Kansas City

Confirmation of Coverage

Group Name:	City of Lee's Summit
Offer Name:	2019 Renewal
Group Number:	34136000
Effective Date:	01/01/2019
Important Notes:	

Offer-Related Information

A. General Information	
Contract Term:	12 Months
Subsequent Renewal Terms:	12 Months
Renewal Notification:	120 Days
Annual Enrollment Period Start:	30 Days prior to Group Anniversary Date
Annual Enrollment Period End:	15 Days after Group Anniversary Date
Waiting Period:	30 Days
Eligibility Rule:	First Day of Month Following Waiting Period
Termination Rule:	Last day of month following termination
Dependent Limiting Age:	26 Years
Dependent Limiting Age Termination:	EOY following birthday
Is Employer subject to ERISA?:	No
Are Section 125 Enrollment Changes Allowed?:	Yes
HSA Bank Selection:	UMB
Reinstatement Fee:	$500
B. Medical Programs and Services	
AHY (subscribers/spouse with medical):	AHY (100+)
AHY Standard Buyup (employees with no medical):	Yes $2.0 - PMPM
Wellness Fund:	$35,000
24-Hour Nurse Line:	Yes

Blue Vue 10/100:	No
Blue Vue 10/130:	No
Blue Vue 10/150:	No
Blue Vue 10/200:	No
Blue Vue 0/130:	No
Blue Vue 0/150:	No
Blue Vue 0/200:	No
Blue Vue Non-Standard:	No
D. USAble Coverage	
Term Life:	No
AD&D:	No
Blue KC Provided Billing Service:	
E. Principal Coverage	
Group Term Life:	No
Voluntary Life:	No
Long Term Disability (LTD):	No
Short Term Disability (STD):	No
Critical Illness:	No
Accident:	No
Dental:	No
Vision:	No

Offer Summary and Signatures

Plans included in this Offer:

For details about the plans included in this offer, please see the attached Plan information.

Preferred-Care Blue PPO Plan	
Preferred-Care Blue Blue Choice PPO Plan	
Preferred-Care Blue BlueSaver PPO Plan	
Blue Dental PPO	
Healthy Companion:	Yes
Little Stars Prenatal Program:	Yes
Rx Personal Medication Coach:	Yes
Rx Savings Solution:	Yes
C. Blue KC Vision Coverage	
Blue Vue Base:	No

Confirmed by: City of Lee's Summit

Signature

Title

Date

Accepted by Blue Cross and Blue Shield of Kansas City:

Signature

Title

Date

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Plan Information	
Group Name:	City of Lee's Summit
Plan Name:	Preferred-Care Blue PPO Plan
Group Number:	34136000
Effective Date:	01/01/2019
For Internal Use Only:	Package: 1834420538 XREF: C1U4 Medical: 0710170437 Rx: 1834480663
1. General Plan Information	
Benefit Period	Calendar Year
Funding	Fully Insured with Maximum Refund
Grandfathered Status	Non-Grandfathered
Classification of Eligible Employees	All full-time employees actively working 30 hours per week; Retirees and their Dependents who are eligible in accordance with the Employer's Employee Benefits Program
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	Employer
Are Domestic Partners Covered?	No
Are Same Sex Spouses Covered?	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Compass	Compass not included
2. Network	
Local Medical Network	Preferred-Care Blue
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	$500	$1,500
Family	$1,000	$3,000
Pharmacy Deductible	No Pharmacy Deductible	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	10%	30%
Plan Pays	90%	70%

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	$2,800	$8,400
Family	$5,600	$16,800
Pharmacy Out-of-Pocket Limit	Separate Out-of-Pocket Limit (see Pharmacy Section)	
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.	$25 Copay/Visit, no Deductible	30% Coinsurance after Deductible
BDTC 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 optometrist, psychologists and chiropractors.	$50 Copay/Visit, no Deductible	30% Coinsurance after Deductible
Urgent Care Office Visit	$50 Copay/Visit, no Deductible	30% Coinsurance after Deductible
BDTC Urgent Care Office Visit	Does not apply	Not applicable
Designated Telehealth Care Visit	Does not apply	Not applicable
Other Benefits (in alphabetical order)	**In-Network**	**Out-of-Network**
Abortion	Not covered	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	10% Coinsurance after Deductible	30% Coinsurance after Deductible

Allergy Treatment (Injections)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Allergy Treatment (Serum)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Ambulance - Air Air Ambulance Allowable Option: Unlimited (No Cost Sharing) Benefit	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
Ambulance - Ground Ground Ambulance Allowable Option: 150% of Medicare	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
Assisted Reproductive Services	Not covered	Not covered
Autism Services, including ABA Therapy Autism Services Coverage: Mandated Services Autism Services Limits: Mandated Limits	Covered	Covered
Bariatric	Not covered	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
BDC+ Surgery	Not covered	Not covered
Chiropractic Services Office Visit	Same as Specialist Office Visit Cost Shares	Same as Specialist Office Visit Cost Shares
Diabetic Equipment and Supplies Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Diabetic Footwear	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Diabetic Pump	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Diabetic Self Management Education/Training (DSMT)	No member cost share	30% Coinsurance after Deductible
Durable Medical Equipment (DME) Prior Authorization Policy Applies No Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$200 Copay/Visit, then Deductible then 10% Coinsurance	$200 Copay/Visit, then In-Network Deductible then 10% Coinsurance
Food and Food Products for PKU No Limits	Covered	Covered
Foot Orthotics	Not covered	Not covered
Gender Dysphoria Treatment Prior Authorization Policy Applies	Covered	Covered
Hearing Aids	Not covered	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider	10% Coinsurance after Deductible	30% 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	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Home Hospice	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Treatment	Not covered	Not covered
Inpatient Hospice Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Physician Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Labs Performed in Office / Independent Lab	No member cost share	30% Coinsurance after Deductible
Maternity Dependent Daughters Maternity Covered?: Yes	Covered	Covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Inpatient Physician Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Office Visit	$25 Copay/Visit, no Deductible	30% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Facility Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Therapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible

Organ Transplant Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider INN Tier 1 Cost Share Providers: Designated Providers OON Cost Share Providers: All Other Providers	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Chiropractic Office Visit (including Skeletal Manipulation) Prior Authorization Policy Applies Out-ofNetwork	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Other Services Performed in Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Physician Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Surgery Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Cardiac Therapy No Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Cognitive Therapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy Combined with Speech Therapy Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy Combined with Physical Therapy Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Outpatient Therapy - Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Pulmonary Therapy No Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Private Duty Nursing Combined with Home Health Care Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible

Routine Preventive Care Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	30% 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	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Temporomandibular Joint (TMJ) TMJ Diagnosis and Surgical Treatment (for accidental injury, fracture, tumors): Yes TMJ Non-surgical Treatment: No TMJ Orthognathic Surgery: No	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Vision Exam-Routine	Not covered	Not covered
Weight Management - Naturally Slim	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider	10% Coinsurance after Deductible	30% Coinsurance after Deductible

General Pharmacy Information		
Pharmacy Network(s)	National Plus – **Walgreens not included**	
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	National Preferred	
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**	**Out-of-Network**
	Does Not Apply	Does Not Apply
Outpatient Prescription Drug Outof-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**	**Out-of-Network**
	Individual: $1,500 Family: $4,500	Individual: $1,500 Family: $4,500

Maintenance Medication Program	**Incentive Choice** – Member will pay a higher cost-sharing for staying at retail for their maintenance medications after two courtesy fills unless they choose Home Delivery. $10 Penalty
Generics Program	Not applicable

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		
	In-Network	**Out-of-Network**
Retail Pharmacy (Short-term supply: Up to 34 Days**)** **Drug Tier 1:** Generic / Generic Specialty	**National Plus:** $10 Copay/Fill	$10 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**National Plus:** 40% Coinsurance (Max: $100)	40% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**National Plus:** 60% Coinsurance (Max: $150)	60% Coinsurance
Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$20 Copay/Fill	$20 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	40% Coinsurance (Max: $200)	40% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	60% Coinsurance (Max: $300)	60% Coinsurance
Infertility and Impotency Drugs	Not covered	Not covered

Plan Information	
Group Name:	City of Lee's Summit
Plan Name:	Preferred-Care Blue Blue Choice PPO Plan
Group Number:	34136000
Effective Date:	01/01/2019
For Internal Use Only:	Package: 1831280865 XREF: C1U2 Medical: 1831570849 Rx: 0332260126
1. General Plan Information	
Benefit Period	Calendar Year
Funding	Fully Insured with Maximum Refund
Grandfathered Status	Non-Grandfathered
Classification of Eligible Employees	All full-time employees actively working 30 hours per week; Retirees and their Dependents who are eligible in accordance with the Employer's Employee Benefits Program
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	Employer
Are Domestic Partners Covered?	No
Are Same Sex Spouses Covered?	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Compass	Compass not included
2. Network	
Local Medical Network	Preferred-Care Blue
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	$0	$500
Family	$0	$1,500
Pharmacy Deductible	No Pharmacy Deductible	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	0%	20%
Plan Pays	100%	80%

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	$9,000
Family	$6,000	$18,000
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.	$20 Copay/Visit	20% Coinsurance after Deductible
BDTC 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 optometrist, psychologists and chiropractors.	$40 Copay/Visit	20% Coinsurance after Deductible
Urgent Care Office Visit	$40 Copay/Visit	20% Coinsurance after Deductible
BDTC Urgent Care Office Visit	Does not apply	Not applicable
Designated Telehealth Care Visit	Does not apply	Not applicable
Other Benefits (in alphabetical order)	**In-Network**	**Out-of-Network**
Abortion	Not covered	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	No member cost share	20% Coinsurance after Deductible

Allergy Treatment (Injections)	No member cost share	20% Coinsurance after Deductible
Allergy Treatment (Serum)	No member cost share	20% Coinsurance after Deductible
Ambulance - Air Air Ambulance Allowable Option: Unlimited (No Cost Sharing) Benefit	No member cost share	No member cost share
Ambulance - Ground Ground Ambulance Allowable Option: 150% of Medicare	No member cost share	No member cost share
Assisted Reproductive Services	Not covered	Not covered
Autism Services, including ABA Therapy Autism Services Coverage: Mandated Services Autism Services Limits: Mandated Limits	Covered	Covered
Bariatric	Not covered	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
BDC+ Surgery	Not covered	Not covered
Chiropractic Services Office Visit	Same as Specialist Office Visit Cost Shares	Same as Specialist Office Visit Cost Shares
Diabetic Equipment and Supplies Prior Authorization Policy Applies	No member cost share	20% Coinsurance after Deductible
Diabetic Footwear	No member cost share	20% Coinsurance after Deductible
Diabetic Pump	No member cost share	20% Coinsurance after Deductible
Diabetic Self Management Education/Training (DSMT)	No member cost share	20% Coinsurance after Deductible
Durable Medical Equipment (DME) Prior Authorization Policy Applies No Limits	No member cost share	20% Coinsurance after Deductible
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$200 Copay/Visit	$200 Copay/Visit
Food and Food Products for PKU No Limits	Covered	Covered
Foot Orthotics	Not covered	Not covered
Gender Dysphoria Treatment Prior Authorization Policy Applies	Covered	Covered
Hearing Aids	Not covered	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider High Tech Radiology ER Copay Waiver Rule (when ER Copay also applies): High Tech Radiology Copay Waived	$100 Copay/Day Limited to $100 Copay Max per Calendar Year	20% 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	No member cost share	20% Coinsurance after Deductible
Home Hospice	No member cost share	20% Coinsurance after Deductible
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Treatment	Not covered	Not covered
Inpatient Hospice Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$150 Copay/Day Limited to Inpatient/Outpatient $1,500 Copay Max per Calendar Year	20% Coinsurance after Deductible
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider	$300 Copay/Day Limited to Inpatient/Outpatient $1,500 Copay Max per Calendar Year	20% Coinsurance after Deductible
Inpatient Physician Services	No member cost share	20% Coinsurance after Deductible
Labs Performed in Office / Independent Lab	No member cost share	20% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Maternity Dependent Daughters Maternity Covered?: Yes	Covered	Covered
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$300 Copay/Day Limited to Inpatient/Outpatient $1,500 Copay Max per Calendar Year	20% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Inpatient Physician Services	No member cost share	20% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Office Visit	$20 Copay/Visit	20% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Facility Prior Authorization Policy Applies	No member cost share	20% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Therapy	No member cost share	20% Coinsurance after Deductible

Organ Transplant Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes INN Tier 1 Cost Share Providers: Designated Providers OON Cost Share Providers: All Other Providers	$300 Copay/Day Limited to Inpatient/Outpatient $1,500 Copay Max per Calendar Year	20% Coinsurance after Deductible
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Chiropractic Office Visit (including Skeletal Manipulation) Prior Authorization Policy Applies Out-ofNetwork	No member cost share	20% Coinsurance after Deductible
Other Services Performed in Office	No member cost share	20% Coinsurance after Deductible
Outpatient Physician Services	No member cost share	20% Coinsurance after Deductible
Outpatient Surgery Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider	No member cost share	20% Coinsurance after Deductible
Outpatient Therapy - Cardiac Therapy No Limits	No member cost share	20% Coinsurance after Deductible
Outpatient Therapy - Cognitive Therapy	No member cost share	20% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Outpatient Therapy - Hearing Therapy Combined with Speech Therapy Limits	No member cost share	20% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy Combined with Physical Therapy Limits	No member cost share	20% Coinsurance after Deductible
Outpatient Therapy - Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	No member cost share	20% Coinsurance after Deductible
Outpatient Therapy - Pulmonary Therapy No Limits	No member cost share	20% Coinsurance after Deductible
Outpatient Therapy - Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	No member cost share	20% Coinsurance after Deductible

Private Duty Nursing Combined with Home Health Care Limits	No member cost share	20% Coinsurance after Deductible
Routine Preventive Care Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	20% 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	No member cost share	20% Coinsurance after Deductible
Temporomandibular Joint (TMJ) TMJ Diagnosis and Surgical Treatment (for accidental injury, fracture, tumors): Yes TMJ Non-surgical Treatment: No TMJ Orthognathic Surgery: No	No member cost share	20% Coinsurance after Deductible
Vision Exam-Routine	Not covered	Not covered
Vision Hardware	Not covered	Not covered
Weight Management - Naturally Slim	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider	No member cost share	20% Coinsurance after Deductible

General Pharmacy Information	
Pharmacy Network(s)	National Plus - **Walgreens not included**
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	National Preferred

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 Outof-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
Maintenance Medication Program	**Incentive Choice** – Member will pay a higher cost-sharing for staying at retail for their maintenance medications after two courtesy fills unless they choose Home Delivery. $10 Penalty	
Generics Program	Not applicable	

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		
	In-Network	**Out-of-Network**
Retail Pharmacy (Short-term supply: Up to 34 Days**)** **Drug Tier 1:** Generic / Generic Specialty	**National Plus:** $10 Copay/Fill	$10 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**National Plus:** $40 Copay/Fill	$40 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**National Plus:** $65 Copay/Fill	$65 Copay/Fill, then 50% Coinsurance
Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$20 Copay/Fill	$20 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	$80 Copay/Fill	$80 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	$130 Copay/Fill	$130 Copay/Fill, then 50% Coinsurance
Infertility and Impotency Drugs	Not covered	Not covered

Plan Information	
Group Name:	City of Lee's Summit
Plan Name:	Preferred-Care Blue BlueSaver PPO Plan
Group Number:	34136000
Effective Date:	01/01/2019
For Internal Use Only:	Package: 1237550583 XREF: C1RW Medical: 0712280078 Rx: 1238060755
1. General Plan Information	
Benefit Period	Calendar Year
Funding	Fully Insured with Maximum Refund
Grandfathered Status	Non-Grandfathered
Classification of Eligible Employees	All full-time employees actively working 30 hours per week; Retirees and their Dependents who are eligible in accordance with the Employer's Employee Benefits Program
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	Employer
Are Domestic Partners Covered?	No
Are Same Sex Spouses Covered?	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Compass	Compass not included
2. Network	
Local Medical Network	Preferred-Care Blue
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	$2,700	$2,700
Family	$5,400	$5,400
Pharmacy Deductible	Combined with Medical	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	0%	30%
Plan Pays	100%	70%

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	$2,700	$5,400
Family	$5,400	$10,800
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.	Deductible, then no charge	30% Coinsurance after Deductible
BDTC 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 optometrist, psychologists and chiropractors.	Deductible, then no charge	30% Coinsurance after Deductible
Urgent Care Office Visit	Deductible, then no charge	30% Coinsurance after Deductible
BDTC Urgent Care Office Visit	Does not apply	Not applicable
Designated Telehealth Care Visit	Does not apply	Not applicable
Other Benefits (in alphabetical order)	**In-Network**	**Out-of-Network**
Abortion	Not covered	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	Deductible, then no charge	30% Coinsurance after Deductible

Allergy Treatment (Injections)	Deductible, then no charge	30% Coinsurance after Deductible
Allergy Treatment (Serum)	Deductible, then no charge	30% Coinsurance after Deductible
Ambulance - Air Air Ambulance Allowable Option: Unlimited (No Cost Sharing) Benefit	Deductible, then no charge	Deductible, then no charge
Ambulance - Ground Ground Ambulance Allowable Option: 150% of Medicare	Deductible, then no charge	Deductible, then no charge
Assisted Reproductive Services	Not covered	Not covered
Autism Services, including ABA Therapy Autism Services Coverage: Mandated Services Autism Services Limits: Mandated Limits	Covered	Covered
Bariatric	Not covered	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
BDC+ Surgery	Not covered	Not covered
Chiropractic Services Office Visit	Same as Specialist Office Visit Cost Shares	Same as Specialist Office Visit Cost Shares
Diabetic Equipment and Supplies Prior Authorization Policy Applies	Deductible, then no charge	30% Coinsurance after Deductible
Diabetic Footwear	Deductible, then no charge	30% Coinsurance after Deductible
Diabetic Pump	Deductible, then no charge	30% Coinsurance after Deductible
Diabetic Self Management Education/Training (DSMT)	Deductible, then no charge	30% Coinsurance after Deductible
Durable Medical Equipment (DME) Prior Authorization Policy Applies No Limits	Deductible, then no charge	30% Coinsurance after Deductible
Emergency Services	Deductible, then no charge	Deductible, then no charge
Food and Food Products for PKU No Limits	Covered	Covered
Foot Orthotics	Not covered	Not covered
Gender Dysphoria Treatment Prior Authorization Policy Applies	Covered	Covered
Hearing Aids	Not covered	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider	Deductible, then no charge	30% 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	Deductible, then no charge	30% Coinsurance after Deductible

Home Hospice	Deductible, then no charge	30% Coinsurance after Deductible
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Treatment	Not covered	Not covered
Inpatient Hospice Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	Deductible, then no charge	30% Coinsurance after Deductible
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider	Deductible, then no charge	30% Coinsurance after Deductible
Inpatient Physician Services	Deductible, then no charge	30% Coinsurance after Deductible
Labs Performed in Office / Independent Lab	Deductible, then no charge	30% Coinsurance after Deductible
Maternity Dependent Daughters Maternity Covered?: Yes	Covered	Covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider	Deductible, then no charge	30% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Inpatient Physician Services	Deductible, then no charge	30% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Office Visit	Deductible, then no charge	30% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Facility Prior Authorization Policy Applies	Deductible, then no charge	30% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Therapy	Deductible, then no charge	30% Coinsurance after Deductible

Organ Transplant Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider INN Tier 1 Cost Share Providers: Designated Providers OON Cost Share Providers: All Other Providers	Deductible, then no charge	30% Coinsurance after Deductible
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Chiropractic Office Visit (including Skeletal Manipulation) Prior Authorization Policy Applies Out-ofNetwork	Deductible, then no charge	30% Coinsurance after Deductible
Other Services Performed in Office	Deductible, then no charge	30% Coinsurance after Deductible
Outpatient Physician Services	Deductible, then no charge	30% Coinsurance after Deductible
Outpatient Surgery Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider	Deductible, then no charge	30% Coinsurance after Deductible
Outpatient Therapy - Cardiac Therapy No Limits	Deductible, then no charge	30% Coinsurance after Deductible
Outpatient Therapy - Cognitive Therapy	Deductible, then no charge	30% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy Combined with Speech Therapy Limits	Deductible, then no charge	30% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy Combined with Physical Therapy Limits	Deductible, then no charge	30% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Outpatient Therapy - Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	30% Coinsurance after Deductible
Outpatient Therapy - Pulmonary Therapy No Limits	Deductible, then no charge	30% Coinsurance after Deductible
Outpatient Therapy - Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	30% Coinsurance after Deductible
Private Duty Nursing Combined with Home Health Care Limits	Deductible, then no charge	30% Coinsurance after Deductible

Routine Preventive Care Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	30% 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	Deductible, then no charge	30% Coinsurance after Deductible
Temporomandibular Joint (TMJ) TMJ Diagnosis and Surgical Treatment (for accidental injury, fracture, tumors): Yes TMJ Non-surgical Treatment: No TMJ Orthognathic Surgery: No	Deductible, then no charge	30% Coinsurance after Deductible
Vision Exam-Routine	Not covered	Not covered
Weight Management - Naturally Slim	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology Maximum benefit of $200/Day for Out-ofNetwork/Non-Participating/In-Area Provider	Deductible, then no charge	30% Coinsurance after Deductible

General Pharmacy Information		
Pharmacy Network(s)	National Plus - **Walgreens not included**	
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	National Preferred	
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**	**Out-of-Network**
	Combined with Medical Deductible	Combined with Medical Deductible
Outpatient Prescription Drug Outof-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**	**Out-of-Network**
	Combined with Medical Out-of-Pocket	Combined with Medical Out-of-Pocket

Maintenance Medication Program	**Incentive Choice** – Member will pay a higher cost-sharing for staying at retail for their maintenance medications after two courtesy fills unless they choose Home Delivery. $10 Penalty
Generics Program	Not applicable

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		
	In-Network	**Out-of-Network**
Retail Pharmacy (Short-term supply: Up to 34 Days**)** **Drug Tier 1:** Generic / Generic Specialty	**National Plus:** Deductible, then no charge	Deductible, then $10 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**National Plus:** Deductible, then no charge	Deductible, then $40 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**National Plus:** Deductible, then no charge	Deductible, then $65 Copay/Fill, then 50% Coinsurance
Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	Deductible, then no charge	Deductible, then $20 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	Deductible, then no charge	Deductible, then $80 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	Deductible, then no charge	Deductible, then $130 Copay/Fill, then 50% Coinsurance
Preventive Drugs **Retail Drug Tier 1:** Generic / Generic Specialty	**National Plus:** Deductible, then no charge	Deductible, then $10 Copay/Fill, then 50% Coinsurance
Retail Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**National Plus:** Deductible, then no charge	Deductible, then $40 Copay/Fill, then 50% Coinsurance
Retail Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**National Plus:** Deductible, then no charge	Deductible, then $65 Copay/Fill, then 50% Coinsurance
Mail Order Drug Tier 1: Generic / Generic Specialty	Deductible, then no charge	Deductible, then $20 Copay/Fill, then 50% Coinsurance
Mail Order Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	Deductible, then no charge	Deductible, then $80 Copay/Fill, then 50% Coinsurance
Mail Order Drug Tier 3: NonPreferred Brand / Non-Preferred Brand Specialty	Deductible, then no charge	Deductible, then $130 Copay/Fill, then 50% Coinsurance
Infertility and Impotency Drugs	Not covered	Not covered