BlueCross BlueShield of Kansas City
An Independent Licensee of the Blue Cross and Blue Shield Association

Turner School District

Health Benefit Plan Summary

Effective Date: 10/1/18

This Benefit Summary provides only a highlight of the services covered by Blue Cross and Blue Shield of Kansas City. ***www.bluekc.com***

	Preferred-Care Blue $500 PPO Plan
Plan Type	A Preferred Provider Organization (PPO)
Plan Description *(Visit our website at www.bluekc.com to receive a complete listing of network hospitals and physicians)*	Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue PPO network.
Embedded Deductible	$500 per individual/$1,000 per family *An Individual must meet their INDIVIDUAL deductible before benefits are paid on that individual*
Coinsurance *(1)*	Network: 80% Non-network: 60%
Out-of-Pocket Maximum *(2)*	Network: $4,500 individual/$9,000 family; Non-network: $9,000 individual/$18,000 family
Physician Office Visits	Network: PCP: $35 copay (office visit only) *(3)* Specialist: $70 copay (office visit only) *(3)* Non-network: Deductible then coinsurance
Lab Services Lab Performed in Physician's Office/Independent Lab/Urgent Care Facility	Network: No copay Non-network: Deductible then coinsurance
Lab Performed in Hospital/Outpatient Facility	Network: Deductible then coinsurance Non-network: Deductible then coinsurance
X-ray and Other Radiology Procedures	Network: Deductible then coinsurance *(3)* Non-network: Deductible then coinsurance
Routine Preventive Care *(Contract lists covered services)*	Network Routine Services: 100% Office Visit/Wellness Exam: 100% Non-network: deductible then coinsurance
Mammograms, Pap Smears and PSA tests	Network Services: 100% Office Visit: 100% Non-network: Deductible then coinsurance
Childhood Immunizations	Network Services: 100% Office Visit: 100% Non-network: Deductible then coinsurance
Routine Vision Care	Network: $35 copay Non-network: Deductible then coinsurance One vision exam per year
Inpatient Hospital Services/Outpatient Surgery*	Deductible then coinsurance *(4)*
Emergency Room/Urgent Care	ER: $150 copay then Deductible then 80% Urgent Care: Network: $70 copay (office visit only) *(3)* Non-Network: Deductible then coinsurance
Ambulance	Deductible then 80% Ground ambulance No limit per use.
Durable Medical Equipment*	Deductible then coinsurance
Allergy Testing, Treatment, Injections	Deductible then coinsurance

[1]Portion of covered charges paid by BCBSKC after you satisfy your deductible and required copayments.
[2]Total of deductible, coinsurance and copays members pay each year toward covered charges before BCBSKC pays 100% of benefits.
[3]Other services/procedures not specified on this benefit schedule that are performed in a physician's office are subject to the Network Deductible and Coinsurance level.
[4]Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to a $200 calendar year maximum. Inpatient hospital services in a Non-Participating Hospital inside our service area are limited to a $200 maximum per day and are limited to 30 days per calendar year. Outpatient services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility (including an ambulatory surgical center) inside our service area are limited to a $200 calendar year maximum. These limits do not pertain to these services outside our service area and will be subject to applicable deductible and coinsurance.

Log on to *www.bluekc.com* for Provider Directories, claims status and much more!

	Preferred-Care Blue $500 PPO Plan
Home Health Services*	Deductible then coinsurance 60 visit calendar year maximum
Inpatient Hospice Facility*	Deductible then coinsurance 14 day lifetime maximum
Skilled Nursing Facility*	Deductible then coinsurance 30 day calendar year maximum
Outpatient Therapy* *(Speech, Hearing, Physical and Occupational)*	Deductible then coinsurance Physical and Occupational: Combined 60 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum
Chiropractic Services*	Deductible then coinsurance
Inpatient Mental Illness/Substance Abuse	Deductible then coinsurance *(3)*
Outpatient Mental Illness/Substance Abuse	Network: Office Visit: $35 copay All other services: Deductible then coinsurance Non-Network: Deductible then coinsurance
Organ Transplant*	Deductible then coinsurance Unlimited Organ Transplant lifetime maximum
Contraceptive devices, implants, injections and elective sterilization (includes insertion of devices)	Network: Covered at 100% Non-Network: Deductible then 60%
Prescription Drugs*	**BCBSKC Rx Network** $10 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $60 copay for Tier 2 brand drug; $80 copay for Tier 3 brand drug Non-network: 50% after copay *(Copays apply to out-of-pocket maximum)*
Prescription Drugs: **Express Scripts: Mail order drug program – 102 day supply**	$30 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $180 copay for Tier 2 brand drug; $240 copay for Tier 3 brand drug *(Copays apply to out-of-pocket maximum)*
Lifetime Maximum	Unlimited
Dependent Coverage	End of the year the children reach age 26
Prior Authorization Penalty*	You are responsible for prior authorization for services received from non-network and out-of-area providers. If prior authorization is not obtained for services which require prior authorization, you are responsible for the cost of the services.
Late Enrollees	For employees or dependents applying after the eligibility period and not within a special enrollment period, coverage will become effective only on the group's anniversary date.
Detailed Benefit Information Exclusions and Limitations	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.
Customer Service	**816-395-2270 or *www.bluekc.com***

*Prior Authorization will be required for elective inpatient admissions, durable medical equipment (DME), infusion therapy and self injectables, organ and tissue transplants, some outpatient surgeries and services,hi-tech scans, prosthetics and appliances, mental health and chemical dependency, some outpatient prescriptions, skilled nursing facility, inpatient hospice facility, dental implants and bone grafts, and chiropractic services received from a non-network chiropractor. This list of services is subject to change. Please refer to your contract for the current list of services, which require Prior Authorization.

The covered services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the contract.

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Turner School District

Health Benefit Plan Summary

Effective Date: 10/1/18

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	Preferred-Care Blue HSA BlueSaver Plan
Plan Type	A Preferred Provider Organization (PPO)
Plan Description *(Visit our website at www.bluekc.com to receive a complete listing of network hospitals and physicians)*	Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue PPO network.
Embedded Deductible	$2,700 per individual/$5,400 per family *An Individual must meet their INDIVIDUAL deductible before benefits are paid on that individual*
Coinsurance *(1)*	Network: 80% Non-network: 60%
Out-of-Pocket Maximum *(2)*	Network: $4,000 individual/$8,000 family; Non-network: $8,000 individual/$16,000 family
Physician Office Visits	Deductible then coinsurance
Lab Services	Deductible then coinsurance
X-ray and Other Radiology Procedures	Network: Deductible then coinsurance *(3)* Non-network: Deductible then coinsurance
Routine Preventive Care *(Contract lists covered services)*	Network Routine Services: 100% Office Visit/Wellness Exam: 100% Non-network: deductible then coinsurance
Mammograms, Pap Smears and PSA tests	Network Services: 100% Office Visit: 100% Non-network: Deductible then coinsurance
Childhood Immunizations	Network Services: 100% Office Visit: 100% Non-network: Deductible then coinsurance
Routine Vision Care	Deductible then coinsurance (limited to one exam per calendar year)
Inpatient Hospital Services/Outpatient Surgery*	Deductible then coinsurance *(3)*
Emergency Room/Urgent Care	ER: Deductible then 80% Urgent Care: Deductible then coinsurance
Ambulance	Deductible then 80% Ground ambulance No limit per use.
Durable Medical Equipment*	Deductible then coinsurance
Allergy Testing, Treatment, Injections	Deductible then coinsurance
Home Health Services*	Deductible then coinsurance 60 visit calendar year maximum
Inpatient Hospice Facility*	Deductible then coinsurance 14 day lifetime maximum
Skilled Nursing Facility*	Deductible then coinsurance 30 day calendar year maximum

[1]Portion of covered charges paid by BCBSKC after you satisfy your deductible and required copayments.
[2]Total of deductible, coinsurance and copays members pay each year toward covered charges before BCBSKC pays 100% of benefits.
[3]Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to a $200 calendar year maximum. Inpatient hospital services in a Non-Participating Hospital inside our service area are limited to a $200 maximum per day and are limited to 30 days per calendar year. Outpatient services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility (including an ambulatory surgical center) inside our service area are limited to a $200 calendar year maximum. These limits do not pertain to these services outside our service area and will be subject to applicable deductible and coinsurance.

Log on to *www.bluekc.com* for Provider Directories, claims status and much more!

	Preferred-Care Blue HSA BlueSaver Plan
Outpatient Therapy* *(Speech, Hearing, Physical and Occupational)*	Deductible then coinsurance Physical and Occupational: Combined 60 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum
Chiropractic Services*	Deductible then coinsurance
Inpatient Mental Illness/Substance Abuse	Deductible then coinsurance *(3)*
Outpatient Mental Illness/Substance Abuse	Deductible then coinsurance
Organ Transplant*	Deductible then coinsurance Unlimited Organ Transplant lifetime maximum
Contraceptive devices, implants, injections and elective sterilization (includes insertion of devices)	Network: Covered at 100% Non-Network: Deductible then 60%
Prescription Drugs*	**BCBSKC Rx Network** Deductible, then $10 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100%; some brand name prescriptions covered at 100% if no generic is available Deductible, then $60 copay for Tier 2 brand drug; Deductible, then $80 copay for Tier 3 brand drug Non-network: Deductible, then 50% after applicable copay *(Copays apply to out-of-pocket maximum)*
Prescription Drugs: **Express Scripts: Mail order drug program – 102 day supply**	Deductible, then $30 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100%; some brand name prescriptions covered at 100% if no generic is available Deductible, then $180 copay for Tier 2 brand drug; Deductible, then $240 copay for Tier 3 brand drug *(Copays apply to out-of-pocket maximum)*
Lifetime Maximum	Unlimited
Dependent Coverage	End of the year the children reach age 26
Prior Authorization Penalty*	You are responsible for prior authorization for services received from non-network and out-of-area providers. If prior authorization is not obtained for services which require prior authorization, you are responsible for the cost of the services.
Late Enrollees	For employees or dependents applying after the eligibility period and not within a special enrollment period, coverage will become effective only on the group's anniversary date.
Detailed Benefit Information Exclusions and Limitations	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.
Customer Service	**816-395-2270 or *www.bluekc.com***

*Prior Authorization will be required for elective inpatient admissions, durable medical equipment (DME), infusion therapy and self injectables, organ and tissue transplants, some outpatient surgeries and services,hi-tech scans, prosthetics and appliances, mental health and chemical dependency, some outpatient prescriptions, skilled nursing facility, inpatient hospice facility, dental implants and bone grafts, and chiropractic services received from a non-network chiropractor. This list of services is subject to change. Please refer to your contract for the current list of services, which require Prior Authorization.

The covered services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the contract.

Kansas City

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Effective Date: 10/01/2018

Turner School District

Health Benefit Plan Summary – Spira Care BlueSelect Plus EPO - $1000 Deductible

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	**An Exclusive Provider Organization (EPO)** Members must receive all care from in-network preferred 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 physician is available on BlueKC.com.	**In Area:** BlueSelect Plus **Out-of-Area:** Blue-Card	
Embedded Deductible *An Individual must meet their Individual deductible before benefits are paid on that individual*	**In-Network** Individual: $1,000 Family: $2,000	**Out-of-Network** Not Covered
Coinsurance Coinsurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. *Note – The amount the plan pays for covered services is based on the allowed amount.*	**In-Network** Member Pays: 0% Plan Pays: 100%	**Out-of-Network** Not Covered
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. **Applies to:** All Medical and Rx Cost Sharing	**In-Network** Individual: $1,000 Family: $2,000	**Out-of-Network** Not Covered
Plan Benefits - Medical	**In-Network**	**Out-of-Network**
When you visit a Spira Care Center…		
Office Visit – Routine	No Charge	Not Covered
Office Visit – Urgent/Acute	No Charge	Not Covered
Chronic Disease Care (excluding drugs & equipment)	No Charge	Not Covered
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%.	No Charge	Not Covered
Outpatient Mental Health, Behavioral Health, and Substance Abuse Services	No Charge	Not Covered
Labs	No Charge	Not Covered
X-ray – Basic diagnostic x-rays for fracture and other injuries	No Charge	Not Covered
When you visit another Physician's Office…		
Physician Office Visit	Deductible	Not Covered
Urgent Care Telehealth Visit Blue KC members have access to the following Telehealth Providers for **$49** per online visit before deductible: American Well	Deductible	Not Covered

Plan Benefits - Medical	In-Network	Out-of-Network
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%.	No Charge	Not Covered
Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility	Deductible	Not Covered
Allergy Testing, Treatment, Injections	Deductible	Not Covered
Other Services and Procedures performed in a provider's office	Deductible	Not Covered
When you need radiology services…		
X-Ray Reminder – X-ray services provided at your neighborhood Spira Health Center are available at no cost to you.	Deductible	Not Covered
Mammogram – Preventive	No Charge	Not Covered
Other Radiology Procedures (MRI, CT/PET Scans, MRA) Prior authorization is required.	Deductible	Not Covered
When you have out-patient surgery…		
Outpatient Surgery Facility Fees Prior authorization is required.	Deductible	Not Covered
Physician (Surgeon) Services	Deductible	Not Covered
If you need immediate medical attention…		
Urgent Care Center Office Visit	Deductible	Not Covered
Emergency Services – Facility	Deductible	In-Network Deductible
Emergency Services – Physician	Deductible	In-Network Deductible
Ground Ambulance	Deductible	In-Network Deductible
Air Ambulance	Deductible	In-Network Deductible
If you have a hospital stay…		
Hospital Facility Fees	Deductible	Not Covered
Physician (Surgeon) Services	Deductible	Not Covered
Labs Performed in a Hospital/Outpatient Facility	Deductible	Not Covered
If you need help recovering or have other special health needs…		
Skilled Nursing Care Prior authorization is required. Benefits are limited to a 30 day calendar year maximum.	Deductible	Not Covered
Home Health Services Benefits are limited to a 60 visit calendar year maximum.	Deductible	Not Covered
Occupational & Physical Therapy Benefits are limited to a combined 60 visit calendar year maximum (for Occupational, Physical Therapy and Skeletal Manipulations)	Deductible	Not Covered
Speech & Hearing Therapy Prior authorization is required for Hearing Therapy. Benefits are limited to a combined **20** visit calendar year maximum.	Deductible	Not Covered
Durable Medical Equipment Prior authorization is required.	Deductible	Not Covered
Inpatient Hospice Services Prior authorization is required for services received at an inpatient facility. Benefits are limited to a **14** day lifetime maximum at an inpatient facility.	Deductible	Not Covered
Home Hospice Services	Deductible	Not Covered

Plan Benefits - Medical	In-Network	Out-of-Network
If you have behavioral health, or substance abuse needs…		
Outpatient Mental Health, Behavioral Health, and Substance Abuse Services	Deductible	Not Covered
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services Requires Prior Authorization from New Directions.	Deductible	Not Covered
Family Planning & Pregnancy…		
Contraceptive Devices, Implants, and Injections See also pharmacy benefits.	No Charge	Not Covered
Elective Sterilization – Women	No Charge	Not Covered
Elective Sterilization – Men	No Charge	Not Covered
Prenatal and postnatal care Coverage for Dependent Daughters is not ncluded.	Deductible	Not Covered
Delivery and all inpatient services	Deductible	Not Covered
Infertility	Not Covered	Not Covered
General Pharmacy Information		
Pharmacy Network(s)	National Plus	
Prescription Drug List	National Preferred	
Exclusions & Limitations	Covers up to 34 day supply (retail) and between 35 to 102 day supply (mail order). Prescriptions for a specialty drug will need to be filled at a designated specialty pharmacy. Limited to a one month supply.	
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.pm CST.	Register online at **MyBlueKC.com** and stay up-to-date on cost saving opportunities. **Email:** info@rxsavingsllc.com **PH:** 1-800-268-4476	
Specialty Pharmacy Prescriptions for a specialty medication will need to be filled through a designated Specialty Pharmacy.	**Designated Specialty Pharmacy:** Accredo **PH:** 877-259-2295	
Plan Benefits – Pharmacy	**In-Network**	**Out-of-Network**
Retail (up to a 34 day supply) Tier 1 – Generic Drugs Tier 2 – Preferred Brand Drug Tier 3 – Non-preferred Brand Drug	**Contraceptives (generic & brand if no generic is available):** No Charge **Tier 1:** $15 Copay **Tier 2:** $50 Copay **Tier 3:** Deductible	Not Covered
Mail order drug program – up to 102 day supply	**Contraceptives (generic & brand if no generic is available):** No Charge **Tier 1:** $15 Copay **Tier 2:** $125 Copay **Tier 3:** Deductible	Not Covered
Specialty Pharmacy Prescriptions for a specialty medication will need to be filled through a designated Specialty Pharmacy.	**Designated Specialty Pharmacy:** Accredo **PH:** 877-259-2295	

***Infertilty and Impotency Services are not covered under Spira Care.**

Kansas City

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Effective Date: 10/01/2018

Turner School District

Health Benefit Plan Summary – Spira Care BlueSelect Plus EPO - $2500 Deductible

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	**An Exclusive Provider Organization (EPO)** Members must receive all care from in-network preferred 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 physician is available on BlueKC.com.	**In Area:** BlueSelect Plus **Out-of-Area:** Blue-Card	
Embedded Deductible *An Individual must meet their Individual deductible before benefits are paid on that individual*	**In-Network** Individual: $2,500 Family: $5,000	**Out-of-Network** Not Covered
Coinsurance Coinsurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. *Note – The amount the plan pays for covered services is based on the allowed amount.*	**In-Network** Member Pays: 0% Plan Pays: 100%	**Out-of-Network** Not Covered
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. **Applies to:** All Medical and Rx Cost Sharing	**In-Network** Individual: $2,500 Family: $5,000	**Out-of-Network** Not Covered
Plan Benefits - Medical	**In-Network**	**Out-of-Network**
When you visit a Spira Care Center…		
Office Visit – Routine	No Charge	Not Covered
Office Visit – Urgent/Acute	No Charge	Not Covered
Chronic Disease Care (excluding drugs & equipment)	No Charge	Not Covered
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%.	No Charge	Not Covered
Outpatient Mental Health, Behavioral Health, and Substance Abuse Services	No Charge	Not Covered
Labs	No Charge	Not Covered
X-ray – Basic diagnostic x-rays for fracture and other injuries	No Charge	Not Covered
When you visit another Physician's Office…		
Physician Office Visit	Deductible	Not Covered
Urgent Care Telehealth Visit Blue KC members have access to the following Telehealth Providers for **$49** per online visit before deductible: American Well	Deductible	Not Covered

Plan Benefits - Medical	In-Network	Out-of-Network
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%.	No Charge	Not Covered
Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility	Deductible	Not Covered
Allergy Testing, Treatment, Injections	Deductible	Not Covered
Other Services and Procedures performed in a provider's office	Deductible	Not Covered
When you need radiology services…		
X-Ray Reminder – X-ray services provided at your neighborhood Spira Health Center are available at no cost to you.	Deductible	Not Covered
Mammogram – Preventive	No Charge	Not Covered
Other Radiology Procedures (MRI, CT/PET Scans, MRA) Prior authorization is required.	Deductible	Not Covered
When you have out-patient surgery…		
Outpatient Surgery Facility Fees Prior authorization is required.	Deductible	Not Covered
Physician (Surgeon) Services	Deductible	Not Covered
If you need immediate medical attention…		
Urgent Care Center Office Visit	Deductible	Not Covered
Emergency Services – Facility	Deductible	In-Network Deductible
Emergency Services – Physician	Deductible	In-Network Deductible
Ground Ambulance	Deductible	In-Network Deductible
Air Ambulance	Deductible	In-Network Deductible
If you have a hospital stay…		
Hospital Facility Fees	Deductible	Not Covered
Physician (Surgeon) Services	Deductible	Not Covered
Labs Performed in a Hospital/Outpatient Facility	Deductible	Not Covered
If you need help recovering or have other special health needs…		
Skilled Nursing Care Prior authorization is required. Benefits are limited to a 30 day calendar year maximum.	Deductible	Not Covered
Home Health Services Benefits are limited to a 60 visit calendar year maximum.	Deductible	Not Covered
Occupational & Physical Therapy Benefits are limited to a combined 60 visit calendar year maximum (for Occupational, Physical Therapy and Skeletal Manipulations)	Deductible	Not Covered
Speech & Hearing Therapy Prior authorization is required for Hearing Therapy. Benefits are limited to a combined **20** visit calendar year maximum.	Deductible	Not Covered
Durable Medical Equipment Prior authorization is required.	Deductible	Not Covered
Inpatient Hospice Services Prior authorization is required for services received at an inpatient facility. Benefits are limited to a **14** day lifetime maximum at an inpatient facility.	Deductible	Not Covered
Home Hospice Services	Deductible	Not Covered

Plan Benefits - Medical	In-Network	Out-of-Network
If you have behavioral health, or substance abuse needs…		
Outpatient Mental Health, Behavioral Health, and Substance Abuse Services	Deductible	Not Covered
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services Requires Prior Authorization from New Directions.	Deductible	Not Covered
Family Planning & Pregnancy…		
Contraceptive Devices, Implants, and Injections See also pharmacy benefits.	No Charge	Not Covered
Elective Sterilization – Women	No Charge	Not Covered
Elective Sterilization – Men	No Charge	Not Covered
Prenatal and postnatal care Coverage for Dependent Daughters is not ncluded.	Deductible	Not Covered
Delivery and all inpatient services	Deductible	Not Covered
Infertility	Not Covered	Not Covered
General Pharmacy Information		
Pharmacy Network(s)	National Plus	
Prescription Drug List	National Preferred	
Exclusions & Limitations	Covers up to 34 day supply (retail) and between 35 to 102 day supply (mail order). Prescriptions for a specialty drug will need to be filled at a designated specialty pharmacy. Limited to a one month supply.	
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.pm CST.	Register online at **MyBlueKC.com** and stay up-to-date on cost saving opportunities. **Email:** info@rxsavingsllc.com **PH:** 1-800-268-4476	
Specialty Pharmacy Prescriptions for a specialty medication will need to be filled through a designated Specialty Pharmacy.	**Designated Specialty Pharmacy:** Accredo **PH:** 877-259-2295	
Plan Benefits – Pharmacy	**In-Network**	**Out-of-Network**
Retail (up to a 34 day supply) Tier 1 – Generic Drugs Tier 2 – Preferred Brand Drug Tier 3 – Non-preferred Brand Drug	**Contraceptives (generic & brand if no generic is available):** No Charge **Tier 1:** $15 Copay **Tier 2:** $50 Copay **Tier 3:** Deductible	Not Covered
Mail order drug program – up to 102 day supply	**Contraceptives (generic & brand if no generic is available):** No Charge **Tier 1:** $15 Copay **Tier 2:** $125 Copay **Tier 3:** Deductible	Not Covered
Specialty Pharmacy Prescriptions for a specialty medication will need to be filled through a designated Specialty Pharmacy.	**Designated Specialty Pharmacy:** Accredo **PH:** 877-259-2295	

***Infertilty and Impotency Services are not covered under Spira Care.**

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	BlueSelect Plus $2,700 HSA BlueSaver Plan
Plan Type	A Preferred Provider Organization (PPO)
Plan Description *(Visit our website at www.bluekc.com to receive a complete listing of network hospitals and physicians)*	BlueSelect Plus members can receive services from any hospital or physician but receive greater benefits when they use the BlueSelect Plus network. **BlueSelect Plus is a much smaller, limited Blue KC PPO hospital and physician network.**
Embedded Deductible	Network:$2,700 per individual/$5,400 per family Non-network: $5,400 individual/$10,800 per family *An Individual must meet their INDIVIDUAL deductible before benefits are paid on that individual*
Coinsurance *(1)*	Network: 80% Non-network: 50%
Out-of-Pocket Maximum *(2)*	Network: $4,000 individual/$8,000 family; Non-network: $20,000 individual/$40,000 family
Physician Office Visits	Deductible then coinsurance
Lab Services	Deductible then coinsurance
X-ray and Other Radiology Procedures	Network: Deductible then coinsurance *(3)* Non-network: Deductible then coinsurance
Routine Preventive Care *(Contract lists covered services)*	Network Routine Services: 100% Office Visit/Wellness Exam: 100% Non-network: deductible then coinsurance
Mammograms, Pap Smears and PSA tests	Network Services: 100% Office Visit: 100% Non-network: Deductible then coinsurance
Childhood Immunizations	Network Services: 100% Office Visit: 100% Non-network: Deductible then coinsurance
Routine Vision Care	Deductible then coinsurance (limited to one exam per calendar year)
Inpatient Hospital Services/Outpatient Surgery*	Deductible then coinsurance *(3)*
Emergency Room/Urgent Care	ER: Deductible then 80% Urgent Care: Deductible then coinsurance
Ambulance	Deductible then 80% Ground ambulance No limit per use.
Durable Medical Equipment*	Deductible then coinsurance
Allergy Testing, Treatment, Injections	Deductible then coinsurance
Home Health Services*	Deductible then coinsurance 60 visit calendar year maximum
Inpatient Hospice Facility*	Deductible then coinsurance 14 day lifetime maximum
Skilled Nursing Facility*	Deductible then coinsurance 30 day calendar year maximum

[1]Portion of covered charges paid by BCBSKC after you satisfy your deductible and required copayments.
[2]Total of deductible, coinsurance and copays members pay each year toward covered charges before BCBSKC pays 100% of benefits.
[3]Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to a $200 calendar year maximum. Inpatient hospital services in a Non-Participating Hospital inside our service area are limited to a $200 maximum per day and are limited to 30 days per calendar year. Outpatient services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility (including an ambulatory surgical center) inside our service area are limited to a $200 calendar year maximum. These limits do not pertain to these services outside our service area and will be subject to applicable deductible and coinsurance.

Log on to *www.bluekc.com* for Provider Directories, claims status and much more!

	BlueSelect Plus $2,700 HSA BlueSaver Plan
Outpatient Therapy* *(Speech, Hearing, Physical and Occupational)*	Deductible then coinsurance Physical and Occupational: Combined 60 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum
Chiropractic Services*	Deductible then coinsurance
Inpatient Mental Illness/Substance Abuse	Deductible then coinsurance *(3)*
Outpatient Mental Illness/Substance Abuse	Deductible then coinsurance
Organ Transplant*	Deductible then coinsurance Unlimited Organ Transplant lifetime maximum
Contraceptive devices, implants, injections and elective sterilization (includes insertion of devices)	Network: Covered at 100% Non-Network: Deductible then 60%
Prescription Drugs*	**BCBSKC Rx Network** Deductible, then $10 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100%; some brand name prescriptions covered at 100% if no generic is available Deductible, then $60 copay for Tier 2 brand drug; Deductible, then $80 copay for Tier 3 brand drug Non-network: Deductible, then 50% after applicable copay *(Copays apply to out-of-pocket maximum)*
Prescription Drugs: **Express Scripts: Mail order drug program – 102 day supply**	Deductible, then $30 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100%; some brand name prescriptions covered at 100% if no generic is available Deductible, then $180 copay for Tier 2 brand drug; Deductible, then $240 copay for Tier 3 brand drug *(Copays apply to out-of-pocket maximum)*
Lifetime Maximum	Unlimited
Dependent Coverage	End of the year the children reach age 26
Prior Authorization Penalty*	You are responsible for prior authorization for services received from non-network and out-of-area providers. If prior authorization is not obtained for services which require prior authorization, you are responsible for the cost of the services.
Late Enrollees	For employees or dependents applying after the eligibility period and not within a special enrollment period, coverage will become effective only on the group's anniversary date.
Detailed Benefit Information Exclusions and Limitations	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.
Customer Service	**816-395-2270 or *www.bluekc.com***

*Prior Authorization will be required for elective inpatient admissions, durable medical equipment (DME), infusion therapy and self injectables, organ and tissue transplants, some outpatient surgeries and services,hi-tech scans, prosthetics and appliances, mental health and chemical dependency, some outpatient prescriptions, skilled nursing facility, inpatient hospice facility, dental implants and bone grafts, and chiropractic services received from a non-network chiropractor. This list of services is subject to change. Please refer to your contract for the current list of services, which require Prior Authorization.

The covered services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the contract.

BlueCross BlueShield of Kansas City
An Independent Licensee of the Blue Cross and Blue Shield Association

Turner School District

Health Benefit Plan Summary

Effective Date: 10/1/18

This Benefit Summary provides only a highlight of the services covered by Blue Cross and Blue Shield of Kansas City. ***www.bluekc.com***

	BlueSelect Plus $3,500 HSA BlueSaver Plan
Plan Type	A Preferred Provider Organization (PPO)
Plan Description *(Visit our website at www.bluekc.com to receive a complete listing of network hospitals and physicians)*	BlueSelect Plus members can receive services from any hospital or physician but receive greater benefits when they use the BlueSelect Plus network. **BlueSelect Plus is a much smaller, limited Blue KC PPO hospital and physician network.**
Embedded Deductible	Network:$3,500 per individual/$7,000 per family Non-network: $7,000 individual/$14,000 per family *An Individual must meet their INDIVIDUAL deductible before benefits are paid on that individual*
Coinsurance *(1)*	Network: 80% Non-network: 50%
Out-of-Pocket Maximum *(2)*	Network: $6,000 individual/$12,000 family; Non-network: $30,000 individual/$60,000 family
Physician Office Visits	Deductible then coinsurance
Lab Services	Deductible then coinsurance
X-ray and Other Radiology Procedures	Network: Deductible then coinsurance *(3)* Non-network: Deductible then coinsurance
Routine Preventive Care *(Contract lists covered services)*	Network Routine Services: 100% Office Visit/Wellness Exam: 100% Non-network: deductible then coinsurance
Mammograms, Pap Smears and PSA tests	Network Services: 100% Office Visit: 100% Non-network: Deductible then coinsurance
Childhood Immunizations	Network Services: 100% Office Visit: 100% Non-network: Deductible then coinsurance
Routine Vision Care	Deductible then coinsurance (limited to one exam per calendar year)
Inpatient Hospital Services/Outpatient Surgery*	Deductible then coinsurance *(3)*
Emergency Room/Urgent Care	ER: Deductible then 80% Urgent Care: Deductible then coinsurance
Ambulance	Deductible then 80% Ground ambulance No limit per use.
Durable Medical Equipment*	Deductible then coinsurance
Allergy Testing, Treatment, Injections	Deductible then coinsurance
Home Health Services*	Deductible then coinsurance 60 visit calendar year maximum
Inpatient Hospice Facility*	Deductible then coinsurance 14 day lifetime maximum
Skilled Nursing Facility*	Deductible then coinsurance 30 day calendar year maximum

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