



Unified School District No. 500, Wyandotte County, KS

Health Benefit Plan Summary - Blue-Care HMO 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>Health Maintenance Organization (HMO) Members must receive all care from HMO providers except for emergency services. Members choose a primary care physician. Members may self-refer to physician specialists in the Blue-Care network. Urgent care and an exclusive network of specialists are also covered; other services must be ordered by an HMO physician.</p>
<p>Medical Network(s) A complete listing of network hospitals and physicians is available on MyBlueKC.com.</p>	<p>In Area: Blue-Care Out-of-Area: BlueCard Excluded</p>
<p>Deductible – You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services.</p>	<p>In-Network Not applicable</p>
<p>Coinsurance Applies only as specified in your contract. Coinsurance is noted in this summary where applicable.</p>	<p>In-Network Member Pays: Not applicable Plan Pays: 100%</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, Copays Applies to: All Medical and Rx Cost Sharing</p>	<p>In-Network Individual: \$4,000 Family: \$10,000</p>
<p>Blue KC 24-Hour Nurse Line Available 7 days a week, 365 days a year to help you with symptoms or answer health-related questions.</p>	<p>PH: 877-852-5422</p>
<p>Customer Service</p>	<p>PH: 888-989-8842 or (816) 395-2270</p>
<p>Plan Benefits - Medical</p>	
<p><i>When you visit a health care provider's office or clinic...</i></p>	
<p>Physician Primary Care Physician (PCP) - An internist, family practitioner, general practitioner, or pediatrician. You select a Blue-Care PCP to manage your healthcare needs.</p>	<p>\$25 Copay/Visit</p>



Unified School District No. 500, Wyandotte County, KS

Health Benefit Plan Summary - BlueSaver BSP 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	Preferred Provider Organization (PPO) Members can receive services from any hospital or physician, but receive greater benefits when using in-network providers. Services rendered at Out-of-Network providers are subject to Out-of-Network allowables as stated in your contract, and balance billing may occur.	
Medical Network(s) A complete listing of network hospitals and physicians is available on MyBlueKC.com .	In Area: BlueSelect Plus 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.	In-Network Individual: \$2,800 Family: \$5,600	Out-of-Network Individual: \$5,600 Family: \$11,200
Coinsurance 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.	In-Network Member Pays: 0% Plan Pays: 100%	Out-of-Network Member Pays: 30% Plan Pays: 70%
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: \$2,800 Family: \$5,600	Out-of-Network Individual: \$13,500 Family: \$27,000
Blue KC 24-Hour Nurse Line Available 7 days a week, 365 days a year to help you with symptoms or answer health-related questions.	PH: 877-852-5422	
Customer Service	PH: 888-989-8842 or (816) 395-2270	
Plan Benefits - Medical		
<i>When you visit a health care provider's office or clinic...</i>	In-Network	Out-of-Network
Physician Primary Care Physician (PCP) - An internist, family practitioner, general practitioner, or pediatrician.	Deductible, then no charge	30% Coinsurance after Deductible

Specialist - 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	30% Coinsurance after Deductible
Other Services & Procedures performed in a provider's office and not included with an office visit	Deductible, then no charge	30% Coinsurance after Deductible
Urgent Care Center	Deductible, then no charge	30% Coinsurance after Deductible
Blue KC Virtual Care - Office Visit Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	Deductible, then no charge	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	Deductible, then no charge	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	30% Coinsurance after Deductible
Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility	Deductible, then no charge	30% Coinsurance after Deductible
Allergy		
Allergy Testing	Deductible, then no charge	30% Coinsurance after Deductible
Allergy Treatment	Deductible, then no charge	30% Coinsurance after Deductible
<i>When you need radiology services...</i>	In-Network	Out-of-Network
X-Ray	Deductible, then no charge	30% Coinsurance after Deductible
Other Radiology Procedures (MRI, CT/PET Scans, MRA) Prior Authorization Policy Applies	Deductible, then no charge	30% Coinsurance after Deductible
<i>When you have out-patient surgery...</i>	In-Network	Out-of-Network
Outpatient Surgery Facility Fees Prior Authorization Policy Applies	Deductible, then no charge	30% Coinsurance after Deductible
Physician (Surgeon) Services	Deductible, then no charge	30% Coinsurance after Deductible
<i>If you need immediate medical attention...</i>	In-Network	Out-of-Network
Urgent Care Center Office Visit	Deductible, then no charge	30% Coinsurance after Deductible
Emergency Services 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
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.	Deductible, then no charge	In-Network Deductible, then no charge
Air Ambulance	Deductible, then no charge	In-Network Deductible, then no charge
<i>If you have a hospital stay...</i>	In-Network	Out-of-Network

Hospital Facility Fees Prior Authorization Policy Applies	Deductible, then no charge	30% Coinsurance after Deductible
Physician (Surgeon) Services	Deductible, then no charge	30% Coinsurance after Deductible
<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 Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	30% Coinsurance after Deductible
Home Health Services Prior Authorization Policy Applies Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	30% Coinsurance after Deductible
Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	30% Coinsurance after Deductible
Occupational Therapy Combined with Physical Therapy Limits	Deductible, then no charge	30% Coinsurance after Deductible
Skeletal Manipulation Prior Authorization Policy Applies Out-of-Network Combined with Physical Therapy Limits	Deductible, then no charge	30% Coinsurance after Deductible
Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	30% Coinsurance after Deductible
Hearing Therapy Combined with Speech Therapy Limits	Deductible, then no charge	30% Coinsurance after Deductible
Durable Medical Equipment Prior Authorization Policy Applies	Deductible, then no charge	30% Coinsurance after Deductible
Inpatient Hospice Services Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	Deductible, then no charge	30% Coinsurance after Deductible
Home Hospice Services	Deductible, then no charge	30% Coinsurance after Deductible
<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	Deductible, then no charge	30% Coinsurance after Deductible
Therapy	Deductible, then no charge	30% Coinsurance after Deductible
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees) Prior Authorization Policy Applies	Deductible, then no charge	30% Coinsurance after Deductible
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician) Includes: Therapy & Other Services, partial hospitalizations	Deductible, then no charge	30% Coinsurance after Deductible
<i>Family Planning & Pregnancy...</i>	In-Network	Out-of-Network

Contraceptive Devices, Implants, and Injections See also pharmacy benefits.	No member cost share	30% Coinsurance after Deductible
Elective Sterilization – Women	No member cost share	30% Coinsurance after Deductible
Elective Sterilization – Men	No member cost share	30% Coinsurance after Deductible
Maternity Dependent Daughters are not covered for maternity services	Covered	Covered
Infertility and Impotency Diagnosis and Treatment Pharmacy Coverage: See Member Certificate for more details.	Not covered	Not covered
<i>Routine Vision Care...</i>	In-Network	Out-of-Network
Routine Eye Exam Maximum benefit of 1 Exam(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	30% Coinsurance after Deductible
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	Blue KC Preferred 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: 855-427-4682	
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	Out-of-Network
	Combined with Medical Deductible	Combined with Medical Deductible
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	Combined with Medical Out-of-Pocket Limits
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		
<i>When you use a retail or specialty pharmacy...</i>	In-Network	Out-of-Network
Retail Pharmacy (Short-term supply: Up to 34 Days)		
Drug Tier 1: Generic / Generic Specialty	RxPremier: Deductible, then no charge Contraceptives – No member cost share	Deductible, then \$15 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: Deductible, then no charge	Deductible, then \$40 Copay/Fill, then 50% Coinsurance

Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: Deductible, then no charge	Deductible, then \$60 Copay/Fill, then 50% Coinsurance
<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	Deductible, then no charge Contraceptives – No member cost share	Deductible, then \$30 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic	Deductible, then no charge	Deductible, then \$80 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand	Deductible, then no charge	Deductible, then \$120 Copay/Fill, then 50% Coinsurance

Discrimination is Against the Law

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. Blue KC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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.

If you believe that Blue KC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Appeals Department, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you, or someone you're helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-410-6716.

Spanish: 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 1-877-410-6716.

Chinese: 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 1-877-410-6716。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-410-6716.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-410-6716 an.

Korean: 가 [Blue KC] 가
1-877-410-6716

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-877-410-6716.

Arabic:

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-410-6716.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue KC, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-410-6716.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue KC, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-410-6716.

Tagalog: Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Blue KC, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-410-6716.

Laotian: ຖ້າ ທ່ານ ຫຼື ຄົນ ອື່ນ ທ່ານ ກຳ ລັງ ຈຸ ວ ຍ ຫຼື ອ, ມ ອ ຫາ ຖາ ມ ກ ງ ງ ອ ກ ບ ບ Blue KC, ທ່ານ ມ ີ ສ ດ ອ ທ ຈ ລ ດ ັ ດ ຮ ັ ບ ກ າ ນ ຈ ຸ ວ ຍ ຫຼື ອ ດ ລ ະ ອ ຂ ັ ມ ູ ນ ຂ ັ າ ວ ສ າ ນ ອ ທ ດ ັ ບ ມ ຫ ັ າ ໃ ຊ ັ ລ ັ າ ຍ. ກ າ ນ ໂ ອ ັ ດ ມ ກ ັ ບ ນ າ ຍ ພ າ ສ າ, ໃ ຫ ັ ໂ ຫ ຫ າ 1-877-410-6716.

Pennsylvanian Dutch: "Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Blue KC, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kansch du 1-877-410-6716 uffrufe.

Persian: اگر شما، یا کسی که شما به او کمک میکنید، سوال در مورد Blue KC، داشته باشید حق این را دارید که کمک اطلاعات به زبان خود را به طور رایگان دریافت نمایید. تماس حاصل نمایید. 1-877-410-6716

Cushite: Isin yookan namni biraa isin deeggartan Blue KC irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-877-410-6716 tiin bilbilaa.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue KC, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-410-6716.

For TTY services, please call 1-816-842-5607.



An Independent Licensee of the Blue Cross and Blue Shield Association



Unified School District No. 500, Wyandotte County, KS

Health Benefit Plan Summary - BlueSaver 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>Preferred Provider Organization (PPO) Members can receive services from any hospital or physician, but receive greater benefits when using in-network providers. Services rendered at Out-of-Network providers are subject to Out-of-Network allowables as stated in your contract, and balance billing may occur.</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: \$2,800 Family: \$5,600</p>	<p>Out-of-Network Individual: \$2,800 Family: \$5,600</p>
<p>Coinsurance 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.</p>	<p>In-Network Member Pays: 0% Plan Pays: 100%</p>	<p>Out-of-Network Member Pays: 20% Plan Pays: 80%</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: \$2,800 Family: \$5,600</p>	<p>Out-of-Network Individual: \$5,600 Family: \$11,200</p>
<p>Blue KC 24-Hour Nurse Line Available 7 days a week, 365 days a year to help you with symptoms or answer health-related questions.</p>	<p>PH: 877-852-5422</p>	
<p>Customer Service</p>	<p>PH: 888-989-8842 or (816) 395-2270</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>Deductible, then no charge</p>	<p>20% Coinsurance after Deductible</p>

Specialist - 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
Other Services & Procedures performed in a provider's office and not included with an office visit	Deductible, then no charge	20% Coinsurance after Deductible
Urgent Care Center	Deductible, then no charge	20% Coinsurance after Deductible
Blue KC Virtual Care - Office Visit Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	Deductible, then no charge	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	Deductible, then no charge	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	20% Coinsurance after Deductible
Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility	Deductible, then no charge	20% Coinsurance after Deductible
Allergy		
Allergy Testing	Deductible, then no charge	20% Coinsurance after Deductible
Allergy Treatment	Deductible, then no charge	20% Coinsurance after Deductible
<i>When you need radiology services...</i>	In-Network	Out-of-Network
X-Ray	Deductible, then no charge	20% Coinsurance after Deductible
Other Radiology Procedures (MRI, CT/PET Scans, MRA) Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
<i>When you have out-patient surgery...</i>	In-Network	Out-of-Network
Outpatient Surgery Facility Fees Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
Physician (Surgeon) Services	Deductible, then no charge	20% Coinsurance after Deductible
<i>If you need immediate medical attention...</i>	In-Network	Out-of-Network
Urgent Care Center Office Visit	Deductible, then no charge	20% Coinsurance after Deductible
Emergency Services 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
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.	Deductible, then no charge	In-Network Deductible, then no charge
Air Ambulance	Deductible, then no charge	In-Network Deductible, then no charge
<i>If you have a hospital stay...</i>	In-Network	Out-of-Network

Hospital Facility Fees Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
Physician (Surgeon) Services	Deductible, then no charge	20% Coinsurance after Deductible
<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 Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
Home Health Services Prior Authorization Policy Applies Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
Occupational Therapy Combined with Physical Therapy Limits	Deductible, then no charge	20% Coinsurance after Deductible
Skeletal Manipulation Prior Authorization Policy Applies Out-of-Network Combined with Physical Therapy Limits	Deductible, then no charge	20% Coinsurance after Deductible
Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
Hearing Therapy Combined with Speech Therapy Limits	Deductible, then no charge	20% Coinsurance after Deductible
Durable Medical Equipment Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
Inpatient Hospice Services Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
Home Hospice Services	Deductible, then no charge	20% Coinsurance after Deductible
<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	Deductible, then no charge	20% Coinsurance after Deductible
Therapy	Deductible, then no charge	20% Coinsurance after Deductible
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees) Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician) Includes: Therapy & Other Services, partial hospitalizations	Deductible, then no charge	20% Coinsurance after Deductible
<i>Family Planning & Pregnancy...</i>	In-Network	Out-of-Network

Contraceptive Devices, Implants, and Injections See also pharmacy benefits.	No member cost share	20% Coinsurance after Deductible
Elective Sterilization – Women	No member cost share	20% Coinsurance after Deductible
Elective Sterilization – Men	No member cost share	20% Coinsurance after Deductible
Maternity Dependent Daughters are not covered for maternity services	Covered	Covered
Infertility and Impotency Diagnosis and Treatment Pharmacy Coverage: See Member Certificate for more details.	Not covered	Not covered
<i>Routine Vision Care...</i>	In-Network	Out-of-Network
Routine Eye Exam Maximum benefit of 1 Exam(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
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	Blue KC Preferred 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: 855-427-4682	
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	Out-of-Network
	Combined with Medical Deductible	Combined with Medical Deductible
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	Combined with Medical Out-of-Pocket Limits
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		
<i>When you use a retail or specialty pharmacy...</i>	In-Network	Out-of-Network
Retail Pharmacy (Short-term supply: Up to 34 Days)		
Drug Tier 1: Generic / Generic Specialty	RxPremier: Deductible, then no charge Contraceptives – No member cost share	Deductible, then \$15 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: Deductible, then no charge	Deductible, then \$40 Copay/Fill, then 50% Coinsurance

Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: Deductible, then no charge	Deductible, then \$60 Copay/Fill, then 50% Coinsurance
<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	Deductible, then no charge Contraceptives – No member cost share	Deductible, then \$30 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic	Deductible, then no charge	Deductible, then \$80 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand	Deductible, then no charge	Deductible, then \$120 Copay/Fill, then 50% Coinsurance

Discrimination is Against the Law

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. Blue KC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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.

If you believe that Blue KC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Appeals Department, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you, or someone you're helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-410-6716.

Spanish: 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 1-877-410-6716.

Chinese: 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 1-877-410-6716。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-410-6716.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-410-6716 an.

Korean:

가 [Blue KC] 가
1-877-410-6716

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-877-410-6716.

Arabic:

إن كان لديك أو لدى شخص تساعدك أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-410-6716.



Unified School District No. 500, Wyandotte County, KS

Health Benefit Plan Summary - BlueSelect Plus 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: BlueSelect Plus 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.	In-Network Individual: \$0 Family: \$0	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: 0% Plan Pays: 100%	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: \$4,000 Family: \$10,000	Out-of-Network Not covered
Blue KC 24-Hour Nurse Line Available 7 days a week, 365 days a year to help you with symptoms or answer health-related questions.	PH: 877-852-5422	
Customer Service	PH: 888-989-8842 or (816) 395-2270	
Plan Benefits - Medical		
<i>When you visit a health care provider's office or clinic...</i>	In-Network	Out-of-Network
Physician Primary Care Physician (PCP) - An internist, family practitioner, general practitioner, or pediatrician.	\$25 Copay/Visit	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.	\$50 Copay/Visit	Not covered
Other Services & Procedures performed in a provider's office and not included with an office visit	No member cost share	Not covered
Urgent Care Center	\$50 Copay/Visit	Not covered
Blue KC Virtual Care - Office Visit Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	\$50 Copay/Visit	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	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	No member cost share	Not covered
Allergy Treatment	No member cost share	Not covered
When you need radiology services...	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	\$200 Copay/Provider per Day	Not covered
When you have out-patient surgery...	In-Network	Out-of-Network
Outpatient Surgery Facility Fees Prior Authorization Policy Applies In-Network	\$300 Copay/Day Limited to Inpatient/Outpatient \$1,500 Copay Max per Calendar Year	Not covered
Physician (Surgeon) Services	No member cost share	Not covered
If you need immediate medical attention...	In-Network	Out-of-Network
Urgent Care Center Office Visit	\$50 Copay/Visit	Not covered
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.	\$200 Copay/Visit	\$200 Copay/Visit
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.	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	\$300 Copay/Day Limited to Inpatient/Outpatient \$1,500 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 Combined with Physical Therapy Limits	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	\$150 Copay/Day Limited to Inpatient/Outpatient \$1,500 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	\$25 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	\$300 Copay/Day Limited to Inpatient/Outpatient \$1,500 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 not covered for maternity services	Covered	Not covered
Infertility and Impotency Diagnosis and Treatment Pharmacy Coverage: See Member Certificate for more details.	Not covered	Not covered
<i>Routine Vision Care...</i>	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	Blue KC Preferred 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: 855-427-4682	
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
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		
<i>When you use a retail or specialty pharmacy...</i>	In-Network	Out-of-Network
Retail Pharmacy (Short-term supply: Up to 34 Days)		
Drug Tier 1: Generic / Generic Specialty	RxPremier: \$15 Copay/Fill Contraceptives – No member cost share	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: \$40 Copay/Fill	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: \$60 Copay/Fill	Not covered
Retail Pharmacy (Long-term supply: Between 35-102 Days)		
Drug Tier 1: Generic / Generic Specialty	RxPremier: \$45 Copay/Fill	Not covered

Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: \$120 Copay/Fill	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: \$180 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	\$30 Copay/Fill Contraceptives – No member cost share	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic	\$80 Copay/Fill	Not covered
Drug Tier 3: Non-Preferred Brand	\$120 Copay/Fill	Not covered
<i>Value-Based Benefits (VBB)...</i>	In-Network	Out-of-Network
Included Conditions: Value-Based Benefits (VBB) Included Conditions: Diabetes, CAD		
Retail Pharmacy (Short-term supply)		
Drug Tier 1: Generic / Generic Specialty	RxPremier: No member cost share	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: No member cost share	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: \$30 Copay/Fill	Not covered
Retail Pharmacy (Long-term supply)		
Drug Tier 1: Generic / Generic Specialty	RxPremier: No member cost share	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: No member cost share	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: \$90 Copay/Fill	Not covered
Mail Order Pharmacy		
Drug Tier 1: Generic / Generic Specialty	No member cost share	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	No member cost share	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	\$60 Copay/Fill	Not covered

Discrimination is Against the Law

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. Blue KC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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.

If you believe that Blue KC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Appeals Department, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you, or someone you're helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-410-6716.

Spanish: 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 1-877-410-6716.

Chinese: 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 1-877-410-6716。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-410-6716.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-410-6716 an.

Korean:

가 [Blue KC] 가
1-877-410-6716

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-877-410-6716.

Arabic:

إن كان لديك أو لدى شخص تساعدك أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-410-6716.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue KC, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-410-6716.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue KC, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-410-6716.

Tagalog: Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Blue KC, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-410-6716.

Laotian: ຖ້າ ທ່ານ ຫຼື ຄົນ ທ່ານ ກຳ ລັງ ຈຸ ວ ຍ ຫຼື ອ, ມ ະ ສາ ຖາ ມ ກ ງ ງ ອ ກ ບ Blue KC, ທ່ານ ມ ີ ສ ັ ດ ະ ທ ຈ ລ ດ ັ ຮ ັ ບ ກ າ ນ ຈ ຸ ວ ຍ ຫຼື ອ ດ ລ ະ ະ ຂ ື ມ ຸ ນ ຂ ັ າ ວ ສ າ ນ ະ ທ ຈ ັ ບ ນ ພ າ ສ າ ຂ ອ ງ ທ ັ ນ ະ ບ ມ ຄ ັ າ ໄ ຊ ັ ລ ັ າ ຍ. ກ າ ນ ໂ ອ ັ ດ ັ ມ ກ ັ ບ ນ າ ຍ ພ າ ສ າ, ໃ ທ ື ໂ ຫ ຫ າ 1-877-410-6716.

Pennsylvanian Dutch: "Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Blue KC, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kansch du 1-877-410-6716 uffrufe.

Persian:

اگر شما، یا کسی که شما به او کمک میکنید، سوال در مورد Blue KC، داشته باشید حق این را دارید که کمک اطلاعات به زبان خود را به طور رایگان دریافت نمایید. تماس حاصل نمایید. 1-877-410-6716

Cushite: Isin yookan namni biraa isin deeggartan Blue KC irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-877-410-6716 tiin bilbilaa.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue KC, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-410-6716.

For TTY services, please call 1-816-842-5607.



Unified School District No. 500, Wyandotte County, KS

Health Benefit Plan Summary - BlueSelect Plus Spira Care EPO \$2,800 HSA

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. This plan is an HSA Qualified High Deductible Health Plan.	
Medical Network(s) A complete listing of network hospitals and physicians is available on MyBlueKC.com .	In Area: BlueSelect Plus 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.	In-Network Individual: \$2,800 Family: \$5,600	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: 0% Plan Pays: 100%	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: \$2,800 Family: \$5,600	Out-of-Network Not covered
Blue KC 24-Hour Nurse Line Available 7 days a week, 365 days a year to help you with symptoms or answer health-related questions.	PH: 877-852-5422	
Customer Service & Care Guide Services	Local: 913-29-SPIRA (77472) Toll Free: 877-33-SPIRA (77472)	
Plan Benefits - Medical		
<i>When you visit a Spira Care Center...</i>	In-Network	Out-of-Network

<p>Visits to a Spira Care Center include:</p> <ul style="list-style-type: none"> • Office Visit – Routine • Office Visit – Urgent/Acute • Chronic Disease Care (excluding drugs & equipment) • Outpatient Mental Health, Behavioral Health, and Substance Abuse Services <p><i>Included as part of office visit and no member cost share:</i></p> <ul style="list-style-type: none"> • Labs • X-ray (basic diagnostic x-rays for fracture and other injuries or illness) <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>	Deductible, then no charge	Not covered
<p>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.</p>	No member cost share	Not covered
<p><i>When you visit another Physician's Office...</i></p>	In-Network	Out-of-Network
<p>Physician Primary Care Physician (PCP) - An internist, family practitioner, general practitioner, or pediatrician.</p>	Deductible, then no charge	Not covered
<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>	Deductible, then no charge	Not covered
<p>Other Services & Procedures performed in a provider's office and not included with an office visit</p>	Deductible, then no charge	Not covered
<p>Urgent Care Center</p>	Deductible, then no charge	Not covered
<p>Blue KC Virtual Care - Office Visit Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.</p>	Deductible, then no charge	Not applicable
<p>Blue KC Virtual Care - Behavioral Health Therapy Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.</p>	Deductible, then no charge	Not applicable
<p>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.</p>	No member cost share	Not covered
<p>Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility</p>	Deductible, then no charge	Not covered

Allergy		
Allergy Testing	Deductible, then no charge	Not covered
Allergy Treatment	Deductible, then no charge	Not covered
<i>When you need radiology services...</i>	In-Network	Out-of-Network
X-Ray	Deductible, then no charge	Not covered
Other Radiology Procedures (MRI, CT/PET Scans, MRA) Prior Authorization Policy Applies In-Network	Deductible, then no charge	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	Deductible, then no charge	Not covered
Physician (Surgeon) Services	Deductible, then no charge	Not covered
<i>If you need immediate medical attention...</i>	In-Network	Out-of-Network
Urgent Care Center Office Visit	Deductible, then no charge	Not covered
Emergency Services 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
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.	Deductible, then no charge	In-Network Deductible, then no charge
Air Ambulance	Deductible, then no charge	In-Network Deductible, then no charge
<i>If you have a hospital stay...</i>	In-Network	Out-of-Network
Hospital Facility Fees Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Physician (Surgeon) Services	Deductible, then no charge	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	Deductible, then no charge	Not covered
Home Health Services Prior Authorization Policy Applies In-Network Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Occupational Therapy Combined with Physical Therapy Limits	Deductible, then no charge	Not covered
Skeletal Manipulation Combined with Physical Therapy Limits	Deductible, then no charge	Not covered

Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Hearing Therapy Combined with Speech Therapy Limits	Deductible, then no charge	Not covered
Durable Medical Equipment Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Inpatient Hospice Services Prior Authorization Policy Applies In-Network Maximum benefit of 14 Day(s)/Lifetime for In-Network	Deductible, then no charge	Not covered
Home Hospice Services	Deductible, then no charge	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	Deductible, then no charge	Not covered
Therapy	Deductible, then no charge	Not covered
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees) Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician) Includes: Therapy & Other Services, partial hospitalizations	Deductible, then no charge	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	Deductible, then no charge	Not covered
Maternity Dependent Daughters are not covered for maternity services	Covered	Not covered
Infertility and Impotency Diagnosis and Treatment Pharmacy Coverage: See Member Certificate for more details.	Not covered	Not covered
<i>Routine Vision Care...</i>	In-Network	Out-of-Network
Routine Eye Exam	Not covered	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	Blue KC Preferred Formulary	

<p>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</p>	OptumRx Specialty Services PH: 855-427-4682	
<p>Outpatient Prescription Drug Deductible You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services.</p>	In-Network Combined with Medical Deductible	Out-of-Network Not covered
<p>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.</p>	In-Network Combined with Medical Out-of-Pocket Limits	Out-of-Network Not covered
<p>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.</p>	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		
<i>When you use a retail or specialty pharmacy...</i>	In-Network	Out-of-Network
Retail Pharmacy (Short-term supply: Up to 34 Days)		
Drug Tier 1: Generic / Generic Specialty	RxPremier: Deductible, then no charge Contraceptives – No member cost share	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: Deductible, then no charge	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: Deductible, then no charge	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	Deductible, then no charge Contraceptives – No member cost share	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic	Deductible, then no charge	Not covered
Drug Tier 3: Non-Preferred Brand	Deductible, then no charge	Not covered

Discrimination is Against the Law

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. Blue KC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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.

If you believe that Blue KC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Appeals Department, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you, or someone you're helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-410-6716.

Spanish: 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 1-877-410-6716.

Chinese: 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 1-877-410-6716。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-410-6716.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-410-6716 an.

Korean: 가 [Blue KC] 가 .
1-877-410-6716

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-877-410-6716.

Arabic:

إن كان لديك أو لدى شخص تساعدك أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-410-6716.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue KC, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-410-6716.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue KC, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-410-6716.

Tagalog: Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Blue KC, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-410-6716.

Laotian: ຖ້າ ທ່ານ ຫຼື ຄົນ ທ່ານ ກຳ ລັງ ຈຸ ວຍ ຫຼື ອ, ມ ະ ສາ ຖາ ມ ກ ັ ງ ກັ ບ Blue KC, ທ່ານ ມ ີ ສິ ດ ະ ທ ຈ ລ ະ ໄ ດ້ ຮັ ບ ການ ຈຸ ວຍ ຫຼື ອ ແ ລ ະ ະ ຂ ັ ມ ຸ ນ ຂ ັ າ ວ ສາ ນ ະ ທ ຈ ລ ະ ນ ພ າ ສາ ຂ ອ ງ ທ ັ ນ ະ ບ ມ ຄ ັ າ ໄ ຊ້ ລ ັ ຍ. ການ ໂອ້ ລົ ມ ກັ ບ ນາ ຍ ພ າ ສາ, ໃ ທ້ ໂ ຫ ຫາ 1-877-410-6716.

Pennsylvanian Dutch: "Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Blue KC, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kansch du 1-877-410-6716 uffrufe.

Persian: اگر شما، یا کسی که شما به او کمک میکنید، سوال در مورد Blue KC، داشته باشید حق این را دارید که کمک اطلاعات به زبان خود را به طور رایگان دریافت نمایید. تماس حاصل نمایید. 1-877-410-6716

Cushite: Isin yookan namni biraa isin deeggartan Blue KC irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-877-410-6716 tiin bilbilaa.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue KC, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-410-6716.

For TTY services, please call 1-816-842-5607.



Unified School District No. 500, Wyandotte County, KS

Health Benefit Plan Summary - BSP Spira Care EPO \$3,500

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: BlueSelect Plus 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.	In-Network Individual: \$3,500 Family: \$7,000	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: 0% Plan Pays: 100%	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: \$3,500 Family: \$7,000	Out-of-Network Not covered
Blue KC 24-Hour Nurse Line Available 7 days a week, 365 days a year to help you with symptoms or answer health-related questions.	PH: 877-852-5422	
Customer Service & Care Guide Services	Local: 913-29-SPIRA (77472) Toll Free: 877-33-SPIRA (77472)	
Plan Benefits - Medical		
<i>When you visit a Spira Care Center...</i>	In-Network	Out-of-Network

<p>Visits to a Spira Care Center include:</p> <ul style="list-style-type: none"> • Office Visit – Routine • Office Visit – Urgent/Acute • Chronic Disease Care (excluding drugs & equipment) • Outpatient Mental Health, Behavioral Health, and Substance Abuse Services <p><i>Included as part of office visit and no member cost share:</i></p> <ul style="list-style-type: none"> • Labs • X-ray (basic diagnostic x-rays for fracture and other injuries or illness) <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>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.</p>	No member cost share	Not covered
<p><i>When you visit another Physician's Office...</i></p>	In-Network	Out-of-Network
<p>Physician Primary Care Physician (PCP) - An internist, family practitioner, general practitioner, or pediatrician.</p>	Deductible, then no charge	Not covered
<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>	Deductible, then no charge	Not covered
<p>Other Services & Procedures performed in a provider's office and not included with an office visit</p>	Deductible, then no charge	Not covered
<p>Urgent Care Center</p>	Deductible, then no charge	Not covered
<p>Blue KC Virtual Care - Office Visit Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.</p>	Deductible, then no charge	Not applicable
<p>Blue KC Virtual Care - Behavioral Health Therapy Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.</p>	Deductible, then no charge	Not applicable
<p>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.</p>	No member cost share	Not covered
<p>Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility</p>	Deductible, then no charge	Not covered

Allergy		
Allergy Testing	Deductible, then no charge	Not covered
Allergy Treatment	Deductible, then no charge	Not covered
<i>When you need radiology services...</i>	In-Network	Out-of-Network
X-Ray	Deductible, then no charge	Not covered
Other Radiology Procedures (MRI, CT/PET Scans, MRA) Prior Authorization Policy Applies In-Network	Deductible, then no charge	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	Deductible, then no charge	Not covered
Physician (Surgeon) Services	Deductible, then no charge	Not covered
<i>If you need immediate medical attention...</i>	In-Network	Out-of-Network
Urgent Care Center Office Visit	Deductible, then no charge	Not covered
Emergency Services 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
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.	Deductible, then no charge	In-Network Deductible, then no charge
Air Ambulance	Deductible, then no charge	In-Network Deductible, then no charge
<i>If you have a hospital stay...</i>	In-Network	Out-of-Network
Hospital Facility Fees Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Physician (Surgeon) Services	Deductible, then no charge	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	Deductible, then no charge	Not covered
Home Health Services Prior Authorization Policy Applies In-Network Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Occupational Therapy Combined with Physical Therapy Limits	Deductible, then no charge	Not covered
Skeletal Manipulation Combined with Physical Therapy Limits	Deductible, then no charge	Not covered

Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Hearing Therapy Combined with Speech Therapy Limits	Deductible, then no charge	Not covered
Durable Medical Equipment Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Inpatient Hospice Services Prior Authorization Policy Applies In-Network Maximum benefit of 14 Day(s)/Lifetime for In-Network	Deductible, then no charge	Not covered
Home Hospice Services	Deductible, then no charge	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	Deductible, then no charge	Not covered
Therapy	Deductible, then no charge	Not covered
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees) Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician) Includes: Therapy & Other Services, partial hospitalizations	Deductible, then no charge	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 not covered for maternity services	Covered	Not covered
Infertility and Impotency Diagnosis and Treatment Pharmacy Coverage: See Member Certificate for more details.	Not covered	Not covered
<i>Routine Vision Care...</i>	In-Network	Out-of-Network
Routine Eye Exam	Not covered	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	Blue KC Preferred Formulary	

<p>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</p>	<p>OptumRx Specialty Services PH: 855-427-4682</p>	
<p>Outpatient Prescription Drug Deductible You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services.</p>	<p>In-Network Combined with Medical Deductible</p>	<p>Out-of-Network Not covered</p>
<p>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.</p>	<p>In-Network Combined with Medical Out-of-Pocket Limits</p>	<p>Out-of-Network Not covered</p>
<p>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.</p>	<p>Register online at MyBlueKC.com and stay up-to-date on cost saving opportunities. Email: info@rxsavingsllc.com PH: 1-800-268-4476</p>	
<p>Plan Benefits – Pharmacy</p>		
<p><i>When you use a retail or specialty pharmacy...</i></p>	<p>In-Network</p>	<p>Out-of-Network</p>
<p>Retail Pharmacy (Short-term supply: Up to 34 Days)</p>		
<p>Drug Tier 1: Generic / Generic Specialty</p>	<p>RxPremier: \$15 Copay/Fill, no Deductible Contraceptives – No member cost share</p>	<p>Not covered</p>
<p>Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty</p>	<p>RxPremier: \$50 Copay/Fill, no Deductible</p>	<p>Not covered</p>
<p>Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty</p>	<p>RxPremier: Deductible, then no charge</p>	<p>Not covered</p>
<p><i>When you use a mail order pharmacy...</i></p>	<p>In-Network</p>	<p>Out-of-Network</p>
<p>Mail Order Pharmacy (Mail Order supply: Between 35-102 Days)</p>		
<p>Drug Tier 1: Generic</p>	<p>\$15 Copay/Fill, no Deductible Contraceptives – No member cost share</p>	<p>Not covered</p>
<p>Drug Tier 2: Preferred Brand / Non-Preferred Generic</p>	<p>\$125 Copay/Fill, no Deductible</p>	<p>Not covered</p>
<p>Drug Tier 3: Non-Preferred Brand</p>	<p>Deductible, then no charge</p>	<p>Not covered</p>

Discrimination is Against the Law

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. Blue KC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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.

If you believe that Blue KC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Appeals Department, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you, or someone you're helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-410-6716.

Spanish: 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 1-877-410-6716.

Chinese: 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 1-877-410-6716。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-410-6716.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-410-6716 an.

Korean:

가 [Blue KC] 가
1-877-410-6716

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-877-410-6716.

Arabic:

إن كان لديك أو لدى شخص تساعدك أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-410-6716.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue KC, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-410-6716.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue KC, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-410-6716.

Tagalog: Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Blue KC, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-410-6716.

Laotian: ຖ້າ ທ່ານ, ຫຼື ຄົນ ທີ່ ທ່ານ ກຳ ລັງ ຈຸ ວ ຍ ຫຼື ອ, ມ ີ ສ ັ ດ ທ າ ມ ກ ັ ນ ງ ອ ກ ັ ບ Blue KC, ທ່ານ ມ ີ ສ ັ ດ ທ າ ຈ ຳ ດ ັ ັ ບ ກ າ ນ ຈ ຳ ວ ຍ ຫຼື ອ ດ ລ ະ ັ ຂ ື ມ ູ ນ ຂ ັ າ ວ ສ າ ນ ທ າ ບ າ ສ າ ຂ ອ ງ ທ າ ນ ັ ບ ມ າ ທ າ ໃ ຊ ື ລ າ ຍ. ກ າ ນ ໂ ອ ັ ດ ມ ກ ັ ບ ນ າ ຍ ພ າ ສ າ, ໃ ທ ື ໂ ຫ ຫ າ 1-877-410-6716.

Pennsylvanian Dutch: "Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Blue KC, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kansch du 1-877-410-6716 uffrufe.

Persian: اگر شما، یا کسی که شما به او کمک میکنید، سوال در مورد Blue KC، داشته باشید حق این را دارید که کمک اطلاعات به زبان خود را به طور رایگان دریافت نمایید. تماس حاصل نمایید. 1-877-410-6716

Cushite: Isin yookan namni biraa isin deeggartan Blue KC irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-877-410-6716 tiin bilbilaa.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue KC, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-410-6716.

For TTY services, please call 1-816-842-5607.



An Independent Licensee of the Blue Cross and Blue Shield Association



Unified School District No. 500, Wyandotte County, KS

Health Benefit Plan Summary - First Dollar Coverage \$1,000 Deductible 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>Preferred Provider Organization (PPO) Members can receive services from any hospital or physician, but receive greater benefits when using in-network providers. Services rendered at Out-of-Network providers are subject to Out-of-Network allowables as stated in your contract, and balance billing may occur.</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: \$1,000 Family: \$3,000</p>	<p>Out-of-Network Individual: \$3,000 Family: \$9,000</p>
<p>Coinsurance 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.</p>	<p>In-Network Member Pays: 20% Plan Pays: 80%</p>	<p>Out-of-Network Member Pays: 30% Plan Pays: 70%</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: \$5,800 Family: \$11,600</p>	<p>Out-of-Network Individual: \$11,600 Family: \$23,200</p>
<p>Blue KC 24-Hour Nurse Line Available 7 days a week, 365 days a year to help you with symptoms or answer health-related questions.</p>	<p>PH: 877-852-5422</p>	
<p>Customer Service</p>	<p>PH: 888-989-8842 or (816) 395-2270</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>\$25 Copay/Visit, no Deductible</p>	<p>30% Coinsurance after Deductible</p>

Specialist - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrists, psychologists and chiropractors.	\$50 Copay/Visit, no Deductible	30% Coinsurance after Deductible
Other Services & Procedures performed in a provider's office and not included with an office visit	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care Center	\$50 Copay/Visit, no Deductible	30% Coinsurance after Deductible
Blue KC Virtual Care - Office Visit Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	\$50 Copay/Visit, no Deductible	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy 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
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	30% Coinsurance after Deductible
Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility	No member cost share	30% Coinsurance after Deductible
Allergy		
Allergy Testing	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Allergy Treatment	20% Coinsurance after Deductible	30% Coinsurance after Deductible
When you need radiology services...	In-Network	Out-of-Network
X-Ray	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Other Radiology Procedures (MRI, CT/PET Scans, MRA) Prior Authorization Policy Applies	20% Coinsurance after Deductible	30% Coinsurance after Deductible
When you have out-patient surgery...	In-Network	Out-of-Network
Outpatient Surgery Facility Fees Prior Authorization Policy Applies	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Physician (Surgeon) Services	20% Coinsurance after Deductible	30% Coinsurance after Deductible
If you need immediate medical attention...	In-Network	Out-of-Network
Urgent Care Center Office Visit	\$50 Copay/Visit, no Deductible	30% Coinsurance after 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.	\$200 Copay/Visit, then Deductible, then 20% Coinsurance	\$200 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

<i>If you have a hospital stay...</i>	In-Network	Out-of-Network
Hospital Facility Fees Prior Authorization Policy Applies	\$400 Copay/Admission, then Deductible	30% Coinsurance after Deductible
Physician (Surgeon) Services	20% Coinsurance after Deductible	30% Coinsurance after Deductible
<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 Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Home Health Services Prior Authorization Policy Applies Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Occupational Therapy Combined with Physical Therapy Limits	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Skeletal Manipulation Prior Authorization Policy Applies Out-of-Network Combined with Physical Therapy Limits	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Hearing Therapy Combined with Speech Therapy Limits	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Durable Medical Equipment Prior Authorization Policy Applies	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Hospice Services Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Home Hospice Services	20% Coinsurance after Deductible	30% Coinsurance after Deductible
<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	\$25 Copay/Visit, no Deductible	30% Coinsurance after Deductible
Therapy	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees) Prior Authorization Policy Applies	\$400 Copay/Admission, then Deductible	30% Coinsurance after Deductible
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician) Includes: Therapy & Other Services, partial hospitalizations	20% Coinsurance after Deductible	30% Coinsurance after Deductible

<i>Family Planning & Pregnancy...</i>	In-Network	Out-of-Network
Contraceptive Devices, Implants, and Injections See also pharmacy benefits.	No member cost share	30% Coinsurance after Deductible
Elective Sterilization – Women	No member cost share	30% Coinsurance after Deductible
Elective Sterilization – Men	No member cost share	30% Coinsurance after Deductible
Maternity Dependent Daughters are not covered for maternity services	Covered	Covered
Infertility and Impotency Diagnosis and Treatment Pharmacy Coverage: See Member Certificate for more details.	Not covered	Not covered
<i>Routine Vision Care...</i>	In-Network	Out-of-Network
Routine Eye Exam Maximum benefit of 1 Exam(s)/Calendar Year for In-Network and Out-of-Network	\$25 Copay/Visit, no Deductible	30% Coinsurance after Deductible
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	Blue KC Preferred 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: 855-427-4682	
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	Combined with Medical Out-of-Pocket Limits
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		
<i>When you use a retail or specialty pharmacy...</i>	In-Network	Out-of-Network
Retail Pharmacy (Short-term supply: Up to 34 Days)		
Drug Tier 1: Generic / Generic Specialty	RxPremier: \$15 Copay/Fill Contraceptives – No member cost share	\$15 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: \$40 Copay/Fill	\$40 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: \$60 Copay/Fill	\$60 Copay/Fill, then 50% Coinsurance
<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	\$30 Copay/Fill Contraceptives – No member cost share	\$30 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic	\$80 Copay/Fill	\$80 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand	\$120 Copay/Fill	\$120 Copay/Fill, then 50% Coinsurance
Value-Based Benefits (VBB)...	In-Network	Out-of-Network
Included Conditions: Value-Based Benefits (VBB) Included Conditions: Diabetes, CAD		
Retail Pharmacy (Short-term supply)		
Drug Tier 1: Generic / Generic Specialty	RxPremier: No member cost share	50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: No member cost share	50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: \$30 Copay/Fill	\$30 Copay/Fill, then 50% Coinsurance
Mail Order Pharmacy		
Drug Tier 1: Generic / Generic Specialty	No member cost share	50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	No member cost share	50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	\$60 Copay/Fill	\$60 Copay/Fill, then 50% Coinsurance

Discrimination is Against the Law

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. Blue KC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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.

If you believe that Blue KC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Appeals Department, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you, or someone you're helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-410-6716.

Spanish: 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 1-877-410-6716.

Chinese: 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 1-877-410-6716。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-410-6716.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-410-6716 an.

Korean: 가 [Blue KC] 가 .
1-877-410-6716

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-877-410-6716.

Arabic:

إن كان لديك أو لدى شخص تساعدك أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-410-6716.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue KC, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-410-6716.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue KC, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-410-6716.

Tagalog: Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Blue KC, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-410-6716.

Laotian: ຖ້າ ທ່ານ, ຫຼື ຄົນ ທີ່ ທ່ານ ກຳ ລັງ ຈຸ ວ ຍ ຫຼື ອ, ມີ ສາ ຖາ ມ ກ ງ ງ ອ ກ ບ ບ Blue KC, ທ່ານ ມີ ສິ ດ ທີ່ ຈະ ໄດ້ ຮັ ບ ການ ຈຸ ວ ຍ ຫຼື ອ ດ ລ ະ ອ ຂ ື້ ມູ ນ ຂ ື້ າ ວ ສາ ນ ທີ່ ບໍ ຕ ື້ ນ ພາ ສາ ຂ ອ ງ ທ ື້ າ ນ ື້ ບ ມ ຄ ື້ າ ໃ ຊ ື້ ລ ື້ າ ຍ. ການ ໂ ອ້ ວ ມ ກ ັ ບ ນ າ ຍ ພາ ສາ, ໃ ຫ້ ໂ ຫ ຫາ 1-877-410-6716.

Pennsylvanian Dutch: "Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Blue KC, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kansch du 1-877-410-6716 uffrufe.

Persian: اگر شما، یا کسی که شما به او کمک میکنید، سوال در مورد Blue KC، داشته باشید حق این را دارید که کمک اطلاعات به زبان خود را به طور رایگان دریافت نمایید. تماس حاصل نمایید. 1-877-410-6716

Cushite: Isin yookan namni biraa isin deeggartan Blue KC irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-877-410-6716 tiin bilbilaa.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue KC, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-410-6716.

For TTY services, please call 1-816-842-5607.



An Independent Licensee of the Blue Cross and Blue Shield Association



Unified School District No. 500, Wyandotte County, KS

Health Benefit Plan Summary - First Dollar Coverage \$2,500 Deductible BSP 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>Preferred Provider Organization (PPO) Members can receive services from any hospital or physician, but receive greater benefits when using in-network providers. Services rendered at Out-of-Network providers are subject to Out-of-Network allowables as stated in your contract, and balance billing may occur.</p>	
<p>Medical Network(s) A complete listing of network hospitals and physicians is available on MyBlueKC.com.</p>	<p>In Area: BlueSelect Plus 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: \$2,500 Family: \$7,500</p>	<p>Out-of-Network Individual: \$5,000 Family: \$15,000</p>
<p>Coinsurance 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.</p>	<p>In-Network Member Pays: 10% Plan Pays: 90%</p>	<p>Out-of-Network Member Pays: 40% Plan Pays: 60%</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: \$5,400 Family: \$10,800</p>	<p>Out-of-Network Individual: \$27,000 Family: \$54,000</p>
<p>Blue KC 24-Hour Nurse Line Available 7 days a week, 365 days a year to help you with symptoms or answer health-related questions.</p>	<p>PH: 877-852-5422</p>	
<p>Customer Service</p>	<p>PH: 888-989-8842 or (816) 395-2270</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>\$25 Copay/Visit, no Deductible</p>	<p>40% Coinsurance after Deductible</p>

Specialist - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrists, psychologists and chiropractors.	\$50 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Other Services & Procedures performed in a provider's office and not included with an office visit	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care Center	\$50 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Blue KC Virtual Care - Office Visit Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	\$50 Copay/Visit, no Deductible	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	10% Coinsurance after Deductible	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	40% Coinsurance after Deductible
Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility	No member cost share	40% Coinsurance after Deductible
Allergy		
Allergy Testing	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Allergy Treatment	10% Coinsurance after Deductible	40% Coinsurance after Deductible
When you need radiology services...	In-Network	Out-of-Network
X-Ray	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Other Radiology Procedures (MRI, CT/PET Scans, MRA) Prior Authorization Policy Applies	10% Coinsurance after Deductible	40% Coinsurance after Deductible
When you have out-patient surgery...	In-Network	Out-of-Network
Outpatient Surgery Facility Fees Prior Authorization Policy Applies	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Physician (Surgeon) Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible
If you need immediate medical attention...	In-Network	Out-of-Network
Urgent Care Center Office Visit	\$50 Copay/Visit, no Deductible	40% Coinsurance after 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.	\$200 Copay/Visit, then Deductible, then 10% Coinsurance	\$200 Copay/Visit, then In-Network Deductible, then 10% 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.	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
Air Ambulance	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible

<i>If you have a hospital stay...</i>	In-Network	Out-of-Network
Hospital Facility Fees Prior Authorization Policy Applies	\$600 Copay/Admission, then Deductible, then 10% Coinsurance	40% Coinsurance after Deductible
Physician (Surgeon) Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible
<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 Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Health Services Prior Authorization Policy Applies Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Occupational Therapy Combined with Physical Therapy Limits	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Skeletal Manipulation Prior Authorization Policy Applies Out-of-Network Combined with Physical Therapy Limits	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Hearing Therapy Combined with Speech Therapy Limits	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Durable Medical Equipment Prior Authorization Policy Applies	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Hospice Services Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Hospice Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible
<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	\$25 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Therapy	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees) Prior Authorization Policy Applies	\$600 Copay/Admission, then Deductible, then 10% Coinsurance	40% Coinsurance after Deductible
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician) Includes: Therapy & Other Services, partial hospitalizations	10% Coinsurance after Deductible	40% Coinsurance after Deductible

<i>Family Planning & Pregnancy...</i>	In-Network	Out-of-Network
Contraceptive Devices, Implants, and Injections See also pharmacy benefits.	No member cost share	40% Coinsurance after Deductible
Elective Sterilization – Women	No member cost share	40% Coinsurance after Deductible
Elective Sterilization – Men	No member cost share	40% Coinsurance after Deductible
Maternity Dependent Daughters are not covered for maternity services	Covered	Covered
Infertility and Impotency Diagnosis and Treatment Pharmacy Coverage: See Member Certificate for more details.	Not covered	Not covered
<i>Routine Vision Care...</i>	In-Network	Out-of-Network
Routine Eye Exam Maximum benefit of 1 Exam(s)/Calendar Year for In-Network and Out-of-Network	\$25 Copay/Visit, no Deductible	40% Coinsurance after Deductible
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	Blue KC Preferred 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: 855-427-4682	
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 Combined with Medical Out-of-Pocket Limits
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		
<i>When you use a retail or specialty pharmacy...</i>	In-Network	Out-of-Network
Retail Pharmacy (Short-term supply: Up to 34 Days)		
Drug Tier 1: Generic / Generic Specialty	RxPremier: \$15 Copay/Fill Contraceptives – No member cost share	\$15 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: \$40 Copay/Fill	\$40 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: \$60 Copay/Fill	\$60 Copay/Fill, then 50% Coinsurance
<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	\$30 Copay/Fill Contraceptives – No member cost share	\$30 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic	\$80 Copay/Fill	\$80 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand	\$120 Copay/Fill	\$120 Copay/Fill, then 50% Coinsurance
Value-Based Benefits (VBB)...	In-Network	Out-of-Network
Included Conditions: Value-Based Benefits (VBB) Included Conditions: Diabetes, CAD		
Retail Pharmacy (Short-term supply)		
Drug Tier 1: Generic / Generic Specialty	RxPremier: No member cost share	50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: No member cost share	50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: \$30 Copay/Fill	\$30 Copay/Fill, then 50% Coinsurance
Mail Order Pharmacy		
Drug Tier 1: Generic / Generic Specialty	No member cost share	50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	No member cost share	50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	\$60 Copay/Fill	\$60 Copay/Fill, then 50% Coinsurance

Discrimination is Against the Law

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. Blue KC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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.

If you believe that Blue KC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Appeals Department, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you, or someone you're helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-410-6716.

Spanish: 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 1-877-410-6716.

Chinese: 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 1-877-410-6716。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-410-6716.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-410-6716 an.

Korean: 가 [Blue KC] 가 .
1-877-410-6716

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-877-410-6716.

Arabic:

إن كان لديك أو لدى شخص تساعدك أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-410-6716.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue KC, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-410-6716.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue KC, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-410-6716.

Tagalog: Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Blue KC, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-410-6716.

Laotian: ຖ້າ ທ່ານ, ຫຼື ຄົນ ທ່ານ ກຳ ລັງ ຊ່ວຍ ຫຼື ອ, ມີ ສາ ຖາ ມາ ກ່ ຽວ ກັບ Blue KC, ທ່ານ ມີ ສິ ດ ທີ່ ຈະ ໄດ້ ຮັບ ການ ຊ່ວຍ ຫຼື ອ ແລະ ອື່ ນ ຂໍ ຈາ ກ ສາ ນ ທີ່ ບໍ່ ມີ ນາ ສາ ຂ ອ ງ ທ ຳ ບໍ່ ມີ ຄ່ ຳ ໃ ຊ້ ຈ່ ຳ ຍ. ການ ໂອ້ ລົ ມ ກັ ບ ນາ ຍ ພາ ສາ, ໃ ຫ້ ໂ ຫ ຫາ 1-877-410-6716.

Pennsylvanian Dutch: "Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Blue KC, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kansch du 1-877-410-6716 uffrufe.

Persian:

اگر شما، یا کسی که شما به او کمک میکنید، سوال در مورد Blue KC، داشته باشید حق این را دارید که کمک اطلاعات به زبان خود را به طور رایگان دریافت نمایید. تماس حاصل نمایید. 1-877-410-6716

Cushite: Isin yookan namni biraa isin deeggartan Blue KC irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-877-410-6716 tiin bilbilaa.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue KC, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-410-6716.

For TTY services, please call 1-816-842-5607.



An Independent Licensee of the Blue Cross and Blue Shield Association



Unified School District No. 500, Wyandotte County, KS

Health Benefit Plan Summary - First Dollar Coverage \$2,500 Deductible 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>Preferred Provider Organization (PPO) Members can receive services from any hospital or physician, but receive greater benefits when using in-network providers. Services rendered at Out-of-Network providers are subject to Out-of-Network allowables as stated in your contract, and balance billing may occur.</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: \$2,500 Family: \$7,500</p>	<p>Out-of-Network Individual: \$5,000 Family: \$15,000</p>
<p>Coinsurance 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.</p>	<p>In-Network Member Pays: 10% Plan Pays: 90%</p>	<p>Out-of-Network Member Pays: 30% Plan Pays: 70%</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: \$5,400 Family: \$10,800</p>	<p>Out-of-Network Individual: \$10,800 Family: \$21,600</p>
<p>Blue KC 24-Hour Nurse Line Available 7 days a week, 365 days a year to help you with symptoms or answer health-related questions.</p>	<p>PH: 877-852-5422</p>	
<p>Customer Service</p>	<p>PH: 888-989-8842 or (816) 395-2270</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>\$25 Copay/Visit, no Deductible</p>	<p>30% Coinsurance after Deductible</p>

Specialist - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrists, psychologists and chiropractors.	\$50 Copay/Visit, no Deductible	30% Coinsurance after Deductible
Other Services & Procedures performed in a provider's office and not included with an office visit	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care Center	\$50 Copay/Visit, no Deductible	30% Coinsurance after Deductible
Blue KC Virtual Care - Office Visit Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	\$50 Copay/Visit, no Deductible	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	10% Coinsurance after Deductible	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	30% Coinsurance after Deductible
Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility	No member cost share	30% Coinsurance after Deductible
Allergy		
Allergy Testing	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Allergy Treatment	10% Coinsurance after Deductible	30% Coinsurance after Deductible
When you need radiology services...	In-Network	Out-of-Network
X-Ray	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Other Radiology Procedures (MRI, CT/PET Scans, MRA) Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
When you have out-patient surgery...	In-Network	Out-of-Network
Outpatient Surgery Facility Fees Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Physician (Surgeon) Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
If you need immediate medical attention...	In-Network	Out-of-Network
Urgent Care Center Office Visit	\$50 Copay/Visit, no Deductible	30% Coinsurance after 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.	\$200 Copay/Visit, then Deductible, then 10% Coinsurance	\$200 Copay/Visit, then In-Network Deductible, then 10% 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.	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
Air Ambulance	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible

<i>If you have a hospital stay...</i>	In-Network	Out-of-Network
Hospital Facility Fees Prior Authorization Policy Applies	\$600 Copay/Admission, then Deductible, then 10% Coinsurance	30% Coinsurance after Deductible
Physician (Surgeon) Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
<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 Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Home Health Services Prior Authorization Policy Applies Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Occupational Therapy Combined with Physical Therapy Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Skeletal Manipulation Prior Authorization Policy Applies Out-of-Network Combined with Physical Therapy Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Hearing Therapy Combined with Speech Therapy Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Durable Medical Equipment Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Hospice Services Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Home Hospice Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
<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	\$25 Copay/Visit, no Deductible	30% Coinsurance after Deductible
Therapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees) Prior Authorization Policy Applies	\$600 Copay/Admission, then Deductible, then 10% Coinsurance	30% Coinsurance after Deductible
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician) Includes: Therapy & Other Services, partial hospitalizations	10% Coinsurance after Deductible	30% Coinsurance after Deductible

<i>Family Planning & Pregnancy...</i>	In-Network	Out-of-Network
Contraceptive Devices, Implants, and Injections See also pharmacy benefits.	No member cost share	30% Coinsurance after Deductible
Elective Sterilization – Women	No member cost share	30% Coinsurance after Deductible
Elective Sterilization – Men	No member cost share	30% Coinsurance after Deductible
Maternity Dependent Daughters are not covered for maternity services	Covered	Covered
Infertility and Impotency Diagnosis and Treatment Pharmacy Coverage: See Member Certificate for more details.	Not covered	Not covered
<i>Routine Vision Care...</i>	In-Network	Out-of-Network
Routine Eye Exam Maximum benefit of 1 Exam(s)/Calendar Year for In-Network and Out-of-Network	\$25 Copay/Visit, no Deductible	30% Coinsurance after Deductible
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	Blue KC Preferred 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: 855-427-4682	
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	Combined with Medical Out-of-Pocket Limits
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		
<i>When you use a retail or specialty pharmacy...</i>	In-Network	Out-of-Network
Retail Pharmacy (Short-term supply: Up to 34 Days)		
Drug Tier 1: Generic / Generic Specialty	RxPremier: \$15 Copay/Fill Contraceptives – No member cost share	\$15 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: \$40 Copay/Fill	\$40 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: \$60 Copay/Fill	\$60 Copay/Fill, then 50% Coinsurance
<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	\$30 Copay/Fill Contraceptives – No member cost share	\$30 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic	\$80 Copay/Fill	\$80 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand	\$120 Copay/Fill	\$120 Copay/Fill, then 50% Coinsurance
Value-Based Benefits (VBB)...	In-Network	Out-of-Network
Included Conditions: Value-Based Benefits (VBB) Included Conditions: Diabetes, CAD		
Retail Pharmacy (Short-term supply)		
Drug Tier 1: Generic / Generic Specialty	RxPremier: No member cost share	50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: No member cost share	50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: \$30 Copay/Fill	\$30 Copay/Fill, then 50% Coinsurance
Mail Order Pharmacy		
Drug Tier 1: Generic / Generic Specialty	No member cost share	50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	No member cost share	50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	\$60 Copay/Fill	\$60 Copay/Fill, then 50% Coinsurance

Discrimination is Against the Law

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. Blue KC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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.

If you believe that Blue KC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Appeals Department, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you, or someone you're helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-410-6716.

Spanish: 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 1-877-410-6716.

Chinese: 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 1-877-410-6716。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-410-6716.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-410-6716 an.

Korean:

가 [Blue KC] 가
1-877-410-6716

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-877-410-6716.

Arabic:

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-410-6716.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue KC, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-410-6716.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue KC, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-410-6716.

Tagalog: Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Blue KC, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-410-6716.

Laotian: ຖ້າ ທ່ານ, ຫຼື ຄົນ ທ່ານ ກຳ ລັງ ຈຸ ວ ຍ ຫຼື ອ, ມ ີ ສ ັ ດ ທ າ ມ ກ ັ ນ ງ ອ ກ ັ ບ Blue KC, ທ່ານ ມ ີ ສ ັ ດ ທ າ ຈ ຳ ດ ັ ບ ກ າ ນ ຈ ຳ ວ ຍ ຫຼື ອ ດ ລ ະ ອ ັ ຂ ັ ມ ູ ນ ຂ ັ າ ວ ສ າ ນ ທ າ ບ າ ສ າ ຂ ອ ງ ທ າ ນ ັ ບ ມ າ ທ າ ໃ ຊ ຳ ລ ຳ າ ຍ. ກ າ ນ ໂ ອ ັ ດ ມ ກ ັ ບ ນ າ ຍ ມ າ ສ າ, ໃ ທ ື ໂ ຫ ຫ າ 1-877-410-6716.

Pennsylvanian Dutch: "Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Blue KC, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kansch du 1-877-410-6716 uffrufe.

Persian:

اگر شما، یا کسی که شما به او کمک میکنید، سوال در مورد Blue KC، داشته باشید حق این را دارید که کمک اطلاعات به زبان خود را به طور رایگان دریافت نمایید. تماس حاصل نمایید. 1-877-410-6716

Cushite: Isin yookan namni biraa isin deeggartan Blue KC irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-877-410-6716 tiin bilbilaa.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue KC, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-410-6716.

For TTY services, please call 1-816-842-5607.





Unified School District No. 500, Wyandotte County, KS

Health Benefit Plan Summary - Preferred-Care Blue \$500 Deductible PPO 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>Preferred Provider Organization (PPO) Members can receive services from any hospital or physician, but receive greater benefits when using in-network providers. Services rendered at Out-of-Network providers are subject to Out-of-Network allowables as stated in your contract, and balance billing may occur.</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: \$500 Family: \$1,500</p>	<p>Out-of-Network Individual: \$1,000 Family: \$3,000</p>
<p>Coinsurance 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.</p>	<p>In-Network Member Pays: 10% Plan Pays: 90%</p>	<p>Out-of-Network Member Pays: 30% Plan Pays: 70%</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: \$5,750 Family: \$11,500</p>	<p>Out-of-Network Individual: \$11,500 Family: \$23,000</p>
<p>Blue KC 24-Hour Nurse Line Available 7 days a week, 365 days a year to help you with symptoms or answer health-related questions.</p>	<p>PH: 877-852-5422</p>	
<p>Customer Service</p>	<p>PH: 888-989-8842 or (816) 395-2270</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>\$25 Copay/Visit, no Deductible</p>	<p>30% Coinsurance after Deductible</p>

Specialist - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrists, psychologists and chiropractors.	\$50 Copay/Visit, no Deductible	30% Coinsurance after Deductible
Other Services & Procedures performed in a provider's office and not included with an office visit	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care Center	\$50 Copay/Visit, no Deductible	30% Coinsurance after Deductible
Blue KC Virtual Care - Office Visit Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	\$50 Copay/Visit, no Deductible	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	10% Coinsurance after Deductible	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	30% Coinsurance after Deductible
Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility	No member cost share	30% Coinsurance after Deductible
Allergy		
Allergy Testing	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Allergy Treatment	10% Coinsurance after Deductible	30% Coinsurance after Deductible
When you need radiology services...	In-Network	Out-of-Network
X-Ray	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Other Radiology Procedures (MRI, CT/PET Scans, MRA) Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
When you have out-patient surgery...	In-Network	Out-of-Network
Outpatient Surgery Facility Fees Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Physician (Surgeon) Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
If you need immediate medical attention...	In-Network	Out-of-Network
Urgent Care Center Office Visit	\$50 Copay/Visit, no Deductible	30% Coinsurance after 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.	\$200 Copay/Visit, then Deductible, then 10% Coinsurance	\$200 Copay/Visit, then In-Network Deductible, then 10% 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.	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
Air Ambulance	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible

<i>If you have a hospital stay...</i>	In-Network	Out-of-Network
Hospital Facility Fees Prior Authorization Policy Applies	\$400 Copay/Admission, then Deductible	30% Coinsurance after Deductible
Physician (Surgeon) Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
<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 Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Home Health Services Prior Authorization Policy Applies Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Occupational Therapy Combined with Physical Therapy Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Skeletal Manipulation Prior Authorization Policy Applies Out-of-Network Combined with Physical Therapy Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Hearing Therapy Combined with Speech Therapy Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Durable Medical Equipment Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Hospice Services Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Home Hospice Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
<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	\$25 Copay/Visit, no Deductible	30% Coinsurance after Deductible
Therapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees) Prior Authorization Policy Applies	\$400 Copay/Admission, then Deductible	30% Coinsurance after Deductible
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician) Includes: Therapy & Other Services, partial hospitalizations	10% Coinsurance after Deductible	30% Coinsurance after Deductible

<i>Family Planning & Pregnancy...</i>	In-Network	Out-of-Network
Contraceptive Devices, Implants, and Injections See also pharmacy benefits.	No member cost share	30% Coinsurance after Deductible
Elective Sterilization – Women	No member cost share	30% Coinsurance after Deductible
Elective Sterilization – Men	No member cost share	30% Coinsurance after Deductible
Maternity Dependent Daughters are not covered for maternity services	Covered	Covered
Infertility and Impotency Diagnosis and Treatment Pharmacy Coverage: See Member Certificate for more details.	Not covered	Not covered
<i>Routine Vision Care...</i>	In-Network	Out-of-Network
Routine Eye Exam Maximum benefit of 1 Exam(s)/Calendar Year for In-Network and Out-of-Network	\$25 Copay/Visit, no Deductible	30% Coinsurance after Deductible
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	Blue KC Preferred 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: 855-427-4682	
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	Combined with Medical Out-of-Pocket Limits
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		
<i>When you use a retail or specialty pharmacy...</i>	In-Network	Out-of-Network
Retail Pharmacy (Short-term supply: Up to 34 Days)		
Drug Tier 1: Generic / Generic Specialty	RxPremier: \$15 Copay/Fill Contraceptives – No member cost share	\$15 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: \$40 Copay/Fill	\$40 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: \$60 Copay/Fill	\$60 Copay/Fill, then 50% Coinsurance
<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	\$30 Copay/Fill Contraceptives – No member cost share	\$30 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic	\$80 Copay/Fill	\$80 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand	\$120 Copay/Fill	\$120 Copay/Fill, then 50% Coinsurance
Value-Based Benefits (VBB)...	In-Network	Out-of-Network
Included Conditions: Value-Based Benefits (VBB) Included Conditions: Diabetes, CAD		
Retail Pharmacy (Short-term supply)		
Drug Tier 1: Generic / Generic Specialty	RxPremier: No member cost share	50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: No member cost share	50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: \$30 Copay/Fill	\$30 Copay/Fill, then 50% Coinsurance
Mail Order Pharmacy		
Drug Tier 1: Generic / Generic Specialty	No member cost share	50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	No member cost share	50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	\$60 Copay/Fill	\$60 Copay/Fill, then 50% Coinsurance

Discrimination is Against the Law

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. Blue KC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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.

If you believe that Blue KC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Appeals Department, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you, or someone you're helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-410-6716.

Spanish: 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 1-877-410-6716.

Chinese: 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 1-877-410-6716。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-410-6716.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-410-6716 an.

Korean: 가 [Blue KC] 가 .
1-877-410-6716

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-877-410-6716.

Arabic:

إن كان لديك أو لدى شخص تساعدك أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-410-6716.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue KC, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-410-6716.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue KC, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-410-6716.

Tagalog: Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Blue KC, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-410-6716.

Laotian: ຖ້າ ທ່ານ ຫຼື ຄົນ ທີ່ ທ່ານ ກຳ ລັງ ຈຸ ວ ຍ ຫຼື ອ, ມ ີ ສ ັ ດ ທ າ ກ າ ມ ກ ັ ບ ກ ັ ບ Blue KC, ທ່ານ ມ ີ ສ ັ ດ ທ າ ຈ ຳ ດ ັ ບ ຮ ັ ບ ກ າ ນ ຈ ຳ ດ ັ ບ ຫຼື ອ ດ ດ ະ ອ ັ ຂ ັ ມ ູ ນ ຂ ັ າ ວ ສ າ ນ ທ າ ຈ ຳ ດ ັ ບ ນ ພ າ ສ າ ຂ ອ ງ ທ າ ນ ັ ບ ມ າ ທ າ ໃ ຊ ຳ ລ ຳ າ ຍ. ກ າ ນ ໂ ອ ັ ດ ມ ກ ັ ບ ນ າ ຍ ພ າ ສ າ, ໃ ທ ື ໂ ຫ ຫ າ 1-877-410-6716.

Pennsylvanian Dutch: "Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Blue KC, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kansch du 1-877-410-6716 uffrufe.

Persian: اگر شما، یا کسی که شما به او کمک میکنید، سوال در مورد Blue KC، داشته باشید حق این را دارید که کمک اطلاعات به زبان خود را به طور رایگان دریافت نمایید. تماس حاصل نمایید. 1-877-410-6716

Cushite: Isin yookan namni biraa isin deeggartan Blue KC irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-877-410-6716 tiin bilbilaa.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue KC, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-410-6716.

For TTY services, please call 1-816-842-5607.



Specialist - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrists, psychologists and chiropractors.	\$50 Copay/Visit
Other Services & Procedures performed in a provider's office and not included with an office visit	No member cost share
Urgent Care Center	\$50 Copay/Visit
Blue KC Virtual Care - Office Visit Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	\$50 Copay/Visit
Blue KC Virtual Care - Behavioral Health Therapy Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	No member cost share
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
Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility	No member cost share
Allergy	
Allergy Testing	\$100 Copay/Visit
Allergy Treatment	No member cost share
When you need radiology services...	In-Network
X-Ray	No member cost share
Other Radiology Procedures (MRI, CT/PET Scans, MRA) Prior Authorization Policy Applies In-Network	\$200 Copay/Provider per Day
When you have out-patient surgery...	In-Network
Outpatient Surgery Facility Fees Prior Authorization Policy Applies In-Network	\$300 Copay/Day Limited to Inpatient/Outpatient \$1,500 Copay Max per Calendar Year
Physician (Surgeon) Services	No member cost share
If you need immediate medical attention...	In-Network
Urgent Care Center Office Visit	\$50 Copay/Visit
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.	\$200 Copay/Visit
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.	No member cost share
Air Ambulance	No member cost share

<i>If you have a hospital stay...</i>	In-Network
Hospital Facility Fees Prior Authorization Policy Applies In-Network	\$300 Copay/Day Limited to Inpatient/Outpatient \$1,500 Copay Max per Calendar Year
Physician (Surgeon) Services	No member cost share
<i>If you need help recovering or have other special health needs...</i>	In-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
Home Health Services Prior Authorization Policy Applies In-Network Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share
Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share
Occupational Therapy Combined with Physical Therapy Limits	No member cost share
Skeletal Manipulation Combined with Physical Therapy Limits	No member cost share
Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network	No member cost share
Hearing Therapy Combined with Speech Therapy Limits	No member cost share
Durable Medical Equipment Prior Authorization Policy Applies In-Network	No member cost share
Inpatient Hospice Services Prior Authorization Policy Applies In-Network Maximum benefit of 14 Day(s)/Lifetime for In-Network	\$150 Copay/Day Limited to Inpatient/Outpatient \$1,500 Copay Max per Calendar Year
Home Hospice Services	No member cost share
<i>If you have behavioral health, or substance abuse needs...</i>	In-Network
Outpatient Mental Health, Behavioral Health, and Substance Abuse Services	
Office Visit	\$25 Copay/Visit
Therapy	No member cost share
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees) Prior Authorization Policy Applies In-Network	\$300 Copay/Day Limited to Inpatient/Outpatient \$1,500 Copay Max per Calendar Year
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician) Includes: Therapy & Other Services, partial hospitalizations	No member cost share
<i>Family Planning & Pregnancy...</i>	In-Network

Contraceptive Devices, Implants, and Injections See also pharmacy benefits.	No member cost share
Elective Sterilization – Women	No member cost share
Elective Sterilization – Men	No member cost share
Maternity Dependent Daughters are not covered for maternity services	Covered
Infertility and Impotency Diagnosis and Treatment Pharmacy Coverage: See Member Certificate for more details.	Not covered
<i>Routine Vision Care...</i>	In-Network
Routine Eye Exam Maximum benefit of 1 Exam(s)/Calendar Year for In-Network	\$10 Copay/Visit
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	Blue KC Preferred 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: 855-427-4682
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
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	
<i>When you use a retail or specialty pharmacy...</i>	In-Network
Retail Pharmacy (Short-term supply: Up to 34 Days)	
Drug Tier 1: Generic / Generic Specialty	RxPremier: \$15 Copay/Fill Contraceptives – No member cost share
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: \$40 Copay/Fill
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: \$60 Copay/Fill
Retail Pharmacy (Long-term supply: Between 35-102 Days)	
Drug Tier 1: Generic / Generic Specialty	RxPremier: \$45 Copay/Fill
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: \$120 Copay/Fill

Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: \$180 Copay/Fill
<i>When you use a mail order pharmacy...</i>	In-Network
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days)	
Drug Tier 1: Generic	\$30 Copay/Fill Contraceptives – No member cost share
Drug Tier 2: Preferred Brand / Non-Preferred Generic	\$80 Copay/Fill
Drug Tier 3: Non-Preferred Brand	\$120 Copay/Fill
<i>Value-Based Benefits (VBB)...</i>	In-Network
Included Conditions: Value-Based Benefits (VBB) Included Conditions: Diabetes, CAD	
Retail Pharmacy (Short-term supply)	
Drug Tier 1: Generic / Generic Specialty	RxPremier: No member cost share
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: No member cost share
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: \$30 Copay/Fill
Retail Pharmacy (Long-term supply)	
Drug Tier 1: Generic / Generic Specialty	RxPremier: No member cost share
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	RxPremier: No member cost share
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	RxPremier: \$90 Copay/Fill
Mail Order Pharmacy	
Drug Tier 1: Generic / Generic Specialty	No member cost share
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	No member cost share
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	\$60 Copay/Fill

Discrimination is Against the Law

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. Blue KC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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.

If you believe that Blue KC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Appeals Department, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you, or someone you're helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-410-6716.

Spanish: 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 1-877-410-6716.

Chinese: 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 1-877-410-6716。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-410-6716.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-410-6716 an.

Korean:

가 [Blue KC] 가
1-877-410-6716

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-877-410-6716.

Arabic:

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-410-6716.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue KC, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-410-6716.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue KC, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-410-6716.

Tagalog: Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Blue KC, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-410-6716.

Laotian: ຖ້າ ທ່ານ, ຫຼື ຄົນ ທີ່ ທ່ານ ກຳ ລັງ ຈຸ ວ ຍ ຫຼື ອ, ມ ີ ສ ັ ດ ທ າ ມ ກ ັ ນ ງ ອ ກ ັ ບ Blue KC, ທ່ານ ມ ີ ສ ັ ດ ທ າ ຈ ຳ ດ ັ ບ ກ າ ນ ຈ ຳ ວ ຍ ຫຼື ອ ດ ລ ະ ອ ັ ຂ ັ ມ ູ ນ ຂ ັ າ ວ ສ າ ນ ທ າ ທ າ ນ ບ າ ສ າ ຂ ອ ງ ທ າ ນ ັ ບ ມ າ ທ າ ໃ ຊ ຳ ລ ຳ າ ຍ. ກ າ ນ ໂ ອ ັ ດ ມ ັ ກ ັ ບ ນ າ ຍ ພ າ ສ າ, ໃ ທ ື ໂ ຫ ຫ າ 1-877-410-6716.

Pennsylvanian Dutch: "Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Blue KC, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kansch du 1-877-410-6716 uffrufe.

Persian: اگر شما، یا کسی که شما به او کمک میکنید، سوال در مورد Blue KC، داشته باشید حق این را دارید که کمک اطلاعات به زبان خود را به طور رایگان دریافت نمایید. تماس حاصل نمایید. 1-877-410-6716

Cushite: Isin yookan namni biraa isin deeggartan Blue KC irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-877-410-6716 tiin bilbilaa.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue KC, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-410-6716.

For TTY services, please call 1-816-842-5607.



An Independent Licensee of the Blue Cross and Blue Shield Association