

Wyandot Behavioral Health Network

Health Benefit Plan Summary - BlueSelect Plus EPO Spira Care - Buy-Up

This Benefit Summary provides only highlights of the services covered by Blue Cross and Blue Shield of Kansas City (Blue KC). For Additional details, exclusions and limitations refer to your member certificate available at [MyBlueKC.com](https://mybluekc.com).

General Plan Information

Plan Type	Exclusive Provider Organization (EPO) Members receive all care from in-network providers except for emergency services. Non-emergency services received out-of-network will not be covered.	
Medical Network(s) A complete listing of network hospitals and physicians is available on MyBlueKC.com .	In Area: BlueSelect Plus Out-of-Area: BlueCard PPO/EPO	
Deductible – Embedded You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services.	In-Network Individual: \$3,500 Family: \$7,000	Out-of-Network Not covered
Coinsurance Applies only as specified in your contract. Coinsurance is noted in this summary where applicable.	In-Network Member Pays: 0% Plan Pays: 100%	Out-of-Network Not covered
Out-of-Pocket Limits – Embedded The Out-of-Pocket Limit is the most you could pay during the Calendar Year for your share of the cost of covered services. These cost shares apply to the Out-of-Pocket Limit: Coinsurance, Deductibles, Copays Applies to: All Medical and Rx Cost Sharing	In-Network Individual: \$3,500 Family: \$7,000	Out-of-Network Not covered
Customer Service & Care Guide Services	Local: 913-29-SPIRA (77472) Toll Free: 1-877-33-SPIRA (77472)	

Plan Benefits - Medical		
When you visit a Spira Care Center...	In-Network	Out-of-Network
Visits to a Spira Care Center include: - Office Visit – Routine - Office Visit – Urgent/Acute - Chronic Disease Care (excluding drugs & equipment) - Outpatient Mental Health, Behavioral Health, and Substance Abuse Services <i>Included as part of office visit and no member cost share:</i> - Labs - X-ray (basic diagnostic x-rays for fracture and other injuries or illness) <i>Workers' Comp</i> Your health coverage through any of the Blue Cross and Blue Shield of Kansas City plans, including Spira Care and Spira Care (HSA Eligible), cannot be used for an on-the-job or work-related injury or illness. However, members may have access to workers' compensation insurance paid for by their employers which may provide monetary benefits and/or medical care coverage for a work related injury or illness. Please speak with your human resources representative for more information.	No member cost share	Not covered
Preventive Screenings & Immunizations (Children & Adults) Blue KC health plans include routine preventive benefits that are consistent with the guidelines developed by the United States Preventive Services Task Force (USPSTF), Health Resources and Services Administration (HRSA), and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Services must be billed with a primary diagnosis of preventive to be covered at 100%. Refer to your member certificate for additional details.	No member cost share	Not covered
When you visit another Physician's Office...	In-Network	Out-of-Network
Physician Primary Care Physician (PCP) - An internist, family practitioner, general practitioner, or pediatrician.	Deductible, then no charge	Not covered
Specialist - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrists, psychologists and chiropractors.	Deductible, then no charge	Not covered
Other Services & Procedures performed in a provider's office and not included with an office visit	Deductible, then no charge	Not covered
Urgent Care Center	Deductible, then no charge	In-Network Deductible, then no charge
Blue KC Virtual Care - Office Visit Virtual Care provided by Blue KC virtual care partner(s).	No member cost share	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual Care provided by Blue KC virtual care partner(s).	Deductible, then no charge	Not applicable
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Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility	Deductible, then no charge	Not covered
Allergy		
Allergy Testing	Deductible, then no charge	Not covered
Allergy Treatment	Deductible, then no charge	Not covered
<i>When you need radiology services...</i>	In-Network	Out-of-Network
X-Ray	Deductible, then no charge	Not covered
Other Radiology Procedures (MRI, CT/PET Scans, MRA) Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
<i>When you have out-patient surgery...</i>	In-Network	Out-of-Network
Outpatient Surgery Facility Fees Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Physician (Surgeon) Services	Deductible, then no charge	Not covered
<i>If you need immediate medical attention...</i>	In-Network	Out-of-Network
Urgent Care Center Office Visit	Deductible, then no charge	In-Network Deductible, then no charge
Emergency Services Out-of-Network benefits are subject to the plan's allowable charge. Out-of-Network providers may bill the member for the remaining balance. See Certificate for details.	Deductible, then no charge	In-Network Deductible, then no charge
Ground Ambulance Out-of-Network benefits are subject to the plan's allowable charge. Out-of-Network providers may bill the member for the remaining balance. See Certificate for details.	Deductible, then no charge	In-Network Deductible, then no charge
Air Ambulance	Deductible, then no charge	In-Network Deductible, then no charge
<i>If you have a hospital stay...</i>	In-Network	Out-of-Network
Hospital Facility Fees Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Physician (Surgeon) Services	Deductible, then no charge	Not covered
<i>If you need help recovering or have other special health needs...</i>	In-Network	Out-of-Network
Skilled Nursing Care Prior Authorization Policy Applies In-Network Maximum benefit of 30 Day(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Home Health Services Prior Authorization Policy Applies In-Network Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Occupational Therapy Combined with Physical Therapy Limits	Deductible, then no charge	Not covered
Skeletal Manipulation Combined with Physical Therapy Limits	Deductible, then no charge	Not covered

Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Hearing Therapy Combined with Speech Therapy Limits	Deductible, then no charge	Not covered
Durable Medical Equipment Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Inpatient Hospice Services Prior Authorization Policy Applies In-Network Maximum benefit of 14 Day(s)/Lifetime for In-Network	Deductible, then no charge	Not covered
Home Hospice Services	Deductible, then no charge	Not covered
<i>If you have behavioral health, or substance abuse needs...</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Outpatient Mental Health, Behavioral Health, and Substance Abuse Services Office Visit	Deductible, then no charge	Not covered
Therapy	Deductible, then no charge	Not covered
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees) Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician) Includes: Therapy & Other Services, partial hospitalizations	Deductible, then no charge	Not covered
<i>Family Planning & Pregnancy...</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Contraceptive Devices, Implants, and Injections See also pharmacy benefits.	No member cost share	Not covered
Elective Sterilization – Women	No member cost share	Not covered
Elective Sterilization – Men	No member cost share	Not covered
Maternity Dependent daughters are covered for maternity services	Covered	Not covered
Infertility and Impotency Diagnosis and Treatment Pharmacy Coverage: Not Covered	Not covered	Not covered
<i>Routine Vision Care...</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Routine Eye Exam	Not covered	Not covered
General Pharmacy Information		
Retail Pharmacy Network(s)	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 at MyBlueKC.com	Select Formulary	

Specialty Pharmacy A Specialty Pharmacy is one that provides specialized care for patients with complex chronic health conditions. Learn more about the drugs covered by your plan, drug category/ tier, prior authorization and step therapy by reviewing your prescription drug list at MyBlueKC.com	OptumRx Specialty Services PH: 1-855-427-4682	
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 Not covered
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 Limits	Out-of-Network Not covered
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	
Plan Benefits – Pharmacy		
<i>When you use a retail or specialty pharmacy...</i>	In-Network	Out-of-Network
Retail Pharmacy (Short-term supply: Up to 34 Days)		
Drug Tier 1: Generic / Generic Specialty	RxPremier: \$15 Copay/Fill, no Deductible Contraceptives – No member cost share	Not covered
Drug Tier 2: Preferred / Preferred Specialty	RxPremier: \$50 Copay/Fill, no Deductible	Not covered
Drug Tier 3: Non-Preferred / Non-Preferred Specialty	RxPremier: Deductible, then no charge	Not covered
<i>When you use a mail order pharmacy...</i>	In-Network	Out-of-Network
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days)		
Drug Tier 1: Generic	\$15 Copay/Fill, no Deductible Contraceptives – No member cost share	Not covered
Drug Tier 2: Preferred	\$125 Copay/Fill, no Deductible	Not covered
Drug Tier 3: Non-Preferred	Deductible, then no charge	Not covered

Discrimination is Against the Law

Blue Cross and Blue Shield of Kansas City (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.

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.

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.

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, 844-395-7126 (Toll free), languagehelp@bluekc.com.

