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 14th day of October, 2015.

Sherria Kavanaugh, President of
Board of Aldermen

Approved this the 14th day of October, 2015.

Winford Gilliam, Mayor

Attest: _____
Debra Davis, City Clerk

Kavanaugh - nay, Trosper - aye, Mass - aye, Swinney - aye

CITY OF HAMILTON

Health Insurance Rates

9-25-2016

SUBSCRIBER	HEALTH RATES	DENTAL	TERM	TOTAL
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)	$157.15	$26.00	$ 3.00	$186.15
	$3,340.81	$155.00	$112.24	$3,698.05

Renewal

High Deductible Plan 3 – Missouri
BENEFIT PPO SCHEDULE

High Deductible Plan 3 Missouri PBHD3A	**Dependent Limiting Age:** 26
Preexisting Condition Exclusion Period: None	

Covered Services	PREFERRED PROVIDER Copayment, Deductible, Coinsurance and limitations	NON-PREFERRED PROVIDER Deductible, Coinsurance and limitations
Calendar Year Deductible (Individual/Family)	$2,500/$5,000	$2,500/$5,000
Out-of-Pocket Maximum (Individual/Family) *Includes Deductible*	$2,500/$5,000	$5,000/$10,000
Primary Care Office Visit	Deductible	Deductible then 20% Coinsurance
Specialty Care Office Visit	Deductible	Deductible then 20% Coinsurance
Lab Services	Deductible	Deductible then 20% Coinsurance
X-ray and other Radiology Procedures*	Deductible	Deductible then 20% 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	Deductible then 20% Coinsurance
Diagnostic and Routine Preventive Mammograms, Pap Smears and PSA tests	No Copayment	Deductible then 20% Coinsurance
Emergency Services	Deductible	Deductible
Urgent Care	Deductible	Deductible then 20% Coinsurance
Ambulance	Deductible	Deductible
Inpatient Hospital Services**	Deductible	Deductible then 20% Coinsurance*
Outpatient Surgery in Hospital or other Outpatient Facility**	Deductible	Deductible then 20% Coinsurance*
Durable Medical Equipment**	Deductible	Deductible then 20% Coinsurance
Formula and Food Products for Phenylketonuria	Deductible	Deductible then 20% Coinsurance but never greater than 50% of the cost of the formula or food product
Home Health Services**	Deductible	Deductible then 20% Coinsurance
	60 visit Calendar Year Maximum	
Skilled Nursing Facility**	Deductible	Deductible then 20% Coinsurance
	30 day Calendar Year Maximum	
Outpatient Therapy (Speech, Hearing, Physical, and Occupational Therapy)**	Deductible	Deductible then 20% Coinsurance
	Physical and Occupational: 40 visit Calendar Year Maximum *Speech and Hearing: 20 visit Calendar Year Maximum*	
Chiropractic Services	Deductible	Deductible then 20% Coinsurance**

High Deductible Plan 3 – Missouri
BENEFIT PPO SCHEDULE

Covered Services		PREFERRED PROVIDER Copayment, Deductible, Coinsurance and limitations	NON-PREFERRED PROVIDER Deductible, Coinsurance and limitations
Outpatient Mental Illness		Deductible	Deductible then 20% Coinsurance*
Inpatient Mental Illness**		Deductible	Deductible then 20% Coinsurance*
Organ Transplant**		Deductible	Deductible then 20% Coinsurance
Contraceptive devices, implants, injections and elective sterilization for women		Covered at 100%	Not Covered
Outpatient Prescription Drugs** Includes oral and injectable contraceptives, and contraceptive devices and implants		Covered. Not subject to Calendar Year Maximum.	
Short-Term Supply	**Tier 1**	$12 Copayment/contraceptives covered at 100%	$12 copayment then 50% coinsurance
	Tier 2	$35 Copayment	$35 copayment then 50% coinsurance
	Tier 3	$60 Copayment	$60 copayment then 50% coinsurance
Long-Term Supply	**Tier 1**	$30 Copayment/contraceptives covered at 100%	$30 copayment then 50% coinsurance
	Tier 2	$87.50 Copayment	$87.50 copayment then 50% coinsurance
	Tier 3	$150 Copayment	$150 copayment then 50% coinsurance
All other Covered Services		Deductible	Deductible then 20% Coinsurance
Vision Care***		$20 Copayment	$20 Copayment, $45 benefit maximum
Lifetime Maximum		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
Deductible	None	$50 per person
BCBSKC Pays *(Preferred-Care Providers)*	80%	80%
BCBSKC Pays *(Non-Preferred-Care Providers)*	60% of allowable charges	60% of allowable charges
Covered Services	**Diagnostic and preventive services:** 2 oral evaluations per calendar year **Dental X-rays:** Complete mouth survey x-rays or panoramic x-rays - 1 every three calendar years; Periapical (single tooth) x-rays - 12 per calendar year **Bitewing:** 2 per calendar year **Fluoride treatment:** 2 per calendar year for members age 19 and under **Prophylaxis (teeth cleaning):** 2 per calendar year **Sealants:** 1 treatment per tooth in any 3 calendar year period for members age 14 and under **Fixed and Removable Space Maintainers:** Initial appliance only **Emergency palliative treatment (pain relief)**	**Fillings** **Other Restorative Services:** Sedative fillings and recementation of inlays, crowns and bridges **Endodontics:** Root canals and pulpotomies **Tooth Extractions** **General Anesthesia:** Payable only if provided in connection with a covered service
Calendar Year Maximum	$1,000 per person for all services	
Dependent Age	26	
Late Enrollees	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.