

**Johnson County Government Employees  
Health Plan Summaries**

*Effective Date: 1/1/2022*

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

**www.BlueKC.com**

	<b>BlueSaver - \$3,000 Deductible Plan</b>	<b>BlueSaver - \$5,000 Deductible Plan</b>
<b>Plan Type</b>	A Preferred Provider Organization (PPO)	A Preferred Provider Organization (PPO)
<b>Plan Description</b> <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.
<b>Deductible</b>	Network: \$3,000 per individual/\$6,000 per family Non-network: \$6,000 per individual/\$12,000 per family	Network: \$5,000 per individual/\$10,000 per family Non-network: \$10,000 per individual/\$20,000 per family
<b>Coinsurance *</b>	Network: 100% / Non-network: 70%	Network: 100% Non-network: 70%
<b>Out-of-Pocket Maximum **</b> <i>Applies to all Cost Sharing (Medical and Rx)</i>	Network: \$3,000 individual/\$6,000 family; Non-network: \$12,000 individual/\$24,000 family	Network: \$5,000 individual/\$10,000 family; Non-network: \$20,000 individual/\$40,000 family
<b>Physician Office Visits</b>	Network: Deductible then 100% Non-network: Deductible then 70%	Network: Deductible then 100% Non-network: Deductible then 70%
<b>Skeletal Manipulations</b>	Network: Deductible then 100% Non-network: Deductible then 70% 40 per year calendar year maximum	Network: Deductible then 100% Non-network: Deductible then 70% 40 per year calendar year maximum
<b>Lab Performed in a Physician's Office/Independent Lab</b>	Network: Deductible then 100% Non-network: Deductible then 70%	Network: Deductible then 100% Non-network: Deductible then 70%
<b>Lab Performed in a Hospital/Outpatient Facility</b>	Network: Deductible then 100% Non-network: Deductible then 70%	Network: Deductible then 100% Non-network: Deductible then 70%
<b>X-ray and Other Radiology Procedures ♦</b>	Network: Deductible then 100% Non-network: Deductible then 70%	Network: Deductible then 100% Non-network: Deductible then 70%
<b>Routine Preventive Care</b> <i>(Certificate lists covered services)</i>	Network Routine Services: 100% Office Visit/Wellness Exam: 100% Non-network: Deductible then coinsurance Unlimited Calendar Year Maximum	Network Routine Services: 100% Office Visit/Wellness Exam: 100% Non-network: Deductible then coinsurance Unlimited Calendar Year Maximum
<b>Additional Women's Routine Preventive Care</b> <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
<b>Inpatient Hospital Services/Outpatient Surgery♦</b>	Network: Deductible then 100% Non-network: Deductible then 70%	Network: Deductible then 100% Non-network: Deductible then 70%
<b>Emergency Room</b>	Deductible then 100%	Deductible then 100%

\*Portion of covered charges paid by Blue KC after you satisfy your deductible.

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

♦ 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.

	<b>BlueSaver - \$3,000 Deductible Plan</b>	<b>BlueSaver - \$5,000 Deductible Plan</b>
<b>Urgent Care</b>	Network: Deductible then 100% Non-network: Deductible then 70%	Network: Deductible then 100% Non-network: Deductible then 70%
<b>Blue KC Virtual Care</b> <i>(using AmWell or on-line App)</i>	Network: No member cost share Non-network: Not applicable	Network: No member cost share Non-network: Not applicable
<b>Telehealth</b> <i>(using physician)</i>	Network: No member cost share Non-network: Deductible then coinsurance	Network: No member cost share Non-network: Deductible then coinsurance
<b>Ambulance</b>	Deductible then 100% Subject to usual and customary allowable charge	Deductible then 100% Subject to usual and customary allowable charge
<b>Mammograms, Pap Smears and PSA Tests</b>	Network: 100% Non-network: Deductible then 30%	Network: 100% Non-network: Deductible then 30%
<b>Routine Hearing Care</b>	Deductible then coinsurance	Deductible then coinsurance
<b>Childhood Immunizations</b> <i>(Certificate lists covered services)</i>	Network: 100% Non-network: 100% Any office visit charges incurred in conjunction with immunizations will be subject to the office visit charge, coinsurance and deductible requirements.	Network: 100% Non-network: 100% Any office visit charges incurred in conjunction with immunizations will be subject to the office visit charge, coinsurance and deductible requirements.
<b>Durable Medical Equipment♦</b>	Network: Deductible then 100% Non-network: Deductible then 70%	Network: Deductible then 100% Non-network: Deductible then 70%
<b>Allergy Testing, Treatment, Injections</b>	Network: Deductible then 100% Non-network: Deductible then 70%	Network: Deductible then 100% Non-network: Deductible then 70%
<b>Home Health Services</b>	Network: Deductible then 100% Non-network: Deductible then 70% 60 visit calendar year maximum	Network: Deductible then 100% Non-network: Deductible then 70% 60 visit calendar year maximum
<b>Outpatient Therapy</b> <i>(Speech, Hearing, Physical, and Occupational)</i>	Network: Deductible then 100% Non-network: Deductible then 70% Physical and Occupational; Combined 40 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum	Network: Deductible then 100% Non-network: Deductible then 70% Physical and Occupational; Combined 40 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum
<b>Infertility Services</b> <i>(Diagnostic testing only)</i>	Network: Deductible then 100% Non-network: Deductible then 70%	Network: Deductible then 100% Non-network: Deductible then 70%
<b>Assisted Reproductive Services</b> <i>(Certificate lists covered services)</i>	Network and Non-Network: Deductible & Coinsurance \$15,000 Lifetime Maximum	Network and Non-Network: Deductible & Coinsurance \$15,000 Lifetime Maximum
<b>Inpatient Mental Illness/Substance Abuse♦</b>	Network: Deductible then 100% Non-network: Deductible then 70%	Network: Deductible then 100% Non-network: Deductible then 70%
<b>Outpatient Mental Illness/Substance Abuse</b>	Network: Deductible then 100% Non-network: Deductible then 70%	Network: Deductible then 100% Non-network: Deductible then 70%
<b>Skilled Nursing Facility♦</b>	Network: Deductible then 100% Non-network: Deductible then 70% 30 day calendar year maximum	Network: Deductible then 100% Non-network: Deductible then 70% 30 day calendar year maximum
<b>Inpatient Hospice Facility♦</b>	Network: Deductible then 100% Non-network: Deductible then 70% 90 day lifetime maximum	Network: Deductible then 100% Non-network: Deductible then 70% 90 day lifetime maximum
<b>Organ Transplant♦</b>	Deductible then coinsurance	Deductible then coinsurance
<b>Foot Orthotics</b>	Network: Deductible then 100% Non-network: Not covered \$500 Calendar year Maximum	Network: Deductible then Coinsurance Non-network: Not covered \$500 Calendar year Maximum

	<b>BlueSaver - \$3,000 Deductible Plan</b>	<b>BlueSaver - \$5,000 Deductible Plan</b>
<b>Hearing Aids</b>	Cost of Initial/Replacement/Repair of Existing Hearing Aid Network: Deductible then 100% Non-network: Not Covered \$2,000 Calendar Year Maximum	Cost of Initial/Replacement/Repair of Existing Hearing Aid Network: Deductible then 100% Non-network: Not Covered \$2,000 Calendar Year Maximum
<b>Bariatric Surgery for Morbid Obesity♦</b>	Network: Deductible & Coinsurance*** Non-network: Not Covered \$20,000 Lifetime Maximum	Network: Deductible & Coinsurance Non-network: Not Covered \$20,000 Lifetime Maximum
<b>Lifetime Benefit Maximum</b>	Unlimited	
<b>Dependent Coverage</b>	Dependents are covered through the end of the month in which they turn 26	
<b>Prior Authorization Penalty♦</b>	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.	
<b>Late Enrollees</b>	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.	
<b>Detailed Benefit Information Exclusions and Limitations</b>	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.	
<b>Customer Service</b>	<b>Customer Service (816) 395-3364 or Toll Free - 1-866-242-1487 or <a href="http://www.BlueKC.com">www.BlueKC.com</a></b>	
<b>24 hr. Nurse Line</b>	<b>Toll Free - 877-852-5422</b>	

♦ 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.

\*\*\*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](mailto: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](mailto: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 بـ1-844-395-7126.

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 tinutulongan, 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 ກ່ຽວກັບ Blue KC, ທ່ານ ມີ ສິດ ທີ່ ຈະ ໄດ້ ຮັບ ການ ຊ່ວຍ ຫຼື ອະ ດີ ມູ ນ ຂ່າວ ສານ ທີ່ ບໍ່ ມີ ນາ ສາ ຂອງ ທ່ານ ບໍ່ ມີ ຄ່າ ໃຊ້ ຈ່າຍ. ການ ໂອ້ ລົມ ກັບ ນາຍ ພາ ສາ, 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 کمک و اطلاعات 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.