Blue Cross and Blue Shield of Kansas City

COST-PLUS ADDENDUM

This Cost-Plus Addendum amends and is incorporated into and made a part of the Group Contract(s) entered into by and between Blue Cross and Blue Shield of Kansas City, on behalf of itself and its subsidiary, Good Health HMO, Inc., d/b/a Blue-Care, if applicable (collectively, "BCBSKC") and Raytown C-1 School District ("Employer"). This Addendum shall be effective July 1, 2018 (the "Effective Date").

WHEREAS, the parties have entered into the Group Contract(s) numbered 33060000 and the associated Health and, if applicable, Dental Benefit Certificate(s) (collectively, the "Group Contract(s)"), pursuant to which BCBSKC has agreed to arrange for the provision of certain health care services and/or dental care to Employer's eligible Employees and their covered Dependents in accordance with the terms, conditions, limitations and exclusions specified in the Group Contract(s);

WHEREAS, the parties desire to implement an alternative funding arrangement for the Group Contract(s), as set forth herein; and

WHEREAS, this Addendum, while implementing an alternative funding arrangement, does not alter any terms or conditions of the benefits covered under the Group Contract(s).

NOW, THEREFORE, in consideration of the foregoing, the mutual promises and agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

Article 1
Employer's Obligations

1.1 Funding under Group Contracts. Employer agrees that the funding for coverage under the Group Contract(s) shall be determined as set forth in this Addendum.

1.2 Fixed Premium. Employer shall pay BCBSKC, on a monthly basis, the Fixed Premium in accordance with Article 3.2.

1.3 Employer's Claims Obligations. In order to fulfill the Employer's total financial obligations under the terms of this Addendum, the Employer shall make payments to BCBSKC as set forth herein and in accordance with Article 3.1. For each month that this Addendum is in effect, Employer shall pay to BCBSKC an amount set forth in (a) and (b) below:

(a) the lesser of:

i. the Cumulative Paid Claims; or

ii. the Cumulative Monthly Claims Limit

LESS

(b) the Cumulative Prior Payment Amount.

Example:

	January	**February**	**March**	**April**
Paid Claims	70	80	110	90
Cumulative Paid Claims	70	150	260	350
Monthly Claims Limit	100	100	100	100
Cumulative Monthly Claims Limit	100	200	300	400
Cumulative Prior Payment Amount	0	70	150	260
Actual Payment Owed	70	80	110	90

Notwithstanding the foregoing: (1) Paid Claims in excess of the Individual Pooling Limit for any Covered Person will not be counted as Paid Claims for the purposes of the calculation set forth above; and (2) the Cumulative Monthly Claims Limit for the full Contract Period shall not be less than the Minimum Annual Claims Limit set forth in Exhibit A (Cost Plus Provisions). Furthermore, the Employer's financial obligations may be ameliorated by the Year-End Adjustment described in Article 1.4.

1.4 Year-End Adjustment. A Year-End Adjustment of no more than 80% of Pooling Charges directly related to the Individual Pooling Limit will be refunded to the Employer if the Individual Pooling Loss Ratio is less than 80%. The Year-End Adjustment will be calculated no later than 90 calendar days after the end of the Contract Period.

1.5 Statutory Assessments. To the extent BCBSKC is required to pay any Statutory Assessments, Employer will pay BCBSKC an amount equal to the Statutory Assessments based upon BCBSKC's determination of such amounts. BCBSKC shall bill the Employer these Statutory Assessments on the Monthly Settlement Report, and the Employer shall pay such Statutory Assessments in accordance with Article 3. If BCBSKC determines, in its sole and reasonable discretion, that its methodology for paying the Health Insurance Providers Fee (aka HIT Tax) was incorrect (e.g., BCBSKC required Employer to pay the HIT Tax on all amounts paid by Employer to BCBSKC, but BCBSKC subsequently determines that a portion of the amounts paid by Employer are not subject to the HIT Tax, or vice versa), resulting in an underpayment or overpayment by Employer of the HIT Tax, then BCBSKC shall notify Employer of the shortfall or excess, and: (a) Employer shall promptly pay to BCBSKC such shortfall; or (b) BCBSKC shall reimburse Employer for such excess (which may include, at BCBSKC's option, applying a credit to subsequent Employer invoices), as applicable. Notwithstanding the foregoing, BCBSKC's determination of the HIT Tax percentage set forth in Exhibit B (Rate Exhibits) is not subject to this Article 1.4.

1.6 Collateral. Upon BCBSKC's request, Employer shall procure a letter of credit (in such form as is reasonably acceptable to BCBSKC) from a financial institution reasonably acceptable to BCBSKC that evidences a commitment by the financial institution of funds payable to BCBSKC upon reasonable request (without any further or additional action or authorization by Employer). Employer shall maintain such letter of credit until the end of the Runout Period.

Alternatively, upon BCBSKC's request, Employer shall deliver to BCBSKC an amount reasonably requested by BCBSKC as collateral ("Collateral") for Employer's obligations under this Agreement. In the event Employer fails to pay amounts due to BCBSKC hereunder, BCBSKC may use as much or all of the Collateral as is needed to satisfy Employer's obligations. Any unused Collateral will be returned to Employer at the end of the Runout Period.

Article 2
BCBSKC Rights and Obligations

2.1 Benefit Determinations. For the purpose of this Addendum, BCBSKC shall have the right to determine the amount of Benefits, if any, payable for any Covered Person. Such determination shall be on the same basis as would be applicable under the Group Contract(s) in the absence of this Addendum. In the event of legal action against BCBSKC, by or on behalf of a Covered Person for Benefits under the Group Contract(s) with respect to a denied claim, BCBSKC, at its own expense, shall undertake the defense of such action and shall pay any judgment rendered therein. BCBSKC shall have the right to settle any such action. The Employer shall reimburse BCBSKC for the portion of any such judgment or settlement which is for a Paid Claim under the Group Contract(s), and such Paid Claim shall be administered in accordance with the terms of this Addendum, including Articles 1 and 3.

Article 3
Payment Due Dates, Grace Periods and Payment Changes

3.1 Monthly Settlement. Monthly payments for Paid Claims, Access Fees, Statutory Assessments and related charges, as indicated on the Monthly Settlement Report, are due and payable by the Employer within 31 calendar days following delivery to Employer by BCBSKC of the Monthly Settlement Report. The Employer shall have no grace period for such monthly payment.

3.2 Fixed Premium. The Fixed Premium is due and payable by the Employer the first day of each month; provided, that any Statutory Assessments and Access Fees will be due and payable by Employer with the Monthly Settlement as set forth in Article 3.1. The Employer shall have a grace period of 31 calendar days for such monthly Fixed Premium.

3.3 Changes in Employer's Obligation. BCBSKC reserves the right to change any and all fees, charges and factors upon a 31 calendar day written notice prior to the end of a Contract Period, to be effective for the following Contract Period.

3.4 Late Payment Charge. BCBSKC reserves the right to charge a late payment fee of $9,000 in each instance in which Employer fails to timely pay any amount due to BCBSKC in accordance with this Article 3.

Article 4
Amendments

4.1 General. Except as provided in Article 3.3, BCBSKC may amend any other term or condition of this Addendum upon 60 calendar days written notice to conform to statutes of the state in which this Addendum is issued for delivery.

4.2 Notice. Notice of an amendment may be in the form of a new Addendum, a rider, or an amendment to this Addendum or otherwise as BCBSKC may elect.

Article 5
Termination

5.1 Term. The term of this Addendum shall begin on the Effective Date and shall continue until terminated as set forth in this Article 5.

5.2 Termination by Either Party. This Addendum may be terminated by BCBSKC or the Employer provided such party gives the other party written notice of its election to terminate the Addendum at least 30 calendar days prior to the end of the then current Contract Period. This Addendum and the underlying Group Contract(s) shall automatically terminate on the date of termination of the Group Contract(s).

5.3 Termination Due to Material Default. Except as provided in Article 5.4 below, either party may terminate this Addendum for cause upon written notice if the other party materially defaults in the performance of a provision of this Addendum and such default continues for a period of 60 calendar days after written notice to the defaulting party from the aggrieved party stating the specific default.

5.4 Termination Due to Non-Payment. Notwithstanding anything to the contrary herein, if Employer fails to pay BCBSKC in accordance with Article 3, this Addendum and the underlying Group Contract(s) may be terminated by BCBSKC, effective retroactively to the last day of the month in which all amounts owed to BCBSKC for such month were paid by the Employer.

5.5 Runout.

(a) Runout Claims and Services. Upon termination of this Addendum, and except in the event of Employer's material breach of this Addendum (including Employer's non-payment), BCBSKC shall provide Runout Services for Runout Claims.

(b) Runout Services Fee and Claims Obligation. Monthly payments for Runout Claims and the Runout Services Fee are due and payable by Employer for each month during the Runout Period within 31 calendar days following delivery to Employer by BCBSKC of the Monthly Settlement Report. The Employer shall have no grace period for such payments. Unless Employer purchases Terminal Liability Coverage as set forth in Article 5.6 below, Employer shall have the total obligation for Runout Claims.

(c) Statutory Assessments for Runout Claims and/or Runout Services. To the extent that any Statutory Assessments apply to Employer's payment obligations under Article 5.5 and/or 5.6, as determined by BCBSKC in its sole and reasonable discretion, then Employer shall pay to BCBSKC an amount equal to such Statutory Assessments.

5.6 Terminal Liability Coverage. Employer may choose to purchase, at the time of execution of this Addendum, Terminal Liability Coverage; provided, that there is no Individual Pooling Limit with respect to Runout Claims. If Employer purchases Terminal Liability Coverage, the following shall apply:

(a) Terminal Liability Coverage Charges. Terminal Liability Coverage Charges will be included with the Pooling Charges and paid by the Employer in accordance with Article 3.2.

(b) Terminal Liability Factors. The Employer's obligation for Runout Claims is limited to the amounts set forth in the "Terminal Liability Factors" section of Exhibit B (Rate Exhibits) for each Coverage Class and Product Type combination, multiplied by the number of such Coverage Class and Product Type combinations, based on the greater of:

1. enrollment during the last month of the final Contract Period; or

2. the average enrollment during the last three (3) months of the final Contract Period.

5.7 Late Payment. BCBSKC reserves the right to charge a late payment fee of $9,000 in each instance in which Employer fails to timely pay any amount due to BCBSKC in accordance with this Article 5.

Article 6
General Provisions

6.1 Modification of Group Contracts. The provisions of the Group Contract(s) are amended to the extent necessary to be consistent with the provisions set forth in this Addendum and to that extent the provisions of this Addendum shall govern notwithstanding anything in the Group Contract(s) to the contrary.

6.2 Waiver. Neither the failure nor any delay by either party to exercise any right, power or privilege hereunder shall operate as a waiver thereof, nor shall any single or partial exercise of any such right, power or privilege preclude any other or further exercise thereof, or the exercise of any other right, power or privilege. In the event that a party does waive any breach of any provision of this Addendum, such waiver shall not be deemed or construed as a continuing waiver of any breach of the same or different provision.

6.3 BlueCard Fees. Employer understands and agrees: (a) to pay certain fees and compensation to BCBSKC which BCBSKC is obligated under BlueCard to pay to Licensees, to the Blue Cross and Blue Shield Association, or to the BlueCard vendors; and (b) that fees and

compensation under BlueCard may be revised from time to time without Employer's prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard. Some of these fees and compensation are charged each time a claim is processed through BlueCard and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency Fees, and ITS Transaction Fees. Other fees include, but are not limited to, an 800 number fee and a fee for provider directories. Employer may contact BCBSKC if Employer would like an updated listing of these types of fees. These fees are included in the Fixed Costs Fees and are guaranteed for the term of this Addendum.

6.4 BlueCard Recoveries. Under BlueCard, recoveries from a Licensee or from participating providers of a Licensee can arise in several ways, including, but not limited to, anti-fraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Licensee will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard policies, which generally require correction on a claim-by-claim or prospective basis. Unless otherwise agreed to by the Licensee, BCBSKC may request adjustments from the Licensee for full provider refunds due to the retroactive cancellation of membership only for one year after the Inter-Licensee financial settlement process date of the original claim. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if the recovery conflicts with the Licensee's state law, provider contracts or jeopardizes its relationship with its providers.

6.5 BCBSKC Recoveries. BCBSKC may pursue recoveries of Paid Claims in accordance with its rules and procedures (including via the use of third parties acting on BCBSKC's behalf), which may arise in several ways, including but not limited to, anti-fraud and abuse audits, provider/hospital audits, utilization review refunds, and class action settlement recoveries from health care providers and manufacturers of health care or other products or services. Any recovery will be credited to the Employer, subject to the terms of this Addendum, including with respect to Pooling Limits, and BCBSKC's rules and procedures; provided, that BCBSKC may charge the Employer a fee for such recoveries which will be netted against any such recovery.

6.6 Medical Value Payments. Employer acknowledges that BCBSKC may have value-based payment arrangements with providers participating in certain health care delivery programs, including but not limited to patient-centered medical homes, accountable care organizations or episode-based provider payments. These providers are known as "Blue Distinction Total Care" providers. Pursuant to such health care delivery programs, Blue Distinction Total Care providers may be eligible for alternative payments, in lieu of or in addition to, traditional fee-for-service reimbursement, including but not limited to, withholds, bonuses, incentive payments, provider credits and member management fees (collectively, "Medical Value Payments"). The amount of Medical Value Payments Blue Distinction Total Care providers receive is specific to the Blue Distinction program and/or provider and may or may not be directly related to Employer, any Covered Person, or any other group or individual. Employer acknowledges that Medical Value Payments payable to any one or more Blue Distinction Total Care providers (a) will be included in Paid Claims, (b) may include compensation for services that are related to Covered Services, including, but not limited to, coordination of care, and (c) may include compensation in

recognition of Blue Distinction Total Care provider's achievement of stated performance objectives, including, but not limited to, quality of care, patient outcomes or cost.

6.7 BCBSKC Prescription Drug Program. BCBSKC contracts with a pharmacy benefit manager ("PBM") for certain prescription drug administrative services, including prescription drug rebate administration and pharmacy network contracting services.

Under the agreement, PBM obtains rebates from drug manufacturers based on the utilization of certain prescription products by Covered Persons, and PBM retains the benefit of the rebate funds prior to disbursement. In addition, pharmaceutical manufacturers pay administrative fees to PBM in connection with PBM's services of administering, invoicing, allocating, and/or collecting rebates. Such administrative fees retained by PBM in connection with its rebate program do not exceed the greater of (i) 5.5% of the average wholesale price, or (ii) 4.58% of the wholesale acquisition cost of the products. AWP does not represent a true wholesale price, but rather is a fluctuating benchmark provided by third party pricing sources. PBM may also receive other service fees from manufacturers as compensation for various services unrelated to rebates or rebate-associated administrative fees.

In addition, BCBSKC and PBM also contract with pharmacies to provide prescription products at discounted rates for BCBSKC members. The discounted rates paid by PBM and BCBSKC to these pharmacies differ among pharmacies within a network, as well as between networks. For pharmacies that contract with the PBM, BCBSKC pays a uniform discount rate under the BCBSKC contract with the PBM regardless of the various discount rates PBM pays to the pharmacies. Thus, where the BCBSKC rate exceeds the rate the PBM negotiated with a particular pharmacy, the PBM will realize a positive margin on the applicable prescription. The reverse may also be true, resulting in negative margin for the PBM. In addition, when the PBM receives payment from BCBSKC before payment to a pharmacy is due, the PBM retains the benefit of the use of these funds between these payments. BCBSKC is guaranteed a minimum level of discount whether through the PBM or where BCBSKC directly contracts with network pharmacies, which could result in the amount paid by Employer to be more or less than the amount PBM and/or BCBSKC pay to pharmacies.

Employer acknowledges and agrees for itself and its Covered Persons that BCBSKC is not acting as a fiduciary with respect to rebate administration, pharmacy network management, or the prescription drug plan. Employer further acknowledges for itself and its Covered Persons that BCBSKC receives rebates from the PBM and may receive positive margin in connection with the pharmacy network, as well as other financial credits, administrative fees and/or other amounts from network pharmacies, drug manufacturers or the PBM (collectively "Financial Credits"). Employer acknowledges and agrees for itself and its Covered Persons that BCBSKC shall retain sole and exclusive right to all Financial Credits, which constitute BCBSKC property (and are not plan assets), and BCBSKC may use such Financial Credits in its sole and absolute discretion, including without limitation to help stabilize BCBSKC's overall rates and to offset expenses, and BCBSKC does not share Financial Credits with the Employer.

Without limitation to the foregoing, Employer acknowledges and agrees to the following ("Financial Credit Rules") for itself and its Covered Persons that: (1) Employer and/or Covered

Persons shall have no right to receive, claim or possess any beneficial interest in any Financial Credits; (2) Applicable drug benefit copayments, coinsurance, outpatient prescription drug deductible, deductible and/or maximum allowable benefits (including without limitation Calendar Year Maximum and Lifetime Maximum benefits) shall in no way be adjusted or otherwise affected as a result of any Financial Credits, except as may be required by law; (3) Any deductible and/or coinsurance required for prescription drugs shall be based upon the allowable charge at the pharmacy, and shall not change as a result of any Financial Credits, except as may be required by law; and (4) Amounts paid to pharmacies or any prices charged at pharmacies shall in no way be adjusted or otherwise affected as a result of any Financial Credits.

6.8 Audit of BCBSKC. During the term of this Addendum, Employer may, without charge by BCBSKC, perform an audit once during a Contract Period for the sole purpose of auditing BCBSKC's performance of certain of its obligations under this Addendum. BCBSKC supports two audit approaches: (a) testing up to a statistically valid random sample, based upon a 95% confidence level (plus or minus 3% precision) and 97% expected performance; or (b) testing a targeted sample, up to a number of sample items equivalent to that which would result from the above random sample approach.

Employer may engage a third party to perform any or all of the audit on its behalf upon BCBSKC's prior written consent, not to be unreasonably withheld. If Employer engages a third party to perform all or any part of an audit, such third party shall, upon BCBSKC's request (and Employer shall cause such third party to), enter into a confidentiality and non-disclosure agreement with BCBSKC prior to, and as a condition of, conducting any function of the audit. BCBSKC shall provide BCBSKC with at least thirty (30) business days' notice of its desire to conduct an audit, and the parties (including the third party engaged by Employer, as applicable) shall execute a Records Audit Agreement, which will set forth in detail the terms and conditions of the audit. Notwithstanding anything to the contrary in this Addendum or the Records Audit Agreement, in no event will provider reimbursement or other proprietary information under the control of BCBSKC be subject to audit unless BCBSKC, in its sole discretion, permits access to such information.

6.9 Entire Agreement. This Addendum and the Group Contract(s) constitute the entire Agreement between the parties concerning this subject matter and supersede all other agreements, representations or communications, oral or written, between the parties or their predecessors relating to the transactions contemplated by or which are the subject matter of this Addendum, and both parties understand and agree that prior agreements, practices or statements inconsistent with the language, terms and conditions of this Addendum are of no force or effect.

Article 7
Definitions

Access Fee The amount paid by Employer to BCBSKC for network management and access, determined as set forth in Exhibit A (Cost Plus Provisions) Exhibit B (Rate Exhibit) for each Coverage Class and Product Type combination, multiplied by the number of such Coverage Class and Product Type combinations in effect as of the first day of such month.

Contract Period The current contract term specified in the Group Contract(s) (which may be referred to in the Group Contract(s) as "Contract Year").

Coverage Class The level of coverage selected by an Employee as set forth in Exhibit B (Rate Exhibits) (e.g., "Individual", "Family", etc.).

Covered Person(s) Those individuals as defined in the Group Contract(s).

Covered Services Those services, supplies, equipment and care as defined in the Group Contract(s).

Cumulative Monthly Claims Limit The amount of Paid Claims for all Covered Persons' Covered Services for a Contract Period at which Employer has no further obligation, calculated as the sum of the Monthly Claims Limit for each month of the Contract Period to date.

Cumulative Paid Claims The sum of Paid Claims for each month of the Contract Period to date.

Cumulative Prior Payment Amount The sum of the amounts paid by Employer under Article 1.3 for each prior month (i.e., excluding the current month in question) of the Contract Period to date.

Fixed Cost Fees The amount of money to be paid by the Employer to BCBSKC for services under the Group Contract including such services as claims processing and investigation, utilization management, claims management, production and distribution of member identification cards, wellness services, web-based member services, brokerage fees, BlueCard fees and other general services. For any month during the Contract Period, Fixed Cost Fees shall equal the amounts set forth in the Fixed Cost Fees section of Exhibit B (Rate Exhibit) for each Coverage Class and Product Type combination, multiplied by the number of such Coverage Class and Product Type combinations in effect as of the first day of such month.

Fixed Premium The Fixed Cost Fees, Pooling Charges, Access Fees and Statutory Assessments as set forth in Exhibit A (Cost-Plus Provisions) and/or Exhibit B (Rate Exhibits), as applicable; provided, that the Access Fees and any Statutory Assessments shall be billed with the Monthly Settlement Report.

Group Contract(s) Those Group Contract(s) identified in Exhibit A (Cost Plus Provisions).

Individual Pooling Limit The amount at which any Paid Claims for a Covered Person's Covered Services in excess of such amount during a Contract Period are not counted as Paid Claims for purposes of determining Employer's claims obligations under Article 1.3 during such Contract Period.

Individual Pooling Loss Ratio The amount calculated by dividing total paid claims exceeding the Individual Pooling Limit by the total Pooling Charges directly related to the Individual Pooling Limit for that Contract Period.

Monthly Claims Limit For any month during the term of this Addendum, the amounts set forth in the Monthly Claims Limit section of Exhibit B (Rate Exhibit) for each Coverage Class and Product Type combination, multiplied by the number of such Coverage Class and Product Type combinations in effect as of the first day of such month.

Monthly Settlement Report The Employer claims, network access and other obligations as reported for a given month by BCBSKC. The Monthly Settlement Report may include Paid Claims, Access Fees and Statutory Assessments, and, during the Runout Period, Runout Services Fee, as applicable.

Paid Claims All payments for Covered Services during the Contract Period and the Runout Period for claims that were incurred between 7/01/2017 and 6/30/2019 for the Individual Pool Limit and between 7/01/2017 and 6/30/2019 for the Monthly Claims Limit while this Addendum was in effect, or for claims that were incurred under this Addendum between the parties for the previous Contract Period, if applicable; including Medical Value Payments and other provider charges, such as capitation, when applicable. Paid Claims are those amounts paid to a provider, which the provider has agreed to accept as payment in full at the time of claim payment for Covered Services provided to Covered Persons. Paid Claims are not reduced by any administration fees, network management fees, provider and pharmaceutical rebates, incentive arrangements, or any other reductions or credits a provider may periodically give BCBSKC, or any other amounts that a provider may pay BCBSKC for services such as administration, marketing, managed care or quality improvement programs performed by BCBSKC for the provider. BCBSKC retains these amounts and they do not reduce the amount of Paid Claims. All services are deemed to be incurred on the date the service was actually rendered. A claim shall be deemed to be paid when a valid draft for payment of such benefit has been issued to the person or persons authorized for such purpose by agreement of the Employer and BCBSKC.

Pooling Charges The amount payable by the Employer to BCBSKC for limiting the Employer's claims obligation under the terms of the Cumulative Monthly Claims Limit and Individual Pooling Limit, and, if applicable, for Terminal Liability Coverage. For any month during the Contract Period, Pooling Charges shall equal the amounts set forth in the Pooling Charges section of Exhibit B (Rate Exhibit) for each Coverage Class and Product Type combination, multiplied by the number of such Coverage Class and Product Type combinations in effect as of the first day of such month.

Product Type The type of product(s) offered by Employer to Covered Persons, as set forth in Exhibit B (Rate Exhibits) (e.g., Blue Advantage, Blue Care, Dental, etc.).

Runout Claims Claims for Covered Services incurred by Covered Persons prior to the termination of this Addendum but paid by BCBSKC during the Runout Period. For purposes of clarification, Runout Claims do not include claims incurred after termination of this Addendum.

Runout Period The first twelve (12) months following termination of this Addendum.

Runout Services The services provided by BCBSKC for Runout Claims after termination of this Addendum.

Runout Services Fee The fee payable by Employer to BCBSKC for Runout Services, which is equal to the sum of: (a) ten percent (10%) of Runout Claims during the month; and (b) ten percent (10%) of the difference between billed charges and the Allowable Charge for all Runout Claims (i.e., 10% of network discounts) during the month.

Statutory Assessments Governmental entities assess a variety of fees, taxes, surcharges and/or assessments on employer-sponsored health coverage. These include, but are not limited to, state premium taxes, Affordable Care Act (ACA) assessments such as the Health Insurance Providers Fee, the Patient-Centered Outcomes Research Institute Fee (aka Comparative Effectiveness Fee) and the Transitional Reinsurance Fee, as well as miscellaneous state or local assessments, including but not limited to, the New York Healthcare Reform surcharge and the Maine Dirigo Access Payment.

Terminal Liability Coverage Coverage for Runout Claims exceeding a specified maximum at termination of this Addendum.

Terminal Liability Coverage Charges The cost associated with the purchase of Terminal Liability Coverage.

Year-End Adjustment The maximum amount BCBSKC could owe to Employer as described in Article 1.4.

Other Defined Terms Any other capitalized term used in this Addendum and not specifically defined herein, shall have the meaning ascribed to it in the Group Contract(s).

IN WITNESS WHEREOF, BCBSKC and Employer have caused this Addendum to be executed effective as of the Effective Date.

Raytown C-1 School District	**Blue Cross and Blue Shield of Kansas City**
BY:_____	BY:_____
NAME: _____	NAME: _____
TITLE:_____	TITLE:_____
DATE:_____	DATE:_____

Exhibit A
Cost Plus Provisions

1. This Addendum shall be applicable to:

   __X__ Employer's Group Health Contract: Group Number(s) 33060000
   _____ Employer's Group Dental Contract: Group Number(s) _____

2. The Individual Pooling Limit per Covered Person shall be $250,000.

3. The Access Fee is due and payable with the Monthly Settlement Report and shall be:

   $15.00 per Employee per month

4. Minimum Annual Claims Limit:

   The greater of: (a) $7,589,627; or (b) 90% of the amounts set forth in the Monthly Claims Limit section of Exhibit B (Rate Exhibit) for each Coverage Class and Product Type combination, multiplied by the number of such Coverage Class and Product Type combinations for the first month of the Contract Period, times the number of months of the Contract Period as defined in Article 7.

Fixed Premium

The Fixed Cost Fees are as follows:

Employee	$30.54
Employee & Spouse	$70.21
Employee & Chil(ren)	$57.11
Family	$96.20

2. Pooling Charges (including Terminal Liability Coverage Charges, if applicable) are as follows:

Employee	$127.05
Employee & Spouse	$292.24
Employee & Chil(ren)	$237.64
Family	$400.26

3. Access Fees are as follows:

$15.00 per Employee per month

4. Statutory Assessments are as follows:

A. The Health Insurance Providers Fee (aka HIT Tax) is due and payable with the Monthly Settlement Report and shall be 1.7% of the sum of the amounts payable under Articles 1.2 1.3 and 1.4.

B. The Patient-Centered Outcomes Research Institute Fee (aka Comparative Effectiveness Fee) is due and payable with the Monthly Settlement Report and shall be $2.39 per Covered Person (which equals $0.20 per Covered Person per month).

Rate Factors

1. Monthly Claims Limit Factors are as follows:

Active	PCB $2,500	PCB $1,500	PCB $1,000	HSA
Employee	$520.06	$611.66	$659.58	$520.06
Employee & Spouse	$1,196.04	$1,406.75	$1,516.92	$1,196.04
Employee & Child(ren)	$972.46	$1,143.78	$1,233.33	$972.46
Family	$1,638.02	$1,926.60	$2,077.51	$1,638.02
Retirees Under 65				
Retiree Under 65	$520.06	$611.66	$659.58	$520.06
Retiree and Spouse Under 65	$1,196.04	$1,406.75	$1,516.92	$1,196.04
Retiree and Child(ren) Under 65	$972.46	$1,143.78	$1,233.33	$972.46
Retiree, Spouse, and Dependents Under 65	$1,638.02	$1,926.60	$2,077.51	$1,638.02
Retirees Over 65				
Retiree Over 65	$520.06	$611.66	$659.58	--
Retiree Over 65, Spouse Under 65	--	$1,370.04	--	--
Retiree Under 65, Spouse Over 65	--	--	--	--
Retiree and Spouse Over 65	$1,008.02	$1,188.92	$1,286.92	--

2. Terminal Liability Factors are as follows:

Active	PCB $2,500	PCB $1,500	PCB $1,000	HSA
Employee	$780.09	$917.49	$989.37	$780.09
Employee & Spouse	$1,794.05	$2,110.12	$2,275.38	$1,794.05
Employee & Child(ren)	$1,458.69	$1,715.67	$1,849.99	$1,458.69
Family	$2,457.03	$2,889.90	$3,116.26	$2,457.03
Retirees Under 65				
Retiree Under 65	$780.09	$917.49	$989.37	$780.09
Retiree and Spouse Under 65	$1,794.05	$2,110.12	$2,275.38	$1,794.05
Retiree and Child(ren) Under 65	$1,458.69	$1,715.67	$1,849.99	$1,458.69
Retiree, Spouse, and Dependents Under 65	$2,457.03	$2,889.90	$3,116.26	$2,457.03
Retirees Over 65				
Retiree Over 65	$780.09	$917.49	$989.36	--
Retiree Over 65, Spouse Under 65	--	$2,055.06	--	--
Retiree Under 65, Spouse Over 65	--	--	--	--
Retiree and Spouse Over 65	$1,512.03	$1,783.39	$1,930.38	--

Kansas City

Confirmation of Coverage

Group Name:	Raytown C-2 School District
Offer Name:	2018 RENEWAL
Group Number:	33060000
Effective Date:	07/01/2018
Important Notes:	

Offer-Related Information

A. General Information	
Contract Term:	12 Months
Subsequent Renewal Terms:	12 Months
Renewal Notification:	180 Days
Annual Enrollment Period Start:	30 Days prior to Group Anniversary Date
Annual Enrollment Period End:	15 Days after Group Anniversary Date
Waiting Period:	Group Assigns
Eligibility Rule:	Group Assigns
Termination Rule:	Group Assigns
Dependent Limiting Age:	26 Years
Dependent Limiting Age Termination:	EOM following birthday
Is Employer subject to ERISA?:	No
Are Section 125 Enrollment Changes Allowed?:	Yes
HSA Bank Selection:	UMB
Reinstatement Fee:	$500
B. Medical Programs and Services	
AHY (subscribers/spouse with medical):	AHY Platinum (1000+)
AHY Standard Buyup (employees with no medical):	No
Wellness Fund:	$40,000
24-Hour Nurse Line:	Yes
Healthy Companion:	Yes
Little Stars Prenatal Program:	Yes
Rx Personal Medication Coach:	Yes
Rx Savings Solution:	Yes
C. Blue KC Vision Coverage	
Blue Vue Base:	No
Blue Vue 10/100:	No
Blue Vue 10/130:	No
Blue Vue 10/150:	No
Blue Vue 10/200:	No
Blue Vue 0/130:	No
Blue Vue 0/150:	No
Blue Vue 0/200:	No

Blue Vue Non-Standard:	No
D. USAble Coverage	
Term Life:	No
AD&D:	No
Blue KC Provided Billing Service:	
E. Principal Coverage	
Group Term Life:	No
Voluntary Life:	No
Long Term Disability (LTD):	No
Short Term Disability (STD):	No
Critical Illness:	No
Accident:	No
Dental:	No
Vision:	No

Offer Summary and Signatures

Plans included in this Offer:

For details about the plans included in this offer, please see the attached Plan information.

- **Preferred Care Blue PPO BlueSaver**
- **Preferred Care Blue PPO $2500 Deductible**
- **Preferred Care Blue PPO $1500 Deductible**
- **Preferred Care Blue PPO $1000 Deductible**

Confirmed by: Raytown C-2 School District

Signature

Title

Date

Accepted by Blue Cross and Blue Shield of Kansas City:

Signature

Title

Date

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Plan Information

Group Name:	Raytown C-2 School District
Plan Name:	Preferred Care Blue PPO BlueSaver
Group Number:	33060000
Effective Date:	07/01/2018
For Internal Use Only:	Package: 0515150269 XREF: C0KX Medical: 2445430823 Rx: 3026390063

1. General Plan Information		
Benefit Period	Calendar Year	
Funding	Cost Plus	
Grandfathered Status	Non-Grandfathered	
Classification of Eligible Employees	All full-time employees who are currently working 30 hours per week; Retirees and their Dependents who are eligible in accordance with the Employer's Employee Benefits Program; grandfathered employees working prorated hours (10-19 hours and 20-29 hours)	
Eligibility		
Min % of Eligible Employees	75%	
% Threshold of Total Employee Enrollment	90%	
Minimum Employer Contribution – Eligible Employees	75%	
Minimum Employer Contribution – Total Account Premium	50%	
COBRA Billing	BCBS	
Are Domestic Partners Covered?	No	
Are Same Sex Spouses Covered?	Yes	
Insurance Coverage Creditable (Medicare Part D)	Yes	
Compass	Compass not included	
2. Network		
Local Medical Network	Preferred-Care Blue	
Out-of-Area Medical Network	BlueCard PPO/EPO	
Pharmacy	See Pharmacy (Sections 5 & 6)	
3. Cost Sharing		
Medical Deductible - Calendar Year, Embedded	**In-Network**	**Out-of-Network**
Individual	$2,700	$2,700
Family	$5,400	$5,400
Pharmacy Deductible	Combined with Medical	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	10%	30%
Plan Pays	90%	70%
Out-of-Pocket Limit - Calendar Year, Embedded The Out-of-Pocket limit includes all Deductibles, Coinsurance, and Copayments a member pays during the Benefit Period.	**In-Network**	**Out-of-Network**
Individual	$4,000	$8,000
Family	$8,000	$16,000
Pharmacy Out-of-Pocket Limit	Combined with Medical	
Annual First Dollar Coverage	Does not apply	Does not apply
Annual Maximum	Does not apply	Does not apply

Lifetime Maximum	Does not apply	Does not apply
4. Benefits		
Professional Services	**In-Network**	**Out-of-Network**
Primary Care Physician Office Visit - An internist, family practitioner, general practitioner, or pediatrician.	10% Coinsurance after Deductible	30% Coinsurance after Deductible
BDTC Primary Care Physician Office Visit	Does not apply	Not applicable
Specialist Physician Office Visit – Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrist, psychologists and chiropractors.	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care Office Visit	10% Coinsurance after Deductible	30% Coinsurance after Deductible
BDTC Urgent Care Office Visit	Does not apply	Not applicable
Designated Telehealth Care Visit	10% Coinsurance after Deductible	Not applicable
Other Benefits (in alphabetical order)	**In-Network**	**Out-of-Network**
Abortion	Not covered	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Allergy Treatment (Injections)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Allergy Treatment (Serum)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Ambulance - Air Air Ambulance Allowable Option: Unlimited (No Cost Sharing) Benefit	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
Ambulance - Ground Ground Ambulance Allowable Option: 150% of Medicare	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
Assisted Reproductive Services	Not covered	Not covered
Autism Services, including ABA Therapy Autism Services Coverage: Mandated Services Autism Services Limits: Mandated Limits	Covered	Covered
BDC+ Surgery	Not covered	Not covered
Bariatric	Not covered	Not covered
Chiropractic Services Office Visit	Same as Specialist Office Visit Cost Shares	Same as Specialist Office Visit Cost Shares
Diabetic Equipment and Supplies Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Diabetic Footwear	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Diabetic Self Management Education/Training (DSMT)	No member cost share	30% Coinsurance after Deductible
Durable Medical Equipment (DME) Prior Authorization Policy Applies No Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Emergency Services	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
Food and Food Products for PKU No Limits	Covered	Covered
Foot Orthotics	Not covered	Not covered

Gender Dysphoria Treatment Prior Authorization Policy Applies	Covered	Covered
Hearing Aids	Not covered	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Home Health Care Prior Authorization Policy Applies Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Home Hospice	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Treatment Maximum benefit of $10,000/Lifetime for In-Network and Out-of-Network Infertility Coverage: Yes Pharmacy Coverage: Yes Impotency Coverage: Yes	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Hospice Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Physician Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Labs Performed in Office / Independent Lab	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Maternity Dependent Daughters Maternity Covered?: Yes	Covered	Covered
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Inpatient Physician Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Office Visit	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Facility Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
	10% Coinsurance after Deductible	30% Coinsurance after Deductible

Mental Health and Substance Abuse Services - Outpatient Therapy		
Organ Transplant Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider INN Tier 1 Cost Share Providers: Designated Providers OON Cost Share Providers: All Other Providers	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Chiropractic Office Visit (including Skeletal Manipulation) Prior Authorization Policy Applies Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Other Services Performed in Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Physician Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Surgery Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Cardiac Therapy No Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Cognitive Therapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy Combined with Speech Therapy Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy Combined with Physical Therapy Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Pulmonary Therapy No Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Therapy - Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Private Duty Nursing Combined with Home Health Care Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Routine Preventive Care Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	30% Coinsurance after Deductible
Skilled Nursing Facility (SNF) Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible

Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network		
Temporomandibular Joint (TMJ) Surgery	Not covered	Not covered
Vision Exam-Routine Maximum benefit of 1 Exam(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Weight Management - Naturally Slim	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	10% Coinsurance after Deductible	30% Coinsurance after Deductible

General Pharmacy Information

Pharmacy Network(s)	**Network 1:** National Plus	
Prescription Drug List Learn more about the drugs covered by your plan, drug category/tier, prior authorization and step therapy by reviewing your prescription drug list at MyBlueKC.com	National Preferred	
Outpatient Prescription Drug Deductible You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services.	**In-Network** Combined with Medical Deductible	**Out-of-Network** Combined with Medical Deductible
Outpatient Prescription Drug Out-of-Pocket Limits The Out-of-Pocket Limit is the most you could pay during the Calendar Year for your share of the cost of covered services.	**In-Network** Combined with Medical Out-of-Pocket	**Out-of-Network** Combined with Medical Out-of-Pocket
Maintenance Medication Program	Not applicable	
Generics Program	Not applicable	
Rx Savings Solutions A team of pharmacists and pharmacy technician will help you make sure you're getting the best possible pricing for your medicines. Member support is available Monday – Friday, 7.a.m. to 7.pm CST.	Register online at MyBlueKC.com and stay up-to-date on cost saving opportunities. **Email:** info@rxsavingsllc.com **PH:** 1-800-268-4476	

Plan Benefits – Pharmacy

	In-Network	Out-of-Network
Retail Pharmacy (Short-term supply: Up to 34 Days**)** **Drug Tier 1:** Generic / Generic Specialty	**National Plus:** Deductible, then $12 Copay/Fill	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**National Plus:** Deductible, then $55 Copay/Fill	Deductible, then $55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**National Plus:** Deductible, then $75 Copay/Fill	Deductible, then $75 Copay/Fill, then 50% Coinsurance
Mail Order Pharmacy	Deductible, then $36 Copay/Fill	Deductible, then $36 Copay/Fill, then 50% Coinsurance

Drug Tier 1: Generic / Generic Specialty		
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	Deductible, then $165 Copay/Fill	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	Deductible, then $225 Copay/Fill	Deductible, then $225 Copay/Fill, then 50% Coinsurance
Preventive Drugs **Retail Drug Tier 1:** Generic / Generic Specialty	**National Plus:** Deductible, then $12 Copay/Fill	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Retail Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**National Plus:** Deductible, then $55 Copay/Fill	Deductible, then $55 Copay/Fill, then 50% Coinsurance
Retail Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**National Plus:** Deductible, then $75 Copay/Fill	Deductible, then $75 Copay/Fill, then 50% Coinsurance
Mail Order Drug Tier 1: Generic / Generic Specialty	Deductible, then $36 Copay/Fill	Deductible, then $36 Copay/Fill, then 50% Coinsurance
Mail Order Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	Deductible, then $165 Copay/Fill	Deductible, then $165 Copay/Fill, then 50% Coinsurance
Mail Order Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	Deductible, then $225 Copay/Fill	Deductible, then $225 Copay/Fill, then 50% Coinsurance
Value-Based Benefits (VBB) **Included Conditions:** None		
VBB Retail Pharmacy (Short-term supply)	**National Plus:** No member cost share	No member cost share
	National Plus: No member cost share	No member cost share
	National Plus: No member cost share	No member cost share
VBB Mail Order Pharmacy	Not covered	No member cost share
	Not covered	No member cost share
	Not covered	No member cost share
Infertility and Impotency Drugs **Drug Tier 1:** Generic / Generic Specialty	**National Plus:** Deductible, then $12 Copay/Fill, then 50% Coinsurance	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**National Plus:** Deductible, then $55 Copay/Fill, then 50% Coinsurance	Deductible, then $55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**National Plus:** Deductible, then $75 Copay/Fill, then 50% Coinsurance	Deductible, then $75 Copay/Fill, then 50% Coinsurance

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Plan Information

Group Name:	Raytown C-2 School District
Plan Name:	Preferred Care Blue PPO $2500 Deductible
Group Number:	33060000
Effective Date:	07/01/2018
For Internal Use Only:	Package: 1022250961 XREF: C0LC Medical: 2447550652 Rx: 2941090383

1. General Plan Information		
Benefit Period	Calendar Year	
Funding	Cost Plus	
Grandfathered Status	Non-Grandfathered	
Classification of Eligible Employees	All full-time employees who are currently working 30 hours per week; Retirees and their Dependents who are eligible in accordance with the Employer's Employee Benefits Program; grandfathered employees working prorated hours (10-19 hours and 20-29 hours)	
Eligibility		
Min % of Eligible Employees	75%	
% Threshold of Total Employee Enrollment	90%	
Minimum Employer Contribution – Eligible Employees	75%	
Minimum Employer Contribution – Total Account Premium	50%	
COBRA Billing	BCBS	
Are Domestic Partners Covered?	No	
Are Same Sex Spouses Covered?	Yes	
Insurance Coverage Creditable (Medicare Part D)	Yes	
Compass	Compass not included	
2. Network		
Local Medical Network	Preferred-Care Blue	
Out-of-Area Medical Network	BlueCard PPO/EPO	
Pharmacy	See Pharmacy (Sections 5 & 6)	
3. Cost Sharing		
Medical Deductible - Calendar Year, Embedded	**In-Network**	**Out-of-Network**
Individual	$2,500	$3,150
Family	$7,500	$9,450
Pharmacy Deductible	No Pharmacy Deductible	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	20%	40%
Plan Pays	80%	60%
Out-of-Pocket Limit - Calendar Year, Embedded The Out-of-Pocket limit includes all Deductibles, Coinsurance, and Copayments a member pays during the Benefit Period.	**In-Network**	**Out-of-Network**
Individual	$6,300	$12,600
Family	$13,200	$37,800
Pharmacy Out-of-Pocket Limit	Combined with Medical	
Annual First Dollar Coverage	Does not apply	Does not apply
Annual Maximum	Does not apply	Does not apply

Lifetime Maximum	Does not apply	Does not apply
4. Benefits		
Professional Services	**In-Network**	**Out-of-Network**
Primary Care Physician Office Visit - An internist, family practitioner, general practitioner, or pediatrician.	$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
BDTC Primary Care Physician Office Visit	Does not apply	Not applicable
Specialist Physician Office Visit – Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrist, psychologists and chiropractors.	$70 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Urgent Care Office Visit	$70 Copay/Visit, no Deductible	40% Coinsurance after Deductible
BDTC Urgent Care Office Visit	Does not apply	Not applicable
Designated Telehealth Care Visit	$70 Copay/Visit, no Deductible	Not applicable
Other Benefits (in alphabetical order)	**In-Network**	**Out-of-Network**
Abortion	Not covered	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Allergy Treatment (Injections)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Allergy Treatment (Serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Ambulance - Air Air Ambulance Allowable Option: Unlimited (No Cost Sharing) Benefit	20% Coinsurance after Deductible	20% Coinsurance after In-Network Deductible
Ambulance - Ground Ground Ambulance Allowable Option: 150% of Medicare	20% Coinsurance after Deductible	20% Coinsurance after In-Network Deductible
Assisted Reproductive Services	Not covered	Not covered
Autism Services, including ABA Therapy Autism Services Coverage: Mandated Services Autism Services Limits: Mandated Limits	Covered	Covered
BDC+ Surgery	Not covered	Not covered
Bariatric	Not covered	Not covered
Chiropractic Services Office Visit	Same as Specialist Office Visit Cost Shares	Same as Specialist Office Visit Cost Shares
Diabetic Equipment and Supplies Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diabetic Footwear	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diabetic Self Management Education/Training (DSMT)	No member cost share	40% Coinsurance after Deductible
Durable Medical Equipment (DME) Prior Authorization Policy Applies No Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$200 Copay/Visit, then Deductible then 20% Coinsurance	$200 Copay/Visit, then In-Network Deductible then 20% Coinsurance
Food and Food Products for PKU No Limits	Covered	Covered

Foot Orthotics	Not covered	Not covered
Gender Dysphoria Treatment Prior Authorization Policy Applies	Covered	Covered
Hearing Aids	Not covered	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Health Care Prior Authorization Policy Applies Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Hospice	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Treatment Maximum benefit of $10,000/Lifetime for In-Network and Out-of-Network Pharmacy Coverage: Yes Impotency Coverage: Yes Infertility Coverage: Yes	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Hospice Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Physician Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Labs Performed in Office / Independent Lab	No member cost share	40% Coinsurance after Deductible
Maternity Dependent Daughters Maternity Covered?: Yes	Covered	Covered
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Inpatient Physician Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Office Visit	$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Facility Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Mental Health and Substance Abuse Services - Outpatient Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Organ Transplant Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider OON Cost Share Providers: All Other Providers INN Tier 1 Cost Share Providers: Designated Providers	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Chiropractic Office Visit (including Skeletal Manipulation) Prior Authorization Policy Applies Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Other Services Performed in Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Physician Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Surgery Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Cardiac Therapy No Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Cognitive Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy Combined with Speech Therapy Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy Combined with Physical Therapy Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Pulmonary Therapy No Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Private Duty Nursing Combined with Home Health Care Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Routine Preventive Care Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	40% Coinsurance after Deductible
Skilled Nursing Facility (SNF) Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network		
Temporomandibular Joint (TMJ) Surgery	Not covered	Not covered
Vision Exam-Routine Maximum benefit of 1 Exam(s)/Calendar Year for In-Network and Out-of-Network	$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Weight Management - Naturally Slim	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	20% Coinsurance after Deductible	40% Coinsurance after Deductible

General Pharmacy Information

Pharmacy Network(s)	**Network 1:** National Plus	
Prescription Drug List Learn more about the drugs covered by your plan, drug category/tier, prior authorization and step therapy by reviewing your prescription drug list at MyBlueKC.com	National Preferred	
Outpatient Prescription Drug Deductible You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services.	**In-Network** Does Not Apply	**Out-of-Network** Does Not Apply
Outpatient Prescription Drug Out-of-Pocket Limits The Out-of-Pocket Limit is the most you could pay during the Calendar Year for your share of the cost of covered services.	**In-Network** Combined with Medical Out-of-Pocket	**Out-of-Network** Combined with Medical Out-of-Pocket
Maintenance Medication Program	Not applicable	
Generics Program	Not applicable	
Rx Savings Solutions A team of pharmacists and pharmacy technician will help you make sure you're getting the best possible pricing for your medicines. Member support is available Monday – Friday, 7.a.m. to 7.pm CST.	Register online at MyBlueKC.com and stay up-to-date on cost saving opportunities. **Email:** info@rxsavingsllc.com **PH:** 1-800-268-4476	

Plan Benefits – Pharmacy

	In-Network	**Out-of-Network**
Retail Pharmacy (Short-term supply: Up to 34 Days**)** **Drug Tier 1:** Generic / Generic Specialty	**National Plus:** $12 Copay/Fill	$12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**National Plus:** $55 Copay/Fill	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**National Plus:** $75 Copay/Fill	$75 Copay/Fill, then 50% Coinsurance

Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$36 Copay/Fill	$36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	$165 Copay/Fill	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	$225 Copay/Fill	$225 Copay/Fill, then 50% Coinsurance
Infertility and Impotency Drugs **Drug Tier 1:** Generic / Generic Specialty	**National Plus:** $12 Copay/Fill, then 50% Coinsurance	$12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**National Plus:** $55 Copay/Fill, then 50% Coinsurance	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**National Plus:** $75 Copay/Fill, then 50% Coinsurance	$75 Copay/Fill, then 50% Coinsurance

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Plan Information

Group Name:	Raytown C-2 School District
Plan Name:	Preferred Care Blue PPO $1500 Deductible
Group Number:	33060000
Effective Date:	07/01/2018
For Internal Use Only:	Package: 0511100580 XREF: C0KW Medical: 2444420526 Rx: 2941090383

1. General Plan Information		
Benefit Period	Calendar Year	
Funding	Cost Plus	
Grandfathered Status	Non-Grandfathered	
Classification of Eligible Employees	All full-time employees who are currently working 30 hours per week; Retirees and their Dependents who are eligible in accordance with the Employer's Employee Benefits Program; grandfathered employees working prorated hours (10-19 hours and 20-29 hours)	
Eligibility		
Min % of Eligible Employees	75%	
% Threshold of Total Employee Enrollment	90%	
Minimum Employer Contribution – Eligible Employees	75%	
Minimum Employer Contribution – Total Account Premium	50%	
COBRA Billing	BCBS	
Are Domestic Partners Covered?	No	
Are Same Sex Spouses Covered?	Yes	
Insurance Coverage Creditable (Medicare Part D)	Yes	
Compass	Compass not included	
2. Network		
Local Medical Network	Preferred-Care Blue	
Out-of-Area Medical Network	BlueCard PPO/EPO	
Pharmacy	See Pharmacy (Sections 5 & 6)	
3. Cost Sharing		
Medical Deductible - Calendar Year, Embedded	**In-Network**	**Out-of-Network**
Individual	$1,500	$1,750
Family	$4,500	$5,250
Pharmacy Deductible	No Pharmacy Deductible	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	20%	40%
Plan Pays	80%	60%
Out-of-Pocket Limit - Calendar Year, Embedded The Out-of-Pocket limit includes all Deductibles, Coinsurance, and Copayments a member pays during the Benefit Period.	**In-Network**	**Out-of-Network**
Individual	$5,750	$17,250
Family	$13,100	$34,500
Pharmacy Out-of-Pocket Limit	Combined with Medical	
Annual First Dollar Coverage	Does not apply	Does not apply
Annual Maximum	Does not apply	Does not apply

Lifetime Maximum	Does not apply	Does not apply
4. Benefits		
Professional Services	**In-Network**	**Out-of-Network**
Primary Care Physician Office Visit - An internist, family practitioner, general practitioner, or pediatrician.	$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
BDTC Primary Care Physician Office Visit	Does not apply	Not applicable
Specialist Physician Office Visit – Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrist, psychologists and chiropractors.	$70 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Urgent Care Office Visit	$70 Copay/Visit, no Deductible	40% Coinsurance after Deductible
BDTC Urgent Care Office Visit	Does not apply	Not applicable
Designated Telehealth Care Visit	$70 Copay/Visit, no Deductible	Not applicable
Other Benefits (in alphabetical order)	**In-Network**	**Out-of-Network**
Abortion	Not covered	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Allergy Treatment (Injections)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Allergy Treatment (Serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Ambulance - Air Air Ambulance Allowable Option: Unlimited (No Cost Sharing) Benefit	20% Coinsurance after Deductible	20% Coinsurance after In-Network Deductible
Ambulance - Ground Ground Ambulance Allowable Option: 150% of Medicare	20% Coinsurance after Deductible	20% Coinsurance after In-Network Deductible
Assisted Reproductive Services	Not covered	Not covered
Autism Services, including ABA Therapy Autism Services Coverage: Mandated Services Autism Services Limits: Mandated Limits	Covered	Covered
BDC+ Surgery	Not covered	Not covered
Bariatric	Not covered	Not covered
Chiropractic Services Office Visit	Same as Specialist Office Visit Cost Shares	Same as Specialist Office Visit Cost Shares
Diabetic Equipment and Supplies Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diabetic Footwear	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diabetic Self Management Education/Training (DSMT)	No member cost share	40% Coinsurance after Deductible
Durable Medical Equipment (DME) Prior Authorization Policy Applies No Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$200 Copay/Visit, then Deductible then 20% Coinsurance	$200 Copay/Visit, then In-Network Deductible then 20% Coinsurance
Food and Food Products for PKU No Limits	Covered	Covered

Foot Orthotics	Not covered	Not covered
Gender Dysphoria Treatment Prior Authorization Policy Applies	Covered	Covered
Hearing Aids	Not covered	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Health Care Prior Authorization Policy Applies Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Hospice	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Treatment Maximum benefit of $10,000/Lifetime for In-Network and Out-of-Network Impotency Coverage: Yes Pharmacy Coverage: Yes Infertility Coverage: Yes	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Hospice Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Physician Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Labs Performed in Office / Independent Lab	No member cost share	40% Coinsurance after Deductible
Maternity Dependent Daughters Maternity Covered?: Yes	Covered	Covered
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Inpatient Physician Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Office Visit	$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Facility Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Mental Health and Substance Abuse Services - Outpatient Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Organ Transplant Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider OON Cost Share Providers: All Other Providers INN Tier 1 Cost Share Providers: Designated Providers	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Chiropractic Office Visit (including Skeletal Manipulation) Prior Authorization Policy Applies Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Other Services Performed in Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Physician Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Surgery Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Cardiac Therapy No Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Cognitive Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy Combined with Speech Therapy Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy Combined with Physical Therapy Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Pulmonary Therapy No Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Private Duty Nursing Combined with Home Health Care Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Routine Preventive Care Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	40% Coinsurance after Deductible
Skilled Nursing Facility (SNF) Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network		
Temporomandibular Joint (TMJ) Surgery	Not covered	Not covered
Vision Exam-Routine Maximum benefit of 1 Exam(s)/Calendar Year for In-Network and Out-of-Network	$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Weight Management - Naturally Slim	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	20% Coinsurance after Deductible	40% Coinsurance after Deductible

General Pharmacy Information

Pharmacy Network(s)	**Network 1:** National Plus	
Prescription Drug List Learn more about the drugs covered by your plan, drug category/tier, prior authorization and step therapy by reviewing your prescription drug list at MyBlueKC.com	National Preferred	
Outpatient Prescription Drug Deductible You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services.	**In-Network** Does Not Apply	**Out-of-Network** Does Not Apply
Outpatient Prescription Drug Out-of-Pocket Limits The Out-of-Pocket Limit is the most you could pay during the Calendar Year for your share of the cost of covered services.	**In-Network** Combined with Medical Out-of-Pocket	**Out-of-Network** Combined with Medical Out-of-Pocket
Maintenance Medication Program	Not applicable	
Generics Program	Not applicable	
Rx Savings Solutions A team of pharmacists and pharmacy technician will help you make sure you're getting the best possible pricing for your medicines. Member support is available Monday – Friday, 7.a.m. to 7.pm CST.	Register online at MyBlueKC.com and stay up-to-date on cost saving opportunities. **Email:** info@rxsavingsllc.com **PH:** 1-800-268-4476	

Plan Benefits – Pharmacy

	In-Network	**Out-of-Network**
Retail Pharmacy (Short-term supply: Up to 34 Days**)** **Drug Tier 1:** Generic / Generic Specialty	**National Plus:** $12 Copay/Fill	$12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**National Plus:** $55 Copay/Fill	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**National Plus:** $75 Copay/Fill	$75 Copay/Fill, then 50% Coinsurance

Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$36 Copay/Fill	$36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	$165 Copay/Fill	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	$225 Copay/Fill	$225 Copay/Fill, then 50% Coinsurance
Infertility and Impotency Drugs **Drug Tier 1:** Generic / Generic Specialty	**National Plus:** $12 Copay/Fill, then 50% Coinsurance	$12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**National Plus:** $55 Copay/Fill, then 50% Coinsurance	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**National Plus:** $75 Copay/Fill, then 50% Coinsurance	$75 Copay/Fill, then 50% Coinsurance

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Plan Information

Group Name:	Raytown C-2 School District
Plan Name:	Preferred Care Blue PPO $1000 Deductible
Group Number:	33060000
Effective Date:	07/01/2018
For Internal Use Only:	Package: 1023440463 XREF: C0LD Medical: 2446500980 Rx: 2941090383

1. General Plan Information		
Benefit Period	Calendar Year	
Funding	Cost Plus	
Grandfathered Status	Non-Grandfathered	
Classification of Eligible Employees	All full-time employees who are currently working 30 hours per week; Retirees and their Dependents who are eligible in accordance with the Employer's Employee Benefits Program; grandfathered employees working prorated hours (10-19 hours and 20-29 hours)	
Eligibility		
Min % of Eligible Employees	75%	
% Threshold of Total Employee Enrollment	90%	
Minimum Employer Contribution – Eligible Employees	75%	
Minimum Employer Contribution – Total Account Premium	50%	
COBRA Billing	BCBS	
Are Domestic Partners Covered?	No	
Are Same Sex Spouses Covered?	Yes	
Insurance Coverage Creditable (Medicare Part D)	Yes	
Compass	Compass not included	
2. Network		
Local Medical Network	Preferred-Care Blue	
Out-of-Area Medical Network	BlueCard PPO/EPO	
Pharmacy	See Pharmacy (Sections 5 & 6)	
3. Cost Sharing		
Medical Deductible - Calendar Year, Embedded	**In-Network**	**Out-of-Network**
Individual	$1,000	$1,250
Family	$3,000	$3,750
Pharmacy Deductible	No Pharmacy Deductible	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	20%	40%
Plan Pays	80%	60%
Out-of-Pocket Limit - Calendar Year, Embedded The Out-of-Pocket limit includes all Deductibles, Coinsurance, and Copayments a member pays during the Benefit Period.	**In-Network**	**Out-of-Network**
Individual	$5,400	$10,800
Family	$12,750	$32,400
Pharmacy Out-of-Pocket Limit	Combined with Medical	
Annual First Dollar Coverage	Does not apply	Does not apply
Annual Maximum	Does not apply	Does not apply

Lifetime Maximum	Does not apply	Does not apply
4. Benefits		
Professional Services	**In-Network**	**Out-of-Network**
Primary Care Physician Office Visit - An internist, family practitioner, general practitioner, or pediatrician.	$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
BDTC Primary Care Physician Office Visit	Does not apply	Not applicable
Specialist Physician Office Visit – Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrist, psychologists and chiropractors.	$70 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Urgent Care Office Visit	$70 Copay/Visit, no Deductible	40% Coinsurance after Deductible
BDTC Urgent Care Office Visit	Does not apply	Not applicable
Designated Telehealth Care Visit	$70 Copay/Visit, no Deductible	Not applicable
Other Benefits (in alphabetical order)	**In-Network**	**Out-of-Network**
Abortion	Not covered	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Allergy Treatment (Injections)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Allergy Treatment (Serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Ambulance - Air Air Ambulance Allowable Option: Unlimited (No Cost Sharing) Benefit	20% Coinsurance after Deductible	20% Coinsurance after In-Network Deductible
Ambulance - Ground Ground Ambulance Allowable Option: 150% of Medicare	20% Coinsurance after Deductible	20% Coinsurance after In-Network Deductible
Assisted Reproductive Services	Not covered	Not covered
Autism Services, including ABA Therapy Autism Services Coverage: Mandated Services Autism Services Limits: Mandated Limits	Covered	Covered
BDC+ Surgery	Not covered	Not covered
Bariatric	Not covered	Not covered
Chiropractic Services Office Visit	Same as Specialist Office Visit Cost Shares	Same as Specialist Office Visit Cost Shares
Diabetic Equipment and Supplies Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diabetic Footwear	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diabetic Self Management Education/Training (DSMT)	No member cost share	40% Coinsurance after Deductible
Durable Medical Equipment (DME) Prior Authorization Policy Applies No Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$200 Copay/Visit, then Deductible then 20% Coinsurance	$200 Copay/Visit, then In-Network Deductible then 20% Coinsurance
Food and Food Products for PKU No Limits	Covered	Covered

Foot Orthotics	Not covered	Not covered
Gender Dysphoria Treatment Prior Authorization Policy Applies	Covered	Covered
Hearing Aids	Not covered	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Health Care Prior Authorization Policy Applies Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Hospice	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Treatment Maximum benefit of $10,000/Lifetime for In-Network and Out-of-Network Impotency Coverage: Yes Infertility Coverage: Yes Pharmacy Coverage: Yes	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Hospice Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Physician Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Labs Performed in Office / Independent Lab	No member cost share	40% Coinsurance after Deductible
Maternity Dependent Daughters Maternity Covered?: Yes	Covered	Covered
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Inpatient Physician Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Office Visit	$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Facility Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Mental Health and Substance Abuse Services - Outpatient Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Organ Transplant Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider INN Tier 1 Cost Share Providers: Designated Providers OON Cost Share Providers: All Other Providers	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Chiropractic Office Visit (including Skeletal Manipulation) Prior Authorization Policy Applies Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Other Services Performed in Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Physician Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Surgery Prior Authorization Policy Applies Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Cardiac Therapy No Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Cognitive Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy Combined with Speech Therapy Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy Combined with Physical Therapy Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Pulmonary Therapy No Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Private Duty Nursing Combined with Home Health Care Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Routine Preventive Care Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	40% Coinsurance after Deductible
Skilled Nursing Facility (SNF) Prior Authorization Policy Applies	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network		
Temporomandibular Joint (TMJ) Surgery	Not covered	Not covered
Vision Exam-Routine Maximum benefit of 1 Exam(s)/Calendar Year for In-Network and Out-of-Network	$35 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Weight Management - Naturally Slim	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology Maximum benefit of $200/Day for Out-of-Network/Non-Participating/In-Area Provider	20% Coinsurance after Deductible	40% Coinsurance after Deductible

General Pharmacy Information

Pharmacy Network(s)	**Network 1:** National Plus	
Prescription Drug List Learn more about the drugs covered by your plan, drug category/tier, prior authorization and step therapy by reviewing your prescription drug list at MyBlueKC.com	National Preferred	
Outpatient Prescription Drug Deductible You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services.	**In-Network** Does Not Apply	**Out-of-Network** Does Not Apply
Outpatient Prescription Drug Out-of-Pocket Limits The Out-of-Pocket Limit is the most you could pay during the Calendar Year for your share of the cost of covered services.	**In-Network** Combined with Medical Out-of-Pocket	**Out-of-Network** Combined with Medical Out-of-Pocket
Maintenance Medication Program	Not applicable	
Generics Program	Not applicable	
Rx Savings Solutions A team of pharmacists and pharmacy technician will help you make sure you're getting the best possible pricing for your medicines. Member support is available Monday – Friday, 7.a.m. to 7.pm CST.	Register online at MyBlueKC.com and stay up-to-date on cost saving opportunities. **Email:** info@rxsavingsllc.com **PH:** 1-800-268-4476	

Plan Benefits – Pharmacy

	In-Network	**Out-of-Network**
Retail Pharmacy (Short-term supply: Up to 34 Days**)** **Drug Tier 1:** Generic / Generic Specialty	**National Plus:** $12 Copay/Fill	$12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**National Plus:** $55 Copay/Fill	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**National Plus:** $75 Copay/Fill	$75 Copay/Fill, then 50% Coinsurance

Mail Order Pharmacy **Drug Tier 1:** Generic / Generic Specialty	$36 Copay/Fill	$36 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	$165 Copay/Fill	$165 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	$225 Copay/Fill	$225 Copay/Fill, then 50% Coinsurance
Infertility and Impotency Drugs **Drug Tier 1:** Generic / Generic Specialty	**National Plus:** $12 Copay/Fill, then 50% Coinsurance	$12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**National Plus:** $55 Copay/Fill, then 50% Coinsurance	$55 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**National Plus:** $75 Copay/Fill, then 50% Coinsurance	$75 Copay/Fill, then 50% Coinsurance

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Kansas City

Retiree & Cobra Rate Confirmation

Preferred-Care Blue PPO $1,000 Plan Retiree	
Employee	**$835.44**
Employee & Spouse	**$1,921.40**
Employee & Spouse Two Eligible Medicare	**$1,696.91**
Employee & Child(ren)	**$1,562.26**
Family	**$2,631.54**

Preferred-Care Blue PPO $1,000 Plan Cobra	
Employee	**$852.15**
Employee & Spouse	**$1,959.81**
Employee & Child(ren)	**$1,593.51**
Family	**$2,684.17**

Preferred-Care Blue PPO $1,500 Plan Retiree	
Employee	**$789.73**
Employee & Spouse	**$1,816.30**
Employee & Spouse Two Eligible Medicare	**$1,603.80**
Employee & Child(ren)	**$1,476.84**
Family	**$2,487.59**

Preferred-Care Blue PPO $1,500 Plan Cobra	
Employee	**$805.54**
Employee & Spouse	**$1,852.63**
Employee & Child(ren)	**$1,506.38**
Family	**$2,537.34**

Preferred-Care Blue PPO $2,500 Plan Retiree	
Employee	**$702.36**
Employee & Spouse	**$1,615.31**
Employee & Spouse Two Eligible Medicare	**$1,431.92**
Employee & Child(ren)	**$1,313.42**
Family	**$2,212.32**

Preferred-Care Blue PPO $2,500 Plan Cobra	
Employee	**$716.41**
Employee & Spouse	**$1,647.62**
Employee & Child(ren)	**$1,339.69**
Family	**$2,256.57**

Preferred-Care Blue BlueSaver PPO Plan Retiree	
Employee	**$702.36**
Employee & Spouse	**$1,615.31**
Employee & Child(ren)	**$1,313.42**
Family	**$2,212.32**

Preferred-Care Blue BlueSaver PPO Plan Cobra	
Employee	**$716.41**
Employee & Spouse	**$1,647.62**
Employee & Child(ren)	**$1,339.69**
Family	**$2,256.57**

Confirmed by:
Raytown School District:

_____
Signature

_____
Title

_____
Date

Approved by:
Blue Cross and Blue Shield of Kansas City

_____
Signature

_____
Title

_____
Date