Kansas City

Plan Information	
Group Name:	Shawnee Mission School District
Plan Name:	BlueSelect Plus PPO Plan
Group Number:	11455000
State:	Kansas
Effective Date:	01/01/2022
Important Notes:	
For Internal Use Only:	Package: 2737420096 XREF: C7YH Medical: 2738050847 Rx: 2738110491
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	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	

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, no Deductible	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	20% Coinsurance after Deductible	Not applicable
Designated Health Clinic Name of Clinic: Marathon 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	50% Coinsurance after Deductible
Allergy Treatment	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Ambulance - Air	20% Coinsurance after Deductible	20% Coinsurance after In-Network Deductible
Ambulance - Ground Ground Ambulance Allowable Option: Billed Charges	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	$80 Copay/Visit, no Deductible	50% 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	50% Coinsurance after Deductible
Diabetic Footwear	20% Coinsurance after Deductible	50% 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	50% Coinsurance after Deductible
Durable Medical Equipment (DME) Prior Authorization Policy Applies No Limits	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Elective Male Sterilization	No member cost share	50% Coinsurance after Deductible
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$250 Copay/Visit, then Deductible, then 20% Coinsurance	$250 Copay/Visit, then In-Network Deductible, then 20% Coinsurance

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Mental Health and Substance Abuse Services - Outpatient Therapy in a Facility	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Therapy in a Provider's Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Nutritional Counseling	Not covered	Not covered
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	50% Coinsurance after Deductible
Outpatient Physician Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Surgery Prior Authorization Policy Applies	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Therapy - Cardiac Therapy No Limits	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Therapy - Cognitive Therapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy in a Facility Combined with Hearing Therapy in a Provider's Office Limits	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy in a Provider's Office Combined with Speech Therapy Limits	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy in a Facility Combined with Occupational Therapy in a Provider's Office Limits	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy in a Provider's Office Combined with Physical Therapy Limits	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Therapy - Physical Therapy in a Facility Combined with Physical Therapy in a Provider's Office Limits	20% Coinsurance after Deductible	50% 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	50% Coinsurance after Deductible
Outpatient Therapy - Pulmonary Therapy No Limits	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Therapy - Skeletal Manipulation Prior Authorization Policy Applies Out-of-Network Combined with Physical Therapy Limits	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Therapy - Speech Therapy in a Facility Combined with Speech Therapy in a Provider's Office Limits	20% Coinsurance after Deductible	50% Coinsurance after Deductible

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.	No
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:** $20 Copay/Fill	$20 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** $60 Copay/Fill	$60 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** $90 Copay/Fill	$90 Copay/Fill, then 50% Coinsurance
Retail Pharmacy (Long-term supply: Between 35-102 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:**$60 Copay/Fill	$60 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:**$180 Copay/Fill	$180 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:**$270 Copay/Fill	$270 Copay/Fill, then 50% Coinsurance
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	$40 Copay/Fill	$40 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic	$120 Copay/Fill	$120 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand	$180 Copay/Fill	$180 Copay/Fill, then 50% Coinsurance