Medical and Dental Rates for Retirees Currently with Blue Cross Blue Shield
Insurance Rates Effective January 1, 2027 – December 31, 2027

Rates	BlueSelect Plus Spira $1,500 EPO	BlueSelect Plus Spira $0 EPO	Blue-Care HMO (Closed to new enrollment)	BlueSelect Plus Spira PPO	Preferred-Care Blue Spira PPO	BlueSaver Spira BlueSelect Plus	BlueSaver Spira Preferred Care Blue
Retiree Under 65	$1,063.83	$1,218.05	$1,333.16	$1,063.83	$1,167.02	$963.83	$1,023.83
Retiree 65+	$1,063.83	$1,218.05	$1,333.16	$1,063.83	$1,167.02	$963.83	$1,023.83
Retiree Under 65; +1 Dep Under 65	$1,613.18	$1,877.29	$2,060.67	$1,623.68	$1,796.33	$1,481.14	$1,573.00
Retiree Under 65; +1 Dep 65+	$1,613.18	$1,877.29	$2,060.67	$1,623.68	$1,796.33	$1,481.14	$1,573.00
Retiree 65+; + 1 Dep Under 65	$1,613.18	$1,877.29	$2,060.67	$1,623.68	$1,796.33	$1,481.14	$1,573.00
Retiree 65+; + 1 Dep 65+	$1,613.18	$1,877.29	$2,060.67	$1,623.68	$1,796.33	$1,481.14	$1,573.00
Retiree Under 65; Deps Under 65	$2,005.13	$2,348.82	$2,581.01	$2,026.13	$2,244.04	$1,834.95	$1,948.35
Retiree Under 65; Deps 65+	$2,005.13	$2,348.82	$2,581.01	$2,026.13	$2,244.04	$1,834.95	$1,948.35
Retiree 65+; Deps Under 65	$2,005.13	$2,348.82	$2,581.01	$2,026.13	$2,244.04	$1,834.95	$1,948.35
Retiree 65+; Deps 65+	$2,005.13	$2,348.82	$2,581.01	$2,026.13	$2,244.04	$1,834.95	$1,948.35
Companion	$1,063.83	$1,218.05	$1,333.16	$1,063.83	$1,167.02	$963.83	$1,023.83
Companion +1	$1,613.18	$1,877.29	$2,060.67	$1,623.68	$1,796.33	$1,481.14	$1,573.00
Companion + 2 or more	$2,005.13	$2,348.82	$2,581.01	$2,026.13	$2,244.04	$1,834.95	$1,948.35

Benefits	BlueSelect Plus Spira $1,500 EPO	BlueSelect Plus Spira $0 EPO	Blue-Care HMO	BlueSelect Plus Spira PPO	Preferred-Care Blue Spira PPO	BlueSaver Spira BlueSelect Plus	BlueSaver Spira 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 indv $3,000 fam	N/A	N/A	$1,500 indv $3,000 fam	$1,500 indv $3,000 fam	$3,500 indv $7,000 fam	$3,500 indv $7,000 fam
Out of Network Deductible	N/A	N/A	N/A	$3,000 indv $6,000 fam	$1,500 indv $3,000 fam	$7,000 indv $14,000 fam	$3,500 indv $7,000 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 indv $3,000 fam	$5,000 indv $15,000 fam	$5,000 indv $15,000 fam	$4,500 indv $9,000 fam	$4,500 indv $9,000 fam	$4,500 indv $9,000 fam	$4,500 indv $9,000 fam
Out of Network Out of Pocket Maximum	N/A	N/A	N/A	$23,000 indv $46,000 fam	$13,500 indv $27,000 fam	$20,000 indv $40,000 fam	$9,000 indv $18,000 fam
Office Visits	Spira: No Cost; Other BSP Provider: Deductible	Spira: No Cost; Other BSP Provider: $40 PCP $100 Specialist copay	$40 PCP $100 Specialist copay	Spira: No Cost; Other BSP Provider: Deductible then 20%	Spira: No Cost; Other PCB Provider: Deductible then 20%	Spira: Fair Market Charge ($60); BSP providers: Deductible then 20%	Spira: Fair Market Charge ($60); PCB providers: Deductible then 20%
Preventative Care	100%	100%	100%	100%	100%	100%	100%
Urgent Care	Deductible	$70 copay	$70 copay	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then 20%
Emergency Services	Deductible	$300 copay	$300 copay	$150 copay then deductible then 20%	$150 copay then deductible then 20%	Deductible then 20%	Deductible then 20%
Inpatient Hospital Services	Deductible	$500 copay per member up to $2,500	$500 copay per member up to $2,500	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then 20%
Scans (MRI's PET, CT etc.)	Deductible	$300 copay	$300 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, 2027 – December 31, 2027

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*** • 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*** • 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*** • 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 *Preventive applies towards Calendar Year Maximum*		
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 **Retiree +1** **Family**	$28.25 $53.11 $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, 2027 – December 31, 2027

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*** • 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*** • 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*** • Single crowns, inlays, onlays, bridges and dentures • Maintenance of Prosthodontics – adjust/ repair of dentures	50%	50%	50%
Type IV-Orthodontia Services • 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 *Dental Rewards does not apply*
Calendar Year Maximum	$1,500 Combined per Covered Person *Preventive applies towards Calendar Year Maximum*
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 **Retiree +1** **Family**	$32.88 $71.86 $93.74

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[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.