

Medical and Dental Rates for Retirees Currently with Blue Cross Blue Shield Insurance Rates Effective January 1, 2024 – December 31, 2024

<u>Rates</u>	BlueSelect Plus Spira	BlueSelect Plus EPO	Blue-Care HMO	BlueSelect Plus PPO	Preferred-Care Blue PPO	Blue Saver Spira BlueSelect Plus	BlueSaver Preferred Care Blue
Retiree Under 65	\$820.00	\$956.00	\$1,054.00	\$820.00	\$911.00	\$730.00	\$790.00
Retiree 65+	\$690.19	\$811.17	\$893.98	\$695.35	\$773.01	\$615.19	\$678.29
Retiree Under 65; +1 Dep Under 65	\$1,298.00	\$1,511.00	\$1,665.00	\$1,298.00	\$1,443.00	\$1,188.00	\$1,269.00
Retiree Under 65; +1 Dep 65+	\$1,044.21	\$1,360.11	\$1,499.33	\$1,174.47	\$1,296.04	\$1,034.17	\$1,106.21
Retiree 65+; +1 Dep Under 65	\$1,020.18	\$1,330.21	\$1,466.36	\$1,148.64	\$1,267.55	\$1,010.37	\$1,080.77
Retiree 65+; +1 Dep 65+	\$843.96	\$1,110.94	\$1,224.65	\$959.30	\$1,058.61	\$835.85	\$894.07
Retiree Under 65; Deps Under 65	\$1,636.00	\$1,907.00	\$2,102.00	\$1,636.00	\$1,819.00	\$1,500.00	\$1,600.00
Retiree Under 65; Deps 65+	\$1,367.98	\$1,778.02	\$1,959.83	\$1,535.35	\$1,694.59	\$1,354.83	\$1,445.22
Retiree 65+; Deps Under 65	\$1,350.15	\$1,755.84	\$1,935.7	\$1,516.20	\$1,673.45	\$1,337.17	\$1,426.37
Retiree 65+; Deps 65+	\$1,234.17	\$1,611.58	\$1,776.38	\$1,391.63	\$1,535.98	\$1,222.30	\$1,303.85
Companion Spouse	\$469.53	\$622.51	\$686.07	\$533.63	\$593.22	\$465.01	\$512.72
Companion Child(ren)	\$485.92	\$665.38	\$733.31	\$570.39	\$634.07	\$481.25	\$530.61

<u>Benefits</u>	BlueSelect Plus Spira	BlueSelect Plus EPO	Blue-Care HMO	BlueSelect Plus PPO	Preferred-Care Blue PPO	Blue Saver Spira BlueSelect Plus	BlueSaver Preferred Care Blue
Network	BlueSelect Plus	BlueSelect Plus	Blue-Care	BlueSelect Plus	Preferred-Care Blue	BlueSelect Plus	Preferred-Care Blue
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	\$3,200 indiv \$6,400 fam	\$3,200 indiv \$6,400 fam
Out of Network Deductible	N/A	N/A	N/A	\$3,000 indiv \$6,000 fam	N/A	\$6,400 indiv \$12,800 fam	\$3,200 indiv \$6,400 fam
In Network Coinsurance	Your share: 0%	N/A	N/A	Your share: 20%	Your share: 20%	Your share: 20% Spira: 0%	Your share: 20%
Out of Network Coinsurance	N/A	N/A	N/A	Your share: 50%	Your share: 50%	Your share: 50%	Your share: 40%
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	\$4,200 indiv \$8,400 fam	\$4,200 indiv \$8,400 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	\$20,000 indiv \$40,000 fam	\$8,400 indiv \$16,800 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%	Spira locations: Fair Market Charge (\$60); BSP providers: Deductible then 20%	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, 2024 – December 31, 2024

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	\$1,000 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, 2024 – December 31, 2024

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	\$1,500 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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