Kansas City

Confirmation of Coverage

Group Name:	Raytown C - 2 School District
Offer Name:	Renewal
Group Number:	33060000
State:	Missouri
Effective Date:	07/01/2024
Important Notes:	

Offer-Related Information

A. General Information	
Contract Term:	12 Months
Subsequent Renewal Terms:	12 Months
Renewal Notification:	180 Days
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:	Group Assigns
Leave of Absence Term:	Not applicable
Dependent Limiting Age:	26 Years
Dependent Limiting Age Termination:	EOM 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:	$45,000
24-Hour Nurse Line:	No
Healthy Companion:	Yes
Virtual Care:	Yes
Livongo Program:	Yes

Genetic Testing:	Yes
APEA:	Yes
Rx Savings Solution:	Yes
Rx Rewards Incentive Program	No
Rx Carve-in Credits:	Yes $40.00 - 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

Offer Summary and Signatures

Plans included in this Offer:

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

Preferred Care Blue PPO BlueSaver (CDOV)
Preferred Care Blue PPO $2500 Deductible (CDP0)
Preferred Care Blue PPO $1500 Deductible (CDOX)
Preferred Care Blue PPO $1000 Deductible (CDOY)
Blue Select Plus PPO BlueSaver (CDOZ)
Blue Select Plus PPO $2500 Deductible (CDOW)

Confirmed by: Raytown C - 2 School District

Signature

Title

Date

Accepted by Blue Cross and Blue Shield of Kansas City:

Signature

Title

Date

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Kansas City

Plan Information	
Group Name:	Raytown C - 2 School District
Plan Name:	Preferred Care Blue PPO BlueSaver
Group Number:	33060000
State:	Missouri
Effective Date:	07/01/2024
Important Notes:	
For Internal Use Only:	Package: 2858230816 XREF: CDOV Medical: 2858460271 Rx: 2858520367

1. General Plan Information	
Benefit Period	Calendar Year
Funding	Cost Plus
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	All full-time employees who are currently working 30 hours per week; Retirees and their Dependents who are eligible in accordance with the Employer's Employee Benefits Program; grandfathered employees working prorated hours (10-19 hours and 20 - 29 hours)
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?	No
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	$3,200	$3,200
Family	$6,400	$6,400
Pharmacy Deductible	Combined with Medical	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	10%	30%
Plan Pays	90%	70%
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	$4,300	$8,600
Family	$8,600	$17,200
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.	10% Coinsurance after Deductible	30% 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.	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care Office Visit	10% Coinsurance after Deductible	30% 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).	10% Coinsurance after Deductible	Not applicable

Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s).	10% Coinsurance after Deductible	Not applicable
Telehealth – Telehealth Providers other than Blue KC Virtual Care - Office Visit – Primary Care	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Telehealth – Telehealth Providers other than Blue KC Virtual Care - Office Visit – Behavioral Health	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Telehealth – Telehealth Providers other than Blue KC Virtual Care - Behavioral Health Therapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Designated Health Clinic Name of Clinic: Raytown Schools Quality Care Clinic	Deductible, then no charge	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	Not covered	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Allergy Treatment	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Ambulance - Air	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
Ambulance - Ground Ground Ambulance Allowable Option: 150% of Medicare	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
Assisted Reproductive Services	Not covered	Not covered
Autism-Related Services No Limits	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Bariatric Services	Not covered	Not covered
Blue Distinction Specialty Care Facility Services No Limits	Not Applicable	Not Applicable
Chiropractic Services Office Visit	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Dental Anesthesia Maximum age limit of 5 Years	Missouri/Kansas Default	Missouri/Kansas Default
Diabetic Equipment and Supplies Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Diabetic Footwear	10% Coinsurance after Deductible	30% 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	30% Coinsurance after Deductible
Durable Medical Equipment (DME) Prior Authorization Policy Applies No Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Elective Male Sterilization	Deductible, then no charge	30% Coinsurance after Deductible
Emergency Services	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
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: No 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	10% Coinsurance after Deductible	30% Coinsurance after Deductible
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% 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	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Home Hospice	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Diagnosis & Treatment Infertility and impotency treatment limited $10,000 per Lifetime Medical Dollar limitations include pharmacy: Yes	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Hospice Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Physician Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Labs Performed in Office / Independent Lab	10% Coinsurance after Deductible	30% 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	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Inpatient Physician Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Mental Health and Substance Abuse Services - Office Visit	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Therapy in a Facility	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Therapy in a Provider's Office	10% Coinsurance after Deductible	30% 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	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Physician Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Surgery Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Cardiac Therapy No Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Cognitive Therapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy in a Facility Combined with Hearing Therapy in a Provider's Office Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy in a Provider's Office Combined with Speech Therapy Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy in a Facility Combined with Occupational Therapy in a Provider's Office Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy in a Provider's Office Combined with Physical Therapy Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Physical Therapy in a Facility Combined with Physical Therapy in a Provider's Office Limits	10% Coinsurance after Deductible	30% 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	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Pulmonary Therapy No Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Speech Therapy in a Facility Combined with Speech Therapy in a Provider's Office Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Outpatient Therapy - Speech Therapy in a Provider's Office Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Penile Prostheses/Implant	Not covered	Not covered
Private Duty Nursing Combined with Home Health Care Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Routine Preventive Care Diabetes Prevention Program (DPP): Covered Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	30% Coinsurance after Deductible
Skeletal Manipulation performed in a Chiropractic Office	10% Coinsurance after Deductible	30% 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	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Sports Physicals by a Physician	Not covered	Not covered
Vision Exam-Routine Maximum benefit of 1 Exam/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Vision Hardware	Not covered	Not covered
Weight Loss Drugs (see Pharmacy cost shares)	Not covered	Not covered
Weight Management - Wondr Health	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology	10% Coinsurance after Deductible	30% 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	$10,000 Combined Medical/Pharmacy limit
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.	Yes
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 $12 Copay/Fill	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then $55 Copay/Fill	Deductible, then $55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then $75 Copay/Fill	Deductible, then $75 Copay/Fill, then 50% Coinsurance
Retail Pharmacy (Long-term supply: Between 35-102 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:**Deductible, then $36 Copay/ Fill	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:**Deductible, then $165 Copay/Fill	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:**Deductible, then $225 Copay/Fill	Deductible, then $225 Copay/Fill, then 50% Coinsurance
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	Deductible, then $36 Copay/Fill	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred	Deductible, then $165 Copay/Fill	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred	Deductible, then $225 Copay/Fill	Deductible, then $225 Copay/Fill, then 50% Coinsurance

Preventive Drugs **Preventive Drugs List: All Preventive** **Retail (Short-Term) Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** No member cost share	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Retail (Short-Term) Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** No member cost share	Deductible, then $55 Copay/Fill, then 50% Coinsurance
Retail (Short-Term) Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** No member cost share	Deductible, then $75 Copay/Fill, then 50% Coinsurance
Retail (Long-Term) Drug Tier 1: Generic / Generic Specialty	**RxPremier:**No member cost share	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Retail (Long-Term) Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:**No member cost share	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Retail (Long-Term) Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:**No member cost share	Deductible, then $225 Copay/Fill, then 50% Coinsurance
Mail Order Drug Tier 1: Generic / Generic Specialty	No member cost share	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Mail Order Drug Tier 2: Preferred / Preferred Specialty	No member cost share	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Mail Order Drug Tier 3: Non-Preferred / Non-Preferred Specialty	No member cost share	Deductible, then $225 Copay/Fill, then 50% Coinsurance
Infertility Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then $12 Copay/Fill, then 50% Coinsurance	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then $55 Copay/Fill, then 50% Coinsurance	Deductible, then $55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then $75 Copay/Fill, then 50% Coinsurance	Deductible, then $75 Copay/Fill, then 50% Coinsurance
Infertility Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then $36 Copay/Fill, then 50% Coinsurance	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then $165 Copay/Fill, then 50% Coinsurance	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then $225 Copay/Fill, then 50% Coinsurance	Deductible, then $225 Copay/Fill, then 50% Coinsurance
Infertility Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	Deductible, then $36 Copay/Fill, then 50% Coinsurance	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	Deductible, then $165 Copay/Fill, then 50% Coinsurance	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	Deductible, then $225 Copay/Fill, then 50% Coinsurance	Deductible, then $225 Copay/Fill, then 50% Coinsurance

Impotency Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then $12 Copay/Fill, then 50% Coinsurance	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then $55 Copay/Fill, then 50% Coinsurance	Deductible, then $55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then $75 Copay/Fill, then 50% Coinsurance	Deductible, then $75 Copay/Fill, then 50% Coinsurance
Impotency Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then $36 Copay/Fill, then 50% Coinsurance	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then $165 Copay/Fill, then 50% Coinsurance	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then $225 Copay/Fill, then 50% Coinsurance	Deductible, then $225 Copay/Fill, then 50% Coinsurance
Impotency Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	Deductible, then $36 Copay/Fill, then 50% Coinsurance	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	Deductible, then $165 Copay/Fill, then 50% Coinsurance	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	Deductible, then $225 Copay/Fill, then 50% Coinsurance	Deductible, then $225 Copay/Fill, then 50% Coinsurance
Weight Loss Drugs	Not covered	Not covered
Abortion Drugs	Not covered	Not covered

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Kansas City

Plan Information	
Group Name:	Raytown C - 2 School District
Plan Name:	Preferred Care Blue PPO $2500 Deductible
Group Number:	33060000
State:	Missouri
Effective Date:	07/01/2024
Important Notes:	
For Internal Use Only:	Package: 2838480301 XREF: CDP0 Medical: 2842510420 Rx: 2858360977

1. General Plan Information	
Benefit Period	Calendar Year
Funding	Cost Plus
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	All full-time employees who are currently working 30 hours per week; Retirees and their Dependents who are eligible in accordance with the Employer's Employee Benefits Program; grandfathered employees working prorated hours (10-19 hours and 20 - 29 hours)
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?	No
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	$2,500	$3,150
Family	$7,500	$9,450
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	$6,300	$12,600
Family	$13,200	$37,800
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.	$35 Copay/Visit, no Deductible	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.	$70 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Urgent Care Office Visit	$70 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).	$70 Copay/Visit, no Deductible	Not applicable

Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s).	20% Coinsurance after Deductible	Not applicable
Telehealth – Telehealth Providers other than Blue KC Virtual Care - Office Visit – Primary Care	$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Telehealth – Telehealth Providers other than Blue KC Virtual Care - Office Visit – Behavioral Health	$35 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 Name of Clinic: Raytown Schools Quality Care Clinic	No member cost share	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	Not covered	Not covered
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: 150% of Medicare	20% Coinsurance after Deductible	20% Coinsurance after In-Network Deductible
Assisted Reproductive Services	Not covered	Not covered
Autism-Related Services No Limits	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Bariatric Services	Not covered	Not covered
Blue Distinction Specialty Care Facility Services No Limits	Not Applicable	Not Applicable
Chiropractic Services Office Visit	$70 Copay/Visit, no Deductible	40% Coinsurance after Deductible
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

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Elective Male Sterilization	No member cost share	40% Coinsurance after Deductible
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$200 Copay/Visit, then Deductible, then 20% Coinsurance	$200 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: No 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 $10,000 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
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

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Mental Health and Substance Abuse Services - Office Visit	$35 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
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

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
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	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 Maximum benefit of 1 Exam/Calendar Year for In-Network and Out-of-Network	$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Vision Hardware	Not covered	Not covered
Weight Loss Drugs (see Pharmacy cost shares)	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	$10,000 Combined Medical/Pharmacy limit
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.	Yes
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.	Yes
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:** $55 Copay/Fill	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $75 Copay/Fill	$75 Copay/Fill, then 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:**$165 Copay/Fill	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:**$225 Copay/Fill	$225 Copay/Fill, then 50% Coinsurance
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	$36 Copay/Fill	$36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred	$165 Copay/Fill	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred	$225 Copay/Fill	$225 Copay/Fill, then 50% Coinsurance

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:** $55 Copay/Fill, then 50% Coinsurance	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $75 Copay/Fill, then 50% Coinsurance	$75 Copay/Fill, then 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:** $165 Copay/Fill, then 50% Coinsurance	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $225 Copay/Fill, then 50% Coinsurance	$225 Copay/Fill, then 50% Coinsurance
Infertility Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$36 Copay/Fill, then 50% Coinsurance	$36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	$165 Copay/Fill, then 50% Coinsurance	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	$225 Copay/Fill, then 50% Coinsurance	$225 Copay/Fill, then 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:** $55 Copay/Fill, then 50% Coinsurance	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $75 Copay/Fill, then 50% Coinsurance	$75 Copay/Fill, then 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:** $165 Copay/Fill, then 50% Coinsurance	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $225 Copay/Fill, then 50% Coinsurance	$225 Copay/Fill, then 50% Coinsurance
Impotency Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$36 Copay/Fill, then 50% Coinsurance	$36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	$165 Copay/Fill, then 50% Coinsurance	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	$225 Copay/Fill, then 50% Coinsurance	$225 Copay/Fill, then 50% Coinsurance
Weight Loss Drugs	Not covered	Not covered
Abortion Drugs	Not covered	Not covered

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Kansas City

Plan Information	
Group Name:	Raytown C - 2 School District
Plan Name:	Preferred Care Blue PPO $1500 Deductible
Group Number:	33060000
State:	Missouri
Effective Date:	07/01/2024
Important Notes:	
For Internal Use Only:	Package: 2858300367 XREF: CDOX Medical: 2859020592 Rx: 2858360977

1. General Plan Information	
Benefit Period	Calendar Year
Funding	Cost Plus
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	All full-time employees who are currently working 30 hours per week; Retirees and their Dependents who are eligible in accordance with the Employer's Employee Benefits Program; grandfathered employees working prorated hours (10-19 hours and 20 - 29 hours)
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?	No
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	$1,500	$1,750
Family	$4,500	$5,250
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	$5,750	$17,250
Family	$13,100	$34,500
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.	$35 Copay/Visit, no Deductible	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.	$70 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Urgent Care Office Visit	$70 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).	$70 Copay/Visit, no Deductible	Not applicable

Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s).	20% Coinsurance after Deductible	Not applicable
Telehealth – Telehealth Providers other than Blue KC Virtual Care - Office Visit – Primary Care	$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Telehealth – Telehealth Providers other than Blue KC Virtual Care - Office Visit – Behavioral Health	$35 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 Name of Clinic: Raytown Schools Quality Care Clinic	No member cost share	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	Not covered	Not covered
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: 150% of Medicare	20% Coinsurance after Deductible	20% Coinsurance after In-Network Deductible
Assisted Reproductive Services	Not covered	Not covered
Autism-Related Services No Limits	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Bariatric Services	Not covered	Not covered
Blue Distinction Specialty Care Facility Services No Limits	Not Applicable	Not Applicable
Chiropractic Services Office Visit	$70 Copay/Visit, no Deductible	40% Coinsurance after Deductible
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

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Elective Male Sterilization	No member cost share	40% Coinsurance after Deductible
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$200 Copay/Visit, then Deductible, then 20% Coinsurance	$200 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: No 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 $10,000 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
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

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Mental Health and Substance Abuse Services - Office Visit	$35 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
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

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
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	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 Maximum benefit of 1 Exam/Calendar Year for In-Network and Out-of-Network	$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Vision Hardware	Not covered	Not covered
Weight Loss Drugs (see Pharmacy cost shares)	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	$10,000 Combined Medical/Pharmacy limit
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.	Yes
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.	Yes
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:** $55 Copay/Fill	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $75 Copay/Fill	$75 Copay/Fill, then 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:**$165 Copay/Fill	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:**$225 Copay/Fill	$225 Copay/Fill, then 50% Coinsurance
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	$36 Copay/Fill	$36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred	$165 Copay/Fill	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred	$225 Copay/Fill	$225 Copay/Fill, then 50% Coinsurance

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:** $55 Copay/Fill, then 50% Coinsurance	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $75 Copay/Fill, then 50% Coinsurance	$75 Copay/Fill, then 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:** $165 Copay/Fill, then 50% Coinsurance	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $225 Copay/Fill, then 50% Coinsurance	$225 Copay/Fill, then 50% Coinsurance
Infertility Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$36 Copay/Fill, then 50% Coinsurance	$36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	$165 Copay/Fill, then 50% Coinsurance	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	$225 Copay/Fill, then 50% Coinsurance	$225 Copay/Fill, then 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:** $55 Copay/Fill, then 50% Coinsurance	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $75 Copay/Fill, then 50% Coinsurance	$75 Copay/Fill, then 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:** $165 Copay/Fill, then 50% Coinsurance	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $225 Copay/Fill, then 50% Coinsurance	$225 Copay/Fill, then 50% Coinsurance
Impotency Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$36 Copay/Fill, then 50% Coinsurance	$36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	$165 Copay/Fill, then 50% Coinsurance	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	$225 Copay/Fill, then 50% Coinsurance	$225 Copay/Fill, then 50% Coinsurance
Weight Loss Drugs	Not covered	Not covered
Abortion Drugs	Not covered	Not covered

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Kansas City

Plan Information	
Group Name:	Raytown C - 2 School District
Plan Name:	Preferred Care Blue PPO $1000 Deductible
Group Number:	33060000
State:	Missouri
Effective Date:	07/01/2024
Important Notes:	
For Internal Use Only:	Package: 2858330687 XREF: CDOY Medical: 2858390982 Rx: 2858360977

1. General Plan Information	
Benefit Period	Calendar Year
Funding	Cost Plus
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	All full-time employees who are currently working 30 hours per week; Retirees and their Dependents who are eligible in accordance with the Employer's Employee Benefits Program; grandfathered employees working prorated hours (10-19 hours and 20 - 29 hours)
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?	No
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	$1,250
Family	$3,000	$3,750
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	$5,400	$10,800
Family	$12,750	$32,400
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.	$35 Copay/Visit, no Deductible	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.	$70 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Urgent Care Office Visit	$70 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).	$70 Copay/Visit, no Deductible	Not applicable

Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s).	20% Coinsurance after Deductible	Not applicable
Telehealth – Telehealth Providers other than Blue KC Virtual Care - Office Visit – Primary Care	$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Telehealth – Telehealth Providers other than Blue KC Virtual Care - Office Visit – Behavioral Health	$35 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 Name of Clinic: Raytown Schools Quality Care Clinic	No member cost share	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	Not covered	Not covered
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: 150% of Medicare	20% Coinsurance after Deductible	20% Coinsurance after In-Network Deductible
Assisted Reproductive Services	Not covered	Not covered
Autism-Related Services No Limits	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Bariatric Services	Not covered	Not covered
Blue Distinction Specialty Care Facility Services No Limits	Not Applicable	Not Applicable
Chiropractic Services Office Visit	$70 Copay/Visit, no Deductible	40% Coinsurance after Deductible
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

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Elective Male Sterilization	No member cost share	40% Coinsurance after Deductible
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$200 Copay/Visit, then Deductible, then 20% Coinsurance	$200 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: No 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 $10,000 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
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

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Mental Health and Substance Abuse Services - Office Visit	$35 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
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

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
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	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 Maximum benefit of 1 Exam/Calendar Year for In-Network and Out-of-Network	$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Vision Hardware	Not covered	Not covered
Weight Loss Drugs (see Pharmacy cost shares)	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	$10,000 Combined Medical/Pharmacy limit
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.	Yes
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.	Yes
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:** $55 Copay/Fill	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $75 Copay/Fill	$75 Copay/Fill, then 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:**$165 Copay/Fill	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:**$225 Copay/Fill	$225 Copay/Fill, then 50% Coinsurance
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	$36 Copay/Fill	$36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred	$165 Copay/Fill	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred	$225 Copay/Fill	$225 Copay/Fill, then 50% Coinsurance

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:** $55 Copay/Fill, then 50% Coinsurance	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $75 Copay/Fill, then 50% Coinsurance	$75 Copay/Fill, then 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:** $165 Copay/Fill, then 50% Coinsurance	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $225 Copay/Fill, then 50% Coinsurance	$225 Copay/Fill, then 50% Coinsurance
Infertility Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$36 Copay/Fill, then 50% Coinsurance	$36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	$165 Copay/Fill, then 50% Coinsurance	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	$225 Copay/Fill, then 50% Coinsurance	$225 Copay/Fill, then 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:** $55 Copay/Fill, then 50% Coinsurance	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $75 Copay/Fill, then 50% Coinsurance	$75 Copay/Fill, then 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:** $165 Copay/Fill, then 50% Coinsurance	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $225 Copay/Fill, then 50% Coinsurance	$225 Copay/Fill, then 50% Coinsurance
Impotency Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$36 Copay/Fill, then 50% Coinsurance	$36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	$165 Copay/Fill, then 50% Coinsurance	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	$225 Copay/Fill, then 50% Coinsurance	$225 Copay/Fill, then 50% Coinsurance
Weight Loss Drugs	Not covered	Not covered
Abortion Drugs	Not covered	Not covered

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Kansas City

Plan Information	
Group Name:	Raytown C - 2 School District
Plan Name:	Blue Select Plus PPO BlueSaver
Group Number:	33060000
State:	Missouri
Effective Date:	07/01/2024
Important Notes:	
For Internal Use Only:	Package: 2819590926 XREF: CDOZ Medical: 2826460046 Rx: 2858520367

1. General Plan Information	
Benefit Period	Calendar Year
Funding	Cost Plus
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	All full-time employees who are currently working 30 hours per week; Retirees and their Dependents who are eligible in accordance with the Employer's Employee Benefits Program; grandfathered employees working prorated hours (10-19 hours and 20 - 29 hours)
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?	No
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 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	$3,200	$3,200
Family	$6,400	$6,400
Pharmacy Deductible	Combined with Medical	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	10%	30%
Plan Pays	90%	70%
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	$4,300	$8,600
Family	$8,600	$17,200
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.	10% Coinsurance after Deductible	30% 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.	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care Office Visit	10% Coinsurance after Deductible	30% 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).	10% Coinsurance after Deductible	Not applicable

Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s).	10% Coinsurance after Deductible	Not applicable
Telehealth – Telehealth Providers other than Blue KC Virtual Care - Office Visit – Primary Care	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Telehealth – Telehealth Providers other than Blue KC Virtual Care - Office Visit – Behavioral Health	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Telehealth – Telehealth Providers other than Blue KC Virtual Care - Behavioral Health Therapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Designated Health Clinic Name of Clinic: Raytown Schools Quality Care Clinic	Deductible, then no charge	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	Not covered	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Allergy Treatment	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Ambulance - Air	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
Ambulance - Ground Ground Ambulance Allowable Option: 150% of Medicare	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
Assisted Reproductive Services	Not covered	Not covered
Autism-Related Services No Limits	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Bariatric Services	Not covered	Not covered
Blue Distinction Specialty Care Facility Services No Limits	Not Applicable	Not Applicable
Chiropractic Services Office Visit	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Dental Anesthesia Maximum age limit of 5 Years	Missouri/Kansas Default	Missouri/Kansas Default
Diabetic Equipment and Supplies Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Diabetic Footwear	10% Coinsurance after Deductible	30% 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	30% Coinsurance after Deductible
Durable Medical Equipment (DME) Prior Authorization Policy Applies No Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Elective Male Sterilization	Deductible, then no charge	30% Coinsurance after Deductible
Emergency Services	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
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: No 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	10% Coinsurance after Deductible	30% Coinsurance after Deductible
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% 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	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Home Hospice	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Diagnosis & Treatment Infertility and impotency treatment limited $10,000 per Lifetime Medical Dollar limitations include pharmacy: Yes	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Hospice Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Physician Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Labs Performed in Office / Independent Lab	10% Coinsurance after Deductible	30% 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	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Inpatient Physician Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Mental Health and Substance Abuse Services - Office Visit	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Therapy in a Facility	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Therapy in a Provider's Office	10% Coinsurance after Deductible	30% 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	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Physician Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Surgery Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Cardiac Therapy No Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Cognitive Therapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy in a Facility Combined with Hearing Therapy in a Provider's Office Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy in a Provider's Office Combined with Speech Therapy Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy in a Facility Combined with Occupational Therapy in a Provider's Office Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy in a Provider's Office Combined with Physical Therapy Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Physical Therapy in a Facility Combined with Physical Therapy in a Provider's Office Limits	10% Coinsurance after Deductible	30% 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	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Pulmonary Therapy No Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Speech Therapy in a Facility Combined with Speech Therapy in a Provider's Office Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Outpatient Therapy - Speech Therapy in a Provider's Office Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Penile Prostheses/Implant	Not covered	Not covered
Private Duty Nursing Combined with Home Health Care Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Routine Preventive Care Diabetes Prevention Program (DPP): Covered Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	30% Coinsurance after Deductible
Skeletal Manipulation performed in a Chiropractic Office	10% Coinsurance after Deductible	30% 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	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Sports Physicals by a Physician	Not covered	Not covered
Vision Exam-Routine Maximum benefit of 1 Exam/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Vision Hardware	Not covered	Not covered
Weight Loss Drugs (see Pharmacy cost shares)	Not covered	Not covered
Weight Management - Wondr Health	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology	10% Coinsurance after Deductible	30% 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	$10,000 Combined Medical/Pharmacy limit
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.	Yes
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 $12 Copay/Fill	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then $55 Copay/Fill	Deductible, then $55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then $75 Copay/Fill	Deductible, then $75 Copay/Fill, then 50% Coinsurance
Retail Pharmacy (Long-term supply: Between 35-102 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:**Deductible, then $36 Copay/ Fill	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:**Deductible, then $165 Copay/Fill	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:**Deductible, then $225 Copay/Fill	Deductible, then $225 Copay/Fill, then 50% Coinsurance
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	Deductible, then $36 Copay/Fill	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred	Deductible, then $165 Copay/Fill	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred	Deductible, then $225 Copay/Fill	Deductible, then $225 Copay/Fill, then 50% Coinsurance

Preventive Drugs **Preventive Drugs List: All Preventive** **Retail (Short-Term) Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** No member cost share	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Retail (Short-Term) Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** No member cost share	Deductible, then $55 Copay/Fill, then 50% Coinsurance
Retail (Short-Term) Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** No member cost share	Deductible, then $75 Copay/Fill, then 50% Coinsurance
Retail (Long-Term) Drug Tier 1: Generic / Generic Specialty	**RxPremier:**No member cost share	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Retail (Long-Term) Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:**No member cost share	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Retail (Long-Term) Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:**No member cost share	Deductible, then $225 Copay/Fill, then 50% Coinsurance
Mail Order Drug Tier 1: Generic / Generic Specialty	No member cost share	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Mail Order Drug Tier 2: Preferred / Preferred Specialty	No member cost share	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Mail Order Drug Tier 3: Non-Preferred / Non-Preferred Specialty	No member cost share	Deductible, then $225 Copay/Fill, then 50% Coinsurance
Infertility Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then $12 Copay/Fill, then 50% Coinsurance	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then $55 Copay/Fill, then 50% Coinsurance	Deductible, then $55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then $75 Copay/Fill, then 50% Coinsurance	Deductible, then $75 Copay/Fill, then 50% Coinsurance
Infertility Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then $36 Copay/Fill, then 50% Coinsurance	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then $165 Copay/Fill, then 50% Coinsurance	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then $225 Copay/Fill, then 50% Coinsurance	Deductible, then $225 Copay/Fill, then 50% Coinsurance
Infertility Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	Deductible, then $36 Copay/Fill, then 50% Coinsurance	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	Deductible, then $165 Copay/Fill, then 50% Coinsurance	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	Deductible, then $225 Copay/Fill, then 50% Coinsurance	Deductible, then $225 Copay/Fill, then 50% Coinsurance

Impotency Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then $12 Copay/Fill, then 50% Coinsurance	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then $55 Copay/Fill, then 50% Coinsurance	Deductible, then $55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then $75 Copay/Fill, then 50% Coinsurance	Deductible, then $75 Copay/Fill, then 50% Coinsurance
Impotency Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then $36 Copay/Fill, then 50% Coinsurance	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	**RxPremier:** Deductible, then $165 Copay/Fill, then 50% Coinsurance	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** Deductible, then $225 Copay/Fill, then 50% Coinsurance	Deductible, then $225 Copay/Fill, then 50% Coinsurance
Impotency Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	Deductible, then $36 Copay/Fill, then 50% Coinsurance	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	Deductible, then $165 Copay/Fill, then 50% Coinsurance	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	Deductible, then $225 Copay/Fill, then 50% Coinsurance	Deductible, then $225 Copay/Fill, then 50% Coinsurance
Weight Loss Drugs	Not covered	Not covered
Abortion Drugs	Not covered	Not covered

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Kansas City

Plan Information	
Group Name:	Raytown C - 2 School District
Plan Name:	Blue Select Plus PPO $2500 Deductible
Group Number:	33060000
State:	Missouri
Effective Date:	07/01/2024
Important Notes:	
For Internal Use Only:	Package: 2858270097 XREF: CDOW Medical: 2858560259 Rx: 2858360977

1. General Plan Information	
Benefit Period	Calendar Year
Funding	Cost Plus
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	All full-time employees who are currently working 30 hours per week; Retirees and their Dependents who are eligible in accordance with the Employer's Employee Benefits Program; grandfathered employees working prorated hours (10-19 hours and 20 - 29 hours)
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?	No
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 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	$2,500	$3,150
Family	$7,500	$9,450
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	$6,300	$12,600
Family	$13,200	$37,800
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.	$35 Copay/Visit, no Deductible	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.	$70 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Urgent Care Office Visit	$70 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).	$70 Copay/Visit, no Deductible	Not applicable

Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s).	20% Coinsurance after Deductible	Not applicable
Telehealth – Telehealth Providers other than Blue KC Virtual Care - Office Visit – Primary Care	$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Telehealth – Telehealth Providers other than Blue KC Virtual Care - Office Visit – Behavioral Health	$35 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 Name of Clinic: Raytown Schools Quality Care Clinic	No member cost share	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	Not covered	Not covered
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: 150% of Medicare	20% Coinsurance after Deductible	20% Coinsurance after In-Network Deductible
Assisted Reproductive Services	Not covered	Not covered
Autism-Related Services No Limits	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Bariatric Services	Not covered	Not covered
Blue Distinction Specialty Care Facility Services No Limits	Not Applicable	Not Applicable
Chiropractic Services Office Visit	$70 Copay/Visit, no Deductible	40% Coinsurance after Deductible
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

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Elective Male Sterilization	No member cost share	40% Coinsurance after Deductible
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$200 Copay/Visit, then Deductible, then 20% Coinsurance	$200 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: No 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 $10,000 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
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

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Mental Health and Substance Abuse Services - Office Visit	$35 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
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

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
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	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 Maximum benefit of 1 Exam/Calendar Year for In-Network and Out-of-Network	$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Vision Hardware	Not covered	Not covered
Weight Loss Drugs (see Pharmacy cost shares)	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	$10,000 Combined Medical/Pharmacy limit
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.	Yes
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.	Yes
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:** $55 Copay/Fill	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $75 Copay/Fill	$75 Copay/Fill, then 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:**$165 Copay/Fill	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:**$225 Copay/Fill	$225 Copay/Fill, then 50% Coinsurance
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	$36 Copay/Fill	$36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred	$165 Copay/Fill	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred	$225 Copay/Fill	$225 Copay/Fill, then 50% Coinsurance

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:** $55 Copay/Fill, then 50% Coinsurance	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $75 Copay/Fill, then 50% Coinsurance	$75 Copay/Fill, then 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:** $165 Copay/Fill, then 50% Coinsurance	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $225 Copay/Fill, then 50% Coinsurance	$225 Copay/Fill, then 50% Coinsurance
Infertility Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$36 Copay/Fill, then 50% Coinsurance	$36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	$165 Copay/Fill, then 50% Coinsurance	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	$225 Copay/Fill, then 50% Coinsurance	$225 Copay/Fill, then 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:** $55 Copay/Fill, then 50% Coinsurance	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $75 Copay/Fill, then 50% Coinsurance	$75 Copay/Fill, then 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:** $165 Copay/Fill, then 50% Coinsurance	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	**RxPremier:** $225 Copay/Fill, then 50% Coinsurance	$225 Copay/Fill, then 50% Coinsurance
Impotency Drugs Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$36 Copay/Fill, then 50% Coinsurance	$36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred / Preferred Specialty	$165 Copay/Fill, then 50% Coinsurance	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	$225 Copay/Fill, then 50% Coinsurance	$225 Copay/Fill, then 50% Coinsurance
Weight Loss Drugs	Not covered	Not covered

Abortion Drugs	Not covered	Not covered

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