Jackson County

Preferred-Care Blue PPO Plan
Benefit & Rate Confirmation
(Effective January 1, 2014)

Benefit and Rate Confirmation
Jackson County – Preferred-Care Blue PPO Plan

Preferred-Care Blue Copayment, Deductible, Coinsurance and Limits		
Hospital and Physician		
Calendar Year Deductible	Network	Non-Network
Individual	$250	$1,000
Family	$750	$3,000
Coinsurance Member Pays		
Preferred	10%	
Non-Preferred	20%	
Out-of-Pocket Maximum	Individual	Family
Preferred	$2,650	$5,300
Non-Preferred	$5,300	$10,600
Physician Office Visit		
Preferred		
PCP	-$30 Copay*	
Specialist	$60 Copay*	
Non-Preferred	Deductible & Coinsurance	
*Copay applies to the Office Visit Charge Only. Other procedures performed in a Physician's office are subject to the applicable deductible and coinsurance level unless otherwise specified in the benefit schedule.		
Pediatric Obesity Office Visit (up to 4 per year for overweight and obese only)		
Preferred	No Copay	
Non-Preferred	No Benefit	
Pediatric Obesity Nutritional Counseling (up to 4 per year for overweight and obese only)		
Preferred	No Copay	
Non-Preferred	No Benefit	
Lab Services		
Preferred	No Copay*	
Physician's Office / Independent Lab	Deductible & Coinsurance	
Outpatient Facility/Hospital	Deductible & Coinsurance	
Non-Preferred		
X-ray and other Radiology Procedures	Deductible & Coinsurance	
Preferred	Deductible & Coinsurance	
Non-Preferred		

Hospital and Physician (cont'd.)	
Routine Preventive Care Preferred	Expanded (ACA Compliant) Women's Preventive*** Routine Services: 100% Related OV: 100% Deductible & Coinsurance
Non-Preferred	
Routine Vision Care	No Benefit
Prenatal Program	Yes
Emergency Room	$200 Copay then Deductible & Preferred Coinsurance *Copay waived if admitted to a Hospital*
Urgent Care Benefit Preferred Non-Preferred	$50 Copay* Deductible & Coinsurance
E-Visit Preferred (Providers in our Service Area) Non-Preferred	$10 Copay No Benefit

Mental Illness/Substance Abuse	
Inpatient Mental Illness/Substance Abuse	Deductible & Coinsurance
Outpatient Mental Illness/Substance Abuse Office Visit	$30 Copay*
Outpatient Mental Illness/Substance Abuse Therapy	Deductible & Coinsurance

****Routine Women's Preventive required under the Affordable Care Act of 2010 ("ACA")*

Ancillary/Miscellaneous	
Air Ambulance	Deductible & Preferred Coinsurance
Ground Ambulance	Deductible & Preferred Coinsurance *$500 limit per trip*
Home Health Services	Deductible & Coinsurance *60 visit Calendar Year Maximum*
Skilled Nursing Facility	Deductible & Coinsurance *30 day Calendar Year Maximum*
Inpatient Hospice	Deductible & Coinsurance *14 Day Lifetime Max*
Outpatient Therapy (Speech, Hearing, Physical and Occupational)	Deductible & Coinsurance *Combined 40 visit Calendar Year Maximum for Physical & Occupational Therapy* *Combined 20 visit Calendar Year Maximum for Speech & Hearing Therapy*
Chiropractic Services *Copay applies to the Office Visit Charge Only. Other procedures performed in a Chiropractor's office are subject to the applicable deductible and coinsurance level unless otherwise specified in the benefit schedule.	Network: $60 Copay* Non-Network: Deductible & Coinsurance
Infertility/Impotency	$10,000 lifetime benefit maximum; drugs are covered at 50% after applicable copay

Benefit and Rate Confirmation
Jackson County – Preferred-Care Blue PPO Plan

Outpatient Prescription Drugs	
Network	BCBSKC Rx
Rx Deductible	None
Long-Term Supply – Mail order only	All covered drugs
Retail Copays: Tier 1/Tier 2/Tier 3	$12/50/70
Mail Order Copays: Tier 1/Tier 2/Tier 3	$36/150/210
Contraceptives:	Generic contraceptive drugs covered at 100% Injectables, implants, and devices covered at 100%
Over the Counter Drugs *(Prevacid OTC, Prilosec OTC, Loratadine/Loratadine-D tablets including rapidly dissolving tablets, and syrup (generic for Claritin and Alavert products) & Zyrtec*	$1 Copay
Out-of-Network:	50% after Copay
ExpressScripts Program:	BlueKC Network without Walgreen's Select Home Delivery

Other	
Look Back Period	None
Pre-existing Condition Exclusion Period	None
Lifetime Maximum	Unlimited
Dependent Limiting Age	26
Maternity	Covered
Dependent Daughters	Covered for maternity
Eligibility/Termination	First day of month/last day of month
Domestic Partner Amendment – Coverage for same sex and opposite sex coverage	Covered
Wellness Fund (Group Total)	$75,000
Nurse Line	Yes

Benefit and Rate Confirmation
Jackson County – Preferred-Care Blue PPO Plan

Underwriting	
Minimum percent of Eligible employees covered	75%
Percentage threshold of total employee enrollment at renewal based on prior year's enrollment	90%
Classification of Eligible Employees	See Attached
Waiting Period	See Attached
Minimum Employer Contribution	75% cost of Eligible Employees/50% total account premium
Section 125 Enrollment Provisions	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Start Date of Annual Enrollment Period	30 days prior to group anniversary date
End Date of Annual Enrollment Period	15 days after group anniversary date
Contract Term	12 months
Subsequent Renewal Terms	12 months
Renewal Notification	180 Days Preliminary; 120 Days Final
Next Renewal	1/1/15
Reinstatement Fee	$500
Subject to ERISA	No

Mandated Offerings	
Speech and Hearing Disorders	☐ Accept ☒ Reject
Child Health Supervision Services	☐ Accept ☒ Reject
Pregnancy Termination	☐ Accept ☒ Reject

Benefit and Rate Confirmation
Jackson County – Preferred-Care Blue PPO Plan

Rates	
Employee	See Cost Plus Agreement
Family	
Cobra	
Employee	$723.42
Family	$2,011.11

A Healthier You™	
Select only one: ☐ AHY 100+ ☒ AHY Platinum (1000+) ☐ Decline AHY(approval needed)	
AHY for Subscriber and Spouse with Medical Coverage	Included in premium

Funding	
	☐ ASO ☐ Cost Plus ☐ Insured ☒ Other Cost Plus

Confirmed by Jackson County:

Signature Michael D. Sanders

County Executive

Title County Executive

10/16/2013

Date

Accepted by Blue Cross and Blue Shield of Kansas City:

Carolyn Wolf

Signature

Dr Underwriter

Title

10/9/13

Date

APPROVED AS TO FORM

County Counselor

ATTEST:

Mary Jo Spino

Clerk of the County Legislature

Jackson County

Blue-Care Low and Blue-Care High HMO Plans

Benefit & Rate Confirmation

(Effective January 1, 2014)

Benefit and Rate Confirmation
Jackson County – Blue-Care Low and Blue-Care High HMO Plans

	Blue-Care Low Copays and Limits	Blue-Care High Copays and Limits
Physician		
Primary Care Office Visit	$35 Copay	$30 Copay
Specialty Care Office Visit	$70 Copay	$60 Copay
Pediatric Obesity Office Visit (up to 4 per year for overweight and obese only)	No Copay	No Copay
Pediatric Obesity Nutritional Counseling (up to 4 per year for overweight and obese only)	No Copay	No Copay
Expanded (ACA Compliant) Women's Preventive** and Related Office Visit	No Copay	No Copay
Routine Vision	$10 Copay	$10 Copay
Allergy Testing	$100 Copay	$100 Copay
Urgent Care	$60 Copay *(Urgent Care copay waived if services provided at local Retail urgent care clinic)*	$50 Copay *(Urgent Care copay waived if services provided at local Retail urgent care clinic)*
Pre-natal Program	Yes	Yes
Hospital		
Emergency Room	$200 Copay *Copay waived if admitted to a hospital*	$150 Copay *Copay waived if admitted to a hospital*
MRI, MRA, CT, and PET scans performed in a Physicians office, imaging center or other outpatient setting (including a hospital)	$200 Copay	$150 Copay
Inpatient Hospital Services or Outpatient Surgery in Hospital or other Outpatient Facility	$400 Copay Per Day *Copays limited to five copays per member per calendar year*	$300 Copay Per Day *Copays limited to five copays per member per calendar year*
Out-of-Pocket Maximum		
Out-of-Pocket Maximum *(applies to all Medical cost-sharing)*		
Individual	$2,400	$2,200
Family	$6,000	$5,500

***Routine Women's Preventive services required under the Affordable Care Act of 2010 ("ACA")*

Mental Illness/Substance Abuse		
Inpatient Mental Illness/Substance Abuse	$400 Copay Per Day *Copays limited to five copays per member per calendar year*	$300 Copay Per Day *Copays limited to five copays per member per calendar year*
Outpatient Mental Illness/Substance Abuse Office Visit/Therapy:	$35 Copay	$30 Copay
Outpatient Mental Illness/Substance Abuse Other Services (including partial hospitalization):	No Copay	No Copay

Ancillary/Miscellaneous		
Air Ambulance	No Copay	No Copay
Ground Ambulance	No Copay *$500 Limit Per Trip*	No Copay *$500 Limit Per Trip*
Home Health Services	No Copay *60 visit Calendar Year Maximum*	No Copay *60 visit Calendar Year Maximum*
Skilled Nursing Facility	No Copay *30 day Calendar Year Maximum*	No Copay *30 day Calendar Year Maximum*
Inpatient Hospice	$200 Copay *Applies to Annual Inpatient/Outpatient Hospital Maximum* *14 Day Lifetime Maximum*	$150 Copay *Applies to Annual Inpatient/Outpatient Hospital Maximum* *14 Day Lifetime Maximum*
Outpatient Therapy (Speech, Hearing, Physical and Occupational)	No Copay *Combined 40 visit Calendar Year Maximum for Physical & Occupational Therapy* *Combined 20 visit Calendar Year Maximum for Speech & Hearing Therapy*	No Copay *Combined 40 visit Calendar Year Maximum for Physical & Occupational Therapy* *Combined 20 visit Calendar Year Maximum for Speech & Hearing Therapy*
Chiropractic Services	No Copay	No Copay
Infertility/Impotency Treatment	$10,000 lifetime benefit maximum	$10,000 lifetime benefit maximum
Infertility/Impotency Drugs	50% after prescription copay	50% after prescription copay

Benefit and Rate Confirmation
Jackson County – Blue-Care Low and Blue-Care High HMO Plans

Outpatient Prescription Drugs		
Network	BCBSKC Rx	BCBSKC Rx
Rx Deductible	None	None
Long-Term Supply – All sources (retail – 3x short-term)	All covered drugs	All covered drugs
Short-Term Retail Copays: Tier 1/Tier 2/Tier 3	$12/50/70	$12/50/70
Long-Term Mail Order Copays: Tier 1/Tier 2/Tier 3	$36/150/210	$36/150/210
Contraceptives:	Generic contraceptive drugs covered at 100% Injectables, implants, and devices covered at 100%	Generic contraceptive drugs covered at 100% Injectables, implants, and devices covered at 100%
Over the Counter Drugs *(Prevacid OTC, Prilosec OTC, Loratadine/Loratadine-D tablets including rapidly dissolving tablets, and syrup (generic for Claritin and Alavert products) & Zyrtec*	$1 Copay	$1 Copay
ExpressScripts Program:	BlueKC Network without Walgreen's Select Home Delivery	BlueKC Network without Walgreen's Select Home Delivery

Other		
Pre-existing Condition Exclusion Period	None	None
Lifetime Maximum	Unlimited	Unlimited
Dependent Limiting Age	26	26
Maternity	Covered	Covered
Dependent Daughters	Covered for maternity	Covered for maternity
Elective Pregnancy Termination	Not covered	Not covered
Eligibility/Termination	First day of month/last day of month	First day of month/last day of month
Domestic Partner Amendment – Coverage for same sex and opposite sex coverage	Covered	Covered
Wellness Fund (Group Total)	$75,000 **Amount applies to group as a whole and amount is not available for each unique product the group offers.*	$75,000 **Amount applies to group as a whole and amount is not available for each unique product the group offers.*
Nurse Line	Yes	Yes

Benefit and Rate Confirmation
Jackson County – Blue-Care Low and Blue-Care High HMO Plans

Underwriting	
Minimum percent of Eligible employees covered	75%
Percentage threshold of total employee enrollment at renewal based on prior year's enrollment	90%
Classification of Eligible Employees	See Attached
Waiting Period	See Attached
Minimum Employer Contribution	75% cost of Eligible Employees/50% total account premium
Section 125 Enrollment Provisions	Yes
Insurance Coverage Creditable (Medicare Part D)	Yes
Start Date of Annual Enrollment Period	30 days prior to group anniversary date
End Date of Annual Enrollment Period	15 days after group anniversary date
Contract Term	12 months
Subsequent Renewal Terms	12 months
Renewal Notification	180 Days Preliminary; 120 Days Final
Next Renewal	1/1/15
Reinstatement Fee	$500
Subject to ERISA	No

Mandated Offerings		
Speech and Hearing Disorders	☐ Accept	☒ Reject
Child Health Supervision Services	☐ Accept	☒ Reject
Pregnancy Termination	☐ Accept	☒ Reject

Benefit and Rate Confirmation
Jackson County – Blue-Care Low and Blue-Care High HMO Plans

Rates		
Employee	See Cost Plus Agreement	See Cost Plus Agreement
Family		
Cobra		
Employee	$479.58	$543.76
Family	$1,333.24	$1,511.64

A Healthier You™	
Select only one: ☐ AHY 100+ ☒ AHY Platinum (1000+) ☐ Decline AHY(approval needed)	
AHY for Subscriber and Spouse with Medical Coverage	Included in premium

Funding	
	☐ ASO ☐ Cost Plus ☐ Insured ☒ Other Cost Plus

Confirmed by Jackson County:

Signature Michael D. Sanders

Title County Executive

Date 10/16/2013

Accepted by Blue Cross and Blue Shield of Kansas City:

Signature Carolyn Wolf

Title Dir Underwriting

Date 10/9/13

APPROVED AS TO FORM

County Counselor

ATTEST:

Clerk of the County Legislature

Jackson County
Preferred-Care Dental
Buy Up Plan
Benefit & Rate Confirmation
Effective (January 1, 2014)

Benefit and Rate Confirmation
Jackson County – Preferred-Care Dental Buy Up Plan

Covered Services	
Type I Services: Diagnostic and Preventive Services	Covered
Type II Services: Basic Restorative Services; **Periodontics;** Endodontics and Extractions	Covered
Type III Services: Major Restorative and Maintenance of Prosthodontics	Covered
Type IV Services: Orthodontic Services	Covered

Calendar Year Deductible: ☐ *Individual/Family* ☒ *Each Covered Person*		
	Preferred	**Non-Preferred**
Type I	Waived	Waived
Types II and III	$50	

Coinsurance:		
	Preferred	**Non-Preferred**
Type I	100%	100%
Types II	80%	60%
Type III	50%	50%
Type IV	60%	50%

Calendar Year Maximum:	**Preferred**	**Non-Preferred**
Types I, II, and III (per covered person)	$1,500	$1,500

Benefit and Rate Confirmation
Jackson County – Preferred-Care Dental Buy Up Plan

Special Benefit Provisions:		
Type III Services		
Temporomandibular Joint (TMJ) Dysfunction	Not Covered	
Dental Implants	Not Covered	
Type IV Services		
	Preferred	**Non-Preferred**
Orthodontia Lifetime Maximum	$1,500 lifetime maximum	$1,500 lifetime maximum
Orthodontia Limiting Age	Limiting age is to 19	
Additional Services		
Provide benefits for replacement of teeth missing **prior** to effective date?	Covered	

Eligibility:	
Dependent Limiting Age	Age 26
Eligibility/Termination	First day of the month/ Last day of the month
Domestic Partner Amendment – Coverage for same sex and opposite sex coverage	Covered

Benefit and Rate Confirmation
Jackson County – Preferred-Care Dental Buy Up Plan

Underwriting:	
Minimum percent of Eligible Employees covered	75%
Percentage threshold of total employee enrollment at renewal based on prior year's enrollment	90%
Classification of Eligible Employees	See Attached
Waiting Period	See Attached
Minimum Employer Contribution ☒ Voluntary	Not Applicable
Section 125 Enrollment Provisions	Yes
Start Date of Annual Enrollment Period	30 days prior to group anniversary date
End Date of Annual Enrollment Period	15 days after group anniversary date
Contract Term	36 months
Subsequent Renewal Terms	12 months
Renewal Notification	180 days Preliminary; 120 Days Final
Next Renewal	1/1/17
Reinstatement Fee	$500

Network
PPO Product: Preferred-Care Dental Network Inside Service Area: Preferred-Care Dental Network Network Outside Service Area: DNoA Network / Preferred and Non-Preferred Inside our Service Area Non-Participating Provider Payments: 90% of UCR based on Captiva Data Outside our Service Area Non-Participating Provider Payment: 90% of UCR based on Captiva Data

Services	
ID card should be sent to:	Member

Benefit and Rate Confirmation
Jackson County – Preferred-Care Dental Buy Up Plan

Rates	
Employee	$21.74
Employee + One	$42.86
Family	$71.56

COBRA Rates	
Employee	$22.17
Employee + One	$43.72
Family	$72.99

Funding

- ☐ Cost Plus
- ☒ Insured
- ☐ Other _____

Confirmed by Jackson County:

Signature Michael D. Sanders

County Executive
Title County Executive

10/16/2013
Date

Accepted by Blue Cross and Blue Shield of Kansas City:

Carolyn Wolf
Signature

Sr Underwriter
Title

10/9/13
Date

APPROVED AS TO FORM

County Counselor

ATTEST:

Mary Jo Spino
Clerk of the County Legislature

Jackson County
Preferred-Care Dental
Base Plan
Benefit & Rate Confirmation
Effective (January 1, 2014)

Benefit and Rate Confirmation
Jackson County – Preferred-Care Dental Plan

Covered Services	
Type I Services: Diagnostic and Preventive Services	Covered
Type II Services: Basic Restorative Services; **Periodontics;** Endodontics and Extractions	Covered
Type III Services: Major Restorative and Maintenance of Prosthodontics	Not Covered
Type IV Services: Orthodontic Services	Not Covered

Calendar Year Deductible: ☐ ***Individual/Family*** ☒ ***Each Covered Person***		
	Preferred	**Non-Preferred**
Type I	Waived	Waived
Type II	$50	

Coinsurance:		
	Preferred	**Non-Preferred**
Type I	100%	100%
Types II	80%	60%

Calendar Year Maximum:	**Preferred**	**Non-Preferred**
Types I & II (per covered person)	$1,500	$1,500

Benefit and Rate Confirmation
Jackson County – Preferred-Care Dental Plan

Special Benefit Provisions:		
Type III Services		
Temporomandibular Joint (TMJ) Dysfunction	Not Covered	
Dental Implants	Not Covered	
Type IV Services		
	Preferred	**Non-Preferred**
Orthodontia Lifetime Maximum	N/A	N/A
Orthodontia Limiting Age	N/A	
Additional Services		
Provide benefits for replacement of teeth missing **prior** to effective date?	N/A	

Eligibility:	
Dependent Limiting Age	Age 26
Eligibility/Termination	First day of the month/ Last day of the month
Domestic Partner Amendment – Coverage for same sex and opposite sex coverage	Covered

Benefit and Rate Confirmation
Jackson County – Preferred-Care Dental Plan

Underwriting:	
Minimum percent of Eligible Employees covered	75%
Percentage threshold of total employee enrollment at renewal based on prior year's enrollment	90%
Classification of Eligible Employees	See Attached
Waiting Period	See Attached
Minimum Employer Contribution ☒ Voluntary	Not Applicable
Section 125 Enrollment Provisions	Yes
Start Date of Annual Enrollment Period	30 days prior to group anniversary date
End Date of Annual Enrollment Period	15 days after group anniversary date
Contract Term	36 months
Subsequent Renewal Terms	12 months
Renewal Notification	180 days Preliminary; 120 Days Final
Next Renewal	1/1/17
Reinstatement Fee	$500

Network
PPO Product: Preferred-Care Dental Network Inside Service Area: Preferred-Care Dental Network Network Outside Service Area: DNoA Network / Preferred and Non-Preferred Inside our Service Area Non-Participating Provider Payments: 90% of UCR based on Captiva Data Outside our Service Area Non-Participating Provider Payment: 90% of UCR based on Captiva Data

Services	
ID card should be sent to:	Member

Benefit and Rate Confirmation
Jackson County – Preferred-Care Dental Plan

Rates	
Employee	$13.78
Employee + One	$25.52
Family	$45.96

COBRA Rates	
Employee	$14.06
Employee + One	$26.03
Family	$46.88

Funding

- ☐ Cost Plus
- ☒ Insured
- ☐ Other _____

Confirmed by Jackson County:

Signature Michael D. Sanders

County Executive
Title County Executive

10/16/2013
Date

Accepted by Blue Cross and Blue Shield of Kansas City:

Carolyn Wolf
Signature

Sr Underwriter
Title

10/9/13
Date

APPROVED AS TO FORM
County Counselor

ATTEST:
Mary Jo Spino
Clerk of the County Legislature

Blue Cross and Blue Shield of Kansas City

COST PLUS AGREEMENT – PAID BASIS

WITNESSETH:

This Agreement 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 (hereinafter, "BCBSKC") on behalf of itself and its subsidiary, Good Health HMO, Inc., d/b/a Blue-Care ("HMO"), if applicable and Jackson County ("Employer"). This Agreement shall be effective January 1, 2014.

WHEREAS, Employer has established a benefit plan to provide benefits for certain eligible classes of Covered Persons under the Group Contract(s) issued to Employer, and

WHEREAS, the Employer desires that BCBSKC provide claims administrative services and stop-loss coverage for Employer, and

WHEREAS, BCBSKC has contracted with various parties to obtain discounts for Covered Services, including prescription drugs, for its clients; and

WHEREAS, BCBSKC is also able to arrange for discounts for Covered Services outside its Service Area through other Blue Cross and Blue Shield plans ("Licensees").

NOW THEREFORE, in consideration of the mutual covenants herein contained, acknowledged to be good and sufficient consideration, the parties do hereby agree as follows:

Article 1
Employer's Rights and Obligations

1.1 Premium for Group Contracts. Employer agrees that premiums for coverage under the Group Contracts shall be determined as set forth in this Agreement and shall be payable in an amount equal to the total of the Employer's claims obligations, Fixed Cost Fees, and Access Fees pursuant to the terms herein.

1.2 Employer's Claims Obligations. In order to insure the Employer's claim obligations, the Employer shall make payments to BCBSKC for Claims Payments in amounts equal to the amount of Paid Claims up to the Specific Stop-Loss Limit per Covered Person and up to the cumulative monthly Aggregate Stop-Loss Limit, in accordance with Article 3.1. In no event shall Employee contributions be used to pay for Stop-Loss coverage. The Aggregate Stop-Loss Limit shall be the sum of the amounts determined by multiplying the number of covered employees/retirees, the number of covered employees/retirees with dependents and the number of covered Medicare complementary individuals covered under the Group Contract(s) on the first day of each month during the Contract Year by the appropriate monthly Aggregate Stop-Loss Limit factors as indicated in Article 8.6.1. However, the minimum Aggregate Stop-Loss Limit shall not be less than the minimum Aggregate Stop-Loss Limit indicated in Article 8.6.2.

1.3 Cumulative Monthly Aggregate Employer Liability. The number of covered employees/retirees, the number of covered employees/retirees with dependents and the number of covered Medicare complementary individuals covered under the Group Contract(s) on the first day of each month during the Contract Year shall be multiplied by the appropriate monthly Aggregate Stop-Loss Limit factors as indicated in Article 8.6.1. This amount represents the Employer's monthly aggregate amount ("Monthly Aggregate Amount"). BCBSKC shall calculate the Employer's total monthly claims liability as set forth below.

(a) The Claims Payment will be subtracted from the cumulative Monthly Aggregate Amount.

(b) In the event the cumulative Monthly Aggregate Amount exceeds the cumulative Claims Payment: (i) the Employer will be required to pay to BCBSKC the cumulative Claims Payment amount; and (ii) the difference between the cumulative Monthly Aggregate Amount and the cumulative Claims Payment shall be added to the next subsequent Monthly Aggregate Amount.

(c) In the event the cumulative Claims Payment exceeds the cumulative Monthly Aggregate Amount: (i) the Employer will be required to pay to BCBSKC the cumulative Monthly Aggregate Amount; and (ii) the difference between cumulative Claims Payment amount and the cumulative Monthly Aggregate Amount shall be added to the next subsequent Claims Payment amount.

1.4 Advance Deposit. The Employer shall pay BCBSKC an advance deposit if indicated in Article 8.7 on or before the date this Agreement is to commence. BCBSKC will use these funds to pay the Employer's claim obligations for Paid Claims as specified in Article 1.2. Employer agrees to pay BCBSKC within 31 calendar days of receipt of the notification ("due date") of the amount necessary to restore to its full amount the advance deposit as stated herein. Failure of the Employer to restore the advance deposit in such time will cause automatic termination of this Agreement and of the underlying Group Contract(s) to which this Cost Plus Agreement is applicable. Such terminations shall be effective on the due date of the restoration of the advance deposit.

1.5 Fixed Cost Fees. Employer shall pay BCBSKC, on a monthly basis, the Fixed Cost Fees as set forth in Article 8.2 and in accordance with Article 3.2.

1.6 Access Fees. Employer shall pay BCBSKC the Access Fee, on a monthly basis, as set forth in Article 8.4 and in accordance with Article 3.3.

1.7 Miscellaneous taxes or assessments: If at any time, during or after the term of this Agreement, BCBSKC is required to pay any taxes or assessments (collectively "Taxes") based upon or measured by: (a) fees paid or payable to BCBSKC, (b) claims paid pursuant to this Agreement, (c) or due to coverage of Covered Person, Employer will pay BCBSKC an additional amount equal to the Taxes based upon the payment by BCBSKC of these additional amounts. Examples of such assessments include New York Healthcare Reform surcharges and assessments, Maine Dirigo Access Payment, et al. BCBSKC shall bill the Employer these additional Taxes on the Claims Payment report and the Employer shall pay such Taxes in accordance with Article 3.1.

Article 2
BCBSKC Rights and Obligation

2.1 Administration of Group Contracts. BCBSKC shall provide claims administrative services for claims submitted under the Group Contract(s). For the purpose of this Agreement, BCBSKC shall have the right to determine the amount of Benefits, if any, payable for any Covered Person [and the Employer agrees to accept and follow such determination]. Such determination shall be on the same basis as would be applicable under the Group Contract(s) in the absence of this Agreement. 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. [Upon prior written approval, which shall not be unreasonably withheld,] BCBSKC shall have the right to settle any such action, when it deems it expedient to do so. [Should Employer not provide written approval, BCBSKC and Employer shall each be responsible for 50% of the expense of the defense of 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) provided such Paid Claim does not exceed the Specific Stop-Loss Limit or Aggregate Stop-Loss Limit.

2.2 Stop-Loss Coverage. BCBSKC shall provide aggregate and specific stop-loss coverage for Employer in accordance with Article 1.2, Article 8.5 and Article 8.6.

Article 3
Payment Due Dates, Grace Periods and Payment Changes

3.1 Claims Payment and Grace Period. Monthly payments for Claims Payments are due and payable by the Employer within 31 calendar days following delivery to Employer by BCBSKC of the Claims Payment report. The Employer shall have no grace period for such monthly Claims Payment. The Employer's obligation for Claims Payments is subject to the Aggregate Stop-Loss Limit and Specific Stop-Loss Limit described herein.

3.2 Fixed Cost Fees and Grace Period. Fixed Cost Fees are due and payable by the Employer the first day of each month. The Employer shall have a grace period of 31 calendar days for such monthly Fixed Cost Fees.

3.3 Access Fees. Access Fees are due and payable by the Employer as indicated in Article 8.4.

3.4 Changes in Fixed Cost Fees and Access Fees. BCBSKC reserves the right to change Fixed Cost Fees and Access Fees upon a 31 calendar day written notice prior to the end of a Contract Year, to be effective for the following Contract Year.

3.5 Late Payment Charge. BCBSKC reserves the right to charge a late payment fee of $13,220 in each instance in which Employer fails to timely pay the Claims Payment, Fixed Cost Fees or Access Fees in accordance with this Article 3. In the event Employer is delinquent in payment for two consecutive months, BCBSKC shall have the option to require Employer to provide BCBSKC a deposit in an amount equal to the average monthly invoice amount for the previous six (6) months or if there is less than six (6) months billing history, then such deposit shall be based on the average monthly invoice of the actual billing history. BCBSKC shall retain the deposit until the termination of this Agreement.

Article 4
Amendments

4.1 General. Except as provided in Article 3.4, BCBSKC may amend any other term or condition of this Agreement upon 31 calendar days written notice to conform with statutes of the state in which this Agreement is issued for delivery.

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

Article 5
Termination

5.1 This Agreement may be terminated by BCBSKC or the Employer provided such party gives the other party written notice of its election to terminate the Agreement at least 30 calendar days prior to the [expiration of the then current term] [termination date]. This Agreement and the underlying Group Contract(s) shall automatically terminate on the date of termination of the Group Contract(s).

5.2 Except as provided in 5.3 below, either party may terminate this Agreement for cause upon written notice if the other party materially defaults in the performance of a provision of this Agreement 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.

5.3 If Employer fails to pay BCBSKC in accordance with Article 3, this Agreement and the underlying Group Contract(s) may be terminated by BCBSKC, effective retroactively to the last day of the month in which the Fixed Cost Fees, Access Fees and/or Claims Payment were paid by the Employer if the Employer fails to pay the Fixed Cost Fees, Access Fees and/or Claims Payment as required in accordance with Article 3.

5.4 Upon termination of this Agreement the Employer shall have the total obligation for all payments of claims for Covered Services incurred prior to such termination but not paid by BCBSKC as of the termination date and for any claims incurred after such termination.

Article 6
General Provisions

6.1 Term. The initial term of this Agreement shall begin on the effective date of this Agreement and continue for a term of one (1) year, and the Agreement shall thereafter renew automatically for successive one (1) year, terms unless it shall have been terminated earlier as provided in Article 5.

6.2 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 Agreement and to that extent the provisions of this Agreement shall govern notwithstanding anything in the Group Contract(s) to the contrary.

6.3 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 Agreement, such waiver shall not be deemed or construed as a continuing waiver of any breach of the same or different provision.

6.4 BlueCard Fees. Employer understands and agrees: (1) 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 (2) 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 Agreement].

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 will pursue recoveries in accordance with BCBSKC's established rules and procedures, or engage third parties to provide such services on behalf of BCBSKC. The fees of such a third party are netted against the recovery. Any recovery amounts, net of such fees, if any, will be credited to the Employer. BCBSKC has no obligation to pursue recovery (including class action settlement recoveries) from health care providers or manufacturers of health care products or services on behalf of Employer for any cause of action including, but not limited to, causes of action arising out of violations of antitrust law, fraud, claims relating to fraud (including claims under the *Racketeering Influenced and Corrupt Organizations Act*).

6.7 BCBSKC Prescription Drug Program. BCBSKC contracts with a pharmacy benefit manager ("PBM") for certain prescription drug rebate administration services and pharmacy network contracting services. Under the agreement, PBM obtains rebates from drug manufacturers based on the utilization of certain branded prescription products by Covered Persons. As partial consideration for these services, pharmaceutical manufacturers pay administrative fees to PBM and PBM retains the benefit of the funds prior to

disbursement. Administrative fees retained by PBM in connection with its rebate program do not exceed the greater of (i) 4.58% of the Average Wholesale Price, or (ii) 5.5% of the wholesale acquisition cost of the products. PBM may also receive other service fees from manufacturers as compensation for various services unrelated to rebates or rebate-associated administrative fees. Employer acknowledges and agrees for itself and its Covered Persons that BCBSKC receives rebates from the PBM and may receive financial credits, administrative fees and/or other amounts (collectively "Financial Credits") from network pharmacies, drug manufacturers or the PBM. Employer acknowledges and agrees for itself and its Covered Persons that BCBSKC shall retain sole and exclusive right to all Financial Credits and 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 for itself and its Covered Persons that: (1) Employer and/or Covered Persons shall have no right to receive, claim or possess any beneficial interest in any Financial Credits; (2) Applicable drug benefit copayments, coinsurance, outpatient prescription drug deductible, deductible and/or maximum allowable benefits (including without limitation Calendar Year Maximum and Lifetime Maximum benefits) shall in no way be adjusted or otherwise affected as a result of any Financial Credits; (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; 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.

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. For pharmacies that contract with the PBM, BCBSKC pays a uniform discount rate under the BCBSKC contract with the PBM regardless of the various discount rates it 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. The PBM and directly contracted network pharmacies have guaranteed BCBSKC a minimum level of discount which could result in a Financial Credit. In the event the discount results in a Financial Credit, the Financial Credit Rules apply. 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 the funds between these payments.

6.8 Audit of BCBSKC. During the term of this Agreement, Employer has the right to audit certain of the functions performed by BCBSKC in administering its Plan. Employer may not have access to provider reimbursement or other proprietary information under the control of BCBSKC, unless Employer has a compelling reason, to be determined at the discretion of BCBSKC, and needs such information to perform its duties in administering the Plan. If Employer uses the services of a third party to perform all or any part of an audit, that third party must execute BCBSKC's current Confidentiality and Nondisclosure Agreement. A copy of BCBSKC's most current Confidentiality and Nondisclosure Agreement may be obtained by requesting it from BCBSKC; however this Agreement is subject to change at any time by BCBSKC. Employer may perform a simple audit of BCBSKC once during the calendar year while this Agreement is in force without any charge by BCBSKC. A "simple audit" is one that requires less than fifty (50) person hours

of work by BCBSKC employees to assist in the audit. The Employer must negotiate the cost and scope with BCBSKC for an audit that does not fit this definition. The parties agree that Employer shall not hire a third party to conduct a contingent fee audit, where the third party's compensation is based on a percentage of errors (or savings, or "uncovered recoveries", etc, which may be found by the third party in its audit). Should Employer err and so contract with a third party to perform such contingent fee audit, BCBSKC has no obligation under the terms of this Agreement to cooperate with said third party in the conduct of such contingent fee audit. Employer's right to audit BCBSKC without any additional charge terminates with the termination of this Agreement.

6.9 Entire Agreement. This Agreement and the Group Contract(s) constitute the entire Agreement between the parties concerning this subject matter and supersedes 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 Agreement, and both parties understand and agree that prior agreements, practices or statements inconsistent with the language, terms and conditions of this Agreement are of no further force or effect.

Article 7
Definitions

"Access Fee" means the amount of money to be paid by the Employer to BCBSKC for savings realized on Paid Claims to providers.

"Aggregate Stop-Loss Limit" means the amount of Paid Claims at which BCBSKC assumes one hundred percent (100%) of the Employer's claims obligation for all Covered Persons' Covered Services for any Contract Year.

"Claims Payment" means the monthly Paid Claims as reported for a given month by BCBSKC.

"Contract Year" means the twelve (12) month period commencing on the effective date of this Agreement and from year to year thereafter, unless terminated as provided in this Agreement.

"Covered Person(s)" means those individuals as defined in the Group Contract(s).

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

"Fixed Cost Fees" means the amount of money to be paid by the Employer to BCBSKC for any premium tax, [the Comparative Effectiveness Fee under the Affordable Care Act,] contract administration, processing and claims investigation, utilization management, claims management, production and distribution of identification cards, brokerage fees, Blue Card fees and other general services, and Stop-Loss Charges as indicated in Article 8.2.

"Group Contract(s)" means those Group Contract(s) identified in Article 8.1.

"Paid Claims" means all payments for Covered Services during the Contract Year for claims that were incurred while this Agreement was in effect [or for claims that were incurred under the Cost-Plus Agreement between the parties for the previous Contract Year, if applicable;]

and, capitation charges 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.

"Specific Stop-Loss Limit" means the amount at which BCBSKC assumes 100% of the Employer's liability for a Covered Persons' Covered Services for any Contract Year.

"Stop-Loss Charges" are those monies due BCBSKC for assuming risk above the Aggregate Stop-Loss Limit and the Specific Stop-Loss Limit.

"Other Defined Terms" means any other capitalized term used in this Agreement and not specifically defined herein, shall have the meaning ascribed to it in the Group Contracts.

Article 8
Schedule

8.1 This Agreement shall be applicable to:

[X] Employer's Group Health Contract: Group Number(s) 31618000
[N/A] Employer's Group Dental Contract: Group Number(s) [_____]

8.2 The Fixed Cost Fees are as follows:

Employee	$37.00
Family	$102.84

8.3 Stop-Loss Charges shall include:

[X] Specific Stop-Loss Limit for health coverage
[X] Aggregate Stop-Loss Limit for health coverage
[N/A] Aggregate Stop-Loss Limit for dental coverage

8.4 The Access Fee is due and payable with the Claims Payment and is 10% of Savings not to exceed $2,000 per claim with an annual cumulative cap of $25.00 per employee per month and shall be subject to the Monthly Maximum Access Fee described below.:

Savings are calculated by taking the total amount of providers' billed charges and subtracting the total of the Benefits payable for claims incurred in that same period, after applying the applicable Discounts. Total Benefits payable are the amounts paid by the Employer plus the Deductible, Coinsurance and Copayments owed by the Covered Person.

Discount means the amount of the initial reduction from a provider's billed charges that a provider has agreed to accept as payment in full at the time of claim payment for Covered Services provided to Covered Persons' utilizing the contracted arrangement. "Discount" does not mean nor include any affiliation fees, 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 are not included in the Discount that BCBSKC makes available to Employer.

8.5 The Specific Stop-Loss Limit per Covered Person shall be $250,000.

8.6.1. Monthly Aggregate Stop-Loss Limit factors

	Blue-Care Low	Blue-Care High	Preferred-Care Blue
Employee	$409.00	$471.43	$646.23
Family	$1,137.02	$1,310.58	$1,796.52

8.6.2. Minimum Aggregate Stop-Loss Limit:

$12,617,996 or 90% of the first month's covered units times the number of months of coverage times the Monthly Aggregate Stop-Loss Limit factors, whichever is greater.

8.7 Initial Deposit

[_____]Yes [X]No If Yes, amount of initial deposit: $[_____]

IN WITNESS WHEREOF, BCBSKC and the Employer have caused this Agreement to be executed in duplicate.

Jackson County

BY: MD Sanders

Michael D. Sanders

TITLE: County Executive

DATE: 10/16/2013

Blue Cross and Blue Shield of Kansas City

BY: Carolyn Wolf

TITLE: Dir Underwriter

DATE: 10/9/13

APPROVED AS TO FORM

County Counselor

ATTEST: Mary Jo Spino

Clerk of the County Legislature

AMENDMENT TO COST PLUS AGREEMENT-PAID BASIS
RUNOUT

This Amendment ("Amendment") is incorporated into and made a part of the Cost Plus Agreement-Paid Basis ("Agreement") entered into by and between Blue Cross and Blue Shield of Kansas City ("BCBSKC") and Jackson County Employer"). This Amendment shall be effective January 1, 2014.

WHEREAS, BCBSKC and Employer have previously entered into a Cost Plus Agreement which sets for the terms of the parties rights and obligations with respect to the Group Contract(s); and

WHEREAS, the parties desire that this Amendment memorialize the modifications that the parties have reached concerning the termination provisions of the Agreement.

NOW, THEREFORE, in consideration of the mutual covenants herein contained, acknowledged to be good and sufficient consideration, the parties do hereby agree as follows:

1. BCBSKC shall provide administrative services for claims for Covered Services incurred prior to the termination of the Agreement, but received by BCBSKC during the first twelve months following termination of the Agreement ("Runout").

2. BCBSKC shall provide aggregate terminal liability coverage for Employer in accordance with Paragraph 4 below. BCBSKC shall not provide specific stop-loss coverage.

3. Monthly Claims Payments for the Runout are due and payable by the Employer in accordance with Article 3.1 of the Agreement.

4. The Employer's maximum liability for the Runout shall be calculated by averaging the number of units of Covered Persons for the last three months of the final Contract Year multiplied by the terminal liability factors. The terminal liability factors are:

	Blue-Care Low	Blue-Care High	Preferred-Care Blue
Employee	$613.50	$707.14	$969.34
Family	$1,705.53	$1,965.86	$2,694.78

5. The Employer shall pay to BCBSKC an administration fee to process the Runout. The administration fee is due and payable by the Employer within 31 calendar days following notification to Employer by BCBSKC of the Claims Payment Report. The administration fee shall be N/A.

6. The Employer shall pay to BCBSKC an Access Fee which is due and payable by the Employer within 31 calendar days following notification to Employer by BCBSKC of the Claims Payment Report. The Access Fee shall be N/A.

7. This Amendment may be terminated by BCBSKC, effective as of the last day of the month during such month in which the administration fee, Access Fee or payments for Claims Payment were not paid by the Employer as required in accordance with Article 3 or other applicable provisions of the Agreement.

8. The Agreement shall remain in effect to the extent necessary to carry out the provisions of this Amendment.

The parties hereto have executed this amendment which is made a part of the Agreement, by and between BCBSKC and Employer.

BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

BY: Carolyn Wood

TITLE: Sr Underwriter

DATE: 10/9/13

Jackson County

BY: _____

Michael D. Sanders

TITLE: County Executive

DATE: 10/16/2013

APPROVED AS TO FORM

_____ for

County Counselor

ATTEST:

_____

Clerk of the County Legislature

Performance Standards Agreement

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

Performance Standards Agreement

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

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 <u>fourteen</u> 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, 2014, and will remain in force through December 31, 2014 (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

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

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 16 **day of** October**, 2013.**

Jackson County:

By: _____

Name: Michael D. Sanders

Title: County Executive

Blue Cross and Blue Shield of Kansas City

By: _____

Name: Jeffrey E. Berry

Title: VP- Underwriting

APPROVED AS TO FORM

_____
County Counselor

ATTEST:

_____
Clerk of the County Legislature

Dental Source

Dental Health Care Plans

APPLICATION FOR GROUP DENTAL SERVICE AGREEMENT

1. Organization: Jackson County

2. Address:_____City:_____ State:____Zip:_____

3. Telephone: (____)_____Fax: (____)_____E-mail:_____

4. Key Contact:_____ Title:_____

5. Effective Date:_____

6. **ELIGIBILITY REQUIRMENTS:** _____

A. Class of employees (members) to be covered: ☐Active ☐ Retirees

B. Number of Eligible Employees:_____ C. Employment Waiting Period:_____

D. Employer Contribution:_____

5. **DENTAL CARE SERVICES:**

   A. Plan Type: H

   B. Rates: **Single $8.76 Couple $14.26 Family $22.00**

6. MONTHLY PREPAYMENT FEE: The monthly prepayment fee for the number of Members in each category is due and payable from the ORGANIZATION by the 25th day of the month preceding coverage.

7. This Agreement shall be for a period of two (2) year(s), and shall automatically be renewed thereafter for successive one-year periods, unless terminated by either party giving 30 days written notice to the other party. Contractor may terminate this agreement if Organization fails to remit monthly prepayment fees on a timely basis.

8. The organization agrees to the Terms and Conditions as established by Dental Source and hereby request membership with Dental Source of MO & KS, Inc.

ORGANIZATION Signature

Michael D. Sanders County Executive
(Print Name and Title)

Jackson County, Missouri
Agent/Broker (Print Name or Organization)

APPROVED AS TO FORM
County Counselor

ATTEST:
Clerk of the County Legislature

Dental Source

Dental Health Care Plans
Schedule of Benefits – Plan H

The American Dental Association (ADA) assigns code numbers to each dental service. The Schedule of Services below provides you with an easy reference to the coverage associated with the Dental Source Program. All copayments are paid directly to your selected participating general dentist and are due at the time of service. All dental services listed in this schedule are provided **exclusively** by Dental Source network general dentists. There is no coverage outside of the Dental Source network. If the services of a Specialist are required, the member will receive a 20% discount off the usual fees from a participating Specialist, where available.

ADA CODE	PROCEDURE	Co-payment
Diagnostic and Preventive – General Dentists Office		
****	Consultation	No Charge
0120	Periodic Oral Examination	No Charge
0140	Limited Oral Evaluation-Problem Focused (Normal Office Hours)	20.00
0150	Comprehensive Oral Evaluation	No Charge
0210	Full Mouth X-Ray	15.00
0220	Initial Periapical X-Ray	No Charge
0230	Additional Periapical X-Ray	No Charge
0240	Occlusal X-Ray	No Charge
0250	Extraoral X-Ray	No Charge
0270-0274	Bitewing X-Ray	No Charge
0330	Panoramic X-Ray	15.00
0460	Tooth Pulp Vitality Test	No Charge
0470	Diagnostic Casts - Study Models	No Charge
1110	Prophylaxis-Adult-Every 6 Months	No Charge
1120	Prophylaxis-Child-Every 6 Months	No Charge
1203	Topical Application of Fluoride-Child- Through age 18 Every 6 Months	No Charge
1204	Topical Application of Fluoride- Adult- Every 6 Months	8.00
1330	Oral Hygiene Instruction	No Charge
1351	Sealant	12.00
1510	Space Maintainer-Fixed-Unilateral	65.00
1515	Space Maintainer-Fixed-Bilateral	65.00
1520	Space Maintainer-Removable-Unilateral	80.00
1525	Space Maintainer-Removable-Bilateral	80.00
*****	Difficult Prophylaxis Subjected to a 25.00 Charge	
Restorative (Fillings, Inlays and Onlays) - General Dentist Office		
2140	Amalgam-Primary, 1 Surface	10.00
2150	Amalgam-Primary, 2 Surfaces	16.00
2160	Amalgam- Primary, 3 Surfaces	21.00
2161	Amalgam- Primary, 4 or More Surfaces	25.00
2140	Amalgam-Permanent, 1 Surface	11.00
2150	Amalgam-Permanent, 2 Surfaces	18.00
2160	Amalgam- Permanent, 3 Surfaces	23.00
2161	Amalgam- Permanent, 4 or More Surfaces	28.00
2210	Silicate Cement – Per Restoration	18.00
2330	Resin-Based Composite 1 Surface- Anterior	20.00
2331	Resin-Based Composite 2 Surfaces – Anterior	30.00
2332	Resin-Based Composite 3 Surfaces – Anterior	40.00
2335	Resin-Based Composite 4 + Surfaces– Anterior (Incisal Angle)	60.00
2390	Resin-Based Composite Crown – Anterior	65.00
2391	Resin-Based Composite 1 Surface–Posterior-Primary	21.00
2392	Resin-Based Composite 2 Surfaces–Posterior-Primary	24.00
2393	Resin-Based 3 Surfaces-Posterior–Primary	28.00
2391	Resin-Based Composite1 Surface–Posterior-Permanent	50.00
2392	Resin-Based Composite 2 Surfaces –Posterior-Permanent	55.00
2393	Resin-Based Composite 3 Surfaces – Posterior-Permanent	60.00
2394	Resin-Based Composite 4 or More Surfaces – Posterior-Permanent	65.00
2510	Inlay-Metallic-1 –Surface	185.00
2520	Inlay-Metallic- 2- Surface	210.00
2530	Inlay-Metallic-3-Surface	235.00
2543	Onlay-Metallic-3 – Surface	250.00
2544	Onlay- Metallic-4- Surface	265.00
2610	Inlay-Porcelain/Ceramic1 Surface	215.00
2620	Inlay-Porcelain/Ceramic 2 Surfaces	250.00
2630	Inlay-Porcelain/Ceramic 3 or More Surfaces	260.00
2642	Onlay-Porcelain/Ceramic 2 Surfaces	250.00
2643	Onlay-Porcelain/Ceramic 3 Surfaces	290.00
2650	Inlay-Composite/Resin-1 Surfaces	150.00
2651	Inlay-Composite/Resin-2 Surfaces	185.00
2652	Inlay-Compsite/Resin- 3 or More Surfaces	225.00
2662	Onlay Composite/Resin-2 Surfaces	175.00
2663	Onlay-Composite/Resin-3 Surfaces	200.00
2664	Onlay-Composite/Resin-4 or MoreSurfaces	225.00
2940	Sedative Fillings	20.00
****	Laboratory Fees Are Not Covered.	
Restorative (Crowns-Single Restorations) - General Dentist Office		
****	Crown-Temporary In Conjunction With Permanent	No Charge
2740	Crown-Porcelain/Ceramic Substrate	295.00
2750	Crown-Porcelain Fused to High Noble Metal	275.00
2751	Crown-Porcelain Fused to Predominantly Base Metal	275.00
2752	Crown-Porcelain Fused to Noble Metal	275.00
2780-83	Crown-3/4	275.00
2790	Crown-Full Cast High Noble Metal	295.00
2791	Crown-Full Cast Predominantly Base Metal	275.00
2792	Crown-Full Cast Noble Metal	275.00
2910	Recement Inlays	20.00
2920	Recement Crowns	25.00
2930	Stainless Steel Crown-Primary Tooth	68.00
2950	Crown Buildup, Including Any Pins	75.00
2951	Pin Retention	18.00
2952	Cast Post & Core In Addition to Crown	100.00
2954	Pre-fab Post & Core In Addition to Crown	80.00
2960	Labial Veneers (Chairside)	250.00
2962	Labial Veneer (Lab)	300.00
2980	Crown Repair - By Report	25.00
****	Laboratory Fees Are Not Covered.	
Endodontics (Root Canal Therapy) - General Dentist Office		
****	Endo Consultation	No Charge
3110	Pulp Cap Direct	15.00
3120	PulpCap Indirect	12.00
3220	Vital Pulpotomy	48.00
3310	Root Canal-Anterior	125.00
3320	Root Canal-Bicuspid	180.00
3330	Root Canal-Molar	250.00
3410	Apicoectomy – Anterior	140.00
3421	Apicoectomy- Bicuspid-First Root	140.00
3425	Apicoectomy-Molar-First Root	175.00
3426	Apicoectomy- Each Additional Root	80.00
3430	Retrograde Filling-Each Root	50.00
Periodontics - General Dentist Office		
****	Perio Consultation	No Charge
4999	Perio Charting	20.00
4210	Gingivectomy or Gingivoplasty (per quadrant)	115.00
4220	Gingival Curettage (per quadrant)	60.00
4240	Gingival Flap Surgery (per quadrant)	265.00
4260	Osseous Surgery (per quadrant)	300.00
4341	Periodontal scaling & root planing (per quadrant)	50.00
4355	Full Mouth Debridement	44.00
4910	Periodontal Maintenance	35.00
Prosthodontics (Removable) - General Dentist Office		
5110	Complete Dentures-Upper	350.00
5120	Complete Dentures-Lower	350.00
5130	Immediate Upper Denture (Excluding Reline)	400.00
5140	Immediate Lower Denture (Excluding Reline)	400.00
5211	Partial Denture-Upper/Resin Base	350.00
5212	Partial Denture-Lower/Resin Base	350.00
5213	Partial Denture-Upper/ Metal Base	425.00
5214	Partial Denture-Lower/Metal Base	425.00
5410	Adjust Complete Denture -Upper	10.00
5411	Adjust Complete Dentures-Lower	10.00
5421	Adjust Partial Denture-Upper	10.00

5422	Adjust Partial Denture-Lower	10.00
5510	Repair Denture Base	35.00
5520	Repair/Replace Broken Tooth/Denture	35.00
5620	Repair Cast Framework	35.00
5630	Repair or Replace Broken Clasp	35.00
5640	Replace Broken Tooth -Per Tooth	35.00
5650	Add Tooth to Existing Partial	35.00
5660	Add Clasp To Existing Partial	35.00
5730	Reline Upper Dentures-Chairside	75.00
5731	Reline Lower Dentures-Chairside	75.00
5740	Reline Upper Partial-Chairside	70.00
5741	Reline Lower Partial-Chairside	70.00
5750	Reline Upper Denture-Lab	85.00
5751	Reline Lower Denture-Lab	85.00
5760	Reline Upper Partial-Lab	85.00
5761	Reline Lower Partial-Lab	85.00
****	Laboratory Fees Are Not Covered.	

Prosthodontics - General Dentist Office

6240	Pontic-Porcelain Fused to High Noble Metal	275.00
6241	Pontic-Porcelain Fused to Predominantly Base Metal	275.00
6242	Pontic-Porcelain Fused to Noble Metal	275.00
6750	Crown-Porcelain Fused to High Noble Metal	275.00
6751	Crown-Porcelain Fused to Predominantly Base Metal	275.00
6752	Crown-Porcelain Fused to Noble Metal	275.00
6790	Crown-Full Cast High Noble Metal	275.00
6791	Crown-Full Cast Predominantly Base Metal	275.00
6792	Crown-Full Cast Noble Metal	275.00
6930	Recement Bridge	25.00
6940	Stress Breaker	10.00
6950	Precision Attachment	195.00
****	Laboratory Fees Are Not Covered.	

Oral Surgery - General Dentist Office

****	Oral Surgery Consultation	No Charge
7111	Extraction-Coronal Remnants-Primary	25.00
7140	Extraction-Erupted Tooth or Exposed Root	25.00
7210	Surgical Removal of Erupted Tooth	50.00
7220	Removal of Impacted Tooth-Soft Tissue	70.00
7230	Removal of Impacted Tooth-Partial Bony	90.00
7240	Removal of Impacted Tooth-Complete Bony	110.00
7241	Removal of Impacted Tooth-Complete Bony w/Comp	175.00
7250	Surgical Removal of Residual Roots	90.00
7281	Surgical Exposure of Tooth	150.00
7310	Alveoplasty In Conjunction w/Extractions/ Per Quadrant	100.00
7320	Alveoloplasty Not In Conjunction w/Extractions/Per Quadrant	150.00
7470	Removal of Exostosis	225.00
7510	Incision & Drainage of Abscess-Intraoral Soft Tissue	55.00
7960	Frenectomy	80.00
****	Post Operative Treatment (Including dry socket treatment)	No Charge

Orthodontics (Braces) - General Dentist Office

****	Ortho Consultation (General Dentist Only)	No Charge
****	Ortho Treatment Plan (Records & Models)	75%
****	Orthodontic Appliance	75%
****	Orthodontic Appliance Therapy	75%
****	Orthodontic Treatment	75%

Adjunctive General Services - General Dentist Office

9215	Local Anesthesia	No Charge
9230	Nitrous Oxide (per 15 minutes)	10.00
9430	Office Visit For Observation (Normal Office Hours)	No Charge
9440	Emergency office visit (After Office Hours)	40.00
9940	Occlusal Guards-By Report	75.00
9951	Occlusal Adjustment-Limited	55.00
9952	Occlusal Adjustment-Complete	125.00
9999	Broken Appointments (Per 15 Minutes Scheduled)	10.00

EMERGENCY TREATMENT COVERAGE:

In the event of a dental emergency, Dental Source members should contact their selected Dental Source provider. If the Dental Source provider is unavailable for emergency care within 24 hours, members may obtain emergency services from any licensed dentist. The covered emergency services include palliative treatment to control pain, bleeding, or infection. Dental Source members will be reimbursed up to $50.00 based on the Dental Source Schedule of Benefits. Any further restorative service must be provided by the member's selected Dental Source provider. In order to receive reimbursement for fees paid, less any applicable co-payment, the member must notify Dental Source within two working days of the onset of the emergency, and written request for reimbursement with receipts must be received by Dental Source within 30 days of the onset of the emergency.

EXCLUSIONS AND LIMITATIONS - GENERAL DENTIST

1. Laboratory fees or lab related charges.
2. Prophylaxis (cleanings) and fluoride treatments are limited to one every 6 months. Difficult prophylaxis (i.e. heavy smoker, neglected teeth) are subject to a $25.00 charge.
3. Procedures provided by any dentists including specialists who are not within the Dental Source provider network.
4. Treatment provided by a participating Dental Source dentist other than your selected dentist prior to receiving approval from the Dental Source office.
5. Dental treatment commenced prior to the member's eligibility or in progress at the time of application or expenses incurred after termination from plan are not covered
6. Dental expenses incurred if a participating dentist is unable to perform a procedure due to a member's general health or physical condition (i.e. patient physically unable to visit dentist office or suffering from a contagious illness or disease).
7. Charges for broken appointments.
8. Any dental procedure not listed as a covered service including but not limited to general anesthesia, the services of an anesthesiologist, prescription medication, implants, treatment required by reason of war, hospital and medical charges of any kind, surgery of fractures and dislocations, loss or theft of dentures or bridgework, and the treatment of malignancies.
9. Services provided to the member by state government, or agencies thereof, or services provided without cost to the member by any municipality, county, or other subdivision.
10. Procedures, appliances, or restorations to correct congenital, developmental, or medically induced dental disorders, including but not limited to, treatment of myo-functional, myo-skeletal, or temporomandibular joint dysfunction (TMJ).
11. Dentures, bridges, and other appliances fabricated under this program can be replaced only once during the period of 5 years after the original insertion. A denture, bridge, or other appliance can be replaced only if it cannot be made satisfactory by reline or repair.
12. A denture, bridge, or other appliance installed while not covered by Dental Source will be replaced only if it cannot be made satisfactory by reline or repair.
13. All covered replacements are subject to the co-payment as listed in the Schedule of Benefits. Replacement of dentures, appliances or bridgework due loss or theft is not covered.
14. Crowns are covered only if the dentist determines that there is not enough retentive quality left in a tooth to hold a filling.
15. Replacement of a satisfactory filling is not covered.
16. Charges for disposable and sterilization fees.
17. Any dental procedure solely for the purpose of cosmetic reasons is not a covered benefit.
18. Sealants are covered through the age 14; replacements covered at no charge within the first twelve months of original application.
19. Failure to pay a scheduled co-payment may prevent future dental services from being received until all fees have been paid in full.
20. A dependent child shall be covered until the age of 25; if unmarried, a state resident and not covered under another benefit plan or government program.

THIS FEE SCHEDULE IS ONLY APPLICABLE FOR THOSE SERVICES PROVIDED BY A PARTICIPATING DENTAL SOURCE GENERAL DENTIST. IF THE SERVICES OF A PARTICIPATING SPECIALIST ARE REQUIRED, MEMBERS WILL RECEIVE A DISCOUNT FROM THAT PARTICIPATING SPECIALIST.