City of Lee's Summit

Group Number: 34136000
Preferred-Care Blue
Blue Choice PPO Plan
Benefit & Rate Confirmation
(Effective January 1, 2018)

Benefit and Rate Confirmation
City of Lee's Summit – Preferred-Care Blue – Blue Choice PPO Plan

	Preferred-Care Blue **Copayment, Deductible, Coinsurance and Limits**
Hospital and Physician	
Calendar Year Deductible	Individual / Family
Preferred	$0 / $0
Non-Preferred	$500 / $1,500
Coinsurance Member Pays	
Preferred	0%
Non-Preferred	20%
Out-of-Pocket Maximum *(Includes Deductible, Coinsurance & All Copays)*	Individual / Family
Preferred	$3,000 / $6,000
Non-Preferred	$9,000 / $18,000
Physician Office Visit	
Preferred	
PCP	$20 Copay*
Specialist	$40 Copay*
Non-Preferred	Deductible & Coinsurance
*Copay applies to the Office Visit Charge Only. Other procedures performed in a Physician's office are subject to the applicable deductible and coinsurance level unless otherwise specified in the benefit schedule.	
Lab Services	
Preferred	
Physician's Office / Independent Lab	No Copay*
Outpatient Facility/Hospital	Deductible & Coinsurance
Non-Preferred	Deductible & Coinsurance
X-ray and other Radiology Procedures	
Preferred	Deductible & Coinsurance
Non-Preferred	Deductible & Coinsurance
Routine Preventive Care	Expanded (ACA Compliant) Women's Preventive***
Preferred	Routine Services: 100% Related OV: 100%
Non-Preferred	Deductible & Coinsurance

****Routine Women's Preventive required under the Affordable Care Act of 2010 ("ACA")*

Hospital and Physician (cont'd.)	
Routine Vision Care	No Benefit
Prenatal Program	Yes
Emergency Room	$200 Copay then Deductible & Preferred Coinsurance *Copay waived if admitted to a Hospital*
Urgent Care Benefit	
Preferred	$40 Copay*
Non-Preferred	Deductible & Coinsurance
Inpatient Hospital Services	
Preferred	$300 Copay per Day *Copay limited to five copays per member per calendar year*
Non-Preferred	Deductible & Coinsurance
Outpatient Surgery in Hospital or other Outpatient Facility	Deductible & Coinsurance
MRIs, PET Scans, CT Scans, & MRAs	
Preferred	$100 Copay then 0% Coinsurance *$100 Maximum Calendar year Copayment (copay limited to 1 per calendar year)*
Non-Preferred	Deductible & Coinsurance

Mental Illness/Substance Abuse	
Inpatient Mental Illness/Substance Abuse	
Preferred	$300 Copay per Day *Copay limited to five copays per member per calendar year*
Non-Preferred	Deductible & Coinsurance
Outpatient Mental Illness/Substance Abuse Office Visit	$20 Copay*
Outpatient Mental Illness/Substance Abuse Therapy	Deductible & Coinsurance

Ancillary/Miscellaneous	
Air Ambulance	Network Deductible & Preferred Coinsurance
Ground Ambulance	Network Deductible & Preferred Coinsurance *No limit per trip*
Home Health Services	Deductible & Coinsurance *60 visit Calendar Year Maximum*
Skilled Nursing Facility	Deductible & Coinsurance *30 day Calendar Year Maximum*
Inpatient Hospice Preferred	$150 Copay per Day *Applies to Annual Inpatient Hospital Maximum*
Non-Preferred	Deductible & Coinsurance *14 Day Lifetime Max*
Outpatient Therapy (Speech, Hearing, Physical, and Occupational)	Deductible & Coinsurance *Combined 60 visit Calendar Year Maximum for Physical & Occupational Therapy* *Combined 20 visit Calendar Year Maximum for Speech & Hearing Therapy*
Chiropractic Services *Copay applies to the Office Visit Charge Only. Other procedures performed in a Chiropractor's office are subject to the applicable deductible and coinsurance level unless otherwise specified in the benefit schedule.	Network: $40 Copay* Non-Network: Deductible & Coinsurance
Infertility/Impotency	Not Covered

Outpatient Prescription Drugs	
Network	BCBSKC Rx
Rx Deductible	None
Long-Term Supply – Mail order only	All covered drugs
Retail Copays: Tier 1/Tier 2/Tier 3	$10/40/65
Mail Order Copays: Tier 1/Tier 2/Tier 3	$20/80/130
Contraceptives:	Generic contraceptive drugs covered at 100% Injectables, implants, and devices covered at 100%
Out-of-Network:	50% after Copay
ExpressScripts Program:	BlueKC Network without Walgreens Select Home Delivery Incentive Choice: $10 additional charge for maintenance medications at Retail Out-of-Network: 50% after Copay

Other	
Lifetime Maximum	Unlimited
Dependent Limiting Age	26
Maternity	Covered
Dependent Daughters	Covered for maternity
Eligibility/Termination	First day of month/last day of month
Domestic Partner Amendment – Coverage for same sex and opposite sex coverage	Not covered
Coverage for Legally Married Same Sex Spouse	Yes
Wellness Fund (Group Total)	$35,000 **Amount applies to group as a whole and amount is not available for each unique product the group offers.*
Nurse Line	Yes

Benefit and Rate Confirmation
City of Lee's Summit – Preferred-Care Blue – Blue Choice PPO Plan

Underwriting	
Minimum percent of Eligible employees covered	75%
Percentage threshold of total employee enrollment at renewal based on prior year's enrollment	90%
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
Waiting Period	First of the Month following one full calendar month of service
Minimum Employer Contribution	75% cost of Eligible Employees/50% total account premium
Section 125 Enrollment Provisions	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Start Date of Annual Enrollment Period	30 days prior to group anniversary date
End Date of Annual Enrollment Period	15 days after group anniversary date
Contract Term	12 months
Subsequent Renewal Terms	12 months
Renewal Notification	120 Days
Next Renewal	1/1/19
Reinstatement Fee	$500
Subject to ERISA	No

Mandated Offerings	
Pregnancy Termination	☐ Accept ☒ Reject

Benefit and Rate Confirmation
City of Lee's Summit – Preferred-Care Blue – Blue Choice PPO Plan

Rates	
Employee	$790.48
Employee & Spouse	$1,728.70
Employee & Child(ren)	$1,728.70
Family	$2,006.69

A Healthier You™	
Select only one: ☒ AHY 100+	
AHY for Subscriber and Spouse with Medical Coverage	Included in premium

A Healthier You Buy-Up Options	
☒ AHY Standard – Employees with no medical*	$2.00 PEPM
*Including individuals with no medical coverage requires automated enrollment via EDI or Blues Enroll.	

Funding	☐ Cost Plus ☒ Insured ☐ Other _____

Confirmed by City of Lee's Summit:

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Signature

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Title

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Date

Accepted by Blue Cross and Blue Shield of Kansas City:

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Signature

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Title

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Date

City of Lee's Summit

Group Number: 34136000
Preferred-Care Blue
PPO Plan
Benefit & Rate Confirmation
(Effective January 1, 2018)

Benefit and Rate Confirmation
City of Lee's Summit – Preferred-Care Blue – PPO Plan

	Preferred-Care Blue **Copayment, Deductible, Coinsurance and Limits**	
Hospital and Physician		
Calendar Year Deductible	Individual	Family
Preferred	$500	$1,000
Non-Preferred	$1,500	$3,000
Coinsurance Member Pays		
Preferred	10%	
Non-Preferred	30%	
Out-of-Pocket Maximum *(Includes Deductible, Coinsurance & All Copays)*	Individual	Family
Preferred	$2,800	$5,600
Non-Preferred	$8,400	$16,800
Physician Office Visit		
Preferred		
PCP	$25 Copay*	
Specialist	$50 Copay*	
Non-Preferred	Deductible & Coinsurance	
*Copay applies to the Office Visit Charge Only. Other procedures performed in a Physician's office are subject to the applicable deductible and coinsurance level unless otherwise specified in the benefit schedule.		
Lab Services		
Preferred		
Physician's Office / Independent Lab	No Copay*	
Outpatient Facility/Hospital	Deductible & Coinsurance	
Non-Preferred	Deductible & Coinsurance	
X-ray and other Radiology Procedures		
Preferred	Deductible & Coinsurance	
Non-Preferred	Deductible & Coinsurance	
Routine Preventive Care	Expanded (ACA Compliant) Women's Preventive***	
Preferred	Routine Services: 100% Related OV: 100%	
Non-Preferred	Deductible & Coinsurance	

****Routine Women's Preventive required under the Affordable Care Act of 2010 ("ACA")*

Hospital and Physician (cont'd.)	
Routine Vision Care	No Benefit
Prenatal Program	Yes
Emergency Room	$200 Copay then Deductible & Preferred Coinsurance *Copay waived if admitted to a Hospital*
Urgent Care Benefit Preferred Non-Preferred	 $50 Copay* Deductible & Coinsurance

Mental Illness/Substance Abuse	
Inpatient Mental Illness/Substance Abuse	Deductible & Coinsurance
Outpatient Mental Illness/Substance Abuse Office Visit	$25 Copay*
Outpatient Mental Illness/Substance Abuse Therapy	Deductible & Coinsurance

Ancillary/Miscellaneous	
Air Ambulance	Network Deductible & Preferred Coinsurance
Ground Ambulance	Network Deductible & Preferred Coinsurance *No limit per trip*
Home Health Services	Deductible & Coinsurance *60 visit Calendar Year Maximum*
Skilled Nursing Facility	Deductible & Coinsurance *30 day Calendar Year Maximum*
Inpatient Hospice	Deductible & Coinsurance *14 Day Lifetime Max*
Outpatient Therapy (Speech, Hearing, Physical, and Occupational)	Deductible & Coinsurance *Combined 60 visit Calendar Year Maximum for Physical & Occupational Therapy* *Combined 20 visit Calendar Year Maximum for Speech & Hearing Therapy*
Chiropractic Services *Copay applies to the Office Visit Charge Only. Other procedures performed in a Chiropractor's office are subject to the applicable deductible and coinsurance level unless otherwise specified in the benefit schedule.	Network: $50 Copay* Non-Network: Deductible & Coinsurance
Infertility/Impotency	Not Covered

Outpatient Prescription Drugs	
Network	BCBSKC Rx
Rx Deductible	None
Long-Term Supply – Mail order only	All covered drugs
Retail In-Network Copays:	
Tier 1:	$10 Copay
Tier 2:	40% up to $100
Tier 3:	60% up to $150
Retail Non-Network Copays:	
Tier 1/ Tier 2/ Tier 3:	50% after $10 Copay/ 40%/ 60%
In-Network Mail Order Copays:	
Tier 1:	$20 Copay
Tier 2:	40% up to $200
Tier 3:	60% up to $300
Non-Network Mail Order Copays:	
Tier 1/ Tier 2/ Tier 3:	50% after $20 Copay/ 40%/ 60%
Contraceptives:	Generic contraceptive drugs covered at 100% Injectables, implants, and devices covered at 100%
Annual Out of Pocket:	$1,500 Individual/ $4,500 Family
ExpressScripts Program:	BlueKC Network without Walgreens Select Home Delivery Incentive Choice: $10 additional charge for maintenance medications at Retail Out-of-Network: 50% after Copay

Other	
Lifetime Maximum	Unlimited
Dependent Limiting Age	26
Maternity	Covered
Dependent Daughters	Covered for maternity
Eligibility/Termination	First day of month/last day of month
Domestic Partner Amendment – Coverage for same sex and opposite sex coverage	Not covered
Coverage for Legally Married Same Sex Spouse	Yes
Wellness Fund (Group Total)	$35,000 **Amount applies to group as a whole and amount is not available for each unique product the group offers.*
Nurse Line	Yes

Benefit and Rate Confirmation
City of Lee's Summit – Preferred-Care Blue – PPO Plan

Underwriting	
Minimum percent of Eligible employees covered	75%
Percentage threshold of total employee enrollment at renewal based on prior year's enrollment	90%
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
Waiting Period	First of the Month following one full calendar month of service
Minimum Employer Contribution	75% cost of Eligible Employees/50% total account premium
Section 125 Enrollment Provisions	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Start Date of Annual Enrollment Period	30 days prior to group anniversary date
End Date of Annual Enrollment Period	15 days after group anniversary date
Contract Term	12 months
Subsequent Renewal Terms	12 months
Renewal Notification	120 Days
Next Renewal	1/1/19
Reinstatement Fee	$500
Subject to ERISA	No

Mandated Offerings	
Pregnancy Termination	☐ Accept ☒ Reject

Benefit and Rate Confirmation
City of Lee's Summit – Preferred-Care Blue – PPO Plan

Rates	
Employee	$707.31
Employee & Spouse	$1,556.97
Employee & Child(ren)	$1,556.97
Family	$1,807.40

A Healthier You™	
Select only one: ☒ AHY 100+	
AHY for Subscriber and Spouse with Medical Coverage	Included in premium

A Healthier You Buy-Up Options	
☒ AHY Standard – Employees with no medical*	$2.00 PEPM
*Including individuals with no medical coverage requires automated enrollment via EDI or Blues Enroll.	

Funding	☐ Cost Plus ☒ Insured ☐ Other _____

Confirmed by City of Lee's Summit:

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Signature

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Title

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Date

Accepted by Blue Cross and Blue Shield of Kansas City:

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Signature

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Title

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Date

City of Lee's Summit

Group Number: 34136000
Preferred-Care Blue
BlueSaver PPO Plan
Benefit & Rate Confirmation
(Effective January 1, 2018)

Benefit and Rate Confirmation
City of Lee's Summit – Preferred-Care Blue – BlueSaver PPO Plan

	Preferred-Care Blue **Copayment, Deductible, Coinsurance and Limits**
Hospital and Physician	
Calendar Year Deductible	Individual / Family
Preferred	$2,700 / $5,400
Non-Preferred	$2,700 / $5,400
Coinsurance Member Pays	
Preferred	0%
Non-Preferred	30%
Out-of-Pocket Maximum *(Includes Deductible, Coinsurance & All Copays)*	Individual / Family
Preferred	$2,700 / $5,400
Non-Preferred	$5,400 / $10,800
Physician Office Visit	Deductible & Coinsurance
Lab Services Performed in a Physician's Office / Independent Lab	Deductible & Coinsurance
X-ray and other Radiology Procedures	Deductible & Coinsurance
Routine Preventive Care Preferred	Expanded (ACA Compliant) Women's Preventive*** Routine Services: 100% Related OV: 100%
Non-Preferred	Deductible & Coinsurance
Routine Vision Care	No Benefit
Prenatal Program	Yes
Emergency Room	Deductible & Preferred Coinsurance
Urgent Care Benefit	Deductible & Coinsurance

Mental Illness/Substance Abuse	
Inpatient Mental Illness/Substance Abuse	Deductible & Coinsurance
Outpatient Mental Illness/Substance Abuse	Deductible & Coinsurance

****Routine Women's Preventive services required under the Affordable Care Act of 2010 ("ACA")*

Ancillary/Miscellaneous	
Air Ambulance	Deductible & Preferred Coinsurance
Ground Ambulance	Deductible & Preferred Coinsurance *No limit per trip*
Home Health Services	Deductible & Coinsurance *60 visit Calendar Year Maximum*
Skilled Nursing Facility	Deductible & Coinsurance *30 day Calendar Year Maximum*
Inpatient Hospice	Deductible & Coinsurance *14 Day Lifetime Max*
Outpatient Therapy (Speech, Hearing, Physical, and Occupational)	Deductible & Coinsurance *Combined 60 visit Calendar Year Maximum for Physical & Occupational Therapy* *Combined 20 visit Calendar Year Maximum for Speech & Hearing Therapy*
Chiropractic Services	Deductible & Coinsurance
Infertility/Impotency	Not Covered

Outpatient Prescription Drugs	
Network	BCBSKC Rx
Long-Term Supply – Mail order only	All covered drugs
Retail Copays: Tier 1/Tier 2/Tier 3	In Network: Deductible then 100% Out of Network: Deductible then 50% after $10/40/65
Mail Order Copays: Tier 1/Tier 2/Tier 3	In Network: Deductible then 100% Out of Network: Deductible then 50% after $20/80/130
Contraceptives:	Generic contraceptive drugs covered at 100% Injectables, implants, and devices covered at 100%
ExpressScripts Program:	BlueKC Network without Walgreens Select Home Delivery Incentive Choice: $10 additional charge for maintenance medications at Retail Out-of-Network: 50% after Copay

Other	
Lifetime Maximum	Unlimited
Dependent Limiting Age	26
Maternity	Covered
Dependent Daughters	Covered for maternity
Eligibility/Termination	First day of month/last day of month
Domestic Partner Amendment – Coverage for same sex and opposite sex coverage	Not covered
Coverage for Legally Married Same Sex Spouse	Yes
Wellness Fund (Group Total)	$35,000 **Amount applies to group as a whole and amount is not available for each unique product the group offers.*
Bank Selection	UMB
Nurse Line	Yes

Benefit and Rate Confirmation
City of Lee's Summit – Preferred-Care Blue – BlueSaver PPO Plan

Underwriting	
Minimum percent of Eligible employees covered	75%
Percentage threshold of total employee enrollment at renewal based on prior year's enrollment	90%
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
Waiting Period	First of the Month following one full calendar month of service
Minimum Employer Contribution	75% cost of Eligible Employees/50% total account premium
Section 125 Enrollment Provisions	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Start Date of Annual Enrollment Period	30 days prior to group anniversary date
End Date of Annual Enrollment Period	15 days after group anniversary date
Contract Term	12 months
Subsequent Renewal Terms	12 months
Renewal Notification	120 Days
Next Renewal	1/1/19
Reinstatement Fee	$500
Subject to ERISA	No

Mandated Offerings	
Pregnancy Termination	☐ Accept ☒ Reject

Benefit and Rate Confirmation
City of Lee's Summit – Preferred-Care Blue – BlueSaver PPO Plan

Rates	
Employee	$654.38
Employee & Spouse	$1,439.88
Employee & Child(ren)	$1,439.88
Family	$1,671.49

A Healthier You™	
Select only one: ☒ AHY 100+	
AHY for Subscriber and Spouse with Medical Coverage	Included in premium

A Healthier You Buy-Up Options	
☒ AHY Standard – Employees with no medical*	$2.00 PEPM
*Including individuals with no medical coverage requires automated enrollment via EDI or Blues Enroll.	

Funding	☐ Cost Plus ☒ Insured ☐ Other _____

Confirmed by City of Lee's Summit:

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Signature

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Title

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Date

Accepted by Blue Cross and Blue Shield of Kansas City:

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Signature

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Title

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Date