The Kansas City Board of Public Utilities

HEALTH BENEFIT PLAN

SPIRA CARE
EXCLUSIVE PROVIDER ORGANIZATION

Amended and Restated Effective October 1, 2020

TO ALL ELIGIBLE EMPLOYEES:

The Plan is designed to provide adequate protection and to meet the health needs of You and Your dependents. The purpose of the Plan is to help protect You and Your family from the financial problems that can be caused by an accident or sickness.

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  - Qualified sign language interpreters
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Spanish:
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BENEFIT SCHEDULE

Amendments, if any, are located in the back of this Plan Document.

BENEFIT SCHEDULE

Group Name: Board of Public Utilities	**Effective Date:** October 1, 2020
Preexisting Condition Exclusion Period: None	**Dependent Limiting Age:** 26

The Covered Services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the Plan.

Your Plan Type is an Exclusive Provider Organization (EPO). Members must receive all care from In-Network Providers, except for Emergency Services. Services provided by Out-of-Network Providers are not covered, except as specifically provided. Please see the Covered Services section for further information.

	IN-NETWORK PROVIDER	**OUT-OF-NETWORK PROVIDER**
Covered Services	**Copayment, Coinsurance and Limitations**	**Coinsurance and Limitations**
Out-of-Pocket Maximum *Individual / Family*	$6,350 / $12,700	Does not apply
Primary Care Office Visit	$20 Copayment	Not applicable
Specialty Care Office Visit	$20 Copayment	Not covered
Urgent Care	$20 Copayment	Not covered
Routine Preventive Care – (See the Routine Preventive Care Benefit under the Covered Services Section for a Description of Routine Preventive Services for which You have Benefits.	No Copayment	Not covered
Diagnostic and Routine Preventive Mammograms, Pap Smears and PSA tests.	No Copayment	Not covered
Emergency Services	$100 Copayment *Copayment waived if admitted to a Hospital*	$100 Copayment
Ambulance	No Copayment	No Copayment

BENEFIT SCHEDULE

	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Covered Services	**Copayment, Coinsurance and Limitations**	**Coinsurance and Limitations**
Inpatient Hospital Services	No Copayment	Not covered
Outpatient Services in a Hospital or Other Outpatient Facility	No Copayment	Not covered
Lab drawn and processed in a Spira Care Center Provider Physician's Office (excluding allergy testing)	No Copayment	Not covered
Lab drawn and processed in a Physician's Office/Independent Lab (excluding allergy testing)	No Copayment	Not covered
X-ray and other Radiology Procedures Performed in a Spira Care Clinic Provider's Office (unless otherwise specified)	No Copayment	Not covered
X-ray and other Radiology Procedures Performed in a Physician's Office/Independent Lab (unless otherwise specified)	No Copayment	Not covered
Durable Medical Equipment	No Copayment	Not covered
Outpatient Therapy (Speech, Hearing, Physical, and Occupational Services)	No Copayment	Not covered
Outpatient Substance Abuse	No Copayment	Not covered
Inpatient Substance Abuse	No Copayment	Not covered
Outpatient Mental Illness	No Copayment	Not covered

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Covered Services		IN-NETWORK PROVIDER Copayment, Coinsurance and Limitations	OUT-OF-NETWORK PROVIDER Coinsurance and Limitations
Inpatient Mental Illness		No Copayment	Not covered
Organ Transplant		No Copayment	Not covered
Outpatient Prescription Drugs		Covered through **SavRx** *$1,000 Calendar Year Out-of-Pocket Maximum (Individual/Family)*	
Short-Term Supplies	**Generic**	$5.00 Copayment	$5.00 Copayment
	Formulary	$20.00 Copayment	$20.00 Copayment
	Non-Formulary	$30.00 Copayment	$30.00 Copayment
Long-Term Supplies (mail order)	**Generic**	$3.00 Copayment	$3.00 Copayment
	Formulary	$20.00 Copayment	$20.00 Copayment
	Non-Formulary	$30.00 Copayment	$30.00 Copayment
Impotency Drugs		Applicable Copayment	Applicable Copayment
Routine Vision Exam		*See Covered Services Section*	
Chiropractic Services		$20 Copayment *40 visit Calendar Year Maximum (per person)*	Not covered
Lifetime Maximum		Unlimited	

The Kansas City Board of Public Utilities

HEALTH BENEFIT PLAN

PREFERRED-CARE BLUE
PREFERRED PROVIDER ORGANIZATION

Amended and Restated Effective October 1, 2020

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BENEFIT SCHEDULE

Group Name: Board of Public Utilities	**Effective Date:** October 1, 2020
Preexisting Condition Exclusion Period: None	**Dependent Limiting Age:** 26

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	PREFERRED PROVIDER	**NON-PREFERRED PROVIDER**
Covered Services	**Copayment, Coinsurance and Limitations**	**Coinsurance and Limitations**
Out-of-Pocket Maximum *Individual / Family*	$6,350 / $12,700	Unlimited
Primary Care Office Visit	$20 Copayment	10% Coinsurance
Specialty Care Office Visit	$20 Copayment	10% Coinsurance
Urgent Care	$20 Copayment	10% Coinsurance
Routine Preventive Care – (See the Routine Preventive Care Benefit under the Covered Services Section for a Description of Routine Preventive Services for which You have Benefits.	No Copayment	10% Coinsurance
Diagnostic and Routine Preventive Mammograms, Pap Smears and PSA tests.	No Copayment	10% Coinsurance
Emergency Services	$100 Copayment *Copayment waived if admitted to either a Preferred Provider Hospital or Non-Preferred Provider Hospital*	$100 Copayment
Ambulance	No Copayment	10% Coinsurance

BENEFIT SCHEDULE

	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Covered Services	**Copayment, Coinsurance and Limitations**	**Coinsurance and Limitations**
Inpatient Hospital Services	No Copayment	10% Coinsurance *Inpatient hospital services in a Non-Participating Provider Hospital inside the Service Organization Service Area are limited to a $200 maximum per day.*
Outpatient Services in a Hospital or Other Outpatient Facility	No Copayment	10% Coinsurance *Outpatient services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility inside the Service Organization Service Area are limited to $200 per day.*
Durable Medical Equipment	No Copayment	10% Coinsurance
Outpatient Therapy (Speech, Hearing, Physical, and Occupational Services)	No Copayment	10% Coinsurance
Outpatient Substance Abuse	No Copayment	10% Coinsurance *Outpatient services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility inside the Service Organization Service Area are limited to $200 per day*
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Inpatient Mental Illness		No Copayment	10% Coinsurance *Inpatient hospital services in a Non-Participating Provider Hospital inside the Service Organization Service Area are limited to a $200 maximum per day*
Organ Transplant		No Copayment	10% Coinsurance
Outpatient Prescription Drugs		Covered through **SavRx** *$1,000 Calendar Year Out-of-Pocket Maximum (Individual/Family)*	
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Routine Vision Exam		*See Covered Services Section*	
Chiropractic Services		No Copayment *40 visit Calendar Year Maximum (per person)*	10% Coinsurance
Lifetime Maximum		Unlimited	

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HEALTH BENEFIT PLAN

Blue-Care

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PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-395-7126 (TTY: 1-816-842-5607).

Laotian:
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-844-395-7126. (TTY: 1-816-842-5607).

Pennsylvanian Dutch:
Wann du schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-844-395-7126 (TTY: 1-816-842-5607).

Persian:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شماا. باشد می ف-1-844-395-7126 (TTY: 1-816-842
5607) . بگیرید تماس

Cushite:
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-395-7126 (TTY: 1-816-842-5607).

Portuguese:
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-395-7126 (TTY: 1-816-842-5607).

For TTY services, please call 1-816-842-5607.

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Amendments, if any, are located in the back of this Plan Document.

BENEFIT SCHEDULE

Group Name: Board of Public Utilities	**Effective Date:** October 1, 2020
Preexisting Condition Exclusion Period: None	**Dependent Limiting Age:** 26

The Covered Services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the Plan.

Covered Services	HMO PROVIDER Copayment and Limitations
Out-of-Pocket Maximum ***Individual / Family***	$6,350 / $12,700
Primary Care Office Visit	$20 Copayment per visit
Specialty Care Office Visit	$20 Copayment per visit
Allergy Testing	No Copayment
Emergency Services	$100 Copayment per visit. *Copayment waived if admitted to a Hospital for 24 or more hours.*
Ambulance	No Copayment
Inpatient Hospital Services and Outpatient Surgery in a Hospital or Other Outpatient Facility	No Copayment
MRI, MRA, CT, and PET scan	No Copayment
Durable Medical Equipment	No Copayment
Home Health Services	No Copayment
Skilled Nursing Facility	No Copayment
Routine Preventive Care	No Copayment
Inpatient and Outpatient Therapy (Speech, Hearing, Physical, Occupational	No Copayment

BENEFIT SCHEDULE

Covered Services		HMO PROVIDER Copayment and Limitations
and Skeletal Manipulations not performed by a chiropractor)		*60 visits/days (combined inpatient/outpatient) per incident*
Chiropractic Services		No Copayment *40 visit Calendar Year Maximum (per person)*
Outpatient Substance Abuse		No Copayment
Inpatient Substance Abuse		No Copayment
Outpatient Mental Illness		No Copayment
Inpatient Mental Illness		No Copayment.
Outpatient Prescription Drugs includes oral and injectable contraceptives, and contraceptive devices and implants		Covered through SavRx *$1,000 Calendar Year Out-of-Pocket Maximum (Individual / Family)*
Short-Term Supplies	**Generic**	$5.00 Copayment
	Formulary	$20.00 Copayment
	Non-Formulary	$30.00 Copayment
Long-Term Supplies	**Generic**	$3.00 Copayment
	Formulary	$20.00 Copayment
	Non-Formulary	$30.00 Copayment
Urgent Care		$20 Copayment per visit
Routine Vision Exam		*See Covered Services Section*
Lifetime Maximum		Unlimited