coinsurance  |
| <b>Drug Tier 2:</b> Preferred / Preferred Specialty                                                                                                                                                                                  | <b>RxPreferred:</b> Deductible, then no charge<br><b>RxPremier:</b> Deductible, then no charge                                                                                                                                                  | Deductible, then \$40 Copay/Fill, then 50% Coinsurance  |
| <b>Drug Tier 3:</b> Non-Preferred / Non-Preferred Specialty                                                                                                                                                                          | <b>RxPreferred:</b> Deductible, then no charge<br><b>RxPremier:</b> Deductible, then no charge                                                                                                                                                  | Deductible, then \$65 Copay/Fill, then 50% Coinsurance  |
| <i>When you use a mail order pharmacy...</i>                                                                                                                                                                                         | <b>In-Network</b>                                                                                                                                                                                                                               | <b>Out-of-Network</b>                                   |
| <b>Mail Order Pharmacy (Mail Order supply: Between 35-102 Days)</b>                                                                                                                                                                  |                                                                                                                                                                                                                                                 |                                                         |
| <b>Drug Tier 1:</b> Generic                                                                                                                                                                                                          | Deductible, then no charge<br>Contraceptives – No member cost share                                                                                                                                                                             | Deductible, then \$30 Copay/Fill, then 50% Coinsurance  |
| <b>Drug Tier 2:</b> Preferred                                                                                                                                                                                                        | Deductible, then no charge                                                                                                                                                                                                                      | Deductible, then \$80 Copay/Fill, then 50% Coinsurance  |
| <b>Drug Tier 3:</b> Non-Preferred                                                                                                                                                                                                    | Deductible, then no charge                                                                                                                                                                                                                      | Deductible, then \$130 Copay/Fill, 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](mailto:languagehelp@bluekc.com).

