

CITY OF HAMILTON, MISSOURI

BILL NO. 1014151

ORDINANCE NO. 1580

**AN ORDINANCE AUTHORIZING THE CITY OF HAMILTON TO ENTER INTO A CONTRACT FOR HEALTH INSURANCE FOR EMPLOYEES WITH BLUE CROSS BLUE SHIELD THROUGH AGENT MICHAEL BROWN.**

BE IT ORDAINED BY THE BOARD OF ALDERMEN OF THE CITY OF HAMILTON, MISSOURI AS FOLLOWS, TO WIT:

**SECTION 1:** The Mayor of the City of Hamilton, Missouri is hereby authorized on behalf of the City of Hamilton, Missouri, to enter into a contract for employee health insurance with Blue Cross Blue Shield through agent Michael Brown for 2016 calendar year on the terms as presented to the Board of Aldermen.

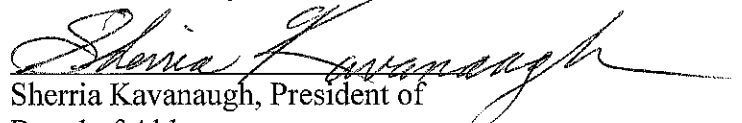
**SECTION 2:** This ordinance repeals any prior ordinance or parts of any prior ordinance that might be in conflict herewith.

**SECTION 3:** This ordinance shall be in full force and effect from and after the date of its passage and approval.

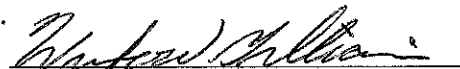
**SECTION 4:** That if any section, subsection, sentence, clause or phrase of this ordinance is, for any reason, held to be unconstitutional, such decision shall not affect the validity of the remaining portions of this ordinance. The Board of Aldermen hereby declares that it would have passed this ordinance, and each section, subsection, clause or phrase thereof, irrespective of the fact that any one or more sections, subsections, sentences, clauses and phrases be declared unconstitutional.


A copy of this Ordinance has been made available for public inspection prior to its adoption by the Board of Aldermen and this bill was read by title in the open meeting two times prior to its final passage.

Passed and approved by the Board of Aldermen on the 14<sup>th</sup> day of October, 2015.

  
Sherria Kavanaugh, President of  
Board of Aldermen

Approved this the 14<sup>th</sup> day of October, 2015.

  
Winford Gilliam, Mayor

Attest:   
Debra Davis, City Clerk

*Kavanaugh - may, Trasper - ay, Mass, ay, Swimmer - ay*

CITY OF HAMILTON

Health Insurance Rates

9-25-2016

| <u>SUBSCRIBER</u>       | <u>HEALTH RATES</u> | <u>DENTAL</u>  | <u>TERM</u>    | <u>TOTAL</u>    |
|-------------------------|---------------------|----------------|----------------|-----------------|
| Ronnie Faulkner         | \$0                 | \$0            | \$27.00        | \$ 27.00        |
| Judy Pickering          | \$733.29            | \$17.00        | \$12.00        | \$762.29        |
| Kenneth Hon (Willie)    | \$209.50            | \$26.00        | \$ 3.00        | \$238.50        |
| Kenneth Hon (Wayne)     | \$680.93            | \$0            | \$12.00        | \$692.93        |
| Dwyana Bond             | \$0                 | \$0            | \$29.64        | \$29.64         |
| Lori Duckworth          | \$602.35            | \$17.00        | \$ 7.60        | \$626.95        |
| Randy Reeder            | \$157.15            | \$26.00        | \$ 3.00        | \$186.15        |
| Logan Branson           | \$157.15            | \$26.00        | \$ 3.00        | \$186.15        |
| Debra Davis             | \$733.29            | \$17.00        | \$12.00        | \$762.29        |
| Caleb Ireland (11-1-15) | <u>\$157.15</u>     | <u>\$26.00</u> | <u>\$ 3.00</u> | <u>\$186.15</u> |
|                         | \$3,340.81          | \$155.00       | \$112.24       | \$3,698.05      |



**High Deductible Plan 3 – Missouri  
BENEFIT PPO SCHEDULE**

|   |                                   |
|---|-----------------------------------|
| <b>High Deductible Plan 3 Missouri PBHD3A</b>       | <b>Dependent Limiting Age: 26</b> |
| <b>Preexisting Condition Exclusion Period: None</b> |                                   |

| Covered Services  | PREFERRED PROVIDER                                 | NON-PREFERRED PROVIDER  |
|---|--|---|
|   | Copayment, Deductible, Coinsurance and limitations | Deductible, Coinsurance and limitations   |
| <b>Calendar Year Deductible (Individual/Family)</b>   | \$2,500/\$5,000                                    | \$2,500/\$5,000   |
| <b>Out-of-Pocket Maximum (Individual/Family)</b><br><i>Includes Deductible</i>  | \$2,500/\$5,000                                    | \$5,000/\$10,000  |
| <b>Primary Care Office Visit</b>  | Deductible   | Deductible then 20% Coinsurance   |
| <b>Specialty Care Office Visit</b>  | Deductible   | Deductible then 20% Coinsurance   |
| <b>Lab Services</b>   | Deductible   | Deductible then 20% Coinsurance   |
| <b>X-ray and other Radiology Procedures*</b>  | Deductible   | Deductible then 20% Coinsurance   |
| <b>Routine Preventive Care</b><br>(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                                       | Deductible then 20% Coinsurance   |
| <b>Diagnostic and Routine Preventive Mammograms, Pap Smears and PSA tests</b>   | No Copayment                                       | Deductible then 20% Coinsurance   |
| <b>Emergency Services</b>   | Deductible   | Deductible  |
| <b>Urgent Care</b>  | Deductible   | Deductible then 20% Coinsurance   |
| <b>Ambulance</b>  | Deductible   | Deductible  |
| <b>Inpatient Hospital Services**</b>  | Deductible   | Deductible then 20% Coinsurance*  |
| <b>Outpatient Surgery in Hospital or other Outpatient Facility**</b>  | Deductible   | Deductible then 20% Coinsurance*  |
| <b>Durable Medical Equipment**</b>  | Deductible   | Deductible then 20% Coinsurance   |
| <b>Formula and Food Products for Phenylketonuria</b>  | Deductible   | Deductible then 20% Coinsurance but never greater than 50% of the cost of the formula or food product |
| <b>Home Health Services**</b>   | Deductible   | Deductible then 20% Coinsurance   |
| <b>Skilled Nursing Facility**</b>   | Deductible   | Deductible then 20% Coinsurance   |
| <b>Outpatient Therapy</b> (Speech, Hearing, Physical, and Occupational Therapy)**   | Deductible   | Deductible then 20% Coinsurance   |
| <b>Chiropractic Services</b>  | Deductible   | Deductible then 20% Coinsurance**   |

*60 visit Calendar Year Maximum*

*30 day Calendar Year Maximum*

*Physical and Occupational: 40 visit Calendar Year Maximum  
Speech and Hearing: 20 visit Calendar Year Maximum*

**High Deductible Plan 3 – Missouri  
BENEFIT PPO SCHEDULE**

| Covered Services  | PREFERRED PROVIDER                                 |   | NON-PREFERRED PROVIDER                  |  |
|---|--|---|---|--|
|   | Copayment, Deductible, Coinsurance and limitations |   | Deductible, Coinsurance and limitations |  |
| <b>Outpatient Mental Illness</b>  | Deductible   |   | Deductible then 20% Coinsurance*        |  |
| <b>Inpatient Mental Illness**</b>   | Deductible   |   | Deductible then 20% Coinsurance*        |  |
| <b>Organ Transplant**</b>   | Deductible   |   | Deductible then 20% Coinsurance         |  |
| <b>Contraceptive devices, implants, injections and elective sterilization for women</b>                                       | Covered at 100%                                    |   | Not Covered                             |  |
| <b>Outpatient Prescription Drugs**</b><br>Includes oral and injectable contraceptives, and contraceptive devices and implants | Covered. Not subject to Calendar Year Maximum.     |   |   |  |
| <b>Short-Term Supply</b>  | <b>Tier 1</b>                                      | \$12 Copayment/contraceptives covered at 100% | \$12 copayment then 50% coinsurance     |  |
|   | <b>Tier 2</b>                                      | \$35 Copayment                                | \$35 copayment then 50% coinsurance     |  |
|   | <b>Tier 3</b>                                      | \$60 Copayment                                | \$60 copayment then 50% coinsurance     |  |
| <b>Long-Term Supply</b>   | <b>Tier 1</b>                                      | \$30 Copayment/contraceptives covered at 100% | \$30 copayment then 50% coinsurance     |  |
|   | <b>Tier 2</b>                                      | \$87.50 Copayment                             | \$87.50 copayment then 50% coinsurance  |  |
|   | <b>Tier 3</b>                                      | \$150 Copayment                               | \$150 copayment then 50% coinsurance    |  |
| <b>All other Covered Services</b>   | Deductible   |   | Deductible then 20% Coinsurance         |  |
| <b>Vision Care***</b>   | \$20 Copayment                                     |   | \$20 Copayment, \$45 benefit maximum    |  |
| <b>Lifetime Maximum</b>   | Unlimited  |   |   |  |

\* Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to \$200 per day. Inpatient hospital services in a Non-Participating Provider Hospital inside Our Service Area are limited to a \$200 maximum per day. Outpatient Services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility inside Our Service Area are limited to \$200 per day.

\*\*Prior Authorization will be required for elective inpatient admissions, durable medical equipment (DME), high-tech diagnostic testing, infusion therapy and self injectables, organ and tissue transplants, some outpatient surgeries and services, hearing therapy, prosthetics and appliances, mental health and substance abuse, some outpatient prescriptions, skilled nursing facility, dental implants and bone grafts, and chiropractic services received from a non-network chiropractor. This list of services is subject to change. Please refer to your contract for the current list of services, which require Prior Authorization.

\*\*\*Vision Care provided by Vision Service Plan (VSP)

The Covered Services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the Contract. **Maternity – Covered**

## Preferred-Care Dental without Major Services

### Group Dental

Plan 1, 00301A, Plan A, Plan C, Plan E, DA02, DA06, DA20, DA30, DA40

|   | Type I  | Type II   |
|---|---|---|
| <b>Deductible</b>                                     | None  | \$50 per person   |
| <b>BCBSKC Pays<br/>(Preferred-Care Providers)</b>     | 80%   | 80%   |
| <b>BCBSKC Pays<br/>(Non-Preferred-Care Providers)</b> | 60% of allowable charges  | 60% of allowable charges  |
| <b>Covered Services</b>                               | <p><b>Diagnostic and preventive services:</b> 2 oral evaluations per calendar year</p> <p><b>Dental X-rays:</b> Complete mouth survey x-rays or panoramic x-rays - 1 every three calendar years; Periapical (single tooth) x-rays - 12 per calendar year</p> <p><b>Bitewing:</b> 2 per calendar year</p> <p><b>Fluoride treatment:</b> 2 per calendar year for members age 19 and under</p> <p><b>Prophylaxis (teeth cleaning):</b> 2 per calendar year</p> <p><b>Sealants:</b> 1 treatment per tooth in any 3 calendar year period for members age 14 and under</p> <p><b>Fixed and Removable Space Maintainers:</b> Initial appliance only</p> <p><b>Emergency palliative treatment (pain relief)</b></p> | <p><b>Fillings</b></p> <p><b>Other Restorative Services:</b> Sedative fillings and recementation of inlays, crowns and bridges</p> <p><b>Endodontics:</b> Root canals and pulpotomies</p> <p><b>Tooth Extractions</b></p> <p><b>General Anesthesia:</b> Payable only if provided in connection with a covered service</p> |
| <b>Calendar Year Maximum</b>                          | \$1,000 per person for all services   |   |
| <b>Dependent Age</b>                                  | 26  |   |
| <b>Late Enrollees</b>                                 | If you or any of your dependents apply for Preferred-Care Dental after your initial enrollment period and do not qualify to enroll under a Special Enrollment Period, your coverage will not become effective until the anniversary date of your employer's group contract with Blue Cross and Blue Shield of Kansas City.  |   |

*Please Note: This document is intended to give a summary description of the Preferred-Care Dental plan. It is not a contract. Please refer to your certificate of insurance for complete terms and conditions.*