

Johnson County Government Employees Health Plan Summaries

Effective Date: 1/1/2021

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

www.BlueKC.com

	PPO Plan	BlueSaver – Employee Only	BlueSaver – Employee + 1/Family
Plan Type	A Preferred Provider Organization (PPO)	A Preferred Provider Organization (PPO)	A Preferred Provider Organization (PPO)
Plan Description <i>(Visit www.BlueKC.com to receive a complete listing of network hospitals and physicians)</i>	Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue or BlueSelect Plus network, depending upon which network they select.	Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue or BlueSelect Plus network, depending upon which network they select.	Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue or BlueSelect Plus network, depending upon which network they select.
Deductible	Network: \$750 per individual/\$1,500 per family Non-network: \$1,500 per individual/\$3,000 per family	Network: \$1,750 per individual Non-network: \$3,500 per individual	\$2,800 network/\$5,600 non-network per Employee +1 \$3,500 network/\$7,000 non-network per family An Individual must meet their INDIVIDUAL deductible before benefits are paid on that individual
Coinsurance *	Network: 80% / Non-network: 60%	Network: 90% Non-network: 60%	Network: 90% / Non-network: 60%
Out-of-Pocket Maximum ** <i>Applies to all Cost Sharing (Medical and Rx)</i>	Network: \$2,500 individual/\$5,000 family; Non-network: \$5,000 individual/\$10,000 family	Network: \$3,250 individual Non-network: \$6,500 individual	Network: \$3,250 individual/\$6,500 family; Non-network: \$6,500 Individual/\$13,000 family
Physician Office Visits	BDTC: \$10 Copay PCP: \$20 copay *** Specialist: \$40 copay*** Non-network: Deductible then coinsurance	Network: Deductible then 90% Non-network: Deductible then 60%	
Skeletal Manipulations	\$40 Copay*** 40 per year calendar year maximum	Network: Deductible then 90% Non-network: Deductible then 60% 40 per year calendar year maximum	
Lab Performed in a Physician's Office/Independent Lab	Network: No copay, paid at 100% Non-network: Deductible then coinsurance	Network: Deductible then 90% *** Non-network: Deductible then 60%	
Lab Performed in a Hospital/Outpatient Facility	Network: Deductible then coinsurance Non-network: Deductible then coinsurance	Network: Deductible then 90% *** Non-network: Deductible then 60%	
X-ray and Other Radiology Procedures	Network: Deductible then coinsurance **** Non-network: Deductible then coinsurance	Network: Deductible then 90% *** Non-network: Deductible then 60%	
Routine Preventive Care <i>(Contract lists covered services)</i>	Network Routine Services: 100% Office Visit/Wellness Exam: 100% Non-network: Deductible then coinsurance Unlimited Calendar Year Maximum	Network: 100% Non-network: Deductible then coinsurance	
Additional Women's Routine Preventive Care <i>(Breastfeeding support and counseling, contraceptive counseling, counseling for screening for interpersonal and domestic violence.)</i>	Network Services: 100% Non-network: Deductible then coinsurance	Network: 100% Non-network: Deductible then coinsurance	
Inpatient Hospital Services/Outpatient Surgery♦	Deductible then coinsurance ****	Network: Deductible then 90% *** Non-network: Deductible then 60%	
Emergency Room	\$100 copay then Deductible then 80%	Deductible then 90%	

* Portion of covered charges paid by Blue KC after you satisfy your deductible and required copayments.

**Total of deductible, coinsurance and copays that members pay each year toward covered charges before Blue KC pays 100% of benefits.

***Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to \$200 per day. Inpatient hospital services in a Non-Participating Hospital inside our service area are limited to \$200 maximum per day. Outpatient services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility (including an ambulatory surgical center) inside our service area are limited to \$200 per day.

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

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Urgent Care	BDTC: \$10 Copay Network: \$40 copay (office visit and lab only) ***** Non-network: Deductible then coinsurance		Network: Deductible then 90% Non-network: Deductible then 60%
Retail Telehealth	PCP \$20 Copay		Deductible then 90%
Ambulance	Deductible then coinsurance Unlimited		Deductible then 90% Subject to usual and customary allowable charge
Mammograms, Pap Smears and PSA Tests	Network: 100% Non-network: Deductible then coinsurance		Network: 100% Non-network: Deductible then coinsurance
Routine Hearing Care	Deductible then coinsurance		Deductible then coinsurance
Childhood Immunizations (Contract lists covered services)	Network: 100% Non-network: 100%		Network: 100% Non-network: 100%
Durable Medical Equipment♦	Deductible then coinsurance		Network: Deductible then 90% Non-network: Deductible then 60%
Allergy Testing, Treatment, Injections	Deductible then coinsurance		Network: Deductible then 90% Non-network: Deductible then 60%
Home Health Services♦	Deductible then coinsurance 60 visit calendar year maximum		Network: Deductible then 90% Non-network: Deductible then 60% 60 visit calendar year maximum
Outpatient Therapy♦ (Speech, Hearing, Physical, and Occupational)	Deductible then coinsurance Physical and Occupational; Combined 40 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum		Network: Deductible then 90% Non-network: Deductible then 60% Physical and Occupational Combined 40 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum
Infertility Services (Diagnostic Only)	Deductible and Coinsurance		Deductible and Coinsurance
Inpatient Mental Illness/Substance Abuse♦	Deductible then coinsurance <i>Prior authorization required from New Directions</i>		Deductible then coinsurance *** <i>Prior authorization required from New Directions</i>
Outpatient Mental Illness/Substance Abuse♦	Office Visit: \$20***** Therapy: Deductible then coinsurance		Deductible then coinsurance ***
Skilled Nursing Facility♦	Deductible then coinsurance 30 day calendar year maximum		Network: Deductible then 90% *** Non-network: Deductible then 60% 30 day calendar year maximum
Inpatient Hospice Facility♦	Deductible then coinsurance 90 day lifetime maximum		Network: Deductible then 90% *** Non-network: Deductible then 60% 90 day lifetime maximum
Organ Transplant♦	Deductible then coinsurance		Network: Deductible then 90% Non-network: Deductible then 60%
Foot Orthotics	Network: Deductible then Coinsurance Non-network: Not covered \$500 Calendar year Maximum		Network: Deductible then Coinsurance Non-network: Not covered \$500 Calendar year Maximum

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Hearing Aids	Cost of Initial/Replacement/Repair of Existing Hearing Aid Deductible then Coinsurance \$2,000 Calendar Year Maximum	Cost of Initial/Replacement/Repair of Existing Hearing Aid Deductible then Coinsurance \$2,000 Calendar Year Maximum	
Bariatric Surgery for Morbid Obesity♦	Network: Deductible & Coinsurance***** Non-network: Not Covered \$20,000 Lifetime Maximum	Network: Deductible & Coinsurance Non-network: Not Covered \$20,000 Lifetime Maximum	
Lifetime Benefit Maximum	Unlimited		
Dependent Coverage	Dependents are covered through the end of the month in which they turn 26		
Prior Authorization Penalty♦	You are responsible for prior authorization for services received from non-network and out-of-area providers. If prior authorization is not obtained for services which require prior authorization, you are responsible for the cost of the services.		
Late Enrollees	For employees or dependents applying after the eligibility period and not within a special enrollment period, coverage will become effective only on the group's anniversary date.		
Detailed Benefit Information Exclusions and Limitations	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.		
Customer Service	Customer Service (816) 395-3364 or Toll Free - 1-866-242-1487 or www.BlueKC.com		
24 hr. Nurse Line	Toll Free - 877-852-5422		

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

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*****Benefits will be paid at the Preferred Provider level only if bariatric surgery services are provided at the Blue Distinction Center for Bariatric Surgery Facility (BDC) in the Kansas City metropolitan area.

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

Discrimination is Against the Law

Blue KC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue KC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue KC:

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

If you need these services, contact Customer Service, 816-395-6340 (local), 844-395-7126 (Toll free), languagehelp@bluekc.com.

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

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

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

If you, or someone you're helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-844-395-7126.

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

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

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-395-7126.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-395-7126 an.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 [Blue KC]에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-395-7126 로 전화하십시오.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-844-395-7126.

Arabic: إن كان لديك أو لدى شخص تساعد أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-395-7126.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue KC, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-395-7126.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue KC, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-395-7126.

Tagalog: Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Blue KC, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-395-7126.

Laotian: ຖ້າທ່ານ, ຫຼື ຄົນ ທ່ານ ກຳລັງ ຊ່ວຍ ຫຼື ອ, ມີ ອຳນາດ ມາ ກັບ ບຸກຄົນ ທ່ານ ມີ ສິດ ທີ່ ຈະ ໄດ້ ຮັບ ການ ຊ່ວຍ ຫຼື ອະ ດີ ມູ ນ ຂ່າວ ສານ ທີ່ ບໍ່ ມີ ນາສາ ຂອງ ທ່ານ ບໍ່ ມີ ຄ່າ ໃຊ້ ຈ່າຍ. ການ ໂອ້ ລົມ ກັບ ນາຍ ພາສາ, ໃຫ້ ໂທ ຫາ 1-844-395-7126.

Pennsylvanian Dutch: “Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Blue KC, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-844-395-7126 uffrufe.

Persian: اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue KC ، داشته باشید حق این را دارید که کمکو اطالعات به زبان خود را به طور رایگان دریافت نمایید 1-844-395-7126. تماس حاصل نمایید.

Cushite: Isin yookan namni biraa isin deeggartan Blue KC irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-844-395-7126 tiin bilbilaa.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue KC, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-395-7126.

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