



An Independent Licensee of the Blue Cross and Blue Shield Association

Effective Date: 01/01/2024

Bonner Springs Edwardsville School District

**Health Benefit Plan Summary - BlueSelect Plus Spira PPO Bluesaver HSA Plan**

This Benefit Summary provides only highlights of the services covered by Blue Cross and Blue Shield of Kansas City (Blue KC). For Additional details, exclusions and limitations refer to your member certificate available at [MyBlueKC.com](http://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.  
 This plan is an HSA Qualified High Deductible Health Plan.  
 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](http://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: \$4,000  
 Family: \$8,000

**Out-of-Network**

Individual: \$4,000  
 Family: \$8,000

**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: 20%  
 Plan Pays: 80%

**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: \$8,000

**Out-of-Network**

Individual: \$8,000  
 Family: \$16,000

**Customer Service & Care Guide Services**

**Local:** 913-29-SPIRA (77472)  
**Toll Free:** 1-877-33-SPIRA (77472)

**Plan Benefits - Medical**

**When you visit a Spira Care Center...**

- Visits to a Spira Care Center include:**
- Office Visit – Routine
  - Office Visit – Urgent/Acute
  - Chronic Disease Care (excluding drugs & equipment)
  - Outpatient Mental Health, Behavioral Health, and Substance Abuse Services

*Included as part of office visit and no member cost share:*

- Labs
- X-ray (basic diagnostic x-rays for fracture and other injuries or illness)

**Workers' Comp**

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.

**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.

**When you visit another Physician's Office...**

**Physician**

**Primary Care Physician (PCP)** - An internist, family practitioner, general practitioner, or pediatrician.

**Specialist** - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrists, psychologists and chiropractors.

**Other Services & Procedures performed in a provider's office and not included with an office visit**

**Urgent Care Center**

**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.

**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.

**In-Network**

Deductible, then no charge

**Out-of-Network**

Not covered

No member cost share

Not covered

**In-Network**

Deductible, then no charge

20% Coinsurance after Deductible

Deductible, then no charge

20% Coinsurance after Deductible

Deductible, then no charge

20% Coinsurance after Deductible

Deductible, then no charge

20% Coinsurance after Deductible

Deductible, then no charge

Not applicable

Deductible, then no charge

Not applicable

<p><b>Preventive Screenings &amp; Immunizations (Children &amp; Adults)</b> Blue KC health plans include routine preventive benefits that are consistent with the guidelines developed by the United States Preventive Services Task Force (USPSTF), Health Resources and Services Administration (HRSA), and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Services must be billed with a primary diagnosis of preventive to be covered at 100%. Refer to your member certificate for additional details.</p>	No member cost share	20% Coinsurance after Deductible
<b>Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility</b>	Deductible, then no charge	20% Coinsurance after Deductible
<b>Allergy</b>	Deductible, then no charge	20% Coinsurance after Deductible
<b>Allergy Testing</b>	Deductible, then no charge	20% Coinsurance after Deductible
<b>Allergy Treatment</b>	Deductible, then no charge	20% Coinsurance after Deductible
<b>When you need radiology services...</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>X-Ray</b>	Deductible, then no charge	20% Coinsurance after Deductible
<b>Other Radiology Procedures (MRI, CT/PET Scans, MRA)</b>	Deductible, then no charge	20% Coinsurance after Deductible
Prior Authorization Policy Applies		
<b>When you have out-patient surgery...</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Outpatient Surgery Facility Fees</b>	Deductible, then no charge	20% Coinsurance after Deductible
Prior Authorization Policy Applies		
<b>Physician (Surgeon) Services</b>	Deductible, then no charge	20% Coinsurance after Deductible
<b>If you need immediate medical attention...</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Urgent Care Center Office Visit</b>	Deductible, then no charge	20% Coinsurance after Deductible
<b>Emergency Services</b>	Deductible, then no charge	In-Network Deductible, then no charge
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.		
<b>Ground Ambulance</b>	Deductible, then no charge	In-Network Deductible, then no charge
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.		
<b>Air Ambulance</b>	Deductible, then no charge	In-Network Deductible, then no charge
<b>If you have a hospital stay...</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Hospital Facility Fees</b>	Deductible, then no charge	20% Coinsurance after Deductible
Prior Authorization Policy Applies		
<b>Physician (Surgeon) Services</b>	Deductible, then no charge	20% Coinsurance after Deductible
<b>If you need help recovering or have other special health needs...</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Skilled Nursing Care</b>	Deductible, then no charge	20% Coinsurance after Deductible
Prior Authorization Policy Applies		
Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network		
<b>Home Health Services</b>	Deductible, then no charge	20% Coinsurance after Deductible
Prior Authorization Policy Applies		
Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network		

<b>Physical Therapy</b> Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
<b>Occupational Therapy</b> Combined with Physical Therapy Limits	Deductible, then no charge	20% Coinsurance after Deductible
<b>Skeletal Manipulation</b> Prior Authorization Policy Applies Out-of-Network Combined with Physical Therapy Limits	Deductible, then no charge	20% Coinsurance after Deductible
<b>Speech Therapy</b> Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
<b>Hearing Therapy</b> Combined with Speech Therapy Limits	Deductible, then no charge	20% Coinsurance after Deductible
<b>Durable Medical Equipment</b> Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
<b>Inpatient Hospice Services</b> 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
<b>Home Hospice Services</b>	Deductible, then no charge	20% Coinsurance after Deductible
<b><i>If you have behavioral health, or substance abuse needs...</i></b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Outpatient Mental Health, Behavioral Health, and Substance Abuse Services</b> <b>Office Visit</b>	Deductible, then no charge	20% Coinsurance after Deductible
<b>Therapy</b>	Deductible, then no charge	20% Coinsurance after Deductible
<b>Inpatient Mental Health, Behavioral Health, and Substance Abuse Services</b> <b>(Facility Fees)</b> Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
<b>Inpatient Mental Health, Behavioral Health, and Substance Abuse Services</b> <b>(Physician)</b> Includes: Therapy & Other Services, partial hospitalizations	Deductible, then no charge	20% Coinsurance after Deductible
<b><i>Family Planning &amp; Pregnancy...</i></b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Contraceptive Devices, Implants, and Injections</b> See also pharmacy benefits.	No member cost share	20% Coinsurance after Deductible
<b>Elective Sterilization – Women</b>	No member cost share	20% Coinsurance after Deductible
<b>Elective Sterilization – Men</b>	Deductible, then no charge	20% Coinsurance after Deductible
<b>Maternity</b> Dependent Daughters are not covered for maternity services	Covered	Covered
<b>Infertility and Impotency Diagnosis and Treatment</b> Pharmacy Coverage: Not Covered	Not covered	Not covered
<b><i>Routine Vision Care...</i></b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Routine Eye Exam</b>	Not covered	Not covered

## General Pharmacy Information

<p><b>Retail Pharmacy Network(s)</b></p> <p><b>Prescription Drug List</b> Learn more about the drugs covered by your plan, drug category/tier, prior authorization and step therapy by reviewing your prescription drug list at <a href="http://MyBlueKC.com">MyBlueKC.com</a></p> <p><b>Specialty Pharmacy</b> A Specialty Pharmacy is one that provides specialized care for patients with complex chronic health conditions. Learn more about the drugs covered by your plan, drug category/tier, prior authorization and step therapy by reviewing your prescription drug list at <a href="http://MyBlueKC.com">MyBlueKC.com</a></p>	<p>RxPremier</p> <p>Premium Formulary</p> <p>OptumRx Specialty Services PH: 1-855-427-4682</p>				
<p><b>Copay Credit Accumulator Adjustment (CCAA)</b></p>	<p>Specialty drug copay card dollars will not be included in your deductible and/or out-of-pocket limits. Only your true out-of-pocket costs will be applied to your deductible and/or out-of-pocket totals.</p>				
<p><b>Outpatient Prescription Drug Deductible</b> You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services.</p> <p><b>Outpatient Prescription Drug Out-of-Pocket Limits</b> The Out-of-Pocket Limit is the most you could pay during the Calendar Year for your share of the cost of covered services.</p>	<table border="1"> <tr> <th data-bbox="503 556 568 1039">In-Network</th> <th data-bbox="503 52 568 546">Out-of-Network</th> </tr> <tr> <td data-bbox="568 556 609 1039">Combined with Medical Deductible</td> <td data-bbox="568 52 609 546">Combined with Medical Deductible</td> </tr> </table>	In-Network	Out-of-Network	Combined with Medical Deductible	Combined with Medical Deductible
In-Network	Out-of-Network				
Combined with Medical Deductible	Combined with Medical Deductible				
<p><b>Rx Savings Solutions</b> A team of pharmacists and pharmacy technician will help you make sure you're getting the best possible pricing for your medicines. Member support is available Monday – Friday, 7 a.m. to 7 p.m. CST.</p>	<table border="1"> <tr> <th data-bbox="625 556 690 1039">In-Network</th> <th data-bbox="625 52 690 546">Out-of-Network</th> </tr> <tr> <td data-bbox="690 556 852 1039">Combined with Medical Out-of-Pocket Limits</td> <td data-bbox="690 52 852 546">Combined with Medical Out-of-Pocket Limits</td> </tr> </table> <p>Register online at <a href="http://MyBlueKC.com">MyBlueKC.com</a> and stay up-to-date on cost saving opportunities.  <b>Email:</b> <a href="mailto:info@rxsavingsllc.com">info@rxsavingsllc.com</a>  <b>PH:</b> 1-800-268-4476</p>	In-Network	Out-of-Network	Combined with Medical Out-of-Pocket Limits	Combined with Medical Out-of-Pocket Limits
In-Network	Out-of-Network				
Combined with Medical Out-of-Pocket Limits	Combined with Medical Out-of-Pocket Limits				
<p><b>Plan Benefits – Pharmacy</b></p>					
<p><i>When you use a retail or specialty pharmacy...</i></p>					
<p><b>Retail Pharmacy (Short-term supply):</b> Up to 34 Days</p>	<p><b>In-Network</b></p>				
<p><b>Drug Tier 1:</b> Generic / Generic Specialty</p>	<p><b>RxPremier:</b> Deductible, then no charge Contraceptives – No member cost share</p>				
<p><b>Drug Tier 2:</b> Preferred / Preferred Specialty</p>	<p><b>RxPremier:</b> Deductible, then no charge</p>				
<p><b>Drug Tier 3:</b> Non-Preferred / Non-Preferred Specialty</p>	<p><b>RxPremier:</b> Deductible, then no charge</p>				
<p><b>Retail Pharmacy (Long-term supply):</b> Between 35-102 Days</p>					
<p><b>Drug Tier 1:</b> Generic / Generic Specialty</p>	<p><b>RxPremier:</b> Deductible, then no charge</p>				
<p><b>Drug Tier 2:</b> Preferred / Preferred Specialty</p>	<p><b>RxPremier:</b> Deductible, then no charge</p>				
<p><b>Drug Tier 3:</b> Non-Preferred / Non-Preferred Specialty</p>	<p><b>RxPremier:</b> Deductible, then no charge</p>				
<p><i>When you use a mail order pharmacy...</i></p>					
<p><b>Mail Order Pharmacy (Mail Order supply):</b> Between 35-102 Days</p>					
<p><b>Drug Tier 1:</b> Generic</p>	<p>Deductible, then no charge Contraceptives – No member cost share</p>				
<p><b>Drug Tier 2:</b> Preferred</p>	<p>Deductible, then no charge</p>				

**Drug Tier 3: Non-Preferred**

Deductible, then no charge

Deductible, then 20% Coinsurance

### **Discrimination is Against the Law**

Blue Cross and Blue Shield of Kansas City (Blue KC) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue KC, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-395-7126.

如果您，或是您正在協助的對象，有關於 Blue KC 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1-844-395-7126。

### **Blue KC:**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service, 844-395-7126 (Toll free), [languagehelp@bluekc.com](mailto:languagehelp@bluekc.com).



# Kansas City

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