

Retiree Medical Insurance
Rates Effective January 1, 2020 – December 31, 2020

Medical Insurance

Rates	BlueSelect Plus Spira	BlueSelect Plus EPO	Blue-Care HMO	BlueSelect Plus PPO	Preferred-Care Blue PPO	BlueSaver Preferred Care Blue	Blue Saver BlueSelect Plus
Retiree Under 65	\$750.00	\$850.00	\$915.00	\$750.00	\$810.00	\$730.00	\$675.00
Retiree 65+	\$632.04	\$721.68	\$776.86	\$636.77	\$687.72	\$615.18	\$568.83
Retiree Under 65; +1 Dep Under 65	\$1,189.00	\$1,344.00	\$1,447.00	\$1,189.00	\$1,284.00	\$1,151.00	\$1,098.00
Retiree Under 65; +1 Dep 65+	\$956.24	\$1,210.07	\$1,302.90	\$1,075.52	\$1,153.06	\$1,003.29	\$956.24
Retiree 65+; + 1 Dep Under 65	\$934.23	\$1,183.47	\$1,274.25	\$1,051.87	\$1,127.71	\$980.21	\$934.23
Retiree 65+; + 1 Dep 65+	\$772.86	\$988.38	\$1,064.21	\$878.48	\$941.82	\$810.89	\$772.86
Retiree Under 65; Deps Under 65	\$1,498.00	\$1,697.00	\$1,827.00	\$1,498.00	\$1,618.00	\$1,450.00	\$1,387.00
Retiree Under 65; Deps 65+	\$1,252.73	\$1,581.87	\$1,703.07	\$1,406.00	\$1,507.65	\$1,310.75	\$1,252.73
Retiree 65+; Deps Under 65	\$1,236.40	\$1,562.14	\$1,681.82	\$1,388.46	\$1,488.84	\$1,293.66	\$1,236.40
Retiree 65+; Deps 65+	\$1,130.19	\$1,433.80	\$1,543.66	\$1,274.39	\$1,366.53	\$1,182.53	\$1,130.19
Companion Spouse	\$429.97	\$553.83	\$596.19	\$488.68	\$527.77	\$465.01	\$429.97
Companion Child(ren)	\$444.98	\$591.97	\$637.24	\$522.33	\$564.11	\$481.24	\$444.98

Medical Insurance Continued

Benefits	BlueSelect Plus Spira	BlueSelect Plus EPO	Blue-Care HMO	BlueSelect Plus PPO	Preferred-Care Blue PPO	BlueSaver Preferred Care Blue	Blue Saver BlueSelect Plus
Network	BlueSelect Plus	BlueSelect Plus	Blue-Care	BlueSelect Plus	Preferred-Care Blue	Preferred-Care Blue	BlueSelect Plus
In Network Deductible	\$1,500 indiv \$3,000 fam	N/A	N/A	\$1,500 indiv \$3,000 fam	\$1,500 indiv \$3,000 fam	\$3,000 indiv \$6,000 fam	\$3,000 indiv \$6,000 fam
Out of Network Deductible	N/A	N/A	N/A	\$3,000 indiv \$6,000 fam	N/A	\$3,000 indiv \$6,000 fam	\$6,000 indiv \$12,000 fam
In Network Coinsurance	Your share: 0%	N/A	N/A	Your share: 20%	Your share: 20%	Your share: 20%	Your share: 20% Spira: 0%
Out of Network Coinsurance	N/A	N/A	N/A	Your share: 50%	Your share: 50%	Your share: 40%	Your share: 50%
In Network Out of Pocket Maximum	\$1,500 indiv \$3,000 fam	\$4,000 indiv \$10,000 fam	\$4,000 indiv \$10,000 fam	\$4,500 indiv \$9,000 fam	\$4,500 indiv \$9,000 fam	\$4,000 indiv \$8,000 fam	\$4,000 indiv \$8,000 fam
Out of Network Out of Pocket Maximum	N/A	N/A	N/A	\$23,000 indiv \$46,000 fam	\$13,500 indiv \$27,000 fam	\$8,000 indiv \$16,000 fam	\$20,000 indiv \$40,000 fam
Office Visits	Spira: No Cost; Other BSP Provider: Deductible	\$35 PCP/\$30 PCMH PCP \$70 Specialist copay	\$35 PCP/\$30 PCMH PCP \$70 Specialist copay	Deductible then 20%	Deductible then 20%	Deductible then 20%	Spira locations: Fair Market Charge (\$60); BSP providers: Deductible then 20%
Preventative Care	100%	100%	100%	100%	100%	100%	100%
Urgent Care	Spira: No Cost; Other BSP Provider: Deductible	\$70 copay	\$70 copay	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then 20%
Emergency Services	Deductible	\$200 copay	\$200 copay	\$150 copay then deductible then 20%	\$150 copay then deductible then 20%	Deductible then 20%	Deductible then 20%
Inpatient Hospital Services	Deductible	\$400 copay per member up to \$2,000	\$400 copay per member up to \$2,000	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then 20%
Scans (MRI's PET, CT etc.)	Deductible	\$200 copay	\$200 copay	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then 20%
Prescription Drugs	\$15/\$50/ Deductible Retail \$15/\$125/ Deductible Mail	Rx Deductible \$100/\$200 then \$10/\$50/\$70 Retail \$20/\$100/\$140 Mail	Rx Deductible \$100/\$200 then \$10/\$50/\$70 Retail \$20/\$100/\$140 Mail	Rx Deductible \$100/\$200 then \$10/\$50/\$70 Retail \$20/\$100/\$140 Mail	Rx Deductible \$100/\$200 then \$10/\$50/\$70 Retail \$20/\$100/\$140 Mail	Deductible then: \$10/\$50/\$70 Retail \$20/\$100/\$140 Mail	Deductible then: \$10/\$50/\$70 Retail \$20/\$100/\$140 Mail

**Retiree Dental Insurance
Base Plan
Rates Effective January 1, 2020 – December 31, 2020**

Dental Service Type	Blue Dental PPO Providers ¹	Blue Dental Choice Providers ²	Non-Participating Providers ³
	Deductible, Coinsurance and Limitations		
Calendar Year Deductible	Combined Basic Services and Major Services: \$50 per person		
Type I-Diagnostic and Preventive Services Deductible Does Not Apply <ul style="list-style-type: none"> • Oral evaluations – 2 per calendar year • X-rays – complete mouth 1 every 3 calendar years; single tooth 12 per calendar year; bitewing 2 occurrences per calendar year • Teeth cleaning – 2 per calendar year • Fluoride treatment – 2 per calendar year age 19 and under • Sealant application on posterior tooth – 1 treatment per tooth every 3 years (age 14 and under) • Fixed and removable space maintainer (initial appliance only) • Emergency treatment – temporary pain relief 	100%	80%	80%
Type II-Basic Services Deductible Applies <ul style="list-style-type: none"> • Fillings – composite fillings on all teeth • Recementation of existing inlays, crowns and bridges • Endodontics – root canals and pulpal therapy • Periodontics – gum/tissue care and surgery • Tooth extraction (simple and surgical including wisdom teeth) • General Anesthesia – payable only if provided in connection with a covered service 	70%	50%	50%
Type III-Major Services Deductible Applies <ul style="list-style-type: none"> • Single crowns, inlays, onlays, bridges and dentures • Maintenance of Prosthodontics – adjust/ repair of dentures 	50%	40%	40%
Dependent Limiting Age	26		
Calendar Year Maximum	\$750 Combined per Covered Person <i>Preventive applies towards Calendar Year Maximum</i>		
Dental Rewards	If you have Calendar Year claims between \$1 - \$300, you will receive \$250 in Rewards to use next year and beyond. Your accumulated Rewards total is capped at \$500.		
Retiree	\$28.25		
Retiree +1	\$53.11		
Family	\$74.41		

¹**Blue Dental PPO Providers:** The preferred network of coverage in the Blue KC service area. **Lowest** out-of-pocket costs for covered services. Outside our service area, providers are available through the GRID Blue Cross and Blue Shield national network.

²**Blue Dental Choice Providers:** An additional network of coverage in the Blue KC service area. **Higher** out-of-pocket costs for covered services. Outside our service area, providers are available through the GRID+ Blue Cross and Blue Shield national network.

³**Non-Participating Providers:** Seeing a non-participating dentist results in the **highest** out-of-pocket costs for covered services. Members may be responsible for filing claims and may be balanced billed by the non-participating provider.

**Retiree Dental Insurance
Buy-Up Plan
Rates Effective January 1, 2020 – December 31, 2020**

Dental Service Type	Blue Dental PPO Providers ¹	Blue Dental Choice Providers ²	Non-Participating Providers ³
	Deductible, Coinsurance and Limitations		
Calendar Year Deductible	Combined Basic Services and Major Services: \$50 per person		
Type I-Diagnostic and Preventive Services Deductible Does Not Apply <ul style="list-style-type: none"> • Oral evaluations – 2 per calendar year • X-rays – complete mouth 1 every 3 calendar years; single tooth 12 per calendar year; bitewing 2 occurrences per calendar year • Teeth cleaning – 2 per calendar year • Fluoride treatment – 2 per calendar year age 19 and under • Sealant application on posterior tooth – 1 treatment per tooth every 3 years (age 14 and under) • Fixed and removable space maintainer (initial appliance only) • Emergency treatment – temporary pain relief 	100%	70%	50%
Type II-Basic Services Deductible Applies <ul style="list-style-type: none"> • Fillings – composite fillings on all teeth • Recementation of existing inlays, crowns and bridges • Endodontics – root canals and pulpal therapy • Periodontics – gum/tissue care and surgery • Tooth extraction (simple and surgical including wisdom teeth) • General Anesthesia – payable only if provided in connection with a covered service 	80%	70%	50%
Type III-Major Services Deductible Applies <ul style="list-style-type: none"> • Single crowns, inlays, onlays, bridges and dentures • Maintenance of Prosthodontics – adjust/ repair of dentures 	50%	50%	50%
Type IV-Orthodontia Services Includes: <ul style="list-style-type: none"> • Covered Retirees Only (does not include spouses) • Covered Children to age 19 	50%	50%	50%
Dependent Limiting Age	26		
Orthodontia Lifetime Maximum	\$1,250 Combined per Covered Person <i>Dental Rewards does not apply</i>		
Calendar Year Maximum	\$1,250 Combined per Covered Person <i>Preventive applies towards Calendar Year Maximum</i>		
Dental Rewards	If you have Calendar Year claims between \$1 - \$300, you will receive \$250 in Rewards to use next year and beyond. Your accumulated Rewards total is capped at \$500.		
Retiree	\$32.88		
Retiree +1	\$71.86		
Family	\$93.74		

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³**Non-Participating Providers:** Seeing a non-participating dentist results in the **highest** out-of-pocket costs for covered services. Members may be responsible for filing claims and may be balanced billed by the non-participating provider.