Kansas City

Plan Information	
Group Name:	Shawnee Mission School District
Plan Name:	Preferred-Care Blue PPO Plan
Group Number:	11455000
State:	Kansas
Effective Date:	01/01/2022
Important Notes:	
For Internal Use Only:	Package: 2737470337 XREF: C7YJ Medical: 2738230883 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	

Local Medical Network	Preferred-Care Blue Services rendered at Out-of-Network providers are subject to Out-of-Network allowables as stated in your contract, and balance billing may occur.	
Out-of-Area Medical Network	BlueCard PPO/EPO	
Pharmacy	See Pharmacy (Sections 5 & 6)	
3. Cost Sharing		
Medical Deductible - Calendar Year, Embedded All INN & OON Cross Accum	**In-Network**	**Out-of-Network**
Individual	$1,500	$1,500
Family	$3,000	$3,000
Pharmacy Deductible	No Pharmacy Deductible	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	20%	40%
Plan Pays	80%	60%
Out-of-Pocket Limit - Calendar Year, Embedded All INN & OON Cross Accum The Out-of-Pocket limit includes all Deductibles, Coinsurance, and Copayments a member pays during the Benefit Period.	**In-Network**	**Out-of-Network**
Individual	$3,000	$6,000
Family	$6,000	$8,000
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, no Deductible	40% Coinsurance after Deductible
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, no Deductible	40% Coinsurance after Deductible
Urgent Care Office Visit	$80 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Total Care Urgent Care Office Visit	Does not apply	Not applicable

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Food and Food Products for PKU Maximum benefit of $5,000/Calendar Year for In-Network and Out-of-Network	Covered	Covered
Foot Orthotics	Not covered	Not covered
Gender Dysphoria-Related Services Prior Authorization Policy Applies 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	Subject to Applicable Cost Shares
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	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Health Care Prior Authorization Policy Applies Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Hospice	20% Coinsurance after Deductible	40% Coinsurance after Deductible
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	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Hospice Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Physician Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Labs Performed in Office / Independent Lab	No member cost share	40% Coinsurance after Deductible
Maternity Dependent Daughters Maternity Covered?: No	Covered	Covered
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Inpatient Physician Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Office Visit	No member cost share	40% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Outpatient Therapy - Speech Therapy in a Provider's Office Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Penile Prostheses/Implant	Not covered	Not covered
Private Duty Nursing Combined with Home Health Care Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Routine Preventive Care Diabetes Prevention Program (DPP): Covered Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	40% Coinsurance after Deductible
Skilled Nursing Facility (SNF) Prior Authorization Policy Applies Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Sports Physicals by a Physician	Not covered	Not covered
Vision Exam-Routine	Not covered	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 Applicable
Wigs	Not covered	Not covered
X-Rays and Radiology	20% Coinsurance after Deductible	40% Coinsurance after Deductible

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	
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** Does Not Apply	**Out-of-Network** Does Not Apply
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	**Out-of-Network** Combined with Medical Out-of-Pocket

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