Kansas City

Plan Information	
Group Name:	Shawnee Mission School District
Plan Name:	BlueSelect Plus EPO Plan
Group Number:	11455000
State:	Kansas
Effective Date:	01/01/2022
Important Notes:	
For Internal Use Only:	Package: 2737520633 XREF: C7YL Medical: 2737550297 Rx: 2737580591
1. General Plan Information	
Benefit Period	Calendar Year
Funding	Cost Plus
Grandfathered Status	Non-Grandfathered
Product Family	EPO
Consumer-Driven Health Plan (CDHP)	N/A
Spira Care Plan?	No
Religious Employer?	N/A
Classification of Eligible Employees	Eligible Employee means a person: (a) employed with the District as an Administrative, Certified, or Classified Employee; and (b) whose normal work week is 20 or more hours, provided that an employee exercising a leave of absence shall remain eligible until termination of employment, so long as the employee's normal work week was 20 or more hours prior to exercising such leave of absence.
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 Same Sex Spouses Covered?	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Blue Connect	Blue Connect not included
Compass	Compass not included
2. Network	
Local Medical Network	BlueSelect Plus

Out-of-Area Medical Network	BlueCard PPO/EPO	
Pharmacy	See Pharmacy (Sections 5 & 6)	
3. Cost Sharing		
Medical Deductible - Calendar Year, Embedded	**In-Network**	**Out-of-Network**
Individual	$0	Does not apply
Family	$0	Does not apply
Pharmacy Deductible	No Pharmacy Deductible	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	Not applicable	Does not apply
Plan Pays	100%	Does not apply
Out-of-Pocket Limit - Calendar Year, Embedded The Out-of-Pocket limit includes all Deductibles, Coinsurance, and Copayments a member pays during the Benefit Period.	**In-Network**	**Out-of-Network**
Individual	$7,900	Does not apply
Family	$15,800	Does not apply
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.	$40 Copay/Visit	Not covered
Total Care Primary Care Physician Office Visit	Does not apply	Not applicable
Specialist Physician Office Visit - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrists, psychologists and chiropractors.	$80 Copay/Visit	Not covered
Urgent Care Office Visit	$80 Copay/Visit	Not covered
Total Care Urgent Care Office Visit	Does not apply	Not applicable
Blue KC Virtual Care - Office Visit Virtual care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	$80 Copay/Visit	Not applicable

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Gender Dysphoria-Related Services Prior Authorization Policy Applies In-Network 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	Not covered
Hearing Aids	Not covered	Not covered
Hearing Aids - Bone Anchored Hearing Aids	Not covered	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies In-Network High Tech Radiology ER Copay Waiver Rule (when ER Copay also applies): High Tech Radiology Copay Waived	$80 Copay/Provider per Day	Not covered
Home Health Care Prior Authorization Policy Applies In-Network Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Home Hospice	No member cost share	Not covered
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Diagnosis & Treatment No Limits Dollar Limitations include Pharmacy: Yes Impotency Drug Coverage: Yes Infertility Drug Coverage: Yes	No member cost share	Not covered
Inpatient Hospice Prior Authorization Policy Applies In-Network Maximum benefit of 14 Day(s)/Lifetime for In-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$375 Copay/Day Limited to $3,750 Copay Max per Calendar Year	Not covered
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies In-Network	$750 Copay/Day Limited to Inpatient/Outpatient $3,750 Copay Max per Calendar Year	Not covered
Inpatient Physician Services	No member cost share	Not covered
Labs Performed in Office / Independent Lab	No member cost share	Not covered
Maternity Dependent Daughters Maternity Covered?: No	Covered	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Outpatient Therapy - Physical Therapy in a Provider's Office Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Outpatient Therapy - Pulmonary Therapy No Limits	No member cost share	Not covered
Outpatient Therapy - Skeletal Manipulation Combined with Physical Therapy Limits	No member cost share	Not covered
Outpatient Therapy - Speech Therapy in a Facility Combined with Speech Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Speech Therapy in a Provider's Office Maximum benefit of 20 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Penile Prostheses/Implant	Not covered	Not covered
Private Duty Nursing Combined with Home Health Care Limits	No member cost share	Not covered
Routine Preventive Care Diabetes Prevention Program (DPP): Covered Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	Not covered
Skilled Nursing Facility (SNF) Prior Authorization Policy Applies In-Network Maximum benefit of 30 Day(s)/Calendar Year for In-Network	No member cost share	Not covered
Sports Physicals by a Physician	Not covered	Not covered
Vision Exam-Routine Maximum benefit of 1 Exam/Calendar Year for In-Network	$80 Copay/Visit	Not covered
Vision Hardware	Not covered	Not covered
Weight Loss Drugs (see Pharmacy cost shares)	Not covered	Not covered
Weight Management - Naturally Slim	No member cost share	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology	No member cost share	Not covered
5. General Pharmacy Information		
Pharmacy Network(s)	**Network 1:** RxPremier	
Prescription Drug List Learn more about the drugs covered by your plan, drug category/tier, prior authorization and step therapy by reviewing your prescription drug list on MyBlueKC.com	Blue KC Preferred Formulary	

Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:**$270 Copay/Fill	Not covered
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	$40 Copay/Fill	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic	$120 Copay/Fill	Not covered
Drug Tier 3: Non-Preferred Brand	$180 Copay/Fill	Not covered
Infertility and Impotency Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $20 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** $60 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** $90 Copay/Fill, then 50% Coinsurance	Not covered
Infertility and Impotency Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $60 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** $180 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** $270 Copay/Fill, then 50% Coinsurance	Not covered
Infertility and Impotency Drugs Mail Order Pharmacy **Drug Tier 1:** Generic	$40 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic	$120 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 3: Non-Preferred Brand	$180 Copay/Fill, then 50% Coinsurance	Not covered
Weight Loss Drugs	Not covered	Not covered