Kansas City

Group Name:	Jackson County
Offer Name:	Renewal
Group Number:	31618000
State:	Missouri
Effective Date:	01/01/2025
Important Notes:	

A. General Information	
Contract Term:	12 Months
Subsequent Renewal Terms:	12 Months
Renewal Notification:	180 Days Preliminary; 120 Days Final
Annual Enrollment Period Start:	30 Days prior to Group Anniversary Date
Annual Enrollment Period End:	15 Days after Group Anniversary Date
Waiting Period:	Group Assigns
Eligibility Rule:	Group Assigns
Termination Rule:	Last day of month following termination
Leave of Absence Term:	Not applicable
Dependent Limiting Age:	26 Years
Dependent Limiting Age Termination:	EOY following birthday
Is Employer subject to ERISA?:	No
Are Section 125 Enrollment Changes Allowed?:	Yes
HSA Bank Selection:	UMB HSA Eligibility File Feed sent - Yes
Reinstatement Fee:	$500
B. Medical Programs and Services	
AHY (subscribers/spouse with medical):	AHY Platinum (1000+)
AHY Standard Buyup (employees with no medical):	No
Wellness Stipend:	$75,000
24-Hour Nurse Line:	No
Healthy Companion:	Yes
Virtual Care:	Yes
Livongo Program:	Yes

Genetic Testing:	Yes
APEA:	Yes
Maven:	No
Rx Savings Solution:	Yes
Rx Rewards Incentive Program	No
Rx Carve-in Credits:	Yes $50.00 - PMPM
C. Blue KC Vision Coverage	
Blue Vue Base:	No
Blue Vue 10/100:	No
Blue Vue 10/130:	No
Blue Vue 10/150:	No
Blue Vue 10/200:	No
Blue Vue 0/130:	No
Blue Vue 0/150:	No
Blue Vue 0/200:	No
Blue Vue Non-Standard:	No
D. USAble Coverage	
Term Life:	No
AD&D:	No
E. Principal Coverage	
Group Term Life:	No
Voluntary Life:	No
Long Term Disability (LTD):	No
Short Term Disability (STD):	No
Critical Illness:	No
Accident:	No
Dental:	No
Vision:	No

Plans included in this Offer:

For details about the plans included in this offer, please see the attached Plan information.

Blue-Care HMO Plan (CF1Y)
PCB PPO Plan (CF1Z)
PCB QHDHP HSA PPO without Spira Plan (CF20)
BSP EPO without Spira Plan (CF21)
BSP QHDHP HSA EPO with Spira Plan (CF22)

Confirmed by: Jackson County

Signature

County Executive

Title

12-12-2024

Date

Accepted by Blue Cross and Blue Shield of Kansas City:

Eric Whitten

Eric Whitten (Jan 7, 2025 14:45 CST)

Signature

Underwriting.Team Lead

Title

Jan 07, 2025

Date

ATTEST:

Clerk of the County Legislature

APPROVED AS TO FORM

County Counselor

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Kansas City

Plan Information	
Group Name:	Jackson County
Plan Name:	Blue-Care HMO Plan
Group Number:	31618000
State:	Missouri
Effective Date:	01/01/2025
Important Notes:	"Gender Dysphoria-related Services" will be referred to as "Gender Affirmation Services" in the Member Certificate.
For Internal Use Only:	Package: 0441560330 XREF: CF1Y Medical: 0442460520 Rx: 0443430475
1. General Plan Information	
Benefit Period	Calendar Year
Funding	Local ASO
Grandfathered Status	Non-Grandfathered
Product Family	HMO
Consumer-Driven Health Plan (CDHP)	N/A
Spira Care Plan?	No
Religious Employer?	N/A
Classification of Eligible Employees	Group Assigns
Eligibility	
Min % of Eligible Employees	75%
% Threshold of Total Employee Enrollment	90%
Minimum Employer Contribution – Eligible Employees	75%
Minimum Employer Contribution – Total Account Premium	50%
COBRA Billing	BCBS
Are Domestic Partners Covered?	Yes
Are Spouses Covered?	Yes
Are Same Sex Spouses Covered?	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Blue Connect	Blue Connect not included
Alight (Concierge service billed through Blue KC)	Alight not included

Smart Shopper	Smart Shopper Included	
2. Network		
Local Medical Network	Blue-Care	
Out-of-Area Medical Network	BlueCard Excluded	
Pharmacy	See Pharmacy (Sections 5 & 6)	
3. Cost Sharing		
Medical Deductible - Calendar Year	**In-Network**	**Out-of-Network**
Individual	Does not apply	Does not apply
Family	Does not apply	Does not apply
Pharmacy Deductible	No Pharmacy Deductible	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	Not applicable	Does not apply
Plan Pays	100%	Does not apply
Out-of-Pocket Limit - Calendar Year, Embedded Deductible Apply to OOP?: N/A Copays Apply to OOP?: Yes Coinsurance Apply to OOP?: Yes	**In-Network**	**Out-of-Network**
Individual	$3,500	Does not apply
Family	$8,750	Does not apply
Pharmacy Out-of-Pocket Limit	Combined with Medical	
Annual First Dollar Coverage	Does not apply	Not Covered
Annual Maximum	Does not apply	Does not apply
Lifetime Maximum	Does not apply	Does not apply
4. Benefits		
Professional Services	**In-Network**	**Out-of-Network**
Primary Care Physician Office Visit - An internist, family practitioner, general practitioner, or pediatrician.	$30 Copay/Visit	Not covered
Retail Health Clinic	No member cost share	Not covered
Total Care Primary Care Physician Office Visit	Does not apply	Not applicable
Specialist Physician Office Visit - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrists, psychologists and chiropractors.	$60 Copay/Visit	Not covered
Urgent Care Office Visit	$60 Copay/Visit	Not covered
Total Care Urgent Care Office Visit	Does not apply	Not applicable
Blue KC Virtual Care - Office Visit Virtual care provided by Blue KC virtual care partner(s).	$60 Copay/Visit	Not applicable

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Diabetic Pump	Covered as Durable Medical Equipment (DME)	Not covered
Diabetic Self Management Education/Training (DSMT)	No member cost share	Not covered
Durable Medical Equipment (DME) Prior Authorization Policy Applies In-Network No Limits	No member cost share	Not covered
Elective Male Sterilization	No member cost share	Not covered
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$300 Copay/Visit	$300 Copay/Visit
Food and Food Products for PKU No Limits	Covered	Not covered
Foot Orthotics	Not covered	Not covered
Gender Dysphoria-Related Services Prior Authorization Policy Applies In-Network Gender Dysphoria Cost Shares Apply to Cosmetic Services: Yes All cosmetic services as specified in the Medical Certificate are covered with a $10,000 Lifetime Maximum. Gender Dysphoria Cost Shares Apply to Non-Surgical Services: Yes Gender Dysphoria Cost Shares Apply to Reassignment Surgery: Yes	Subject to Applicable Cost Shares	Not covered
Hearing Aids Maximum benefit of 1 Set/Every 48 Months for In-Network	No member cost share	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies In-Network High Tech Radiology ER Copay Waiver Rule (when ER Copay also applies): High Tech Radiology Copay Waived	$250 Copay/Provider per Day	Not covered
Home Health Care Prior Authorization Policy Applies In-Network Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Home Hospice	No member cost share	Not covered
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Diagnosis & Treatment Infertility and impotency treatment limited $30,000 per Lifetime Medical Dollar limitations include pharmacy: Yes	No member cost share	Not covered

Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s).	No member cost share	Not applicable
Telehealth - Telehealth Providers other than Blue KC Virtual Care - Office Visit - Primary Care	$30 Copay/Visit	Not covered
Telehealth - Telehealth Providers other than Blue KC Virtual Care - Office Visit - Behavioral Health	$30 Copay/Visit	Not covered
Telehealth - Telehealth Providers other than Blue KC Virtual Care - Behavioral Health Therapy	No member cost share	Not covered
Designated Health Clinic	Does not apply	Not applicable
Other Benefits (in alphabetical order)	**In-Network**	**Out-of-Network**
ABA Services ABA Services Age Limits: Until Covered Person's 19th Birthday	Subject to Applicable Cost Shares	Not covered
Abortion	No member cost share	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	$100 Copay/Visit	Not covered
Allergy Treatment	No member cost share	Not covered
Ambulance - Air	No member cost share	No member cost share
Ambulance - Ground Ground Ambulance Allowable Option: Billed Charges	No member cost share	No member cost share
Assisted Reproductive Services Combined with Infertility and Impotency Treatment Limits	Covered - Expanded	Not covered
Autism-Related Services No Limits	Subject to Applicable Cost Shares	Not covered
Bariatric Services Maximum benefit of $50,000/Lifetime for In-Network Bariatric Coverage Locations: Blue Distinction Specialty Care Facility Only Bariatric Members Covered: All Members Bariatric Surgeries Covered: All surgeries per medical policy INN Tier 1 Cost Share Providers: Blue Distinction Specialty Care Facility Providers	Subject to Applicable Cost Shares	Not covered
Blue Distinction Specialty Care Facility Services No Limits	Not Applicable	Not covered
Chiropractic Office Visit	$60 Copay/Visit	Not covered
Dental Anesthesia Maximum age limit of 5 Years	Missouri/Kansas Default	Not covered
Diabetic Equipment and Supplies Prior Authorization Policy Applies In-Network	No member cost share	Not covered
Diabetic Footwear	No member cost share	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Inpatient Hospice Prior Authorization Policy Applies In-Network Maximum benefit of 14 Day(s)/Lifetime for In-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$200 Copay/Day Limited to $2,000 Copay Max per Calendar Year	Not covered
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies In-Network	$400 Copay/Day Limited to Inpatient/Outpatient $2,000 Copay Max per Calendar Year	Not covered
Inpatient Physician Services	No member cost share	Not covered
Labs Performed in Office / Independent Lab	No member cost share	Not covered
Maternity Dependent Daughters Maternity Covered?: Yes	Covered	Not covered
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies In-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$400 Copay/Day Limited to $2,000 Copay Max per Calendar Year	Not covered
Mental Health and Substance Abuse Services - Inpatient Physician Services	No member cost share	Not covered
Mental Health and Substance Abuse Services - Office Visit	$30 Copay/Visit	Not covered
Mental Health and Substance Abuse Services - Outpatient Therapy in a Facility	No member cost share	Not covered
Mental Health and Substance Abuse Services - Outpatient Therapy in a Provider's Office	No member cost share	Not covered
Nutritional Counseling No Limits Nutritional Counseling Services Covered: Includes all Dx	Subject to Applicable Cost Shares	Not covered
Organ Transplant Services Prior Authorization Policy Applies In-Network	Subject to Applicable Cost Shares **Blue Distinction Specialty Care Facility Services:** Not applicable	Not covered
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Office	No member cost share	Not covered
Outpatient Physician Services	No member cost share	Not covered
Outpatient Surgery Prior Authorization Policy Applies In-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$400 Copay/Day Limited to $2,000 Copay Max per Calendar Year	Not covered
Outpatient Therapy - Cardiac Therapy No Limits	No member cost share	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Outpatient Therapy - Cognitive Therapy	No member cost share	Not covered
Outpatient Therapy - Hearing Therapy in a Facility Combined with Hearing Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Hearing Therapy in a Provider's Office Combined with Speech Therapy Limits	No member cost share	Not covered
Outpatient Therapy - Occupational Therapy in a Facility Combined with Occupational Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Occupational Therapy in a Provider's Office Combined with Physical Therapy Limits	No member cost share	Not covered
Outpatient Therapy - Physical Therapy in a Facility Combined with Physical Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Physical Therapy in a Provider's Office Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Outpatient Therapy - Pulmonary Therapy No Limits	No member cost share	Not covered
Outpatient Therapy - Speech Therapy in a Facility Combined with Speech Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Speech Therapy in a Provider's Office Maximum benefit of 20 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Penile Prostheses/Implant	Not covered	Not covered
Private Duty Nursing Combined with Home Health Care Limits	No member cost share	Not covered
Routine Preventive Care Diabetes Prevention Program (DPP): Covered Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	Not covered
Skeletal Manipulation performed in a Chiropractic Office No Limits	No member cost share	Not covered
Skilled Nursing Facility (SNF) Prior Authorization Policy Applies In-Network Maximum benefit of 30 Day(s)/Calendar Year for In-Network	No member cost share	Not covered
Sports Physicals by a Physician	Not covered	Not covered
Vision Exam-Routine	Not covered	Not covered
Vision Hardware	Not covered	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Weight Management - Wondr Health	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology	No member cost share	Not covered
5. General Pharmacy Information		
Pharmacy Network(s)	**Network 1:** 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 on MyBlueKC.com	Premium Formulary	
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** Does Not Apply	**Out-of-Network** Does Not Apply
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	**Out-of-Network** Does not apply
Infertility/Impotency Drugs	$30,000 Combined Medical/Pharmacy limit	
Biosimilar Product Penalty	Applies	
Maintenance Medication Program	**Mail Service Member Select** – Member must make a choice of where to obtain their maintenance medications after two courtesy fills: long-term supply through Home Delivery or a short-term supply from a retail pharmacy. **Maintenance Look Back Date:** 01/01/2020	
Generics Program	Not Applicable	
Copay Credit Accumulator Adjustment (CCAA): 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.	No	
Variable Copay Solution (VCS): When you use a drug copay card, Specialty prescription drugs may be subject to a new plan benefit cost share. This new cost share will not impact you or the price you pay.	No	
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	
6. Plan Benefits – Pharmacy		

	In-Network	Out-of-Network
Retail Pharmacy (Short-term supply: Up to 34 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $12 Copay/Fill	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance(Max: $100)	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance(Max: $250)	Not covered
Retail Pharmacy (Long-term supply: Between 35-102 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $36 Copay/Fill	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance(Max: $300)	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance(Max: $750)	Not covered
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	$24 Copay/Fill	Not covered
Drug Tier 2: Preferred	20% Coinsurance(Max: $200)	Not covered
Drug Tier 3: Non-Preferred	50% Coinsurance(Max: $500)	Not covered
OTC Drugs (Retail Only) OTC Drugs Retail (Short-Term) Day Supply Range: Up to 34 Days		
OTC Drugs Gastrointestinal	$1 Copay/Fill	Not Covered
OTC Drugs Allergy	$1 Copay/Fill	Not Covered
Infertility Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $12 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance	Not covered
Infertility Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $36 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance	Not covered
Infertility Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$24 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred / Preferred Specialty	20% Coinsurance	Not covered

Drug Tier 3: Non-Preferred / Non-Preferred Specialty	50% Coinsurance	Not covered
Impotency Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $12 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance	Not covered
Impotency Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $36 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance	Not covered
Impotency Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$24 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred / Preferred Specialty	20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	50% Coinsurance	Not covered
Abortion Drugs	Subject to Applicable Cost Shares	Not covered

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Kansas City

Group Name:	Jackson County
Plan Name:	PCB PPO Plan
Group Number:	31618000
State:	Missouri
Effective Date:	01/01/2025
Important Notes:	"Gender Dysphoria-related Services" will be referred to as "Gender Affirmation Services" in the Member Certificate.
For Internal Use Only:	Package: 0444200883 XREF: CF1Z Medical: 0445150432 Rx: 0446020028
1. General Plan Information	
Benefit Period	Calendar Year
Funding	Local ASO
Grandfathered Status	Non-Grandfathered
Product Family	PPO
Consumer-Driven Health Plan (CDHP)	N/A
Spira Care Plan?	No
Religious Employer?	N/A
Classification of Eligible Employees	Group Assigns
Eligibility	
Min % of Eligible Employees	75%
% Threshold of Total Employee Enrollment	90%
Minimum Employer Contribution – Eligible Employees	75%
Minimum Employer Contribution – Total Account Premium	50%
COBRA Billing	BCBS
Are Domestic Partners Covered?	Yes
Are Spouses Covered?	Yes
Are Same Sex Spouses Covered?	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Blue Connect	Blue Connect not included
Alight (Concierge service billed through Blue KC)	Alight not included

Smart Shopper	Smart Shopper Included	
2. Network		
Local Medical Network	Preferred-Care Blue Services rendered at Out-of-Network providers are subject to Out-of-Network allowables as stated in your contract, and balance billing may occur.	
Out-of-Area Medical Network	BlueCard PPO/EPO	
Pharmacy	See Pharmacy (Sections 5 & 6)	
3. Cost Sharing		
Medical Deductible - Calendar Year, Embedded All INN & OON Cross Accum	**In-Network**	**Out-of-Network**
Individual	$1,000	$2,500
Family	$2,000	$4,500
Pharmacy Deductible	No Pharmacy Deductible	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	20%	40%
Plan Pays	80%	60%
Out-of-Pocket Limit - Calendar Year, Embedded All INN & OON Cross Accum The Out-of-Pocket limit includes all Deductibles, Coinsurance, and Copayments a member pays during the Benefit Period.	**In-Network**	**Out-of-Network**
Individual	$4,500	$8,500
Family	$9,000	$16,500
Pharmacy Out-of-Pocket Limit	Combined with Medical	
Annual First Dollar Coverage	Does not apply	Does not apply
Annual Maximum	Does not apply	Does not apply
Lifetime Maximum	Does not apply	Does not apply
4. Benefits		
Professional Services	**In-Network**	**Out-of-Network**
Primary Care Physician Office Visit - An internist, family practitioner, general practitioner, or pediatrician.	$30 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Retail Health Clinic	No member cost share	40% Coinsurance after Deductible
Total Care Primary Care Physician Office Visit	Does not apply	Not applicable
Specialist Physician Office Visit - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrists, psychologists and chiropractors.	$60 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Urgent Care Office Visit	$60 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Total Care Urgent Care Office Visit	Does not apply	Not applicable

Blue KC Virtual Care - Office Visit Virtual care provided by Blue KC virtual care partner(s).	$60 Copay/Visit, no Deductible	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s).	$60 Copay/Visit, no Deductible	Not applicable
Telehealth - Telehealth Providers other than Blue KC Virtual Care - Office Visit - Primary Care	$30 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Telehealth - Telehealth Providers other than Blue KC Virtual Care - Office Visit - Behavioral Health	$30 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Telehealth - Telehealth Providers other than Blue KC Virtual Care - Behavioral Health Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Designated Health Clinic	Does not apply	Not applicable
Other Benefits (in alphabetical order)	**In-Network**	**Out-of-Network**
ABA Services ABA Services Age Limits: Until Covered Person's 19th Birthday	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Abortion	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Acupuncture	Not covered	Not covered
Allergy Testing	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Allergy Treatment	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Ambulance - Air	20% Coinsurance after Deductible	20% Coinsurance after In-Network Deductible
Ambulance - Ground Ground Ambulance Allowable Option: Billed Charges	20% Coinsurance after Deductible	20% Coinsurance after In-Network Deductible
Assisted Reproductive Services Combined with Infertility and Impotency Treatment Limits	Covered - Expanded	Covered - Expanded
Autism-Related Services No Limits	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Bariatric Services Maximum benefit of $50,000/Lifetime for In-Network and Out-of-Network Bariatric Coverage Locations: Blue Distinction Specialty Care Facility Only Bariatric Members Covered: All Members Bariatric Surgeries Covered: All surgeries per medical policy INN Tier 1 Cost Share Providers: Blue Distinction Specialty Care Facility Providers OON Cost Share Providers: All Non-Blue Distinction Specialty Care Facility Providers	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Blue Distinction Specialty Care Facility Services No Limits	Not Applicable	Not Applicable
Chiropractic Office Visit	$60 Copay/Visit, no Deductible	40% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Dental Anesthesia Maximum age limit of 5 Years	Missouri/Kansas Default	Missouri/Kansas Default
Diabetic Equipment and Supplies Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diabetic Footwear	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diabetic Pump	Covered as Durable Medical Equipment (DME)	Covered as Durable Medical Equipment (DME)
Diabetic Self Management Education/Training (DSMT)	No member cost share	40% Coinsurance after Deductible
Durable Medical Equipment (DME) Prior Authorization Policy Applies No Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Elective Male Sterilization	No member cost share	40% Coinsurance after Deductible
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$250 Copay/Visit, then Deductible, then 20% Coinsurance	$250 Copay/Visit, then In-Network Deductible, then 20% Coinsurance
Food and Food Products for PKU No Limits	Covered	Covered
Foot Orthotics	Not covered	Not covered
Gender Dysphoria-Related Services Prior Authorization Policy Applies Gender Dysphoria Cost Shares Apply to Cosmetic Services: Yes All cosmetic services as specified in the Medical Certificate are covered with a $10,000 Lifetime Maximum. Gender Dysphoria Cost Shares Apply to Non-Surgical Services: Yes Gender Dysphoria Cost Shares Apply to Reassignment Surgery: Yes	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Hearing Aids Maximum benefit of 1 Set/Every 48 Months for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Health Care Prior Authorization Policy Applies Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Hospice	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Diagnosis & Treatment Infertility and impotency treatment limited $30,000 per Lifetime Medical Dollar limitations include pharmacy: Yes	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Hospice Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Physician Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Labs Performed in Office / Independent Lab	No member cost share	40% Coinsurance after Deductible
Maternity Dependent Daughters Maternity Covered?: Yes	Covered	Covered
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Inpatient Physician Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Office Visit	$30 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Therapy in a Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Therapy in a Provider's Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Nutritional Counseling No Limits Nutritional Counseling Services Covered: Includes all Dx	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Organ Transplant Services Prior Authorization Policy Applies	Subject to Applicable Cost Shares **Blue Distinction Specialty Care Facility Services:** Not applicable	Subject to Applicable Cost Shares
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Physician Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Surgery Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Cardiac Therapy No Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Cognitive Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy in a Facility Combined with Hearing Therapy in a Provider's Office Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy in a Provider's Office Combined with Speech Therapy Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy in a Facility Combined with Occupational Therapy in a Provider's Office Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Outpatient Therapy - Occupational Therapy in a Provider's Office Combined with Physical Therapy Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Physical Therapy in a Facility Combined with Physical Therapy in a Provider's Office Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Physical Therapy in a Provider's Office Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Pulmonary Therapy No Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Speech Therapy in a Facility Combined with Speech Therapy in a Provider's Office Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Speech Therapy in a Provider's Office Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Penile Prostheses/Implant	Not covered	Not covered
Private Duty Nursing Combined with Home Health Care Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Routine Preventive Care Diabetes Prevention Program (DPP): Covered Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	40% Coinsurance after Deductible
Skeletal Manipulation performed in a Chiropractic Office No Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Skilled Nursing Facility (SNF) Prior Authorization Policy Applies Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Sports Physicals by a Physician	Not covered	Not covered
Vision Exam-Routine	Not covered	Not covered
Vision Hardware	Not covered	Not covered
Weight Management - Wondr Health	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology INN X-Rays and Radiology Included in Office Visit Copay: No	20% Coinsurance after Deductible	40% Coinsurance after Deductible
5. General Pharmacy Information		
Pharmacy Network(s)	**Network 1:** 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 on MyBlueKC.com	Premium Formulary	

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** Does Not Apply	**Out-of-Network** Does Not Apply
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	**Out-of-Network** Combined with Medical Out-of-Pocket
Infertility/Impotency Drugs	$30,000 Combined Medical/Pharmacy limit	
Biosimilar Product Penalty	Applies	
Maintenance Medication Program	**Mail Service Member Select** – Member must make a choice of where to obtain their maintenance medications after two courtesy fills: long-term supply through Home Delivery or a short-term supply from a retail pharmacy. **Maintenance Look Back Date:** 01/01/2020	
Generics Program	Not Applicable	
Copay Credit Accumulator Adjustment (CCAA): 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.	No	
Variable Copay Solution (VCS): When you use a drug copay card, Specialty prescription drugs may be subject to a new plan benefit cost share. This new cost share will not impact you or the price you pay.	No	
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	

6. Plan Benefits – Pharmacy		
	In-Network	**Out-of-Network**
Retail Pharmacy (Short-term supply: Up to 34 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $12 Copay/Fill	$12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance(Max: $100)	20% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance(Max: $250)	50% Coinsurance
Retail Pharmacy (Long-term supply: Between 35-102 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $36 Copay/Fill	$36 Copay/Fill, then 50% Coinsurance

Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance(Max: $300)	20% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance(Max: $750)	50% Coinsurance
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	$24 Copay/Fill	$24 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred	20% Coinsurance(Max: $200)	20% Coinsurance
Drug Tier 3: Non-Preferred	50% Coinsurance(Max: $500)	50% Coinsurance
OTC Drugs (Retail Only) OTC Drugs Retail (Short-Term) Day Supply Range: Up to 34 Days		
OTC Drugs Gastrointestinal	$1 Copay/Fill	Not applicable
OTC Drugs Allergy	$1 Copay/Fill	Not applicable
Infertility Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $12 Copay/Fill, then 50% Coinsurance	$12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance	50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance	50% Coinsurance
Infertility Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $36 Copay/Fill, then 50% Coinsurance	$36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance	50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance	50% Coinsurance
Infertility Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$24 Copay/Fill, then 50% Coinsurance	$24 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	20% Coinsurance	50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	50% Coinsurance	50% Coinsurance
Impotency Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $12 Copay/Fill, then 50% Coinsurance	$12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance	50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance	50% Coinsurance
Impotency Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $36 Copay/Fill, then 50% Coinsurance	$36 Copay/Fill, then 50% Coinsurance

Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance	50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance	50% Coinsurance
Impotency Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$24 Copay/Fill, then 50% Coinsurance	$24 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	20% Coinsurance	50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	50% Coinsurance	50% Coinsurance
Abortion Drugs	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares

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Kansas City

Plan Information	
Group Name:	Jackson County
Plan Name:	PCB QHDHP HSA PPO without Spira Plan
Group Number:	31618000
State:	Missouri
Effective Date:	01/01/2025
Important Notes:	"Gender Dysphoria-related Services" will be referred to as "Gender Affirmation Services" in the Member Certificate.
For Internal Use Only:	Package: 0447040751 XREF: CF20 Medical: 0447480332 Rx: 0448250053
1. General Plan Information	
Benefit Period	Calendar Year
Funding	Local ASO
Grandfathered Status	Non-Grandfathered
Product Family	PPO
Consumer-Driven Health Plan (CDHP)	HSA
Spira Care Plan?	No
Religious Employer?	N/A
Classification of Eligible Employees	Group Assigns
Eligibility	
Min % of Eligible Employees	75%
% Threshold of Total Employee Enrollment	90%
Minimum Employer Contribution – Eligible Employees	75%
Minimum Employer Contribution – Total Account Premium	50%
COBRA Billing	BCBS
Are Domestic Partners Covered?	Yes
Are Spouses Covered?	Yes
Are Same Sex Spouses Covered?	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Blue Connect	Blue Connect not included
Alight (Concierge service billed through Blue KC)	Alight not included

Smart Shopper	Smart Shopper Included	
2. Network		
Local Medical Network	Preferred-Care Blue Services rendered at Out-of-Network providers are subject to Out-of-Network allowables as stated in your contract, and balance billing may occur.	
Out-of-Area Medical Network	BlueCard PPO/EPO	
Pharmacy	See Pharmacy (Sections 5 & 6)	
3. Cost Sharing		
Medical Deductible - Calendar Year, Embedded All INN & OON Cross Accum	**In-Network**	**Out-of-Network**
Individual	$3,300	$3,300
Family	$6,600	$6,600
Pharmacy Deductible	Combined with Medical	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	0%	20%
Plan Pays	100%	80%
Out-of-Pocket Limit - Calendar Year, Embedded All INN & OON Cross Accum The Out-of-Pocket limit includes all Deductibles, Coinsurance, and Copayments a member pays during the Benefit Period.	**In-Network**	**Out-of-Network**
Individual	$3,300	$6,600
Family	$6,600	$13,200
Pharmacy Out-of-Pocket Limit	Combined with Medical	
Annual First Dollar Coverage	Does not apply	Does not apply
Annual Maximum	Does not apply	Does not apply
Lifetime Maximum	Does not apply	Does not apply
4. Benefits		
Professional Services	**In-Network**	**Out-of-Network**
Primary Care Physician Office Visit - An internist, family practitioner, general practitioner, or pediatrician.	Deductible, then no charge	20% Coinsurance after Deductible
Retail Health Clinic	Deductible, then no charge	20% Coinsurance after Deductible
Total Care Primary Care Physician Office Visit	Does not apply	Not applicable
Specialist Physician Office Visit - 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
Urgent Care Office Visit	Deductible, then no charge	20% Coinsurance after Deductible
Total Care Urgent Care Office Visit	Does not apply	Not applicable

Blue KC Virtual Care - Office Visit Virtual care provided by Blue KC virtual care partner(s).	Deductible, then no charge	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s).	Deductible, then no charge	Not applicable
Telehealth - Telehealth Providers other than Blue KC Virtual Care - Office Visit - Primary Care	Deductible, then no charge	20% Coinsurance after Deductible
Telehealth - Telehealth Providers other than Blue KC Virtual Care - Office Visit - Behavioral Health	Deductible, then no charge	20% Coinsurance after Deductible
Telehealth - Telehealth Providers other than Blue KC Virtual Care - Behavioral Health Therapy	Deductible, then no charge	20% Coinsurance after Deductible
Designated Health Clinic	Does not apply	Not applicable
Other Benefits (in alphabetical order)	**In-Network**	**Out-of-Network**
ABA Services ABA Services Age Limits: Until Covered Person's 19th Birthday	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Abortion	Deductible, then no charge	20% Coinsurance after Deductible
Acupuncture	Not covered	Not covered
Allergy Testing	Deductible, then no charge	20% Coinsurance after Deductible
Allergy Treatment	Deductible, then no charge	20% Coinsurance after Deductible
Ambulance - Air	Deductible, then no charge	In-Network Deductible, then no charge
Ambulance - Ground Ground Ambulance Allowable Option: Billed Charges	Deductible, then no charge	In-Network Deductible, then no charge
Assisted Reproductive Services Combined with Infertility and Impotency Treatment Limits	Covered - Expanded	Covered - Expanded
Autism-Related Services No Limits	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Bariatric Services Maximum benefit of $50,000/Lifetime for In-Network and Out-of-Network Bariatric Coverage Locations: Blue Distinction Specialty Care Facility Only Bariatric Members Covered: All Members Bariatric Surgeries Covered: All surgeries per medical policy INN Tier 1 Cost Share Providers: Blue Distinction Specialty Care Facility Providers OON Cost Share Providers: All Non-Blue Distinction Specialty Care Facility Providers	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Blue Distinction Specialty Care Facility Services No Limits	Not Applicable	Not Applicable
Chiropractic Office Visit	Deductible, then no charge	20% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Dental Anesthesia Maximum age limit of 5 Years	Missouri/Kansas Default	Missouri/Kansas Default
Diabetic Equipment and Supplies Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
Diabetic Footwear	Deductible, then no charge	20% Coinsurance after Deductible
Diabetic Pump	Covered as Durable Medical Equipment (DME)	Covered as Durable Medical Equipment (DME)
Diabetic Self Management Education/Training (DSMT)	No member cost share	20% Coinsurance after Deductible
Durable Medical Equipment (DME) Prior Authorization Policy Applies No Limits	Deductible, then no charge	20% Coinsurance after Deductible
Elective Male Sterilization	Deductible, then no charge	20% Coinsurance after Deductible
Emergency Services	Deductible, then no charge	In-Network Deductible, then no charge
Food and Food Products for PKU No Limits	Covered	Covered
Foot Orthotics	Not covered	Not covered
Gender Dysphoria-Related Services Prior Authorization Policy Applies Gender Dysphoria Cost Shares Apply to Cosmetic Services: Yes All cosmetic services as specified in the Medical Certificate are covered with a $10,000 Lifetime Maximum. Gender Dysphoria Cost Shares Apply to Non-Surgical Services: Yes Gender Dysphoria Cost Shares Apply to Reassignment Surgery: Yes	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Hearing Aids Maximum benefit of 1 Set/Every 48 Months for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
Home Health Care 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
Home Hospice	Deductible, then no charge	20% Coinsurance after Deductible
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Diagnosis & Treatment Infertility and impotency treatment limited $30,000 per Lifetime Medical Dollar limitations include pharmacy: Yes	Deductible, then no charge	20% Coinsurance after Deductible
Inpatient Hospice 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
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Inpatient Physician Services	Deductible, then no charge	20% Coinsurance after Deductible
Labs Performed in Office / Independent Lab	Deductible, then no charge	20% Coinsurance after Deductible
Maternity Dependent Daughters Maternity Covered?: Yes	Covered	Covered
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Inpatient Physician Services	Deductible, then no charge	20% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Office Visit	Deductible, then no charge	20% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Therapy in a Facility	Deductible, then no charge	20% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Therapy in a Provider's Office	Deductible, then no charge	20% Coinsurance after Deductible
Nutritional Counseling No Limits Nutritional Counseling Services Covered: Includes all Dx	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Organ Transplant Services Prior Authorization Policy Applies	Subject to Applicable Cost Shares **Blue Distinction Specialty Care Facility Services:** Not applicable	Subject to Applicable Cost Shares
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Office	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Physician Services	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Surgery Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Cardiac Therapy No Limits	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Cognitive Therapy	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy in a Facility Combined with Hearing Therapy in a Provider's Office Limits	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy in a Provider's Office Combined with Speech Therapy Limits	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy in a Facility Combined with Occupational Therapy in a Provider's Office Limits	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy in a Provider's Office Combined with Physical Therapy Limits	Deductible, then no charge	20% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Outpatient Therapy - Physical Therapy in a Facility Combined with Physical Therapy in a Provider's Office Limits	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Physical Therapy in a Provider's Office Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Pulmonary Therapy No Limits	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Speech Therapy in a Facility Combined with Speech Therapy in a Provider's Office Limits	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Speech Therapy in a Provider's Office Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
Penile Prostheses/Implant	Not covered	Not covered
Private Duty Nursing Combined with Home Health Care Limits	Deductible, then no charge	20% Coinsurance after Deductible
Routine Preventive Care Diabetes Prevention Program (DPP): Covered Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	20% Coinsurance after Deductible
Skeletal Manipulation performed in a Chiropractic Office No Limits	Deductible, then no charge	20% Coinsurance after Deductible
Skilled Nursing Facility (SNF) 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
Sports Physicals by a Physician	Not covered	Not covered
Vision Exam-Routine	Not covered	Not covered
Vision Hardware	Not covered	Not covered
Weight Management - Wondr Health	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology	Deductible, then no charge	20% Coinsurance after Deductible
5. General Pharmacy Information		
Pharmacy Network(s)	**Network 1:** 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 on MyBlueKC.com	Premium Formulary	

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** Combined with Medical Deductible	**Out-of-Network** 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** Combined with Medical Out-of-Pocket	**Out-of-Network** Combined with Medical Out-of-Pocket
Infertility/Impotency Drugs	$30,000 Combined Medical/Pharmacy limit	
Biosimilar Product Penalty	Applies	
Maintenance Medication Program	**Mail Service Member Select** – Member must make a choice of where to obtain their maintenance medications after two courtesy fills: long-term supply through Home Delivery or a short-term supply from a retail pharmacy. **Maintenance Look Back Date:** 01/01/2020	
Generics Program	Not Applicable	
Copay Credit Accumulator Adjustment (CCAA): 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.	No	
Variable Copay Solution (VCS): When you use a drug copay card, Specialty prescription drugs may be subject to a new plan benefit cost share. This new cost share will not impact you or the price you pay.	No	
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	
6. Plan Benefits – Pharmacy		
	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	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 20% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 50% Coinsurance
Retail Pharmacy (Long-term supply: Between 35-102 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Deductible, then $36 Copay/Fill, then 50% Coinsurance

Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 20% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 50% Coinsurance
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	Deductible, then no charge	Deductible, then $24 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred	Deductible, then no charge	Deductible, then 20% Coinsurance
Drug Tier 3: Non-Preferred	Deductible, then no charge	Deductible, then 50% Coinsurance
Preventive Drugs **Retail (Short-Term) Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Retail (Short-Term) Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 20% Coinsurance
Retail (Short-Term) Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 50% Coinsurance
Retail (Long-Term) Drug Tier 1: Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Retail (Long-Term) Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 20% Coinsurance
Retail (Long-Term) Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 50% Coinsurance
Mail Order Drug Tier 1: Generic / Generic Specialty	Deductible, then no charge	Deductible, then $24 Copay/Fill, then 50% Coinsurance
Mail Order Drug Tier 2: Preferred / Preferred Specialty	Deductible, then no charge	Deductible, then 20% Coinsurance
Mail Order Drug Tier 3: Non-Preferred / Non-Preferred Specialty	Deductible, then no charge	Deductible, then 50% Coinsurance
OTC Drugs (Retail Only) OTC Drugs Retail (Short-Term) Day Supply Range: Up to 34 Days		
OTC Drugs Gastrointestinal	Deductible, then no charge	Not applicable
OTC Drugs Allergy	Deductible, then no charge	Not applicable
Infertility Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 50% Coinsurance
Infertility Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 50% Coinsurance

Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 50% Coinsurance
Infertility Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	Deductible, then no charge	Deductible, then $24 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	Deductible, then no charge	Deductible, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	Deductible, then no charge	Deductible, then 50% Coinsurance
Impotency Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 50% Coinsurance
Impotency Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 50% Coinsurance
Impotency Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	Deductible, then no charge	Deductible, then $24 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	Deductible, then no charge	Deductible, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	Deductible, then no charge	Deductible, then 50% Coinsurance
Abortion Drugs	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares

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Kansas City

Plan Information	
Group Name:	Jackson County
Plan Name:	BSP EPO without Spira Plan
Group Number:	31618000
State:	Missouri
Effective Date:	01/01/2025
Important Notes:	"Gender Dysphoria-related Services" will be referred to as "Gender Affirmation Services" in the Member Certificate.
For Internal Use Only:	Package: 0449000790 XREF: CF21 Medical: 0449420433 Rx: 0450210888
1. General Plan Information	
Benefit Period	Calendar Year
Funding	Local ASO
Grandfathered Status	Non-Grandfathered
Product Family	EPO
Consumer-Driven Health Plan (CDHP)	N/A
Spira Care Plan?	No
Religious Employer?	N/A
Classification of Eligible Employees	Group Assigns
Eligibility	
Min % of Eligible Employees	75%
% Threshold of Total Employee Enrollment	90%
Minimum Employer Contribution – Eligible Employees	75%
Minimum Employer Contribution – Total Account Premium	50%
COBRA Billing	BCBS
Are Domestic Partners Covered?	Yes
Are Spouses Covered?	Yes
Are Same Sex Spouses Covered?	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Blue Connect	Blue Connect not included
Alight (Concierge service billed through Blue KC)	Alight not included

Smart Shopper	Smart Shopper Included	
2. Network		
Local Medical Network	BlueSelect Plus	
Out-of-Area Medical Network	BlueCard PPO/EPO	
Pharmacy	See Pharmacy (Sections 5 & 6)	
3. Cost Sharing		
Medical Deductible - Calendar Year, Embedded	**In-Network**	**Out-of-Network**
Individual	$0	Does not apply
Family	$0	Does not apply
Pharmacy Deductible	No Pharmacy Deductible	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	Not applicable	Does not apply
Plan Pays	100%	Does not apply
Out-of-Pocket Limit - Calendar Year, Embedded The Out-of-Pocket limit includes all Deductibles, Coinsurance, and Copayments a member pays during the Benefit Period.	**In-Network**	**Out-of-Network**
Individual	$3,500	Does not apply
Family	$8,750	Does not apply
Pharmacy Out-of-Pocket Limit	Combined with Medical	
Annual First Dollar Coverage	Does not apply	Not Covered
Annual Maximum	Does not apply	Does not apply
Lifetime Maximum	Does not apply	Does not apply
4. Benefits		
Professional Services	**In-Network**	**Out-of-Network**
Primary Care Physician Office Visit - An internist, family practitioner, general practitioner, or pediatrician.	$30 Copay/Visit	Not covered
Retail Health Clinic	No member cost share	Not covered
Total Care Primary Care Physician Office Visit	Does not apply	Not applicable
Specialist Physician Office Visit - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrists, psychologists and chiropractors.	$60 Copay/Visit	Not covered
Urgent Care Office Visit	$60 Copay/Visit	$60 Copay/Visit
Total Care Urgent Care Office Visit	Does not apply	Not applicable
Blue KC Virtual Care - Office Visit Virtual care provided by Blue KC virtual care partner(s).	$60 Copay/Visit	Not applicable

Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s).	No member cost share	Not applicable
Telehealth - Telehealth Providers other than Blue KC Virtual Care - Office Visit - Primary Care	$30 Copay/Visit	Not covered
Telehealth - Telehealth Providers other than Blue KC Virtual Care - Office Visit - Behavioral Health	$30 Copay/Visit	Not covered
Telehealth - Telehealth Providers other than Blue KC Virtual Care - Behavioral Health Therapy	No member cost share	Not covered
Designated Health Clinic	Does not apply	Not applicable
Other Benefits (in alphabetical order)	**In-Network**	**Out-of-Network**
ABA Services ABA Services Age Limits: Until Covered Person's 19th Birthday	Subject to Applicable Cost Shares	Not covered
Abortion	No member cost share	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	$100 Copay/Visit	Not covered
Allergy Treatment	No member cost share	Not covered
Ambulance - Air	No member cost share	No member cost share
Ambulance - Ground Ground Ambulance Allowable Option: Billed Charges	No member cost share	No member cost share
Assisted Reproductive Services Combined with Infertility and Impotency Treatment Limits	Covered - Expanded	Not covered
Autism-Related Services No Limits	Subject to Applicable Cost Shares	Not covered
Bariatric Services Maximum benefit of $50,000/Lifetime for In-Network Bariatric Coverage Locations: Blue Distinction Specialty Care Facility Only Bariatric Members Covered: All Members Bariatric Surgeries Covered: All surgeries per medical policy INN Tier 1 Cost Share Providers: Blue Distinction Specialty Care Facility Providers	Subject to Applicable Cost Shares	Not covered
Blue Distinction Specialty Care Facility Services No Limits	Not Applicable	Not covered
Chiropractic Office Visit	$60 Copay/Visit	Not covered
Dental Anesthesia Maximum age limit of 5 Years	Missouri/Kansas Default	Not covered
Diabetic Equipment and Supplies Prior Authorization Policy Applies In-Network	No member cost share	Not covered
Diabetic Footwear	No member cost share	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Diabetic Pump	Covered as Durable Medical Equipment (DME)	Not covered
Diabetic Self Management Education/Training (DSMT)	No member cost share	Not covered
Durable Medical Equipment (DME) Prior Authorization Policy Applies In-Network No Limits	No member cost share	Not covered
Elective Male Sterilization	No member cost share	Not covered
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$300 Copay/Visit	$300 Copay/Visit
Food and Food Products for PKU No Limits	Covered	Not covered
Foot Orthotics	Not covered	Not covered
Gender Dysphoria-Related Services Prior Authorization Policy Applies In-Network Gender Dysphoria Cost Shares Apply to Cosmetic Services: Yes All cosmetic services as specified in the Medical Certificate are covered with a $10,000 Lifetime Maximum. Gender Dysphoria Cost Shares Apply to Non-Surgical Services: Yes Gender Dysphoria Cost Shares Apply to Reassignment Surgery: Yes	Subject to Applicable Cost Shares	Not covered
Hearing Aids Maximum benefit of 1 Set/Every 48 Months for In-Network	No member cost share	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies In-Network High Tech Radiology ER Copay Waiver Rule (when ER Copay also applies): High Tech Radiology Copay Waived	$250 Copay/Provider per Day	Not covered
Home Health Care Prior Authorization Policy Applies In-Network Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Home Hospice	No member cost share	Not covered
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Diagnosis & Treatment Infertility and impotency treatment limited $30,000 per Lifetime Medical Dollar limitations include pharmacy: Yes	No member cost share	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Inpatient Hospice Prior Authorization Policy Applies In-Network Maximum benefit of 14 Day(s)/Lifetime for In-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$200 Copay/Day Limited to $2,000 Copay Max per Calendar Year	Not covered
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies In-Network	$400 Copay/Day Limited to Inpatient/Outpatient $2,000 Copay Max per Calendar Year	Not covered
Inpatient Physician Services	No member cost share	Not covered
Labs Performed in Office / Independent Lab	No member cost share	Not covered
Maternity Dependent Daughters Maternity Covered?: Yes	Covered	Not covered
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies In-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$400 Copay/Day Limited to $2,000 Copay Max per Calendar Year	Not covered
Mental Health and Substance Abuse Services - Inpatient Physician Services	No member cost share	Not covered
Mental Health and Substance Abuse Services - Office Visit	$30 Copay/Visit	Not covered
Mental Health and Substance Abuse Services - Outpatient Therapy in a Facility	No member cost share	Not covered
Mental Health and Substance Abuse Services - Outpatient Therapy in a Provider's Office	No member cost share	Not covered
Nutritional Counseling No Limits Nutritional Counseling Services Covered: Includes all Dx	Subject to Applicable Cost Shares	Not covered
Organ Transplant Services Prior Authorization Policy Applies In-Network	Subject to Applicable Cost Shares **Blue Distinction Specialty Care Facility Services:** Not applicable	Not covered
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Office	No member cost share	Not covered
Outpatient Physician Services	No member cost share	Not covered
Outpatient Surgery Prior Authorization Policy Applies In-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$400 Copay/Day Limited to $2,000 Copay Max per Calendar Year	Not covered
Outpatient Therapy - Cardiac Therapy No Limits	No member cost share	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Outpatient Therapy - Cognitive Therapy	No member cost share	Not covered
Outpatient Therapy - Hearing Therapy in a Facility Combined with Hearing Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Hearing Therapy in a Provider's Office Combined with Speech Therapy Limits	No member cost share	Not covered
Outpatient Therapy - Occupational Therapy in a Facility Combined with Occupational Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Occupational Therapy in a Provider's Office Combined with Physical Therapy Limits	No member cost share	Not covered
Outpatient Therapy - Physical Therapy in a Facility Combined with Physical Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Physical Therapy in a Provider's Office Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Outpatient Therapy - Pulmonary Therapy No Limits	No member cost share	Not covered
Outpatient Therapy - Speech Therapy in a Facility Combined with Speech Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Speech Therapy in a Provider's Office Maximum benefit of 20 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Penile Prostheses/Implant	Not covered	Not covered
Private Duty Nursing Combined with Home Health Care Limits	No member cost share	Not covered
Routine Preventive Care Diabetes Prevention Program (DPP): Covered Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	Not covered
Skeletal Manipulation performed in a Chiropractic Office No Limits	No member cost share	Not covered
Skilled Nursing Facility (SNF) Prior Authorization Policy Applies In-Network Maximum benefit of 30 Day(s)/Calendar Year for In-Network	No member cost share	Not covered
Sports Physicals by a Physician	Not covered	Not covered
Vision Exam-Routine	Not covered	Not covered
Vision Hardware	Not covered	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Weight Management - Wondr Health	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology INN X-Rays and Radiology Included in Office Visit Copay: No	No member cost share	Not covered
5. General Pharmacy Information		
Pharmacy Network(s)	**Network 1:** 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 on MyBlueKC.com	Premium Formulary	
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** Does Not Apply	**Out-of-Network** Does Not Apply
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	**Out-of-Network** Does not apply

Infertility/Impotency Drugs	$30,000 Combined Medical/Pharmacy limit
Biosimilar Product Penalty	Applies
Maintenance Medication Program	**Mail Service Member Select** – Member must make a choice of where to obtain their maintenance medications after two courtesy fills: long-term supply through Home Delivery or a short-term supply from a retail pharmacy. **Maintenance Look Back Date:** 01/01/2020
Generics Program	Not Applicable
Copay Credit Accumulator Adjustment (CCAA): 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.	No
Variable Copay Solution (VCS): When you use a drug copay card, Specialty prescription drugs may be subject to a new plan benefit cost share. This new cost share will not impact you or the price you pay.	No
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

6. Plan Benefits – Pharmacy		
	In-Network	**Out-of-Network**
Retail Pharmacy (Short-term supply: Up to 34 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $12 Copay/Fill	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance(Max: $100)	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance(Max: $250)	Not covered
Retail Pharmacy (Long-term supply: Between 35-102 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $36 Copay/Fill	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance(Max: $300)	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance(Max: $750)	Not covered
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	$24 Copay/Fill	Not covered
Drug Tier 2: Preferred	20% Coinsurance(Max: $200)	Not covered
Drug Tier 3: Non-Preferred	50% Coinsurance(Max: $500)	Not covered

OTC Drugs (Retail Only) OTC Drugs Retail (Short-Term) Day Supply Range: Up to 34 Days		
OTC Drugs Gastrointestinal	$1 Copay/Fill	Not Covered
OTC Drugs Allergy	$1 Copay/Fill	Not Covered
Infertility Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $12 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance	Not covered
Infertility Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $36 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance	Not covered
Infertility Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$24 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred / Preferred Specialty	20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	50% Coinsurance	Not covered
Impotency Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $12 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance	Not covered
Impotency Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $36 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** 20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** 50% Coinsurance	Not covered
Impotency Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$24 Copay/Fill, then 50% Coinsurance	Not covered

Drug Tier 2: Preferred / Preferred Specialty	20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	50% Coinsurance	Not covered
Abortion Drugs	Subject to Applicable Cost Shares	Not covered

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Kansas City

Plan Information	
Group Name:	Jackson County
Plan Name:	BSP QHDHP HSA EPO with Spira Plan
Group Number:	31618000
State:	Missouri
Effective Date:	01/01/2025
Important Notes:	"Gender Dysphoria-related Services" will be referred to as "Gender Affirmation Services" in the Member Certificate.
For Internal Use Only:	Package: 0450550359 XREF: CF22 Medical: 0451340626 Rx: 0452060800
1. General Plan Information	
Benefit Period	Calendar Year
Funding	Local ASO
Grandfathered Status	Non-Grandfathered
Product Family	EPO
Consumer-Driven Health Plan (CDHP)	HSA
Spira Care Plan?	Yes No charge (after deductible) for services received from a designated Spira Care Center Provider. Treatment of work-related injury or illness is not covered under your Blue Cross and Blue Shield of Kansas City health benefit plan. Treatment of work-related injuries and illnesses is typically provided through your workers' compensation program. The Spira Care clinics are not participating providers under workers' compensation programs. Please reference your workers' compensation policies and procedures to direct your employees appropriately for work-related injuries.
Religious Employer?	N/A
Classification of Eligible Employees	Group Assigns
Eligibility	
Min % of Eligible Employees	75%
% Threshold of Total Employee Enrollment	90%
Minimum Employer Contribution – Eligible Employees	75%
Minimum Employer Contribution – Total Account Premium	50%
COBRA Billing	BCBS
Are Domestic Partners Covered?	Yes
Are Spouses Covered?	Yes

Are Same Sex Spouses Covered?	Yes	
Insurance Coverage Creditable (Medicare Part D)	Yes	
Blue Connect	Blue Connect not included	
Alight (Concierge service billed through Blue KC)	Alight not included	
Smart Shopper	Smart Shopper Included	
2. Network		
Local Medical Network	BlueSelect Plus	
Out-of-Area Medical Network	BlueCard PPO/EPO	
Pharmacy	See Pharmacy (Sections 5 & 6)	
3. Cost Sharing		
Medical Deductible - Calendar Year, Embedded	**In-Network**	**Out-of-Network**
Individual	$3,300	Does not apply
Family	$6,600	Does not apply
Pharmacy Deductible	Combined with Medical	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	Not applicable	Does not apply
Plan Pays	100%	Does not apply
Out-of-Pocket Limit - Calendar Year, Embedded The Out-of-Pocket limit includes all Deductibles, Coinsurance, and Copayments a member pays during the Benefit Period.	**In-Network**	**Out-of-Network**
Individual	$3,300	Does not apply
Family	$6,600	Does not apply
Pharmacy Out-of-Pocket Limit	Combined with Medical	
Annual First Dollar Coverage	Does not apply	Not Covered
Annual Maximum	Does not apply	Does not apply
Lifetime Maximum	Does not apply	Does not apply
4. Benefits		
Professional Services	**In-Network**	**Out-of-Network**
Primary Care Physician Office Visit - An internist, family practitioner, general practitioner, or pediatrician.	Deductible, then no charge	Not covered
Retail Health Clinic	Deductible, then no charge	Not covered
Total Care Primary Care Physician Office Visit	Does not apply	Not applicable
Specialist Physician Office Visit - 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	Not covered
Urgent Care Office Visit	Deductible, then no charge	In-Network Deductible, then no charge

Total Care Urgent Care Office Visit	Does not apply	Not applicable
Blue KC Virtual Care - Office Visit Virtual care provided by Blue KC virtual care partner(s).	Deductible, then no charge	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s).	Deductible, then no charge	Not applicable
Telehealth - Telehealth Providers other than Blue KC Virtual Care - Office Visit - Primary Care	Deductible, then no charge	Not covered
Telehealth - Telehealth Providers other than Blue KC Virtual Care - Office Visit - Behavioral Health	Deductible, then no charge	Not covered
Telehealth - Telehealth Providers other than Blue KC Virtual Care - Behavioral Health Therapy	Deductible, then no charge	Not covered
Designated Health Clinic	Does not apply	Not applicable
Other Benefits (in alphabetical order)	**In-Network**	**Out-of-Network**
ABA Services ABA Services Age Limits: Until Covered Person's 19th Birthday	Subject to Applicable Cost Shares	Not covered
Abortion	Deductible, then no charge	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	Deductible, then no charge	Not covered
Allergy Treatment	Deductible, then no charge	Not covered
Ambulance - Air	Deductible, then no charge	In-Network Deductible, then no charge
Ambulance - Ground Ground Ambulance Allowable Option: Billed Charges	Deductible, then no charge	In-Network Deductible, then no charge
Assisted Reproductive Services Combined with Infertility and Impotency Treatment Limits	Covered - Expanded	Not covered
Autism-Related Services No Limits	Subject to Applicable Cost Shares	Not covered
Bariatric Services Maximum benefit of $50,000/Lifetime for In-Network Bariatric Coverage Locations: Blue Distinction Specialty Care Facility Only Bariatric Members Covered: All Members Bariatric Surgeries Covered: All surgeries per medical policy INN Tier 1 Cost Share Providers: Blue Distinction Specialty Care Facility Providers	Subject to Applicable Cost Shares	Not covered
Blue Distinction Specialty Care Facility Services No Limits	Not Applicable	Not covered
Chiropractic Office Visit	Deductible, then no charge	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Dental Anesthesia Maximum age limit of 5 Years	Missouri/Kansas Default	Not covered
Diabetic Equipment and Supplies Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Diabetic Footwear	Deductible, then no charge	Not covered
Diabetic Pump	Covered as Durable Medical Equipment (DME)	Not covered
Diabetic Self Management Education/Training (DSMT)	No member cost share	Not covered
Durable Medical Equipment (DME) Prior Authorization Policy Applies In-Network No Limits	Deductible, then no charge	Not covered
Elective Male Sterilization	Deductible, then no charge	Not covered
Emergency Services	Deductible, then no charge	In-Network Deductible, then no charge
Food and Food Products for PKU No Limits	Covered	Not covered
Foot Orthotics	Not covered	Not covered
Gender Dysphoria-Related Services Prior Authorization Policy Applies In-Network Gender Dysphoria Cost Shares Apply to Cosmetic Services: Yes All cosmetic services as specified in the Medical Certificate are covered with a $10,000 Lifetime Maximum. Gender Dysphoria Cost Shares Apply to Non-Surgical Services: Yes Gender Dysphoria Cost Shares Apply to Reassignment Surgery: Yes	Subject to Applicable Cost Shares	Not covered
Hearing Aids Maximum benefit of 1 Set/Every 48 Months for In-Network	Deductible, then no charge	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Home Health Care Prior Authorization Policy Applies In-Network Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Home Hospice	Deductible, then no charge	Not covered
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Diagnosis & Treatment Infertility and impotency treatment limited $30,000 per Lifetime Medical Dollar limitations include pharmacy: Yes	Deductible, then no charge	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Inpatient Hospice Prior Authorization Policy Applies In-Network Maximum benefit of 14 Day(s)/Lifetime for In-Network	Deductible, then no charge	Not covered
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Inpatient Physician Services	Deductible, then no charge	Not covered
Labs Performed in Office / Independent Lab	Deductible, then no charge	Not covered
Maternity Dependent Daughters Maternity Covered?: Yes	Covered	Not covered
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Mental Health and Substance Abuse Services - Inpatient Physician Services	Deductible, then no charge	Not covered
Mental Health and Substance Abuse Services - Office Visit	Deductible, then no charge	Not covered
Mental Health and Substance Abuse Services - Outpatient Therapy in a Facility	Deductible, then no charge	Not covered
Mental Health and Substance Abuse Services - Outpatient Therapy in a Provider's Office	Deductible, then no charge	Not covered
Nutritional Counseling No Limits Nutritional Counseling Services Covered: Includes all Dx	Subject to Applicable Cost Shares	Not covered
Organ Transplant Services Prior Authorization Policy Applies In-Network	Subject to Applicable Cost Shares **Blue Distinction Specialty Care Facility Services:** Not applicable	Not covered
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Office	Deductible, then no charge	Not covered
Outpatient Physician Services	Deductible, then no charge	Not covered
Outpatient Surgery Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Outpatient Therapy - Cardiac Therapy No Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Cognitive Therapy	Deductible, then no charge	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Outpatient Therapy - Hearing Therapy in a Facility Combined with Hearing Therapy in a Provider's Office Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Hearing Therapy in a Provider's Office Combined with Speech Therapy Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Occupational Therapy in a Facility Combined with Occupational Therapy in a Provider's Office Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Occupational Therapy in a Provider's Office Combined with Physical Therapy Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Physical Therapy in a Facility Combined with Physical Therapy in a Provider's Office Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Physical Therapy in a Provider's Office Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Outpatient Therapy - Pulmonary Therapy No Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Speech Therapy in a Facility Combined with Speech Therapy in a Provider's Office Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Speech Therapy in a Provider's Office Maximum benefit of 20 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Penile Prostheses/Implant	Not covered	Not covered
Private Duty Nursing Combined with Home Health Care Limits	Deductible, then no charge	Not covered
Routine Preventive Care Diabetes Prevention Program (DPP): Covered Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	Not covered
Skeletal Manipulation performed in a Chiropractic Office No Limits	Deductible, then no charge	Not covered
Skilled Nursing Facility (SNF) Prior Authorization Policy Applies In-Network Maximum benefit of 30 Day(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Sports Physicals by a Physician	Not covered	Not covered
Vision Exam-Routine	Not covered	Not covered
Vision Hardware	Not covered	Not covered
Weight Management - Wondr Health	Not covered	Not covered
Wigs	Not covered	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
X-Rays and Radiology	Deductible, then no charge	Not covered
5. General Pharmacy Information		
Pharmacy Network(s)	**Network 1:** 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 on MyBlueKC.com	Premium Formulary	
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** Combined with Medical Deductible	**Out-of-Network** Does not Apply
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	**Out-of-Network** Does not apply
Infertility/Impotency Drugs	$30,000 Combined Medical/Pharmacy limit	
Biosimilar Product Penalty	Applies	
Maintenance Medication Program	Not applicable	
Generics Program	Not Applicable	
Copay Credit Accumulator Adjustment (CCAA): 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.	No	
Variable Copay Solution (VCS): When you use a drug copay card, Specialty prescription drugs may be subject to a new plan benefit cost share. This new cost share will not impact you or the price you pay.	No	
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	
6. Plan Benefits – Pharmacy		
	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	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then no charge	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then no charge	Not covered
Retail Pharmacy (Long-term supply: Between 35-102 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then no charge	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then no charge	Not covered
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	Deductible, then no charge	Not covered
Drug Tier 2: Preferred	Deductible, then no charge	Not covered
Drug Tier 3: Non-Preferred	Deductible, then no charge	Not covered
Preventive Drugs **Retail (Short-Term) Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Not covered
Retail (Short-Term) Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then no charge	Not covered
Retail (Short-Term) Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then no charge	Not covered
Retail (Long-Term) Drug Tier 1: Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Not covered
Retail (Long-Term) Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then no charge	Not covered
Retail (Long-Term) Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then no charge	Not covered
Mail Order Drug Tier 1: Generic / Generic Specialty	Deductible, then no charge	Not covered
Mail Order Drug Tier 2: Preferred / Preferred Specialty	Deductible, then no charge	Not covered
Mail Order Drug Tier 3: Non-Preferred / Non-Preferred Specialty	Deductible, then no charge	Not covered
OTC Drugs (Retail Only) OTC Drugs Retail (Short-Term) Day Supply Range: Up to 34 Days		
OTC Drugs Gastrointestinal	Deductible, then no charge	Not Covered
OTC Drugs Allergy	Deductible, then no charge	Not Covered

Infertility Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then no charge	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then no charge	Not covered
Infertility Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then no charge	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then no charge	Not covered
Infertility Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	Deductible, then no charge	Not covered
Drug Tier 2: Preferred / Preferred Specialty	Deductible, then no charge	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	Deductible, then no charge	Not covered
Impotency Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then no charge	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then no charge	Not covered
Impotency Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Not covered
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then no charge	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then no charge	Not covered
Impotency Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	Deductible, then no charge	Not covered
Drug Tier 2: Preferred / Preferred Specialty	Deductible, then no charge	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	Deductible, then no charge	Not covered
Abortion Drugs	Subject to Applicable Cost Shares	Not covered

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