Kansas City

Plan Information	
Group Name:	Shawnee Mission School District
Plan Name:	Blue-Care HMO Plan
Group Number:	11455000
State:	Kansas
Effective Date:	01/01/2022
Important Notes:	
For Internal Use Only:	Package: 2737490969 XREF: C7YK Medical: 2738180803 Rx: 2738210918
1. General Plan Information	
Benefit Period	Calendar Year
Funding	Cost Plus
Grandfathered Status	Non-Grandfathered
Product Family	HMO
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	Blue-Care

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	Not covered
Abortion	Not covered	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	$100 Copay/Visit	Not covered
Allergy Treatment	No member cost share	Not covered
Ambulance - Air	No member cost share	No member cost share
Ambulance - Ground Ground Ambulance Allowable Option: Billed Charges	No member cost share	No member cost share
Assisted Reproductive Services	Not covered	Not covered
Autism-Related Services No Limits	Subject to Applicable Cost Shares	Not covered
Bariatric Services	Not covered	Not covered
Blue Distinction Specialty Care Facility Services No Limits	Not Applicable	Not covered
Chiropractic Services Office Visit	$80 Copay/Visit	Not covered
Dental Anesthesia Maximum age limit of 5 Years	Missouri/Kansas Default	Not covered
Diabetic Equipment and Supplies Prior Authorization Policy Applies In-Network	No member cost share	Not covered
Diabetic Footwear	No member cost share	Not covered
Diabetic Pump	Covered as Durable Medical Equipment (DME)	Not covered
Diabetic Self Management Education/Training (DSMT)	No member cost share	Not covered
Durable Medical Equipment (DME) Prior Authorization Policy Applies In-Network No Limits	No member cost share	Not covered
Elective Male Sterilization	No member cost share	Not covered
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$250 Copay/Visit	$250 Copay/Visit
Food and Food Products for PKU Maximum benefit of $5,000/Calendar Year for In-Network	Covered	Not covered
Foot Orthotics	Not covered	Not covered
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

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Mental Health and Substance Abuse Services - Outpatient Therapy in a Facility	No member cost share	Not covered
Mental Health and Substance Abuse Services - Outpatient Therapy in a Provider's Office	No member cost share	Not covered
Nutritional Counseling	Not covered	Not covered
Organ Transplant Services Prior Authorization Policy Applies In-Network	Subject to Applicable Cost Shares **Blue Distinction Specialty Care Facility Services:** Not applicable	Not covered
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Office	No member cost share	Not covered
Outpatient Physician Services	No member cost share	Not covered
Outpatient Surgery Prior Authorization Policy Applies In-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$750 Copay/Day Limited to $3,750 Copay Max per Calendar Year	Not covered
Outpatient Therapy - Cardiac Therapy No Limits	No member cost share	Not covered
Outpatient Therapy - Cognitive Therapy	No member cost share	Not covered
Outpatient Therapy - Hearing Therapy in a Facility Combined with Hearing Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Hearing Therapy in a Provider's Office Combined with Speech Therapy Limits	No member cost share	Not covered
Outpatient Therapy - Occupational Therapy in a Facility Combined with Occupational Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Occupational Therapy in a Provider's Office Combined with Physical Therapy Limits	No member cost share	Not covered
Outpatient Therapy - Physical Therapy in a Facility Combined with Physical Therapy in a Provider's Office Limits	No member cost share	Not covered
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

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	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** $60 Copay/Fill	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** $90 Copay/Fill	Not covered
Retail Pharmacy (Long-term supply: Between 35-102 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:**$60 Copay/Fill	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:**$180 Copay/Fill	Not covered
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