2019-20 Benefit Plan Comparisons Costs (Active Employees)

Benefit	Blue Select Plus EPO		Blue Select Plus QHDHP (Aggregate Deductible)		**New Plan Offering** Blue Select Plus Spira Care EPO (Embedded Deductible)	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
BlueCard National Network Access (Non-KC metro)	Yes	No Coverage	Yes	N/A	Yes	No Coverage
Network	Blue Select Plus	No Coverage	Blue Select Plus	N/A	Blue Select Plus	No Coverage
Emergency Care Treated as In-Network	Yes	No Coverage	Yes	N/A	Yes	No Coverage
Access to Spira Care Facilities	No	No Coverage	Yes - $60 per visit	N/A	Yes - $0 copay at 5 locations	No Coverage
Access to Meritas Clinic	Yes -$0 copay/select 4 locations	No Coverage	Yes - Negotiated Fee Schedule	N/A	Yes – Deductible	No Coverage
Deductible (individual/family) *Calendar Year	$0 / $0	No Coverage	**$1,350 / $2,700	$5,000 / $10,000	$1,350 / $2,700	No Coverage
Coinsurance	100%	No Coverage	80%	50%	100%	No Coverage
Out of Pocket Maximum (individual/family) *Calendar Year	$3,500 / $7,000	No Coverage	$3,750 / $7,500	$25,000 / $50,000	$1,350 / $2,700	No Coverage
PCP Office Visit / Specialist Office Visit	$40/$80 copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	Spira Care Facility-Free/ All Others-Deductible	No Coverage
TeleHealth through AmWell	$10 copay		$49 toward Deductible		$0 copay	
Urgent Care Office Visit	$80 copay		Deductible/ Coinsurance		Deductible	
Other Radiology (MRI, CT, PET, MRA)	$75 copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	No Coverage
Hospital Inpatient /Outpatient Surgery	$500 copay per day/$2,500 annual maximum	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	No Coverage
Emergency Room	$150 copay	$150 copay	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	Deductible
Chiropractic Office Visit/Skeletal Manipulation	$40 Copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	No Coverage
Speech, Hearing, Physical & Occupational Therapy	$0 Copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	No Coverage
Generic Rx	$10 copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	$15 copay	No Coverage
Preferred Rx	$50 copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	$50 copay	No Coverage
Non-Preferred Rx	$70 copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	No Coverage
Mail Order Rx	$30 generic / $150 preferred brand / $210 non-preferred brand	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	$15 generic / $125 preferred brand / Deductible non-preferred brand	No Coverage