

North Kansas City School District

**Health Benefit Plan Summary - BlueSelect Plus Spira Care EPO - B3 (\$\$)**

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> BlueSelect Plus <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.</p>	<p><b>In-Network</b> Individual: \$1,350 Family: \$2,700</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: 0% Plan Pays: 100%</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: \$1,350 Family: \$2,700</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> 877-852-5422</p>	
<p><b>Customer Service &amp; Care Guide Services</b></p>	<p><b>Local:</b> 913-29-SPIRA (77472) <b>Toll Free:</b> 1-877-33-SPIRA (77472)</p>	

Plan Benefits - Medical		
<i>When you visit a Spira Care Center...</i>	In-Network	Out-of-Network
<p><b>Visits to a Spira Care Center include:</b></p> <ul style="list-style-type: none"> <li>• Office Visit – Routine</li> <li>• Office Visit – Urgent/Acute</li> <li>• Chronic Disease Care (excluding drugs &amp; equipment)</li> <li>• Outpatient Mental Health, Behavioral Health, and Substance Abuse Services</li> </ul> <p><i>Included as part of office visit and no member cost share:</i></p> <ul style="list-style-type: none"> <li>• Labs</li> <li>• X-ray (basic diagnostic x-rays for fracture and other injuries or illness)</li> </ul> <p><i>Workers' Comp</i> Your health coverage through any of the Blue Cross and Blue Shield of Kansas City plans, including Spira Care and Spira Care (HSA Eligible), cannot be used for an on-the-job or work-related injury or illness. However, members may have access to workers' compensation insurance paid for by their employers which may provide monetary benefits and/or medical care coverage for a work related injury or illness. Please speak with your human resources representative for more information.</p>	No member cost share	Not covered
<p><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.</p>	No member cost share	Not covered
<i>When you visit another Physician's Office...</i>	In-Network	Out-of-Network
<p><b>Physician</b> <i>Primary Care Physician (PCP)</i> - An internist, family practitioner, general practitioner, or pediatrician.</p>	Deductible, then no charge	Not covered
<p><i>Specialist</i> - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrists, psychologists and chiropractors.</p>	Deductible, then no charge	Not covered
<p><i>Other Services &amp; Procedures performed in a provider's office and not included with an office visit</i></p>	Deductible, then no charge	Not covered
<p><b>Urgent Care Center</b></p>	Deductible, then no charge	Not covered
<p><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.</p>	No member cost share	Not applicable
<p><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.</p>	\$40 Copay/Visit, no Deductible	Not applicable
<p><b>Designated Health Clinic</b> <b>Name of Clinic:</b> Meritas PCP Providers</p>	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>	Deductible, then no charge	Not covered
<b>Allergy</b> <b>Allergy Testing</b>	Deductible, then no charge	Not covered
<b>Allergy Treatment</b>	Deductible, then no charge	Not covered
<i>When you need radiology services...</i>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>X-Ray</b>	Deductible, then no charge	Not covered
<b>Other Radiology Procedures (MRI, CT/PET Scans, MRA)</b> Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
<i>When you have out-patient surgery...</i>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Outpatient Surgery Facility Fees</b> Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
<b>Physician (Surgeon) Services</b>	Deductible, then no charge	Not covered
<i>If you need immediate medical attention...</i>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Urgent Care Center Office Visit</b>	Deductible, then no charge	Not covered
<b>Emergency Services</b> 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> 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> Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
<b>Physician (Surgeon) Services</b>	Deductible, then no charge	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	Deductible, then no charge	Not covered
<b>Home Health Services</b> Prior Authorization Policy Applies In-Network Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered

<b>Physical Therapy</b> Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
<b>Occupational Therapy</b> Combined with Physical Therapy Limits	No member cost share	Not covered
<b>Skeletal Manipulation performed in a Chiropractic Office</b>	No member cost share	Not covered
<b>Speech Therapy</b> Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
<b>Hearing Therapy</b> Combined with Speech Therapy Limits	No member cost share	Not covered
<b>Durable Medical Equipment</b> Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
<b>Inpatient Hospice Services</b> Prior Authorization Policy Applies In-Network Maximum benefit of 14 Day(s)/Lifetime for In-Network	Deductible, then no charge	Not covered
<b>Home Hospice Services</b>	Deductible, then no charge	Not covered
<b><i>If you have behavioral health, or substance abuse needs...</i></b>	<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	Not covered
<b>Therapy</b>	No member cost share	Not covered
<b>Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees)</b> Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
<b>Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician)</b> Includes: Therapy & Other Services, partial hospitalizations	Deductible, then no charge	Not covered
<b><i>Family Planning &amp; Pregnancy...</i></b>	<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> Infertility and impotency treatment limited to \$10,000 per Lifetime Pharmacy Coverage: Not Covered	Deductible, then no charge	Not covered
<b><i>Routine Vision Care...</i></b>	<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	No member cost share	Not covered

General Pharmacy Information		
<b>Retail Pharmacy Network(s)</b>	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> 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>Vaible 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 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>Rx Savings Solutions</b> 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="http://MyBlueKC.com">MyBlueKC.com</a> and stay up-to-date on cost saving opportunities. <b>Email:</b> <a href="mailto:info@rxsavingsllc.com">info@rxsavingsllc.com</a> <b>PH:</b> 1-800-268-4476	
Plan Benefits – Pharmacy		
<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>RxPremier:</b> \$5 Copay/Fill Contraceptives – No member cost share	Not covered
<b>Drug Tier 2:</b> Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	<b>RxPremier:</b> \$50 Copay/Fill	Not covered
<b>Drug Tier 3:</b> Non-Preferred Brand / Non-Preferred Brand Specialty	<b>RxPremier:</b> \$55 Copay/Fill	Not covered
<b>Retail Pharmacy (Long-term supply: Between 35-102 Days)</b>		
<b>Drug Tier 1:</b> Generic / Generic Specialty	<b>RxPremier:</b> \$15 Copay/Fill	Not covered
<b>Drug Tier 2:</b> Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	<b>RxPremier:</b> \$125 Copay/Fill	Not covered
<b>Drug Tier 3:</b> Non-Preferred Brand / Non-Preferred Brand Specialty	<b>RxPremier:</b> \$165 Copay/Fill	Not covered
<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	\$15 Copay/Fill Contraceptives – No member cost share	Not covered
<b>Drug Tier 2:</b> Preferred Brand / Non-Preferred Generic	\$125 Copay/Fill	Not covered
<b>Drug Tier 3:</b> Non-Preferred Brand	\$165 Copay/Fill	Not covered

<b>Value-Based Benefits (VBB)...</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Included Conditions: Value-Based Benefits (VBB) Included Conditions:</b> Diabetes, CAD		
<b>Retail Pharmacy (Short-term supply)</b>		
<b>Drug Tier 1:</b> Generic / Generic Specialty	<b>RxPremier:</b> No member cost share	Not covered
<b>Drug Tier 2:</b> Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	<b>RxPremier:</b> No member cost share	Not covered
<b>Drug Tier 3:</b> Non-Preferred Brand / Non-Preferred Brand Specialty	<b>RxPremier:</b> \$50 Copay/Fill	Not covered
<b>Retail Pharmacy (Long-term supply)</b>		
<b>Drug Tier 1:</b> Generic / Generic Specialty	<b>RxPremier:</b> No member cost share	Not covered
<b>Drug Tier 2:</b> Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	<b>RxPremier:</b> No member cost share	Not covered
<b>Drug Tier 3:</b> Non-Preferred Brand / Non-Preferred Brand Specialty	<b>RxPremier:</b> \$150 Copay/Fill	Not covered
<b>Mail Order Pharmacy</b>		
<b>Drug Tier 1:</b> Generic / Generic Specialty	No member cost share	Not covered
<b>Drug Tier 2:</b> Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	No member cost share	Not covered
<b>Drug Tier 3:</b> Non-Preferred Brand / Non-Preferred Brand Specialty	\$150 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).

