Kansas City

Confirmation of Coverage	
Group Name:	Jackson County
Offer Name:	2021 Renewal
Group Number:	31618000
State:	Missouri
Effective Date:	01/01/2021
Important Notes:	

Offer-Related Information	
A. General Information	
Contract Term:	12 Months
Subsequent Renewal Terms:	12 Months
Renewal Notification:	180 Days Preliminary; 120 Days Final
Annual Enrollment Period Start:	30 Days prior to Group Anniversary Date
Annual Enrollment Period End:	15 Days after Group Anniversary Date
Waiting Period:	See Attached
Eligibility Rule:	See Attached
Termination Rule:	Last day of month following termination
Leave of Absence Term:	Not applicable
Dependent Limiting Age:	26 Years
Dependent Limiting Age Termination:	EOY 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 Stipend:	$75,000
24-Hour Nurse Line:	Yes
Healthy Companion:	Yes
Virtual Care:	Yes
Livongo Program:	Yes

Genetic Testing:	Yes
APEA:	Yes
Rx Personal Medication Coach:	Yes
Rx Savings Solution:	Yes
Rx Carve-in Credits:	Yes Rx Carve-in Credit Level: Custom / $16.00 – PMPM
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.

HMO Plan (C6O3)
PPO Plan (C6O4)
QHDHP HSA without Spira Plan (C6O5)
EPO without Spira Plan (C6O6)
EPO HPN without Spira St. Lukes Plan (C6O7)
EPO with Spira Care Plan (C6UH)
QHDHP HSA with Spira Care Plan (C6UI)

Confirmed by: Jackson County

Signature

County Executive

Title

11/13/2020

Date

Accepted by Blue Cross and Blue Shield of Kansas City:

Signature

VP Underwriting

Title

10/26/20

Date

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Kansas City

Plan Information	
Group Name:	Jackson County
Plan Name:	HMO Plan
Group Number:	31618000
State:	Missouri
Effective Date:	01/01/2021
Important Notes:	
For Internal Use Only:	Package: 2201200488 XREF: C6O3 Medical: 2201410313 Rx: 0605150206
1. General Plan Information	
Benefit Period	Calendar Year
Funding	Cost Plus
Grandfathered Status	Non-Grandfathered
Consumer-Driven Health Plan (CDHP)	N/A
Spira Care Plan?	No
Religious Employer?	N/A
Classification of Eligible Employees	See Attached
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?	Yes
Are Same Sex Spouses Covered?	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Blue Connect	Blue Connect not included
Compass	Compass not included
2. Network	
Local Medical Network	Blue-Care
Out-of-Area Medical Network	BlueCard Excluded
Pharmacy	See Pharmacy (Sections 5 & 6)
3. Cost Sharing	

Medical Deductible - Calendar Year	In-Network	Out-of-Network
Individual	Does not apply	Does not apply
Family	Does not apply	Does not apply
Pharmacy Deductible	No Pharmacy Deductible	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	Not applicable	Does not apply
Plan Pays	100%	Does not apply
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	$3,500	Does not apply
Family	$8,750	Does not apply
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.	$30 Copay/Visit	Not covered
Retail Health Clinic	No member cost share	Not covered
Total Care 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 optometrists, psychologists and chiropractors.	$60 Copay/Visit	Not covered
Urgent Care Office Visit	$60 Copay/Visit	Not covered
Total Care Urgent Care Office Visit	Does not apply	Not applicable
Blue KC Virtual Care - Office Visit Virtual care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	$60 Copay/Visit	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	No member cost share	Not applicable
Designated Health Clinic	Does not apply	Not applicable

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
ABA Services ABA Services Age Limits: Mandated Limits ABA Services Hours Limits: Mandated Limits	Subject to Applicable Cost Shares	Not covered
Abortion	No member cost share	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	$100 Copay/Visit	Not covered
Allergy Treatment	No member cost share	Not covered
Ambulance - Air Air Ambulance Allowable Option: Billed Charges	No member cost share	No member cost share
Ambulance - Ground Ground Ambulance Allowable Option: Billed Charges	No member cost share	No member cost share
Assisted Reproductive Services	Not covered	Not covered
Autism-Related Services No limits	Subject to Applicable Cost Shares	Not covered
Bariatric Services	Not covered	Not covered
BDC+ Surgery	Not covered	Not covered
Chiropractic Services Office Visit	$60 Copay/Visit	Not covered
Cranial Remodeling Devices No limits Required to follow Blue KC Medical Policy?: Yes	No member cost share	Not covered
Dental Anesthesia Maximum age limit of 5 Years	Missouri/Kansas Default	Not covered
Diabetic Equipment and Supplies Prior Authorization Policy Applies In-Network	No member cost share	Not covered
Diabetic Footwear	No member cost share	Not covered
Diabetic Pump	Covered as Durable Medical Equipment (DME)	Not covered
Diabetic Self Management Education/Training (DSMT)	No member cost share	Not covered
Durable Medical Equipment (DME) Prior Authorization Policy Applies In-Network No limits	No member cost share	Not covered
Elective Male Sterilization	No member cost share	Not covered
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$300 Copay/Visit	$300 Copay/Visit
Food and Food Products for PKU No limits	Covered	Not covered
Foot Orthotics	Not covered	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Gender Dysphoria-Related Services Prior Authorization Policy Applies In-Network Gender Dysphoria Cost Shares Apply to Cosmetic Surgery: No Gender Dysphoria Cost Shares Apply to Non-Surgical Services: Yes Gender Dysphoria Cost Shares Apply to Reassignment Surgery: Yes	Subject to Applicable Cost Shares	Not covered
Hearing Aids	Not covered	Not covered
Hearing Aids - Bone Anchored Hearing Aids	Not covered	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies In-Network High Tech Radiology ER Copay Waiver Rule (when ER Copay also applies): High Tech Radiology Copay Waived	$250 Copay/Provider per Day	Not covered
Home Health Care Prior Authorization Policy Applies In-Network Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Home Hospice	No member cost share	Not covered
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Diagnosis & Treatment Infertility and impotency treatment limited $10,000 per Lifetime Impotency treatment pills: No limits Dollar Limitations include Pharmacy: Yes Impotency Drug Coverage: Yes Infertility Drug Coverage: Yes	No member cost share	Not covered
Inpatient Hospice Prior Authorization Policy Applies In-Network Maximum benefit of 14 Day(s)/Lifetime for In-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$200 Copay/Day Limited to $2,000 Copay Max per Calendar Year	Not covered
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies In-Network	$400 Copay/Day Limited to Inpatient/Outpatient $2,000 Copay Max per Calendar Year	Not covered
Inpatient Physician Services	No member cost share	Not covered
Labs Performed in Office / Independent Lab	No member cost share	Not covered
Maternity Dependent Daughters Maternity Covered?: Yes	Covered	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies In-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$400 Copay/Day Limited to $2,000 Copay Max per Calendar Year	Not covered
Mental Health and Substance Abuse Services - Inpatient Physician Services	No member cost share	Not covered
Mental Health and Substance Abuse Services - Office Visit	$30 Copay/Visit	Not covered
Mental Health and Substance Abuse Services - Outpatient Therapy in a Facility	No member cost share	Not covered
Mental Health and Substance Abuse Services - Outpatient Therapy in a Provider's Office	No member cost share	Not covered
Nutritional Counseling	Not covered	Not covered
Organ Transplant Services Prior Authorization Policy Applies In-Network	Subject to Applicable Cost Shares	Not covered
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Office	No member cost share	Not covered
Outpatient Physician Services	No member cost share	Not covered
Outpatient Surgery Prior Authorization Policy Applies In-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$400 Copay/Day Limited to $2,000 Copay Max per Calendar Year	Not covered
Outpatient Therapy - Cardiac Therapy No limits	No member cost share	Not covered
Outpatient Therapy - Cognitive Therapy	No member cost share	Not covered
Outpatient Therapy - Hearing Therapy in a Facility Combined with Hearing Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Hearing Therapy in a Provider's Office Combined with Speech Therapy Limits	No member cost share	Not covered
Outpatient Therapy - Occupational Therapy in a Facility Combined with Occupational Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Occupational Therapy in a Provider's Office Combined with Physical Therapy Limits	No member cost share	Not covered
Outpatient Therapy - Physical Therapy in a Facility Combined with Physical Therapy in a Provider's Office Limits	No member cost share	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Outpatient Therapy - Physical Therapy in a Provider's Office Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Outpatient Therapy - Pulmonary Therapy No limits	No member cost share	Not covered
Outpatient Therapy - Speech Therapy in a Facility Combined with Speech Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Speech Therapy in a Provider's Office Maximum benefit of 20 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Penile Prostheses/Implant	Not covered	Not covered
Private Duty Nursing Combined with Home Health Care Limits	No member cost share	Not covered
Routine Preventive Care Diabetes Prevention Program (DPP): Covered Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	Not covered
Skeletal Manipulation performed in a Chiropractic Office	No member cost share	Not covered
Skilled Nursing Facility (SNF) Prior Authorization Policy Applies In-Network Maximum benefit of 30 Day(s)/Calendar Year for In-Network	No member cost share	Not covered
Sports Physicals by a Physician	Not covered	Not covered
Temporomandibular Joint (TMJ) No limits TMJ Diagnosis and Surgical Treatment (for accidental injury, fracture, tumors): Yes TMJ Non-surgical Treatment: No TMJ Orthognathic Surgery: No	No member cost share	Not covered
Vision Exam-Routine	Not covered	Not covered
Vision Hardware	Not covered	Not covered
Weight Loss Drugs (see Pharmacy cost shares)	Not covered	Not covered
Weight Management - Naturally Slim	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology	No member cost share	Not covered
5. General Pharmacy Information		
Pharmacy Network(s)	**Network 1:** RxPremier	
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 on MyBlueKC.com	Blue KC Preferred Formulary	

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** Does not apply
Maintenance Medication Program	**Mail Service Member Select** – Member must make a choice of where to obtain their maintenance medications after two courtesy fills: long-term supply through Home Delivery or a short-term supply from a retail pharmacy.	
Generics Program	Not Applicable	
Copay Credit Accumulator Adjustment (CCAA): Specialty drug copay card dollars will not be included in your deductible and/or out-of-pocket limits. Only your true out-of-pocket costs will be applied to your deductible and/or out-of-pocket totals.	No	
Variable Copay Solution (VCS): When you use a drug copay card, Specialty prescription drugs may be subject to a new plan benefit cost share. This new cost share will not impact you or the price you pay.	No	
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 p.m. CST.	Register online at MyBlueKC.com and stay up-to-date on cost saving opportunities. **Email:** info@rxsavingsllc.com **PH:** 1-800-268-4476	

6. Plan Benefits – Pharmacy		
	In-Network	**Out-of-Network**
Retail Pharmacy (Short-term supply: Up to 34 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $12 Copay/Fill	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** 20% Coinsurance(Max: $100)	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** 50% Coinsurance(Max: $250)	Not covered
Retail Pharmacy (Long-term supply: Between 35-102 Days **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:**$36 Copay/Fill	Not covered

Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:**20% Coinsurance(Max: $200)	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:**50% Coinsurance(Max: $500)	Not covered
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	$24 Copay/Fill	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic	20% Coinsurance(Max: $200)	Not covered
Drug Tier 3: Non-Preferred Brand	50% Coinsurance(Max: $500)	Not covered
OTC Drugs (Retail Only) Prescription Required?: No OTC Drugs Retail (Short-Term) Day Supply Range: Up to 34 Days **OTC Drugs Smoking Cessation**	Not covered	Not Covered
OTC Drugs Gastrointestinal	$1 Copay/Fill	Not Covered
OTC Drugs Allergy	$1 Copay/Fill	Not Covered
Infertility and Impotency Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $12 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** 20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** 50% Coinsurance	Not covered
Infertility and Impotency Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $36 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** 20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** 50% Coinsurance	Not covered
Infertility and Impotency Drugs Mail Order Pharmacy **Drug Tier 1:** Generic	$24 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic	50% Coinsurance	Not covered
Drug Tier 3: Non-Preferred Brand	50% Coinsurance	Not covered
Weight Loss Drugs	Not covered	Not covered

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Kansas City

Plan Information	
Group Name:	Jackson County
Plan Name:	PPO Plan
Group Number:	31618000
State:	Missouri
Effective Date:	01/01/2021
Important Notes:	
For Internal Use Only:	Package: 2208260012 XREF: C6O4 Medical: 2208460539 Rx: 0605180624
1. General Plan Information	
Benefit Period	Calendar Year
Funding	Cost Plus
Grandfathered Status	Non-Grandfathered
Consumer-Driven Health Plan (CDHP)	N/A
Spira Care Plan?	No
Religious Employer?	N/A
Classification of Eligible Employees	See Attached
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?	Yes
Are Same Sex Spouses Covered?	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Blue Connect	Blue Connect not included
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 All INN & OON Cross Accum	**In-Network**	**Out-of-Network**
Individual	$1,000	$2,500
Family	$2,000	$4,500
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 All INN & OON Cross Accum The Out-of-Pocket limit includes all Deductibles, Coinsurance, and Copayments a member pays during the Benefit Period.	**In-Network**	**Out-of-Network**
Individual	$4,500	$8,500
Family	$9,000	$16,500
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.	$30 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Retail Health Clinic	No member cost share	40% Coinsurance after Deductible
Total Care 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 optometrists, psychologists and chiropractors.	$60 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Urgent Care Office Visit	$60 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Total Care Urgent Care Office Visit	Does not apply	Not applicable
Blue KC Virtual Care - Office Visit Virtual care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	$60 Copay/Visit, no Deductible	Not applicable

Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	20% Coinsurance after Deductible	Not applicable
Designated Health Clinic	Does not apply	Not applicable
Other Benefits (in alphabetical order)	**In-Network**	**Out-of-Network**
ABA Services ABA Services Age Limits: Mandated Limits ABA Services Hours Limits: Mandated Limits	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Abortion	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Acupuncture	Not covered	Not covered
Allergy Testing	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Allergy Treatment	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Ambulance - Air Air Ambulance Allowable Option: Billed Charges	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-Related Services No limits	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Bariatric Services	Not covered	Not covered
BDC+ Surgery	Not covered	Not covered
Chiropractic Services Office Visit	$60 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Cranial Remodeling Devices No limits Required to follow Blue KC Medical Policy?: Yes	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Dental Anesthesia Maximum age limit of 5 Years	Missouri/Kansas Default	Missouri/Kansas Default
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 Pump	Covered as Durable Medical Equipment (DME)	Covered as Durable Medical Equipment (DME)
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
Elective Male Sterilization	No member cost share	40% Coinsurance after Deductible
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$250 Copay/Visit, then Deductible, then 20% Coinsurance	$250 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

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Gender Dysphoria-Related Services Prior Authorization Policy Applies Gender Dysphoria Cost Shares Apply to Cosmetic Surgery: No Gender Dysphoria Cost Shares Apply to Non-Surgical Services: Yes Gender Dysphoria Cost Shares Apply to Reassignment Surgery: Yes	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Hearing Aids	Not covered	Not covered
Hearing Aids - Bone Anchored Hearing Aids	Not covered	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies	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 Diagnosis & Treatment Infertility and impotency treatment limited $10,000 per Lifetime Impotency treatment pills: No limits Dollar Limitations include Pharmacy: Yes Impotency Drug Coverage: Yes Infertility Drug 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	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	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	$30 Copay/Visit, no Deductible	40% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Therapy in a Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Mental Health and Substance Abuse Services - Outpatient Therapy in a Provider's Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Nutritional Counseling	Not covered	Not covered
Organ Transplant Services Prior Authorization Policy Applies	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Organ Transplant Travel Expenses	Not covered	Not covered
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	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 in a Facility Combined with Hearing Therapy in a Provider's Office Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy in a Provider's Office Combined with Speech Therapy Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy in a Facility Combined with Occupational Therapy in a Provider's Office Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy in a Provider's Office Combined with Physical Therapy Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Physical Therapy in a Facility Combined with Physical Therapy in a Provider's Office Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Physical Therapy in a Provider's Office 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 in a Facility Combined with Speech Therapy in a Provider's Office Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Therapy - Speech Therapy in a Provider's Office Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Penile Prostheses/Implant	Not covered	Not covered
Private Duty Nursing Combined with Home Health Care Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Routine Preventive Care Diabetes Prevention Program (DPP): Covered Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	40% Coinsurance after Deductible
Skeletal Manipulation performed in a Chiropractic Office Prior Authorization Policy Applies Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Skilled Nursing Facility (SNF) Prior Authorization Policy Applies Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Sports Physicals by a Physician	Not covered	Not covered
Temporomandibular Joint (TMJ) No limits TMJ Diagnosis and Surgical Treatment (for accidental injury, fracture, tumors): Yes TMJ Non-surgical Treatment: No TMJ Orthognathic Surgery: No	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Vision Exam-Routine	Not covered	Not covered
Vision Hardware	Not covered	Not covered
Weight Loss Drugs (see Pharmacy cost shares)	Not covered	Not covered
Weight Management - Naturally Slim	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology	20% Coinsurance after Deductible	40% Coinsurance after Deductible
5. General Pharmacy Information		
Pharmacy Network(s)	**Network 1:** RxPremier	
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 on MyBlueKC.com	Blue KC Preferred Formulary	
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	**Mail Service Member Select** – Member must make a choice of where to obtain their maintenance medications after two courtesy fills: long-term supply through Home Delivery or a short-term supply from a retail pharmacy.
Generics Program	Not Applicable
Copay Credit Accumulator Adjustment (CCAA): Specialty drug copay card dollars will not be included in your deductible and/or out-of-pocket limits. Only your true out-of-pocket costs will be applied to your deductible and/or out-of-pocket totals.	No
Variable Copay Solution (VCS): When you use a drug copay card, Specialty prescription drugs may be subject to a new plan benefit cost share. This new cost share will not impact you or the price you pay.	No
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 p.m. CST.	Register online at MyBlueKC.com and stay up-to-date on cost saving opportunities. **Email:** info@rxsavingsllc.com **PH:** 1-800-268-4476

6. Plan Benefits – Pharmacy		
	In-Network	**Out-of-Network**
Retail Pharmacy (Short-term supply: Up to 34 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $12 Copay/Fill	$12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** 20% Coinsurance(Max: $100)	20% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** 50% Coinsurance(Max: $250)	50% Coinsurance
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	$24 Copay/Fill	$24 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic	20% Coinsurance(Max: $200)	20% Coinsurance
Drug Tier 3: Non-Preferred Brand	50% Coinsurance(Max: $500)	50% Coinsurance
OTC Drugs (Retail Only) Prescription Required?: No OTC Drugs Retail (Short-Term) Day Supply Range: Up to 34 Days **OTC Drugs Smoking Cessation**	Not covered	Not applicable
OTC Drugs Gastrointestinal	$1 Copay/Fill	Not applicable
OTC Drugs Allergy	$1 Copay/Fill	Not applicable

Infertility and Impotency Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $12 Copay/Fill, then 50% Coinsurance	$12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** 20% Coinsurance	50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** 50% Coinsurance	50% Coinsurance
Infertility and Impotency Drugs Mail Order Pharmacy **Drug Tier 1:** Generic	$24 Copay/Fill, then 50% Coinsurance	$24 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic	20% Coinsurance	50% Coinsurance
Drug Tier 3: Non-Preferred Brand	50% Coinsurance	50% Coinsurance
Weight Loss Drugs	Not covered	Not covered

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Kansas City

Plan Information	
Group Name:	Jackson County
Plan Name:	QHDHP HSA without Spira Plan
Group Number:	31618000
State:	Missouri
Effective Date:	01/01/2021
Important Notes:	
For Internal Use Only:	Package: 2230460611 XREF: C6O5 Medical: 2231070588 Rx: 0605040484
1. General Plan Information	
Benefit Period	Calendar Year
Funding	Cost Plus
Grandfathered Status	Non-Grandfathered
Consumer-Driven Health Plan (CDHP)	HSA
Spira Care Plan?	No
Religious Employer?	N/A
Classification of Eligible Employees	See Attached
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?	Yes
Are Same Sex Spouses Covered?	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Blue Connect	Blue Connect not included
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 All INN & OON Cross Accum	**In-Network**	**Out-of-Network**
Individual	$2,800	$2,800
Family	$5,600	$5,600
Pharmacy Deductible	Combined with Medical	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	0%	20%
Plan Pays	100%	80%
Out-of-Pocket Limit - Calendar Year, Embedded All INN & OON Cross Accum The Out-of-Pocket limit includes all Deductibles, Coinsurance, and Copayments a member pays during the Benefit Period.	**In-Network**	**Out-of-Network**
Individual	$2,800	$5,600
Family	$5,600	$11,200
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.	Deductible, then no charge	20% Coinsurance after Deductible
Retail Health Clinic	Deductible, then no charge	20% Coinsurance after Deductible
Total Care 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 optometrists, psychologists and chiropractors.	Deductible, then no charge	20% Coinsurance after Deductible
Urgent Care Office Visit	Deductible, then no charge	20% Coinsurance after Deductible
Total Care Urgent Care Office Visit	Does not apply	Not applicable
Blue KC Virtual Care - Office Visit Virtual care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	Deductible, then no charge	Not applicable

Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	Deductible, then no charge	Not applicable
Designated Health Clinic	Does not apply	Not applicable
Other Benefits (in alphabetical order)	**In-Network**	**Out-of-Network**
ABA Services ABA Services Age Limits: Mandated Limits ABA Services Hours Limits: Mandated Limits	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Abortion	Deductible, then no charge	20% Coinsurance after Deductible
Acupuncture	Not covered	Not covered
Allergy Testing	Deductible, then no charge	20% Coinsurance after Deductible
Allergy Treatment	Deductible, then no charge	20% Coinsurance after Deductible
Ambulance - Air Air Ambulance Allowable Option: Billed Charges	Deductible, then no charge	In-Network Deductible, then no charge
Ambulance - Ground Ground Ambulance Allowable Option: 150% of Medicare	Deductible, then no charge	In-Network Deductible, then no charge
Assisted Reproductive Services	Not covered	Not covered
Autism-Related Services No limits	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Bariatric Services	Not covered	Not covered
BDC+ Surgery	Not covered	Not covered
Chiropractic Services Office Visit	Deductible, then no charge	20% Coinsurance after Deductible
Cranial Remodeling Devices No limits Required to follow Blue KC Medical Policy?: Yes	Deductible, then no charge	20% Coinsurance after Deductible
Dental Anesthesia Maximum age limit of 5 Years	Missouri/Kansas Default	Missouri/Kansas Default
Diabetic Equipment and Supplies Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
Diabetic Footwear	Deductible, then no charge	20% Coinsurance after Deductible
Diabetic Pump	Covered as Durable Medical Equipment (DME)	Covered as Durable Medical Equipment (DME)
Diabetic Self Management Education/Training (DSMT)	Deductible, then no charge	20% Coinsurance after Deductible
Durable Medical Equipment (DME) Prior Authorization Policy Applies No limits	Deductible, then no charge	20% Coinsurance after Deductible
Elective Male Sterilization	Deductible, then no charge	20% Coinsurance after Deductible
Emergency Services	Deductible, then no charge	In-Network Deductible, then no charge
Food and Food Products for PKU No limits	Covered	Covered
Foot Orthotics	Not covered	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Gender Dysphoria-Related Services Prior Authorization Policy Applies Gender Dysphoria Cost Shares Apply to Cosmetic Surgery: No Gender Dysphoria Cost Shares Apply to Non-Surgical Services: Yes Gender Dysphoria Cost Shares Apply to Reassignment Surgery: Yes	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Hearing Aids	Not covered	Not covered
Hearing Aids - Bone Anchored Hearing Aids	Not covered	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies	Deductible, then no charge	20% 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	Deductible, then no charge	20% Coinsurance after Deductible
Home Hospice	Deductible, then no charge	20% Coinsurance after Deductible
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Diagnosis & Treatment Infertility and impotency treatment limited $10,000 per Lifetime Impotency treatment pills: No limits Dollar Limitations include Pharmacy: Yes Impotency Drug Coverage: Yes Infertility Drug Coverage: Yes	Deductible, then no charge	20% Coinsurance after Deductible
Inpatient Hospice Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
Inpatient Physician Services	Deductible, then no charge	20% Coinsurance after Deductible
Labs Performed in Office / Independent Lab	Deductible, then no charge	20% 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	Deductible, then no charge	20% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Inpatient Physician Services	Deductible, then no charge	20% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Office Visit	Deductible, then no charge	20% Coinsurance after Deductible
Mental Health and Substance Abuse Services - Outpatient Therapy in a Facility	Deductible, then no charge	20% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Mental Health and Substance Abuse Services - Outpatient Therapy in a Provider's Office	Deductible, then no charge	20% Coinsurance after Deductible
Nutritional Counseling	Not covered	Not covered
Organ Transplant Services Prior Authorization Policy Applies	Subject to Applicable Cost Shares	Subject to Applicable Cost Shares
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Office	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Physician Services	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Surgery Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Cardiac Therapy No limits	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Cognitive Therapy	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy in a Facility Combined with Hearing Therapy in a Provider's Office Limits	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Hearing Therapy in a Provider's Office Combined with Speech Therapy Limits	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy in a Facility Combined with Occupational Therapy in a Provider's Office Limits	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Occupational Therapy in a Provider's Office Combined with Physical Therapy Limits	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Physical Therapy in a Facility Combined with Physical Therapy in a Provider's Office Limits	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Physical Therapy in a Provider's Office Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Pulmonary Therapy No limits	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Speech Therapy in a Facility Combined with Speech Therapy in a Provider's Office Limits	Deductible, then no charge	20% Coinsurance after Deductible
Outpatient Therapy - Speech Therapy in a Provider's Office Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
Penile Prostheses/Implant	Not covered	Not covered
Private Duty Nursing Combined with Home Health Care Limits	Deductible, then no charge	20% Coinsurance after Deductible

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Routine Preventive Care Diabetes Prevention Program (DPP): Covered Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	20% Coinsurance after Deductible
Skeletal Manipulation performed in a Chiropractic Office Prior Authorization Policy Applies Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
Skilled Nursing Facility (SNF) Prior Authorization Policy Applies Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
Sports Physicals by a Physician	Not covered	Not covered
Temporomandibular Joint (TMJ) No limits TMJ Diagnosis and Surgical Treatment (for accidental injury, fracture, tumors): Yes TMJ Non-surgical Treatment: No TMJ Orthognathic Surgery: No	Deductible, then no charge	20% Coinsurance after Deductible
Vision Exam-Routine	Not covered	Not covered
Vision Hardware	Not covered	Not covered
Weight Loss Drugs (see Pharmacy cost shares)	Not covered	Not covered
Weight Management - Naturally Slim	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology	Deductible, then no charge	20% Coinsurance after Deductible
5. General Pharmacy Information		
Pharmacy Network(s)	**Network 1:** RxPremier	
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 on MyBlueKC.com	Blue KC Preferred Formulary	
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	**Mail Service Member Select** – Member must make a choice of where to obtain their maintenance medications after two courtesy fills: long-term supply through Home Delivery or a short-term supply from a retail pharmacy.
Generics Program	Not Applicable
Copay Credit Accumulator Adjustment (CCAA): Specialty drug copay card dollars will not be included in your deductible and/or out-of-pocket limits. Only your true out-of-pocket costs will be applied to your deductible and/or out-of-pocket totals.	No
Variable Copay Solution (VCS): When you use a drug copay card, Specialty prescription drugs may be subject to a new plan benefit cost share. This new cost share will not impact you or the price you pay.	No
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 p.m. CST.	Register online at MyBlueKC.com and stay up-to-date on cost saving opportunities. **Email:** info@rxsavingsllc.com **PH:** 1-800-268-4476

6. Plan Benefits – Pharmacy		
	In-Network	**Out-of-Network**
Retail Pharmacy (Short-term supply: Up to 34 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 20% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 50% Coinsurance
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) Drug Tier 1: Generic	Deductible, then no charge	Deductible, then $24 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic	Deductible, then no charge	Deductible, then 20% Coinsurance
Drug Tier 3: Non-Preferred Brand	Deductible, then no charge	Deductible, then 50% Coinsurance
Preventive Drugs Retail Drug Tier 1: Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Retail Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 20% Coinsurance
Retail Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 50% Coinsurance

Mail Order Drug Tier 1: Generic / Generic Specialty	Deductible, then no charge	Deductible, then $24 Copay/Fill, then 50% Coinsurance
Mail Order Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	Deductible, then no charge	Deductible, then 20% Coinsurance
Mail Order Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	Deductible, then no charge	Deductible, then 50% Coinsurance
OTC Drugs (Retail Only) Prescription Required?: No OTC Drugs Retail (Short-Term) Day Supply Range: Up to 34 Days **OTC Drugs Smoking Cessation**	Not covered	Not applicable
OTC Drugs Gastrointestinal	Deductible, then no charge	Not applicable
OTC Drugs Allergy	Deductible, then no charge	Not applicable
Infertility and Impotency Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Deductible, then $12 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** Deductible, then no charge	Deductible, then 50% Coinsurance
Infertility and Impotency Drugs Mail Order Pharmacy **Drug Tier 1:** Generic	Deductible, then no charge	Deductible, then $24 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred Brand / Non-Preferred Generic	Deductible, then no charge	Deductible, then 50% Coinsurance
Drug Tier 3: Non-Preferred Brand	Deductible, then no charge	Deductible, then 50% Coinsurance
Weight Loss Drugs	Not covered	Not covered

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Kansas City

Plan Information	
Group Name:	Jackson County
Plan Name:	EPO without Spira Plan
Group Number:	31618000
State:	Missouri
Effective Date:	01/01/2021
Important Notes:	
For Internal Use Only:	Package: 2236170927 XREF: C6O6 Medical: 2236380796 Rx: 0605030610
1. General Plan Information	
Benefit Period	Calendar Year
Funding	Cost Plus
Grandfathered Status	Non-Grandfathered
Consumer-Driven Health Plan (CDHP)	N/A
Spira Care Plan?	No
Religious Employer?	N/A
Classification of Eligible Employees	See Attached
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?	Yes
Are Same Sex Spouses Covered?	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Blue Connect	Blue Connect not included
Compass	Compass not included
2. Network	
Local Medical Network	BlueSelect Plus
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	$0	Does not apply
Family	$0	Does not apply
Pharmacy Deductible	No Pharmacy Deductible	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	Not applicable	Does not apply
Plan Pays	100%	Does not apply
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	$3,500	Does not apply
Family	$8,750	Does not apply
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.	$30 Copay/Visit	Not covered
Retail Health Clinic	No member cost share	Not covered
Total Care 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 optometrists, psychologists and chiropractors.	$60 Copay/Visit	Not covered
Urgent Care Office Visit	$60 Copay/Visit	Not covered
Total Care Urgent Care Office Visit	Does not apply	Not applicable
Blue KC Virtual Care - Office Visit Virtual care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	$60 Copay/Visit	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	No member cost share	Not applicable
Designated Health Clinic	Does not apply	Not applicable

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
ABA Services ABA Services Age Limits: Mandated Limits ABA Services Hours Limits: Mandated Limits	Subject to Applicable Cost Shares	Not covered
Abortion	No member cost share	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	$100 Copay/Visit	Not covered
Allergy Treatment	No member cost share	Not covered
Ambulance - Air Air Ambulance Allowable Option: Billed Charges	No member cost share	No member cost share
Ambulance - Ground Ground Ambulance Allowable Option: Billed Charges	No member cost share	No member cost share
Assisted Reproductive Services	Not covered	Not covered
Autism-Related Services No limits	Subject to Applicable Cost Shares	Not covered
Bariatric Services	Not covered	Not covered
BDC+ Surgery	Not covered	Not covered
Chiropractic Services Office Visit	$60 Copay/Visit	Not covered
Cranial Remodeling Devices No limits Required to follow Blue KC Medical Policy?: Yes	No member cost share	Not covered
Dental Anesthesia Maximum age limit of 5 Years	Missouri/Kansas Default	Not covered
Diabetic Equipment and Supplies Prior Authorization Policy Applies In-Network	No member cost share	Not covered
Diabetic Footwear	No member cost share	Not covered
Diabetic Pump	Covered as Durable Medical Equipment (DME)	Not covered
Diabetic Self Management Education/Training (DSMT)	No member cost share	Not covered
Durable Medical Equipment (DME) Prior Authorization Policy Applies In-Network No limits	No member cost share	Not covered
Elective Male Sterilization	No member cost share	Not covered
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$300 Copay/Visit	$300 Copay/Visit, no Deductible
Food and Food Products for PKU No limits	Covered	Not covered
Foot Orthotics	Not covered	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Gender Dysphoria-Related Services Prior Authorization Policy Applies In-Network Gender Dysphoria Cost Shares Apply to Cosmetic Surgery: No Gender Dysphoria Cost Shares Apply to Non-Surgical Services: Yes Gender Dysphoria Cost Shares Apply to Reassignment Surgery: Yes	Subject to Applicable Cost Shares	Not covered
Hearing Aids	Not covered	Not covered
Hearing Aids - Bone Anchored Hearing Aids	Not covered	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies In-Network High Tech Radiology ER Copay Waiver Rule (when ER Copay also applies): High Tech Radiology Copay Waived	$250 Copay/Provider per Day	Not covered
Home Health Care Prior Authorization Policy Applies In-Network Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Home Hospice	No member cost share	Not covered
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Diagnosis & Treatment Infertility and impotency treatment limited $10,000 per Lifetime Impotency treatment pills: No limits Dollar Limitations include Pharmacy: Yes Impotency Drug Coverage: Yes Infertility Drug Coverage: Yes	No member cost share	Not covered
Inpatient Hospice Prior Authorization Policy Applies In-Network Maximum benefit of 14 Day(s)/Lifetime for In-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$200 Copay/Day Limited to $2,000 Copay Max per Calendar Year	Not covered
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies In-Network	$400 Copay/Day Limited to Inpatient/Outpatient $2,000 Copay Max per Calendar Year	Not covered
Inpatient Physician Services	No member cost share	Not covered
Labs Performed in Office / Independent Lab	No member cost share	Not covered
Maternity Dependent Daughters Maternity Covered?: Yes	Covered	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies In-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$400 Copay/Day Limited to $2,000 Copay Max per Calendar Year	Not covered
Mental Health and Substance Abuse Services - Inpatient Physician Services	No member cost share	Not covered
Mental Health and Substance Abuse Services - Office Visit	$30 Copay/Visit	Not covered
Mental Health and Substance Abuse Services - Outpatient Therapy in a Facility	No member cost share	Not covered
Mental Health and Substance Abuse Services - Outpatient Therapy in a Provider's Office	No member cost share	Not covered
Nutritional Counseling	Not covered	Not covered
Organ Transplant Services Prior Authorization Policy Applies In-Network	Subject to Applicable Cost Shares	Not covered
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Office	No member cost share	Not covered
Outpatient Physician Services	No member cost share	Not covered
Outpatient Surgery Prior Authorization Policy Applies In-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$400 Copay/Day Limited to $2,000 Copay Max per Calendar Year	Not covered
Outpatient Therapy - Cardiac Therapy No limits	No member cost share	Not covered
Outpatient Therapy - Cognitive Therapy	No member cost share	Not covered
Outpatient Therapy - Hearing Therapy in a Facility Combined with Hearing Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Hearing Therapy in a Provider's Office Combined with Speech Therapy Limits	No member cost share	Not covered
Outpatient Therapy - Occupational Therapy in a Facility Combined with Occupational Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Occupational Therapy in a Provider's Office Combined with Physical Therapy Limits	No member cost share	Not covered
Outpatient Therapy - Physical Therapy in a Facility Combined with Physical Therapy in a Provider's Office Limits	No member cost share	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Outpatient Therapy - Physical Therapy in a Provider's Office Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Outpatient Therapy - Pulmonary Therapy No limits	No member cost share	Not covered
Outpatient Therapy - Speech Therapy in a Facility Combined with Speech Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Speech Therapy in a Provider's Office Maximum benefit of 20 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Penile Prostheses/Implant	Not covered	Not covered
Private Duty Nursing Combined with Home Health Care Limits	No member cost share	Not covered
Routine Preventive Care Diabetes Prevention Program (DPP): Covered Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	Not covered
Skeletal Manipulation performed in a Chiropractic Office	No member cost share	Not covered
Skilled Nursing Facility (SNF) Prior Authorization Policy Applies In-Network Maximum benefit of 30 Day(s)/Calendar Year for In-Network	No member cost share	Not covered
Sports Physicals by a Physician	Not covered	Not covered
Temporomandibular Joint (TMJ) No limits TMJ Diagnosis and Surgical Treatment (for accidental injury, fracture, tumors): Yes TMJ Non-surgical Treatment: No TMJ Orthognathic Surgery: No	No member cost share	Not covered
Vision Exam-Routine	Not covered	Not covered
Vision Hardware	Not covered	Not covered
Weight Loss Drugs (see Pharmacy cost shares)	Not covered	Not covered
Weight Management - Naturally Slim	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology	No member cost share	Not covered
5. General Pharmacy Information		
Pharmacy Network(s)	**Network 1:** RxPremier	
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 on MyBlueKC.com	Blue KC Preferred Formulary	

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** Does not apply
Maintenance Medication Program	**Mail Service Member Select** – Member must make a choice of where to obtain their maintenance medications after two courtesy fills: long-term supply through Home Delivery or a short-term supply from a retail pharmacy.	
Generics Program	Not Applicable	
Copay Credit Accumulator Adjustment (CCAA): Specialty drug copay card dollars will not be included in your deductible and/or out-of-pocket limits. Only your true out-of-pocket costs will be applied to your deductible and/or out-of-pocket totals.	No	
Variable Copay Solution (VCS): When you use a drug copay card, Specialty prescription drugs may be subject to a new plan benefit cost share. This new cost share will not impact you or the price you pay.	No	
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 p.m. CST.	Register online at MyBlueKC.com and stay up-to-date on cost saving opportunities. **Email:** info@rxsavingsllc.com **PH:** 1-800-268-4476	

6. Plan Benefits – Pharmacy		
	In-Network	**Out-of-Network**
Retail Pharmacy (Short-term supply: Up to 34 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $12 Copay/Fill	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** 20% Coinsurance(Max: $100)	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** 50% Coinsurance(Max: $250)	Not covered
Retail Pharmacy (Long-term supply: Between 35-102 Days **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:**$36 Copay/Fill	Not covered

Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:**20% Coinsurance(Max: $200)	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:**50% Coinsurance(Max: $500)	Not covered
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	$24 Copay/Fill	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic	20% Coinsurance(Max: $200)	Not covered
Drug Tier 3: Non-Preferred Brand	50% Coinsurance(Max: $500)	Not covered
OTC Drugs (Retail Only) Prescription Required?: No OTC Drugs Retail (Short-Term) Day Supply Range: Up to 34 Days **OTC Drugs Smoking Cessation**	Not covered	Not Covered
OTC Drugs Gastrointestinal	$1 Copay/Fill	Not Covered
OTC Drugs Allergy	$1 Copay/Fill	Not Covered
Infertility and Impotency Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $12 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** 20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** 50% Coinsurance	Not covered
Infertility and Impotency Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $36 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** 20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** 50% Coinsurance	Not covered
Infertility and Impotency Drugs Mail Order Pharmacy **Drug Tier 1:** Generic	$24 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic	20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred Brand	50% Coinsurance	Not covered
Weight Loss Drugs	Not covered	Not covered

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Kansas City

Plan Information	
Group Name:	Jackson County
Plan Name:	EPO HPN without Spira St. Lukes Plan
Group Number:	31618000
State:	Missouri
Effective Date:	01/01/2021
Important Notes:	
For Internal Use Only:	Package: 2243420673 XREF: C6O7 Medical: 2244040622 Rx: 0754400238
1. General Plan Information	
Benefit Period	Calendar Year
Funding	Cost Plus
Grandfathered Status	Non-Grandfathered
Consumer-Driven Health Plan (CDHP)	N/A
Spira Care Plan?	No
Religious Employer?	N/A
Classification of Eligible Employees	See Attached
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?	Yes
Are Same Sex Spouses Covered?	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Blue Connect	Blue Connect not included
Compass	Compass not included
2. Network	
Local Medical Network	Blue High Performance Network
Out-of-Area Medical Network	BlueCard High Performance Network
Pharmacy	See Pharmacy (Sections 5 & 6)
3. Cost Sharing	

Medical Deductible - Calendar Year, Embedded	In-Network	Out-of-Network
Individual	$0	Does not apply
Family	$0	Does not apply
Pharmacy Deductible	No Pharmacy Deductible	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	Not applicable	Does not apply
Plan Pays	100%	Does not apply
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	$3,500	Does not apply
Family	$8,750	Does not apply
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.	$30 Copay/Visit	Not covered
Retail Health Clinic	No member cost share	Not covered
Total Care 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 optometrists, psychologists and chiropractors.	$60 Copay/Visit	Not covered
Urgent Care Office Visit	$60 Copay/Visit	Not covered
Total Care Urgent Care Office Visit	Does not apply	Not applicable
Blue KC Virtual Care - Office Visit Virtual care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	$60 Copay/Visit	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	No member cost share	Not applicable
Designated Health Clinic	Does not apply	Not applicable

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
ABA Services ABA Services Age Limits: Mandated Limits ABA Services Hours Limits: Mandated Limits	Subject to Applicable Cost Shares	Not covered
Abortion	No member cost share	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	$100 Copay/Visit	Not covered
Allergy Treatment	No member cost share	Not covered
Ambulance - Air Air Ambulance Allowable Option: Billed Charges	No member cost share	No member cost share
Ambulance - Ground Ground Ambulance Allowable Option: Billed Charges	No member cost share	No member cost share
Assisted Reproductive Services	Not covered	Not covered
Autism-Related Services No limits	Subject to Applicable Cost Shares	Not covered
Bariatric Services	Not covered	Not covered
BDC+ Surgery	Not covered	Not covered
Chiropractic Services Office Visit	$60 Copay/Visit	Not covered
Cranial Remodeling Devices No limits Required to follow Blue KC Medical Policy?: Yes	No member cost share	Not covered
Dental Anesthesia Maximum age limit of 5 Years	Missouri/Kansas Default	Not covered
Diabetic Equipment and Supplies Prior Authorization Policy Applies In-Network	No member cost share	Not covered
Diabetic Footwear	No member cost share	Not covered
Diabetic Pump	Covered as Durable Medical Equipment (DME)	Not covered
Diabetic Self Management Education/Training (DSMT)	No member cost share	Not covered
Durable Medical Equipment (DME) Prior Authorization Policy Applies In-Network No limits	No member cost share	Not covered
Elective Male Sterilization	No member cost share	Not covered
Emergency Services Copay Waiver Rule: Copay Waived if Admitted	$300 Copay/Visit	$300 Copay/Visit, no Deductible
Food and Food Products for PKU No limits	Covered	Not covered
Foot Orthotics	Not covered	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Gender Dysphoria-Related Services Prior Authorization Policy Applies In-Network Gender Dysphoria Cost Shares Apply to Cosmetic Surgery: No Gender Dysphoria Cost Shares Apply to Non-Surgical Services: Yes Gender Dysphoria Cost Shares Apply to Reassignment Surgery: Yes	Subject to Applicable Cost Shares	Not covered
Hearing Aids	Not covered	Not covered
Hearing Aids - Bone Anchored Hearing Aids	Not covered	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies In-Network High Tech Radiology ER Copay Waiver Rule (when ER Copay also applies): High Tech Radiology Copay Waived	$250 Copay/Provider per Day	Not covered
Home Health Care Prior Authorization Policy Applies In-Network Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Home Hospice	No member cost share	Not covered
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Diagnosis & Treatment Infertility and impotency treatment limited $10,000 per Lifetime Impotency treatment pills: No limits Dollar Limitations include Pharmacy: Yes Impotency Drug Coverage: Yes Infertility Drug Coverage: Yes	No member cost share	Not covered
Inpatient Hospice Prior Authorization Policy Applies In-Network Maximum benefit of 14 Day(s)/Lifetime for In-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$200 Copay/Day Limited to $2,000 Copay Max per Calendar Year	Not covered
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies In-Network	$400 Copay/Day Limited to Inpatient/Outpatient $2,000 Copay Max per Calendar Year	Not covered
Inpatient Physician Services	No member cost share	Not covered
Labs Performed in Office / Independent Lab	No member cost share	Not covered
Maternity Dependent Daughters Maternity Covered?: Yes	Covered	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies In-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$400 Copay/Day Limited to $2,000 Copay Max per Calendar Year	Not covered
Mental Health and Substance Abuse Services - Inpatient Physician Services	No member cost share	Not covered
Mental Health and Substance Abuse Services - Office Visit	$30 Copay/Visit	Not covered
Mental Health and Substance Abuse Services - Outpatient Therapy in a Facility	No member cost share	Not covered
Mental Health and Substance Abuse Services - Outpatient Therapy in a Provider's Office	No member cost share	Not covered
Nutritional Counseling	Not covered	Not covered
Organ Transplant Services Prior Authorization Policy Applies In-Network	Subject to Applicable Cost Shares	Not covered
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Office	No member cost share	Not covered
Outpatient Physician Services	No member cost share	Not covered
Outpatient Surgery Prior Authorization Policy Applies In-Network Copay Applies to Annual Inpatient/ Outpatient Copay Max?: Yes	$400 Copay/Day Limited to $2,000 Copay Max per Calendar Year	Not covered
Outpatient Therapy - Cardiac Therapy No limits	No member cost share	Not covered
Outpatient Therapy - Cognitive Therapy	No member cost share	Not covered
Outpatient Therapy - Hearing Therapy in a Facility Combined with Hearing Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Hearing Therapy in a Provider's Office Combined with Speech Therapy Limits	No member cost share	Not covered
Outpatient Therapy - Occupational Therapy in a Facility Combined with Occupational Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Occupational Therapy in a Provider's Office Combined with Physical Therapy Limits	No member cost share	Not covered
Outpatient Therapy - Physical Therapy in a Facility Combined with Physical Therapy in a Provider's Office Limits	No member cost share	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Outpatient Therapy - Physical Therapy in a Provider's Office Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Outpatient Therapy - Pulmonary Therapy No limits	No member cost share	Not covered
Outpatient Therapy - Speech Therapy in a Facility Combined with Speech Therapy in a Provider's Office Limits	No member cost share	Not covered
Outpatient Therapy - Speech Therapy in a Provider's Office Maximum benefit of 20 Visit(s)/Calendar Year for In-Network	No member cost share	Not covered
Penile Prostheses/Implant	Not covered	Not covered
Private Duty Nursing Combined with Home Health Care Limits	No member cost share	Not covered
Routine Preventive Care Diabetes Prevention Program (DPP): Covered Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	Not covered
Skeletal Manipulation performed in a Chiropractic Office	No member cost share	Not covered
Skilled Nursing Facility (SNF) Prior Authorization Policy Applies In-Network Maximum benefit of 30 Day(s)/Calendar Year for In-Network	No member cost share	Not covered
Sports Physicals by a Physician	Not covered	Not covered
Temporomandibular Joint (TMJ) No limits TMJ Diagnosis and Surgical Treatment (for accidental injury, fracture, tumors): Yes TMJ Non-surgical Treatment: No TMJ Orthognathic Surgery: No	No member cost share	Not covered
Vision Exam-Routine	Not covered	Not covered
Vision Hardware	Not covered	Not covered
Weight Loss Drugs (see Pharmacy cost shares)	Not covered	Not covered
Weight Management - Naturally Slim	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology	No member cost share	Not covered
5. General Pharmacy Information		
Pharmacy Network(s)	**Network 1:** RxPremier	
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 on MyBlueKC.com	Blue KC Preferred Formulary	

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** Does not apply
Maintenance Medication Program	**Mail Service Member Select** – Member must make a choice of where to obtain their maintenance medications after two courtesy fills: long-term supply through Home Delivery or a short-term supply from a retail pharmacy.	
Generics Program	Not Applicable	
Copay Credit Accumulator Adjustment (CCAA): Specialty drug copay card dollars will not be included in your deductible and/or out-of-pocket limits. Only your true out-of-pocket costs will be applied to your deductible and/or out-of-pocket totals.	No	
Variable Copay Solution (VCS): When you use a drug copay card, Specialty prescription drugs may be subject to a new plan benefit cost share. This new cost share will not impact you or the price you pay.	No	
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 p.m. CST.	Register online at MyBlueKC.com and stay up-to-date on cost saving opportunities. **Email:** info@rxsavingsllc.com **PH:** 1-800-268-4476	

6. Plan Benefits – Pharmacy		
	In-Network	**Out-of-Network**
Retail Pharmacy (Short-term supply: Up to 34 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $12 Copay/Fill	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** 20% Coinsurance(Max: $100)	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** 50% Coinsurance(Max: $250)	Not covered
Retail Pharmacy (Long-term supply: Between 35-102 Days **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:**$36 Copay/Fill	Not covered

Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:**20% Coinsurance(Max: $200)	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:**50% Coinsurance(Max: $500)	Not covered
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	$24 Copay/Fill	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic	20% Coinsurance(Max: $200)	Not covered
Drug Tier 3: Non-Preferred Brand	50% Coinsurance(Max: $500)	Not covered
OTC Drugs (Retail Only) Prescription Required?: No OTC Drugs Retail (Short-Term) Day Supply Range: Up to 34 Days **OTC Drugs Smoking Cessation**	Not covered	Not Covered
OTC Drugs Gastrointestinal	$1 Copay/Fill	Not Covered
OTC Drugs Allergy	$1 Copay/Fill	Not Covered
Infertility and Impotency Drugs Retail (Short-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $12 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** 20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** 50% Coinsurance	Not covered
Infertility and Impotency Drugs Retail (Long-term supply) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $36 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** 20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** 50% Coinsurance	Not covered
Infertility and Impotency Drugs Mail Order Pharmacy **Drug Tier 1:** Generic	$24 Copay/Fill, then 50% Coinsurance	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic	20% Coinsurance	Not covered
Drug Tier 3: Non-Preferred Brand	50% Coinsurance	Not covered
Weight Loss Drugs	Not covered	Not covered

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Kansas City

Plan Information	
Group Name:	Jackson County
Plan Name:	EPO with Spira Care Plan
Group Number:	31618000
State:	Missouri
Effective Date:	01/01/2021
Important Notes:	
For Internal Use Only:	Package: 0220050225 XREF: C6UH Medical: 0220540063 Rx: 0605020840
1. General Plan Information	
Benefit Period	Calendar Year
Funding	Cost Plus
Grandfathered Status	Non-Grandfathered
Consumer-Driven Health Plan (CDHP)	N/A
Spira Care Plan?	Yes No charge for services received from a designated Spira Care Center Provider. Treatment of work-related injury or illness is not covered under your Blue Cross and Blue Shield of Kansas City health benefit plan. Treatment of work-related injuries and illnesses is typically provided through your workers' compensation program. The Spira Care clinics are not participating providers under workers' compensation programs. Please reference your workers' compensation policies and procedures to direct your employees appropriately for work-related injuries.
Religious Employer?	N/A
Classification of Eligible Employees	See Attached
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?	Yes
Are Same Sex Spouses Covered?	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Blue Connect	Blue Connect not included
Compass	Compass not included

2. Network		
Local Medical Network	BlueSelect Plus	
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	$2,000	Does not apply
Family	$4,000	Does not apply
Pharmacy Deductible	Combined with Medical	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	Not applicable	Does not apply
Plan Pays	100%	Does not apply
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	$2,000	Does not apply
Family	$4,000	Does not apply
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.	Deductible, then no charge	Not covered
Retail Health Clinic	No member cost share	Not covered
Total Care 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 optometrists, psychologists and chiropractors.	Deductible, then no charge	Not covered
Urgent Care Office Visit	Deductible, then no charge	Not covered
Total Care Urgent Care Office Visit	Does not apply	Not applicable
Blue KC Virtual Care - Office Visit Virtual care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	No member cost share	Not applicable

Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	Deductible, then no charge	Not applicable
Designated Health Clinic	Does not apply	Not applicable
Other Benefits (in alphabetical order)	**In-Network**	**Out-of-Network**
ABA Services ABA Services Age Limits: Mandated Limits ABA Services Hours Limits: Mandated Limits	Subject to Applicable Cost Shares	Not covered
Abortion	Deductible, then no charge	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	Deductible, then no charge	Not covered
Allergy Treatment	Deductible, then no charge	Not covered
Ambulance - Air Air Ambulance Allowable Option: Billed Charges	Deductible, then no charge	In-Network Deductible, then no charge
Ambulance - Ground Ground Ambulance Allowable Option: 150% of Medicare	Deductible, then no charge	In-Network Deductible, then no charge
Assisted Reproductive Services	Not covered	Not covered
Autism-Related Services No limits	Subject to Applicable Cost Shares	Not covered
Bariatric Services	Not covered	Not covered
BDC+ Surgery	Not covered	Not covered
Chiropractic Services Office Visit	Deductible, then no charge	Not covered
Cranial Remodeling Devices No limits Required to follow Blue KC Medical Policy?: Yes	Deductible, then no charge	Not covered
Dental Anesthesia Maximum age limit of 5 Years	Missouri/Kansas Default	Not covered
Diabetic Equipment and Supplies Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Diabetic Footwear	Deductible, then no charge	Not covered
Diabetic Pump	Covered as Durable Medical Equipment (DME)	Not covered
Diabetic Self Management Education/Training (DSMT)	No member cost share	Not covered
Durable Medical Equipment (DME) Prior Authorization Policy Applies In-Network No limits	Deductible, then no charge	Not covered
Elective Male Sterilization	No member cost share	Not covered
Emergency Services	Deductible, then no charge	In-Network Deductible, then no charge
Food and Food Products for PKU No limits	Covered	Not covered
Foot Orthotics	Not covered	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Gender Dysphoria-Related Services Prior Authorization Policy Applies In-Network Gender Dysphoria Cost Shares Apply to Cosmetic Surgery: No Gender Dysphoria Cost Shares Apply to Non-Surgical Services: Yes Gender Dysphoria Cost Shares Apply to Reassignment Surgery: Yes	Subject to Applicable Cost Shares	Not covered
Hearing Aids	Not covered	Not covered
Hearing Aids - Bone Anchored Hearing Aids	Not covered	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Home Health Care Prior Authorization Policy Applies In-Network Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Home Hospice	Deductible, then no charge	Not covered
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Diagnosis & Treatment	Not covered	Not covered
Inpatient Hospice Prior Authorization Policy Applies In-Network Maximum benefit of 14 Day(s)/Lifetime for In-Network	Deductible, then no charge	Not covered
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Inpatient Physician Services	Deductible, then no charge	Not covered
Labs Performed in Office / Independent Lab	Deductible, then no charge	Not covered
Maternity Dependent Daughters Maternity Covered?: Yes	Covered	Not covered
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Mental Health and Substance Abuse Services - Inpatient Physician Services	Deductible, then no charge	Not covered
Mental Health and Substance Abuse Services - Office Visit	Deductible, then no charge	Not covered
Mental Health and Substance Abuse Services - Outpatient Therapy in a Facility	Deductible, then no charge	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Mental Health and Substance Abuse Services - Outpatient Therapy in a Provider's Office	Deductible, then no charge	Not covered
Nutritional Counseling	Not covered	Not covered
Organ Transplant Services Prior Authorization Policy Applies In-Network	Subject to Applicable Cost Shares	Not covered
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Office	Deductible, then no charge	Not covered
Outpatient Physician Services	Deductible, then no charge	Not covered
Outpatient Surgery Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Outpatient Therapy - Cardiac Therapy No limits	Deductible, then no charge	Not covered
Outpatient Therapy - Cognitive Therapy	Deductible, then no charge	Not covered
Outpatient Therapy - Hearing Therapy in a Facility Combined with Hearing Therapy in a Provider's Office Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Hearing Therapy in a Provider's Office Combined with Speech Therapy Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Occupational Therapy in a Facility Combined with Occupational Therapy in a Provider's Office Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Occupational Therapy in a Provider's Office Combined with Physical Therapy Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Physical Therapy in a Facility Combined with Physical Therapy in a Provider's Office Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Physical Therapy in a Provider's Office Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Outpatient Therapy - Pulmonary Therapy No limits	Deductible, then no charge	Not covered
Outpatient Therapy - Speech Therapy in a Facility Combined with Speech Therapy in a Provider's Office Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Speech Therapy in a Provider's Office Maximum benefit of 20 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Penile Prostheses/Implant	Not covered	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Private Duty Nursing Combined with Home Health Care Limits	Deductible, then no charge	Not covered
Routine Preventive Care Diabetes Prevention Program (DPP): Covered Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	Not covered
Skeletal Manipulation performed in a Chiropractic Office	Deductible, then no charge	Not covered
Skilled Nursing Facility (SNF) Prior Authorization Policy Applies In-Network Maximum benefit of 30 Day(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Sports Physicals by a Physician	Not covered	Not covered
Temporomandibular Joint (TMJ) No limits TMJ Diagnosis and Surgical Treatment (for accidental injury, fracture, tumors): Yes TMJ Non-surgical Treatment: No TMJ Orthognathic Surgery: No	Deductible, then no charge	Not covered
Vision Exam-Routine	Not covered	Not covered
Vision Hardware	Not covered	Not covered
Weight Loss Drugs (see Pharmacy cost shares)	Not covered	Not covered
Weight Management - Naturally Slim	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology	Deductible, then no charge	Not covered

5. General Pharmacy Information		
Pharmacy Network(s)	**Network 1:** RxPremier	
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 on MyBlueKC.com	Blue KC Preferred Formulary	
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** 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** Does not apply

Maintenance Medication Program	Not applicable
Generics Program	Not Applicable
Copay Credit Accumulator Adjustment (CCAA): Specialty drug copay card dollars will not be included in your deductible and/or out-of-pocket limits. Only your true out-of-pocket costs will be applied to your deductible and/or out-of-pocket totals.	No
Variable Copay Solution (VCS): When you use a drug copay card, Specialty prescription drugs may be subject to a new plan benefit cost share. This new cost share will not impact you or the price you pay.	No
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 p.m. CST.	Register online at MyBlueKC.com and stay up-to-date on cost saving opportunities. **Email:** info@rxsavingsllc.com **PH:** 1-800-268-4476

6. Plan Benefits – Pharmacy		
	In-Network	**Out-of-Network**
Retail Pharmacy (Short-term supply: Up to 34 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** $15 Copay/Fill, no Deductible	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** $50 Copay/Fill, no Deductible	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** Deductible, then no charge	Not covered
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	$15 Copay/Fill, no Deductible	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic	$125 Copay/Fill, no Deductible	Not covered
Drug Tier 3: Non-Preferred Brand	Deductible, then no charge	Not covered
OTC Drugs (Retail Only) Prescription Required?: No OTC Drugs Retail (Short-Term) Day Supply Range: Up to 34 Days **OTC Drugs Smoking Cessation**	Not covered	Not Covered
OTC Drugs Gastrointestinal	$1 Copay/Fill, no Deductible	Not Covered
OTC Drugs Allergy	$1 Copay/Fill, no Deductible	Not Covered
Weight Loss Drugs	Not covered	Not covered

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Kansas City

Plan Information	
Group Name:	Jackson County
Plan Name:	QHDHP HSA with Spira Care Plan
Group Number:	31618000
State:	Missouri
Effective Date:	01/01/2021
Important Notes:	
For Internal Use Only:	Package: 0223050571 XREF: C6UI Medical: 0223340988 Rx: 0605020024
1. General Plan Information	
Benefit Period	Calendar Year
Funding	Cost Plus
Grandfathered Status	Non-Grandfathered
Consumer-Driven Health Plan (CDHP)	HSA
Spira Care Plan?	Yes No charge (after deductible) for services received from a designated Spira Care Center Provider. Treatment of work-related injury or illness is not covered under your Blue Cross and Blue Shield of Kansas City health benefit plan. Treatment of work-related injuries and illnesses is typically provided through your workers' compensation program. The Spira Care clinics are not participating providers under workers' compensation programs. Please reference your workers' compensation policies and procedures to direct your employees appropriately for work-related injuries.
Religious Employer?	N/A
Classification of Eligible Employees	See Attached
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?	Yes
Are Same Sex Spouses Covered?	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Blue Connect	Blue Connect not included

Compass	Compass not included	
2. Network		
Local Medical Network	BlueSelect Plus	
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	$2,800	Does not apply
Family	$5,600	Does not apply
Pharmacy Deductible	Combined with Medical	
Medical Coinsurance	**In-Network**	**Out-of-Network**
Member Pays	Not applicable	Does not apply
Plan Pays	100%	Does not apply
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	$2,800	Does not apply
Family	$5,600	Does not apply
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.	Deductible, then no charge	Not covered
Retail Health Clinic	Deductible, then no charge	Not covered
Total Care 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 optometrists, psychologists and chiropractors.	Deductible, then no charge	Not covered
Urgent Care Office Visit	Deductible, then no charge	Not covered
Total Care Urgent Care Office Visit	Does not apply	Not applicable

Blue KC Virtual Care - Office Visit Virtual care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	Deductible, then no charge	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	Deductible, then no charge	Not applicable
Designated Health Clinic	Does not apply	Not applicable
Other Benefits (in alphabetical order)	**In-Network**	**Out-of-Network**
ABA Services ABA Services Age Limits: Mandated Limits ABA Services Hours Limits: Mandated Limits	Subject to Applicable Cost Shares	Not covered
Abortion	Deductible, then no charge	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	Deductible, then no charge	Not covered
Allergy Treatment	Deductible, then no charge	Not covered
Ambulance - Air Air Ambulance Allowable Option: Billed Charges	Deductible, then no charge	In-Network Deductible, then no charge
Ambulance - Ground Ground Ambulance Allowable Option: 150% of Medicare	Deductible, then no charge	In-Network Deductible, then no charge
Assisted Reproductive Services	Not covered	Not covered
Autism-Related Services No limits	Subject to Applicable Cost Shares	Not covered
Bariatric Services	Not covered	Not covered
BDC+ Surgery	Not covered	Not covered
Chiropractic Services Office Visit	Deductible, then no charge	Not covered
Cranial Remodeling Devices No limits Required to follow Blue KC Medical Policy?: Yes	Deductible, then no charge	Not covered
Dental Anesthesia Maximum age limit of 5 Years	Missouri/Kansas Default	Not covered
Diabetic Equipment and Supplies Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Diabetic Footwear	Deductible, then no charge	Not covered
Diabetic Pump	Covered as Durable Medical Equipment (DME)	Not covered
Diabetic Self Management Education/Training (DSMT)	Deductible, then no charge	Not covered
Durable Medical Equipment (DME) Prior Authorization Policy Applies In-Network No limits	Deductible, then no charge	Not covered
Elective Male Sterilization	Deductible, then no charge	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Emergency Services	Deductible, then no charge	In-Network Deductible, then no charge
Food and Food Products for PKU No limits	Covered	Not covered
Foot Orthotics	Not covered	Not covered
Gender Dysphoria-Related Services Prior Authorization Policy Applies In-Network Gender Dysphoria Cost Shares Apply to Cosmetic Surgery: No Gender Dysphoria Cost Shares Apply to Non-Surgical Services: Yes Gender Dysphoria Cost Shares Apply to Reassignment Surgery: Yes	Subject to Applicable Cost Shares	Not covered
Hearing Aids	Not covered	Not covered
Hearing Aids - Bone Anchored Hearing Aids	Not covered	Not covered
High Tech Radiology (MRI, MRA, PET, CT) Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Home Health Care Prior Authorization Policy Applies In-Network Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Home Hospice	Deductible, then no charge	Not covered
Immunizations - Not Routine Preventive	Not covered	Not covered
Infertility and Impotency Diagnosis & Treatment	Not covered	Not covered
Inpatient Hospice Prior Authorization Policy Applies In-Network Maximum benefit of 14 Day(s)/Lifetime for In-Network	Deductible, then no charge	Not covered
Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Inpatient Physician Services	Deductible, then no charge	Not covered
Labs Performed in Office / Independent Lab	Deductible, then no charge	Not covered
Maternity Dependent Daughters Maternity Covered?: Yes	Covered	Not covered
Mental Health and Substance Abuse Services - Inpatient Hospital Facility (including Physician Services billed by Facility) Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Mental Health and Substance Abuse Services - Inpatient Physician Services	Deductible, then no charge	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Mental Health and Substance Abuse Services - Office Visit	Deductible, then no charge	Not covered
Mental Health and Substance Abuse Services - Outpatient Therapy in a Facility	Deductible, then no charge	Not covered
Mental Health and Substance Abuse Services - Outpatient Therapy in a Provider's Office	Deductible, then no charge	Not covered
Nutritional Counseling	Not covered	Not covered
Organ Transplant Services Prior Authorization Policy Applies In-Network	Subject to Applicable Cost Shares	Not covered
Organ Transplant Travel Expenses	Not covered	Not covered
Other Services Performed in Office	Deductible, then no charge	Not covered
Outpatient Physician Services	Deductible, then no charge	Not covered
Outpatient Surgery Prior Authorization Policy Applies In-Network	Deductible, then no charge	Not covered
Outpatient Therapy - Cardiac Therapy No limits	Deductible, then no charge	Not covered
Outpatient Therapy - Cognitive Therapy	Deductible, then no charge	Not covered
Outpatient Therapy - Hearing Therapy in a Facility Combined with Hearing Therapy in a Provider's Office Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Hearing Therapy in a Provider's Office Combined with Speech Therapy Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Occupational Therapy in a Facility Combined with Occupational Therapy in a Provider's Office Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Occupational Therapy in a Provider's Office Combined with Physical Therapy Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Physical Therapy in a Facility Combined with Physical Therapy in a Provider's Office Limits	Deductible, then no charge	Not covered
Outpatient Therapy - Physical Therapy in a Provider's Office Maximum benefit of 60 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Outpatient Therapy - Pulmonary Therapy No limits	Deductible, then no charge	Not covered
Outpatient Therapy - Speech Therapy in a Facility Combined with Speech Therapy in a Provider's Office Limits	Deductible, then no charge	Not covered

Other Benefits (in alphabetical order)	In-Network	Out-of-Network
Outpatient Therapy - Speech Therapy in a Provider's Office Maximum benefit of 20 Visit(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Penile Prostheses/Implant	Not covered	Not covered
Private Duty Nursing Combined with Home Health Care Limits	Deductible, then no charge	Not covered
Routine Preventive Care Diabetes Prevention Program (DPP): Covered Preventive Schedule: PPACA+ (Women's Preventive)	No member cost share	Not covered
Skeletal Manipulation performed in a Chiropractic Office	Deductible, then no charge	Not covered
Skilled Nursing Facility (SNF) Prior Authorization Policy Applies In-Network Maximum benefit of 30 Day(s)/Calendar Year for In-Network	Deductible, then no charge	Not covered
Sports Physicals by a Physician	Not covered	Not covered
Temporomandibular Joint (TMJ) No limits TMJ Diagnosis and Surgical Treatment (for accidental injury, fracture, tumors): Yes TMJ Non-surgical Treatment: No TMJ Orthognathic Surgery: No	Deductible, then no charge	Not covered
Vision Exam-Routine	Not covered	Not covered
Vision Hardware	Not covered	Not covered
Weight Loss Drugs (see Pharmacy cost shares)	Not covered	Not covered
Weight Management - Naturally Slim	Not covered	Not covered
Wigs	Not covered	Not covered
X-Rays and Radiology	Deductible, then no charge	Not covered
5. General Pharmacy Information		
Pharmacy Network(s)	**Network 1:** RxPremier	
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 on MyBlueKC.com	Blue KC Preferred Formulary	
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** 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** Does not apply

Maintenance Medication Program	Not applicable
Generics Program	Not Applicable
Copay Credit Accumulator Adjustment (CCAA): Specialty drug copay card dollars will not be included in your deductible and/or out-of-pocket limits. Only your true out-of-pocket costs will be applied to your deductible and/or out-of-pocket totals.	No
Variable Copay Solution (VCS): When you use a drug copay card, Specialty prescription drugs may be subject to a new plan benefit cost share. This new cost share will not impact you or the price you pay.	No
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 p.m. CST.	Register online at MyBlueKC.com and stay up-to-date on cost saving opportunities. **Email:** info@rxsavingsllc.com **PH:** 1-800-268-4476

6. Plan Benefits – Pharmacy		
	In-Network	**Out-of-Network**
Retail Pharmacy (Short-term supply: Up to 34 Days) **Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** Deductible, then no charge	Not covered
Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** Deductible, then no charge	Not covered
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days) **Drug Tier 1:** Generic	Deductible, then no charge	Not covered
Drug Tier 2: Preferred Brand / Non-Preferred Generic	Deductible, then no charge	Not covered
Drug Tier 3: Non-Preferred Brand	Deductible, then no charge	Not covered
Preventive Drugs **Retail Drug Tier 1:** Generic / Generic Specialty	**RxPremier:** Deductible, then no charge	Not covered
Retail Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	**RxPremier:** Deductible, then no charge	Not covered
Retail Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	**RxPremier:** Deductible, then no charge	Not covered
Mail Order Drug Tier 1: Generic / Generic Specialty	Deductible, then no charge	Not covered

Mail Order Drug Tier 2: Preferred Brand / Non-Preferred Generic / Preferred Brand Specialty	Deductible, then no charge	Not covered
Mail Order Drug Tier 3: Non-Preferred Brand / Non-Preferred Brand Specialty	Deductible, then no charge	Not covered
OTC Drugs (Retail Only) Prescription Required?: No OTC Drugs Retail (Short-Term) Day Supply Range: Up to 34 Days **OTC Drugs Smoking Cessation**	Not covered	Not Covered
OTC Drugs Gastrointestinal	Deductible, then no charge	Not Covered
OTC Drugs Allergy	Deductible, then no charge	Not Covered
Weight Loss Drugs	Not covered	Not covered

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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 JACKSON COUNTY MO ("Employer"). This Addendum shall be effective January 1, 2021 (the "Effective Date").

WHEREAS, the parties have entered into the Group Contract(s) numbered 31618000 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).

1.4 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 the applicable portion of 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.

1.5 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 demand (without any further or additional action or authorization byEmployer). 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. Employer delegates to BCBSKC discretionary authority to construe, interpret and apply the Plan for purposes of processing claims and appeals. BCBSKC, as claims fiduciary, has the full, final, binding and exclusive discretion to construe, interpret and apply the terms of the Plan as may be necessary in order to process claims and make determinations on appeal of claims. BCBSKC shall determine the extent of the benefits (if any) to which any Participant is entitled under the Plan. Decisions by BCBSKC shall be complete, final and binding on all parties. 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 $0 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 $0 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 Assignment. BCBSKC shall have the right to assign or delegate its duties and obligations under this Addendum to its affiliated companies. Any other assignment of this Addendum or, of any rights contained in this Addendum, by either party, will be void and of no force or effect, unless agreed upon in writing by the parties.

6.4 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.

6.5 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.

6.6 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, mass tort, or other litigation 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, as described in 6.6.1; provided, that BCBSKC may charge the Employer a fee of up to 30% of the gross recovery including any third party fees and expenses for such recoveries, which will be netted against any such recovery. The recovery fee may exceed 30% if the applicable recovery vendor's fee exceeds that percentage. BCBSKC shall have the right to retain any net recovery not exceeding $500 if 3 years have elapsed since this Addendum terminated.

6.6.1 In the event the BCBSKC obtains, directly or through a third party, recoveries that relate to Paid Claims, the following will apply:

a. Employer shall first reimburse BCBSKC directly a pro rata portion of such recovery;
b. Such portion shall not exceed the amount BCBSKC has paid under the Agreement;
c. Such portion will be net of BCBSKC's portion of recovery fees;
d. Allocation of the recovery fees will be based upon the amount related to such recovery that was paid by BCBSKC and Employer; and
e. Employer will retain or receive the remaining portion of such recovery net of its portion of recovery fees.

6.6.2 Any amounts recovered by BCBSKC shall not apply to and shall not be used to satisfy the Individual Pooling limit.

6.7 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.

6.8 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 may pay administrative fees to PBM in connection with PBM's services of administering, invoicing, allocating, and/or collecting rebates, and the PBM retains the benefit of such amounts prior to disbursement. PBM may also receive other service fees or discounts 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, the amount paid by BCBSKC pays a uniform discount rate to PBM under the BCBSKC contract with the PBM may vary from 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 being 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, except as specifically provided in section 6.8.1 for certain pharmacy carve-in credits, 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, except as specifically provided in section 6.8 ; (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.

6.8.1 Pharmacy Carve-In Credits. BCBSKC agrees to provide Employer with pharmacy carve in-credits as provided in this section. The carve-in credit shall be $16.00 per member per month, and shall be paid on a quarterly basis through a credit against amounts invoiced and due from Employer. The number of members shall be determined from the actual enrollment in the health plans with prescription drug coverage.

BCBSKC has the right, upon notice, to make an equitable adjustment to the carve-in credit amount in the event there is:

(a) a material change in the conditions or assumptions utilized in providing the carve-in credit;
(b) a material change in the size or demographic's of the Employer's membership;
(c) Employer takes an action that has the effect of lowering the amount of Financial Credits available to BCBSKC; or
(d) A material change in law or the pharmacy benefit industry that adversely impacts BCBSKC's ability to obtain Financial Credits.

In order to be eligible for and receive the carve-in credits, Employer's Addendum must be in effect at the time payment of such carve-in credits are to be made.

Employer agrees to fully and accurately disclose and report pharmacy carve-in credits and any other discount, rebate, or other credit received by Employer or retained by BCBSKC and/or its PBM, as required by law.

6.9 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. To the extent an audit occurs, BCBSKC agrees only to the following two audit methodologies: (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. Whether the audit is performed during the term of the Agreement or following termination and regardless of the methodology used, referenced in (a) and (b) above, such samples may only include those claims that were processed by BCBSKC no more than six months prior to the effective date for which the Employer requested the sample. For example, if a sample is requested to be drawn effective as of June 30 of a given year, it could only include claims processed between June 30 and January 1 of the same year. Employer may not request a retroactive effective date for the sample.

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. Any such third party may not be reimbursed by Employer on a contingency or other method based on identification or value of errors. 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 data extraction 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.

6.10 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.

6.11 Mindful by Blue KC Fee: Employer acknowledges that BCBSKC will assess $0.75 per member per month for the Mindful by Blue KC behavioral health initiative. Mindful initiatives include improved network access to providers trained in crisis support, employer education focused on mental health first aid, and resources to support behavioral health integration into our primary care provider practices. The Mindful by Blue KC initiative provides a set of tools and resources to promote whole person wellness, including a limited number of well-being resource visits and access to Mindful Advocates. The well-being resource visits help with major life events (divorce, adoption, loss), stress, financial issues, childcare, and other everyday challenges through lifestyle coaching. These visits are limited to 3 per issue for each Blue KC member every calendar year. Well-being resource visits are not considered Covered Services and will not be billed (or paid) as claims. Mindful Advocates are licensed clinicians and social workers who match members to providers and guide care plans. They act as a single point of contact for listening, connecting, crisis management, benefits guidance, navigating care, and follow-up.

Article 7
Definitions

Access Fee The amount paid by Employer to BCBSKC for network management and access, determined as set forth in 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. The Cumulative Monthly Claims Limit includes the Mindful by Blue KC Fee. The Cumulative Monthly Claims Limit includes BlueCard access and administrative fees.

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.

Fiduciary as used in this Addendum means fiduciary as defined in ERISA at 29 U.S.C. 1002 (21)(A).

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 Persons' 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. The Individual Pooling Limit does not include any capitated payments associated with any Paid Claims or Covered Services. Capitated payments include, but are not limited to, Medical Value and Value-Based and Spira Care Capitation Payments. Medical Value and Value-Based and Spira Care Capitation Payments are value-based payment arrangements with providers participating in certain health care delivery programs, including patient-centered medical homes, accountable care organizations or episode-based medical management. The Individual Pooling Limit does not include Spira Care Capitation Payments. The Individual Pooling Limit does not include Spira Care Capitation Adjustments.

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 1/1/2020 and 12/31/2021 for the Individual Pool Limit and between 1/1/2020 and 12/31/2021 for the Monthly Claims Limit, 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 (including Spira Care Capitation Payments), 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.

Plan as used in as used in this Addendum means plan as defined in ERISA at 29 U.S.C. 1002(3).

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, as well as miscellaneous state or local assessments.

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.

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.

JACKSON COUNTY MO

BY: _____

NAME: Frank White Jr

TITLE: County Executive

DATE 11/13/2020

Blue Cross and Blue Shield of Kansas City

BY: _____

NAME: MATT SEIFERT

TITLE: UNDERWRITER

DATE: 10/30/20

Exhibit A
Cost Plus Provisions

1. This Addendum shall be applicable to:

   __X___Employer's Group Health Contract: Group Number(s) 31618000

2. The Individual Pooling Limit per Covered Person shall be $200,000

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

   $20.00 per Employee

4. Minimum Annual Claims Limit:

   The greater of: (a) $15,100,000; 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.

Exhibit B
Rate Exhibits

Fixed Premium

1. **The Fixed Cost Fees are as follows:**

Employee	$25.52
Employee + One	$63.80
Family	$74.64

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

Employee	$67.04
Employee + One	$167.60
Family	$196.06

3. **Access Fees are as follows:**

$20.00 PEPM

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 2.6% of the sum of the amounts payable under Articles 1.2 1.3 and 1.4.

0%. MES 10/26/20

B. The Patient-Centered Outcomes Research Institute Fee (aka Comparative Effectiveness Fee) is due and payable with the Monthly Settlement Report and shall be $2.65 per Covered Person (which equals $0.22 per Covered Person per month).

Exhibit B
Rate Exhibits

Rate Factors

1. Monthly Claims Limit Factors are as follows:

	HMO BC	$1,000 Ded PCB	H.S.A. PCB	EPO BS+	Spira EPO BS+	Spira H.S.A. BS+	EPO St. Luke's
Employee	$700.00	$684.56	$639.53	$615.43	$595.00	$540.40	$665.00
Employee + 1	$1,578.48	$1,548.62	$1,459.98	$1,387.88	$1,341.71	$1,233.66	$1,499.56
Family	$1,956.77	$1,910.94	$1,779.29	$1,720.34	$1,663.25	$1,503.46	$1,858.93

2. Terminal Liability Factors are as follows:

	HMO BC	$1,000 Ded PCB	H.S.A. PCB	EPO BS+	Spira EPO BS+	Spira H.S.A. BS+	EPO St. Luke's
Employee	$1,050.00	$1,026.85	$959.30	$923.15	$892.50	$810.60	$997.50
Employee + 1	$2,367.72	$2,322.94	$2,189.97	$2,081.82	$2,012.56	$1,850.50	$2,249.34
Family	$2,935.15	$2,866.40	$2,668.94	$2,580.51	$2,494.88	$2,255.19	$2,788.40

SPIRA CARE DISCLOSURE
ASO AND COST-PLUS GROUP CONTRACTS

You have chosen to participate in Blue Cross and Blue Shield of Kansas City's (Blue KC) Spira Care program. There are some special financial features of Spira Care that we describe here.

Introduction. Spira Care provides a financial incentive to participating healthcare providers to use their medical judgment in a fashion that provides cost effective, appropriate medical care. Spira Care healthcare providers may receive additional compensation if they operate in a fashion that shows a beneficial cost impact (as measured by standards described later in this disclosure).

Provider Partners. Initially, Spira Care will operate through an arrangement with third-party healthcare provider organizations (collectively, the "**Provider Partners**"). Members will go to the Spira Care clinics to receive care from these Provider Partners through the Spira Care program.

Group's Capitation Payments. Your group will pay a per-member per-month ("**Capitation**") amount for services provided to your members through the Spira Care clinics. This Capitation amount will cover your group's expense for services provided through the Spira Care clinics, except for (a) drugs dispensed at the Spira Care clinics, and (b) any behavioral health services that are beyond what must be provided to members without cost-sharing under the Mental Health Parity and Addiction Equity Act. Your group will be required to pay those drug and behavioral health expenses in the normal way under your contract. They will not be covered by the Capitation amount you pay for services provided through the Spira Care clinics.

The Capitation amount of Spira Care will vary by the age and sex of members and may adjust on January 1 of each year, regardless of your group's plan year. And the Capitation amount for those members covered by a qualified high-deductible health plan will generally be less than the Capitation amount for those members not covered by such a plan.

In addition to receiving the Capitation amount, Blue KC and the Provider Partners will charge those members covered by a qualified high-deductible health plan who have not yet satisfied their deductible for the year an allowable charge for each visit involving non-preventive services. Blue KC and the Provider Partners will collect and keep this allowable charge.

Clinic Operating Performance. There are two special financial aspects of Spira Care. The first involves what is called a "**Clinic Operating Expenses**" calculation. The actual expenses in operating the Spira Care clinics (the Clinic Operating Expenses) for a year may be more or less than the total of the Capitation payments and any member cost-sharing payments made to the Provider Partners for the year. Blue KC and/or the Provider Partners will effectively bear responsibility for the clinic operating performance. Your plan will not be required to pay an additional Capitation amount to make up for any Clinic Operating Expense shortfall.

In determining whether there is an operating loss or gain from the Spira Care clinics, the Clinic Operating Expenses will include not only items like rent, utilities, medical record software, drug

acquisition costs, and information technology support, but also the compensation paid to the healthcare professionals associated with the Spira Care clinics for providing care to members who have selected Spira Care. And in determining the income associated with the clinics (for purposes of determining any clinic operating loss or gain), that income will include not only the total of the Spira Care Capitation and member cost-sharing payments made for the year, but also any amounts paid for drugs dispensed at the clinic.

Sharing of Cost Savings (or Losses). The second special financial feature of Spira Care is that one or more of the Provider Partners will, while making appropriate medical decisions, have a financial incentive to generate savings int eh total cost of healthcare provided to members who have selected Spira Care. By total cost of healthcare we mean not just the cost of care provided by the Provider Partner but the cost of all covered healthcare provided to members in the Spira Care program, including care provided outside the Spira Care clinics.

In determining whether there have been cost savings, Blue KC will establish a benchmark and compare the Spira Care program's total cost of healthcare provided to members against that benchmark.

Savings. The intent is that the Provider Partners will perform well, as measured by the standard above, generating savings from what one might otherwise have projected healthcare costs to be. If so, one or more of the Provider Partners will receive incentive compensation equal to a percentage of the savings for the year in question (as those savings are determined under the calculations above).

To pay for all of part of any incentive compensation earned by the Provider Partners, groups in the Spira Care program in subsequent years may pay a larger Capitation amount for Spira Care, or Blue KC may charge higher administrative fees, or both. When successful, the group will experience the benefits of the Spira Care program in real time by seeing its healthcare costs decrease from what one might otherwise have projected them to be.

Losses. If the Provider Partners are not successful in generating savings, and the total cost of care for the Spira Care members instead shows a "loss" (determined under the calculations noted above), one or more of the Provider Partners will be required to bear a portion of that loss. In that event, one or more of the Provider Partners will make a payment to Blue KC equal to a percentage of the loss for the year. This payment will not be credited directly to your group. That means your group will have paid a Spira Care Capitation amount, as well as other healthcare expenses, a portion of which will ultimately come back to Blue KC and not back to your group.

Savings and Losses Not Based on Your Individual Group's Experience. Cost savings or losses will be determined across all groups that participate in Spira Care, including both self-insured and insured groups. This means savings or losses will not be determined based on your group's particular experience. And if any savings or losses are reflected in future years' Capitation amounts, the effect on your group will depend on the number of members in your group during the later year for which the Capitation is adjusted. Further, any Capitation adjustments for future years (to reflect savings or losses) may be different for insured groups that are not Cost-Plus groups than for ASO and Cost-Plus groups.

Blue KC's Interest in Provider Partners. Blue KC, or a subsidiary of Blue KC, has an ownership interest in one or more of the Provider Partners, and has the potential to obtain additional ownership in at least one of the Provider Partners. As a consequence, payments made to those Provider Partners may have a financial impact on Blue KC.

Blue KC or Subsidiary. The financial arrangements with the Provider Partners may actually be made between those providers and a subsidiary of Blue KC, rather than with Blue KC directly.

Agreed to and acknowledged:

By: _____
Name: Frank White, Jr.
Title: County Executive
Date: 11/13/2020

Kansas City

Jackson County – Retiree & Cobra Medical Rate Confirmation

Blue-Care HMO Direct Bill Cobra Rate	
Employee	$805.61
Employee + One	$1,833.58
Family	$2,260.91

Blue-Care HMO Direct Bill Retiree Rate	
Employee	$789.82
Employee + One	$1,797.62
Family	$2,216.58

PCB PPO Direct Bill Cobra Rate	
Employee	$789.36
Employee + One	$1,802.16
Family	$2,212.70

PCB PPO Direct Bill Retiree Rate	
Employee	$773.88
Employee + One	$1,766.82
Family	$2,169.32

PCB BlueSaver PPO Direct Bill Cobra Rate	
Employee	$741.98
Employee + One	$1,708.90
Family	$2,074.21

PCB BlueSaver PPO Direct Bill Retiree Rate	
Employee	$727.44
Employee + One	$1,675.40
Family	$2,033.54

BSP EPO Direct Bill Cobra Rate	
Employee	$716.63
Employee + One	$1,633.04
Family	$2,012.18

BSP EPO Direct Bill Retiree Rate	
Employee	$702.58
Employee + One	$1,601.02
Family	$1,972.72

BSP EPO Spira Direct Bill Cobra Rate	
Employee	$695.15
Employee + One	$1,584.47
Family	$1,952.12

BSP EPO Spira Direct Bill Retiree Rate	
Employee	$681.52
Employee + One	$1,553.40
Family	$1,913.84

BSP EPO BlueSaver Spira Direct Bill Cobra Rate	
Employee	$637.70
Employee + One	$1,470.80
Family	$1,784.02

BSP EPO BlueSaver Spira Direct Bill Retiree Rate	
Employee	$625.20
Employee + One	$1,441.96
Family	$1,749.04

St. Lukes HPN EPO Direct Bill Cobra Rate	
Employee	$767.02
Employee + One	$1,751.36
Family	$2,155.60

St. Luke's HPN EPO Direct Bill Retiree Rate	
Employee	$751.98
Employee + One	$1,717.02
Family	$2,113.34

Confirmed by:
Jackson County:

Signature

County Executive
Title

11/13/2020
Date

Approved by:
Blue Cross and Blue Shield of
Kansas City

Signature

UNDERWRITER
Title

10/26/20
Date

Performance Standards Agreement
Jackson County, Missouri

BlueCross BlueShield of Kansas City
An Independent Licensee of the Blue Cross and Blue Shield Association

Administrative Performance Measure
Claims Processing
Claims Administrative Accuracy Administrative accuracy shall be determined by reviewing a statistically valid sample of medical/dental claims for the correctness of coding accuracy in the administration of the plan. Examples of administrative errors include correct amounts sent to the wrong payee, and/or misapplied deductibles and maximums that do not result in payment errors. Administrative accuracy errors do not include any claims that affect claims payment or deductible accumulation, nor any errors that are corrected by Company prior to audit. Administrative accuracy will be determined by counting the number of claims in a monthly sample that contains one or more coding errors (errors that do not affect claim payment) divided by the total number of claims in the sample. The resulting number shall than be subtracted from 1.00 to determine the administrative accuracy rate.
Performance Standards: **97% and greater accuracy No Penalty** **92% to 96.9% accuracy $15,000 Penalty** **Accuracy less than 92% $30,000 Penalty**
Claims Financial Accuracy Financial accuracy shall be determined by reviewing a statistically valid sample of medical and dental claims for the dollar amount of payment errors. Payment errors for financial accuracy shall be defined as claims payments that are either overpayments or underpayments of the amounts due to plan participants (i.e. payment in the wrong amount, duplicate payments, payment for non-eligible benefits, misapplied deductible or maximums resulting in payment errors). A financial error that is corrected by Company prior to audit shall not be considered as being a payment error. Overpayments and underpayments made on the same claim to the same provider that result in a correct net payment being made to such provider on such claim shall not be considered a financial payment error. Financial accuracy of claims payments will be based on the dollar value of the payment errors measured as a percentage of total paid claims (dollar value of payment errors divided by the total dollars paid). The resulting number shall then be subtracted from 1.00 to determine the financial accuracy rate. Performance Standards: Company shall process all claims with a Financial Accuracy of 99% or better.
Performance Standards: **99% and greater accuracy No Penalty** **98.9% to 92% accuracy $15,000 Penalty** **Accuracy less than 92% $30,000 Penalty**
Claims Processing Timeliness Claims processing timeliness shall be determined by reviewing claims systems reports for the length of time incurred in processing clean medical claims. Clean medical and dental claims are defined as claims that do not require investigation or intervention. Claims requiring investigation include all claims that are not yet processed and are being held until Company is provided with all information

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Administrative Performance Measure
pertinent to the claims as requested by Company and as necessary for processing of the claim. Claims requiring intervention include but are not limited to COB claims, claims requiring medical review, etc. Claims requiring investigation or intervention will not be considered for claims processing timeliness. Claims processing time will be determined by measuring the interval of business days between the date the clean claim is received by Company and the date the claim is finalized by Company. Performance Standards: Company shall process 95% or more of all clean claims within fourteen business days.
Performance Standards: **95% or more within 14 days—No Penalty** **90% to 94.9% within 14 days—$15,000 Penalty** **Less than 90% within 14 days—$30,000 Penalty**

Administrative Performance Standards - General Principles

The Administrative Performance Guarantees penalty amounts apply to medical administrative fees as outlined in the Administrative Services Agreement between Blue Cross and the group and will be adjusted in accordance with the performance standards set forth below. The performance measures will be effective January 1, 2021, and will remain in force through December 31, 2021 (hereinafter the "Measurement Period"), or until termination of the Administrative Services Agreement between the two parties, whichever is sooner. Administrator will place a maximum of $90,000 of medical administrative fee at risk. For each category, performance will be measured by, and penalties, if any, will be calculated on the basis of Administrators audits, surveys, or reports as described in this document. The group retains the right to have internal or external auditors verify the accuracy of Administrators reported results at the Group's expenses.

1. Measurement of Administrator performance against the standards shall be performed and reported to Group by Administrator on a quarterly basis or as otherwise noted.
2. The measures discussed herein are average measures relative to the entire Measurement Period, as set out above. The Appropriate penalties will be paid if the result fails to meet the established goal for the entire Measurement Period. Select measures will be reported on a quarterly basis for illustrative purposes only.
3. This performance guarantee agreement applies only in regard to Group's health services provided directly by Administrator. It is not intended to apply to any other service of coverage, including but not limited to dental and/or life insurance coverage, and carve-outs such as vision, prescription drug card and mental health.
4. Any material failure on the part of Group or its designee to perform on a timely basis those responsibilities specified in the Administrative Services Agreement referenced in Paragraph I. above, that are necessary and integral to the Performance Guarantees made by the Administrator shall void, until such time they have been corrected, the applicable Performance Guarantee and the Administrator shall be held harmless.

Payment of Penalties

Although we will provide quarterly performance reports, penalties will be assessed for any Plan Year in which the Company fails to meet or exceed the Performance Standards specified herein for Claims Administrative Accuracy, Claims Financial Accuracy, and Claims Processing Timeliness. Performance will be calculated based on an annual average excluding the best and worst months.

Performance Standards Agreement
Jackson County, Missouri

BlueCross BlueShield of Kansas City
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Audit of Performance

Plan Sponsor agrees to accept the results and the methodology as defined therein under the Company's internal Quality Assurance Review process as the measurement of the criteria set forth in this Agreement.

Except as stated herein, this Agreement shall not be construed to otherwise change any of the terms or conditions of the Master Contract.

Approved and agreed to this 17th **day of** November, **2020.**

Jackson County:		***Blue Cross and Blue Shield of Kansas City***	
By:	[signature]	**By:**	[signature]
Name:	Frank White, Jr.	**Name:**	MATT SEIFERT
Title:	County Executive	**Title:**	UNDERWRITER

R. 20522

REVENUE CERTIFICATE

This contract is made on a need basis and does not obligate Jackson County to pay any specific amount. The availability of funds for specific purchases is subject to annual appropriation.

11-10-2020
Date

Director of Finance and Purchasing

JACKSON COUNTY, MISSOURI

Frank White, Sr.
County Executive

ATTEST:

Mary Jo Spino
Clerk of the Legislature