Public Comment Card

Name Corie McKibben

Address 1506 Hawk Island Dr

City, State, Zip Osage Beach MO 65065

Phone Number 573-348-4754

Brief description of topic or question being presented to the Board at today's meeting:

Controversial Issues

Please give this card to the Secretary of the Board of Education.

Public Comment Card

Name Jeri Landon

Address 68 Sundust Lane

City, State, Zip Sunrise Beach

Phone Number 3746231

Brief description of topic or question being presented to the Board at today's meeting:

Controversial Issues

Please give this card to the Secretary of the Board of Education.

Public Comment Card

Name Barb Jersey

Address 449 Sportsman

City, State, Zip Camdenton, Mo 65020

Phone Number 573-286-2096

Brief description of topic or question being presented to the Board at today's meeting:

I do have one. It will be about separation of Church & State

Please give this card to the Secretary of the Board of Education.

Public Comment Card

Chose not to speak.

Name John Fritz

Address 66 Knotty Pine Dr.

City, State, Zip Centerton, MO, 65020

Phone Number 573-434-6854

Brief description of topic or question being presented to the Board at today's meeting:

Clarifying the importance of a mandatory screening process for future presenters at our school.

Please give this card to the Secretary of the Board of Education.

Public Comment Card

Name Mac McNally

Address 141 Hillside CT

City, State, Zip Fair Seasons, MO 65049

Phone Number 573-280-9225

Brief description of topic or question being presented to the Board at today's meeting:

I am speaking about board policy on Controversial Speakers, specifically the speaker on Jan. 31, 2014.

Please give this card to the Secretary of the Board of Education.

allowing Tina Marie to perform at the Camdenton High School. I am sure their intentions were honorable, however, a simple google search would have revealed her history of "going off script". The school district has a policy in place for "controversial speakers" which was not followed. It is apparent she was not "investigated fully" before being contacted, nor was "an appropriate record made of his or her presentation" as required by the policy.

The policy also states the "teacher/sponsor responsible for inviting the resource person, or any member of the school administration, has the right and the duty to interrupt or suspend any proceedings if the conduct of the resource person is judged to be in poor taste or endangering to the health and safety of students and staff." It is my belief telling students if they wore a purity ring they would be a virgin again, is endangering the health and safety of students. She should have been redirected to stay on topic, and certainly crosses and purity rings being sold in a public school should have been stopped immediately. Why was this not considered inappropriate for a public school? Tina Marie does not have a professional degree in counseling and yet she spoke of suicide. She does not have the background or training to open this subject with the appropriate sensitivity so as not to trigger self harming behaviors. Feelings of guilt and shame can provoke these behaviors in some students, and in other students provoking memories of suicide within a family can trigger other behaviors. It would have been helpful for parents to know ahead of time so we can either keep them home, or be prepared to help our children process the fallout which may occur.

public school. How can this sort of assembly be prevented in the future? It seems policy was not followed, so perhaps the school board needs to be more involved in the selection of assembly speakers.

It is my understanding Tina Marie was brought in to talk about self image and self esteem. What would be more useful is to require specific staff to attend a "Mental Health First Aid" course sponsored by the MO Department of Mental Health. This is an evidenced based curriculum instead of anecdotal opinion. Another way to enhance the mental health of students in the district is to hire master level social workers into the district. Not only are they trained to have a whole community view starting with the person in their entire environment, but they are able to counsel and help garner resources for all students.

As we go forward as a community, how will we change the policy to insure something like this does not happen again and how will the change be implemented and communicated?

Corie Stewart McKibben

1506 Hawk Island Dr

Osage Beach, MO 65065

FILE: INB
BASIC

TEACHING ABOUT CONTROVERSIAL ISSUES

The purpose of the school curriculum is to educate students toward the development of a world in which all human beings may live in dignity. The goals of student learning should include participation in making the decisions which affect their lives, based on open access to information.

Learning experiences should be designed to help students understand the processes and causes of change through the careful analysis of all available data. It is important that learning experiences equip the learner with the ability to participate effectively in the process of change. This approach should foster the development of a value system guided by laws which accord human dignity to all persons and produce empathy with and compassion for other humans of diverse cultures, both in their own countries and in other parts of the world.

Human and cultural differences should be studied and appreciated as varieties of the total human experience. Students must be helped to understand themselves and others and permitted to discuss and reflect upon the nature of self and of others. Controversy, conflict and serious problems of society are as much a part of the student's in-school learning as they are of the student's out-of-school experiences.

Training for effective citizenship is accepted as one of the major purposes of the Camdenton Schools. The school program places great emphasis upon teaching about the American heritage, the rights and privileges we enjoy as citizens and the citizenship responsibilities that must be assumed in maintaining the American way of life. In training for effective citizenship, it is frequently necessary for pupils to study issues that are controversial.

In considering such issues it shall be the pupil's privilege:

a. to study a controversial issue which has political, economic, legal, or social significance and concerning which the student should (at his or her level) begin to have an opinion;

b. to have free access to all relevant information, including the materials that circulate freely in the community;

c. to study under competent instruction in an atmosphere of freedom from bias and prejudice;

consideration as a part of the curriculum.

a. the treatment of the issue in question must be within the range, knowledge, maturity and competence of the students;

b. there should be study materials and other learning aids available from which a reasonable amount of data pertaining to all aspects of the issue can be obtained;

c. the consideration of the issue should require only as much time as is needed for satisfactory study by the class but sufficient to cover the issue adequately;

d. the issue should be current, significant, real and important to the students, teacher and subject matter. Significant issues are those which, in general, concern considerable numbers of people; are related to basic principles; or at the moment are under consideration by the public, media, or various governmental agencies.

In discussing controversial issues, the teacher should keep in mind that the classroom is a forum and not a committee for producing resolutions of dogmatic pronouncements. The class should feel no responsibility for reaching an agreement.

It is the teacher's responsibility to bring out the facts concerning controversial questions. The teacher has the right to express his or her opinions, but in so doing it is important that the students understand that it is the teacher's own opinion and is not to be accepted by them as an authoritative answer.

The principal and department chairman bear a major responsibility for the administration and supervision of the curriculum, including working with the teacher in the selection of materials and methods of instruction. They must be continuously aware of what is being taught in the classroom. A teacher who is in doubt concerning the advisability of discussing certain issues in the classroom should confer with the principal and/or department chairman as to the appropriateness of doing so.

It is recognized that citizens of the community have a right to protest to the school administration when convinced that unfair and prejudiced presentations are being made by any teacher. In considering such protests, the school administration should provide for a hearing if in its judgment such a procedure is required. Teachers of subjects involving controversial issues should be assured of the school administration's support, if it is found that such teachers have been subjected to unfair criticism or partisan pressures from individuals or groups.

****

Note: The reader is encouraged to check the index located at the beginning of this section for other pertinent policies and to review administrative procedures and/or forms for related information.

Adopted: 08/08/1994

I. Introduction of presenters

II. The dilemma- increased plan cost

   a. Review of Claim Cost Summary

   b. Affordable Care Act taxes and mandates

      i. Transitional reinsurance fee (approximately $68,800)

      ii. Other mandates

III. Potential solutions

   a. Population management

      i. Wellness- how can current offerings be improved?

      ii. Chronic disease management through AHDI

   b. Plan design

      i. Adjust premium contribution rates for employees and/or dependent spouses & children

      ii. Modify the benefit design of the Plan

   c. Spousal options

      i. Review the different options available & the implications of each.

IV. Questions

CAMDENTON R-III SCHOOL DISTRICT
2010-2012 PLAN YEAR CLAIM COST SUMMARY

	TOTAL 2010-2011		TOTAL 2011-2012		TOTAL 2012-2013
EMPLOYEE GROSS CLAIMS PAID	$ 2,256,264		$ 1,898,631		$ 3,059,925
SPOUSE GROSS CLAIMS PAID	$ 994,666		$ 862,621		$ 1,268,571
CHILD GROSS CLAIMS PAID	$ 354,956		$ 364,200		$ 783,692
TOTAL CLAIMS PAID	**$ 3,605,886**		**$ 3,125,452**		**$ 5,112,188**

	Dec-10		Dec-11		Dec-12
EMPLOYEE ENROLLMENT	619		631		634
SPOUSE ENROLLMENT	120		110		107
CHILD ENROLLMENT	280		303		336
TOTAL MEMBERS	**1,019**		**1,044**		**1,077**

GROSS CLAIMS COST PER EMPLOYEE PER MONTH	**$ 303.75**		**$ 250.74**	-17%	**$ 402.20**	60%
GROSS CLAIMS COST PER SPOUSE PER MONTH	**$ 690.74**		**$ 653.50**	-5%	**$ 987.98**	51%
GROSS CLAIMS COST PER CHILD PER MONTH	**$ 105.64**		**$ 100.16**	-5%	**$ 194.37**	94%
AVERAGE GROSS CLAIMS COST PER MEMBER PER MONTH	**$ 294.89**		**$ 249.48**	-15%	**$ 395.56**	59%

2013-2014 Monthly Premium

Tier		Rate
EE (CSD PAID)		**$ 450.00**
SPOUSE		**$ 420.00**
1 CHILD		**$ 185.00**
2+ CHILDREN		**$ 255.00**

*NOTE: COSTS DISPLAYED **DO NOT** INCLUDE SPECIFIC REIMBURSMENTS OR FIXED COSTS.*

Brought to you by Wallstreet Group

Compliance Checklist for Health Plan Changes

Health care reform, in the form of the Affordable Care Act (ACA), brought many changes for employers and their health plans. The health care reform changes have staggered effective dates. Many of ACA's changes for health plans became effective for the first plan year beginning on or after Sept. 23, 2010. Other changes have later effective dates.

Sponsors of group health plans should be aware of the health care reform changes affecting their plans. To understand plan coverage and premium rates, sponsors should be familiar with the health care reform changes that are already in place for their plans. In addition, sponsors should be aware of future ACA changes that will affect plan coverage in the coming year.

This Legislative Brief provides a compliance checklist for health care reform changes affecting health plan coverage.

GRANDFATHERED PLAN STATUS

☐ If you have a **grandfathered plan**, determine whether it will maintain its grandfathered status at renewal time.

- A grandfathered plan is one that was in existence when health care reform was enacted on March 23, 2010.
- Grandfathered plans are exempt from some of the health care reform requirements. A grandfathered plan's status will affect its compliance obligations from year to year.
- Plans can maintain their grandfathered status for 2014 and later years.
- If you make certain changes to your plan that go beyond permitted guidelines, your plan is no longer grandfathered. Contact your Wallstreet Group representative if you have questions about changes you have made, or are considering making, to your plan.

☐ If you **move to a non-grandfathered plan**, confirm that the plan has all of the additional patient rights and benefits required by ACA. This includes, for example, coverage of preventive care without cost-sharing requirements.

☐ If you have a grandfathered plan, make sure to include **information about the plan's grandfathered status** in plan materials describing the coverage under the plan, such as summary plan descriptions (SPDs) and open enrollment materials.

- This information must explain to participants that the plan is not subject to some of the consumer protections of the health care reform law.
- Model language is available from the Department of Labor (DOL).

PLAN AMENDMENTS – ALL PLANS

Dependent Coverage to Age 26

☐ Effective for the first plan year beginning on or after Sept. 23, 2010, your plan should cover **dependents up to age 26**.

- If your plan is grandfathered, it is not required to cover adult children who are eligible for coverage sponsored by their employer for plan years beginning before Jan. 1, 2014.
- Other than the relationship between the child and the participant, your plan may not impose any eligibility restrictions on dependents under age 26, such as a requirement that the dependent be a full-time student or unmarried.
- The federal tax code was changed so that the value of this dependent coverage is excluded from an employee's income until the end of the tax year in which the child turns age 26. In addition, all states should now be in conformity with this federal tax law change.

Lifetime and Annual limits

☐ Effective for the first plan year beginning on or after Sept. 23, 2010, your plan must have **eliminated lifetime limits** on essential health benefits.

☐ Effective for the first plan year beginning on or after Jan. 1, 2014, health plans are prohibited from placing annual limits on essential health benefits. Until then, however, **restricted annual limits** are permitted. Unless your plan received an annual limit waiver, its minimum annual limit for plan years beginning on or after Sept. 23, 2012 (but before Jan. 1, 2014) is $2 million.

☐ The waiver program closed to applications effective Sept. 22, 2011. If your plan received a waiver, it must comply with the requirements of the waiver, including **providing a notice** informing current and eligible participants that the plan does not meet the minimum annual limits and has received a waiver of the requirement. A model notice is available from HHS.

Pre-existing Condition Exclusions

☐ Effective for the first plan year beginning on or after Sept. 23, 2010, your plan must have eliminated **pre-existing condition exclusions** for children **under age 19.** (Pre-existing condition exclusions must be eliminated altogether for plan years beginning on or after Jan. 1, 2014.)

Tax-advantaged Medical Accounts

☐ Plans that include tax-advantaged medical accounts, such as **FSAs, HSAs, HRAs or Archer MSAs**, must be amended for ACA requirements.

- Plans that permit reimbursement of **over-the-counter medicine or drugs** must have been amended to provide that these expenses are reimbursable only with a doctor's prescription (except for insulin) if they are incurred after Dec. 31, 2010.
- Plans that cover expenses of dependents must have been amended to be consistent with any dependent eligibility changes related to the **age 26 rule** (note that HSA distribution rules have not been changed).

- **Beginning in 2013**, a health FSA offered through a cafeteria plan will have to limit the amount of salary reduction contributions that employees can make. Effective for taxable years beginning after Dec. 31, 2012, employees may not elect to contribute more than **$2,500 per year** to a health FSA. This amount will increase in future years to reflect cost-of-living increases.

Rescissions

☐ Your plan must have been amended to incorporate rules regarding rescissions.

- A rescission is a termination of coverage that has a retroactive effect. However, a retroactive cancellation is not a rescission to the extent it is caused by a failure to pay premiums.
- Effective for plan years beginning on or after Sept. 23, 2010, rescissions are only permitted in cases of fraud or intentional misrepresentation of a material fact.
- Written notice of any rescission must be provided at least 30 days in advance.

PLAN AMENDMENTS – NON-GRANDFATHERED PLANS ONLY

Preventive Services

☐ Effective for plan years beginning on or after Sept. 23, 2010, your plan must cover recommended **preventive services** without cost-sharing requirements. However, if your plan is grandfathered, this requirement does not apply.

☐ Effective for plan years starting on or after **Aug. 1, 2012**, non-grandfathered plans must cover specific **preventive services for women** without cost-sharing requirements. These services include well-woman visits, STD screening and contraceptives. Exceptions to the contraceptives requirement apply to certain religious employers.

Claims and Appeals Procedures

☐ Non-grandfathered plans must have established an effective claims and appeal process by amending current claims procedures to incorporate new definitions and requirements. This requirement was generally effective for plan years beginning on or after Sept. 23, 2010, although some provisions had delayed effective dates.

- Revised definition of adverse benefit determination.
- Adopted procedures to provide full and fair review and avoid conflicts of interest.
- Ensure plan is following appropriate external review process.
- Include additional information in notices to claimants, such as information identifying the claim, reasons for the denial, the description of the appeals process and information regarding available consumer assistance.
- Provide notices in a culturally and linguistically appropriate manner.

Patient Protections

☐ Effective for plan years beginning on or after Sept. 23, 2010, your plan must include patient protections.

- If the plan requires participants to choose a primary care provider, allow participant to choose any available participating primary care provider or pediatrician.
- Permit participants to obtain OB/GYN care without a pre-authorization or referral.
- Eliminate pre-authorization requirement for emergency services.
- Eliminate increased coinsurance or copayment requirements for out-of-network emergency services.

☐ Non-grandfathered plans must provide a **notice of patient protections** whenever the SPD or similar description of benefits is provided to a participant. Model language is available regarding this requirement from the DOL.

PLAN AMENDMENTS – CHANGES FOR 2014 PLAN YEARS

Annual Limits

☐ Your plan must eliminate all annual limits on essential health benefits for the 2014 plan year and beyond.

Pre-existing Condition Exclusions

☐ Your plan cannot impose pre-existing condition exclusions on any enrollees for the 2014 plan year and beyond.

Dependent Coverage to Age 26

☐ If your plan is grandfathered, it must make coverage available to adult children up to age 26 regardless of whether they are eligible for other employer-sponsored group health coverage, effective for the 2014 plan year and beyond.

Excessive Waiting Periods

☐ If your plan has a waiting period for coverage, the waiting period must be 90 days or less for the 2014 plan year and beyond.

- A waiting period is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll in the plan becomes effective.
- Other conditions for eligibility are permissible, as long as they are not designed to avoid compliance with the 90-day waiting period limit.

Coverage for Clinical Trial Participants – Non-grandfathered plans

☐ For the 2014 plan year and beyond, your plan's terms and operations cannot discriminate against participants who participate in clinical trials.

- Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered health plans cannot terminate coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases or deny coverage for routine care that would otherwise be provided just because an individual is enrolled in a clinical trial.

Limits on Cost-sharing – Non-grandfathered plans

☐ Review your plan's limits on cost-sharing to make sure they comply with ACA's limits on cost-sharing, effective for the 2014 plan year.

- Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered plans are subject to limits on cost-sharing or out-of-pocket costs. Out-of-pocket expenses may not exceed the amount applicable to coverage related to HSAs. (For 2014, $6,350 for self-only coverage and $12,700 for family coverage.) Deductibles may not exceed $2,000 (single coverage) or $4,000 (family coverage). These amounts are indexed for subsequent years.
- Final guidance on this requirement provides that the deductible requirement will apply only to plans in the insured small group market, while the out-of-pocket cost limit will apply to all non-grandfathered health plans (including self-insured plans and plans and issuers in the large group market).

Comprehensive Benefits Package – Non-grandfathered plans

☐ If you have an insured plan subject to ACA's comprehensive benefits package mandate, confirm with the health insurance issuer that the plan will cover the essential health benefits package, effective for the 2014 plan year.

- Starting in 2014, insured plans in the individual and small group market must cover each of the essential benefits categories listed under ACA.
- This requirement does not apply to grandfathered plans, self-funded plans or insured plans in the large group market.

OTHER REQUIREMENTS – ALL PLANS

Summary of Benefits and Coverage

☐ Plans and insurance issuers must provide a **Summary of Benefits and Coverage** (SBC) to participants and beneficiaries.

- The SBC is a concise document – no more than four double-sided pages - providing simple and consistent information about health plan benefits and coverage in plain language.
- A template for the SBC is available, along with instructions and examples for completing the template and a uniform glossary of terms, at www.dol.gov/ebsa/healthreform.

☐ Plans and issuers must start providing the SBC as follows:

- Issuers must provide the SBC to health plans effective Sept. 23, 2012.
- Plans and issuers must provide the SBC to participants and beneficiaries who enroll or re-enroll during an open enrollment period beginning with the first day of the first open enrollment period that begins on or after Sept. 23, 2012.
- For participants who enroll in coverage other than through an open enrollment period (for example, newly eligible individuals and special enrollees), plans and issuers must provide the SBC beginning on the first day of the first plan year that begins on or after Sept. 23, 2012.

60-Day Notice of Plan Changes

- ☐ Plans and issuers must provide **60 days' notice** of any **material modifications** to the plan that are not related to renewals of coverage. Notice can be provided in an updated SBC or a separate summary of material modifications.

Medical Loss Ratio (MLR) Rebates

- ☐ Fully insured plans may receive **rebates** in **August 2013** if they qualify for a rebate from their issuers due to the medical loss ratio (MLR) rules requiring insurance companies to spend a certain percentage of premium dollars on health care. The rebates must be used for the benefit of the plan's enrollees, which may include reducing enrollees' premium payments.

Exchange Notice

- ☐ By **Oct. 1, 2013,** employers must provide all new hires and current employees with a written notice about ACA's Exchanges. Employers may use one of the DOL's model Exchange notices, as applicable, or a modified version, provided the notice meets ACA's content requirements. The DOL provided the following modes:
  - A model Exchange notice for employers who do not offer a health plan; and
  - A model Exchange notice for employers who offer a health plan to some or all employees.

Health Care Reform
Bulletin

Final Employer Shared Responsibility Regulations Issued

Provided by Wallstreet Group

Quick Facts

- Compliance for medium-sized employers is delayed until 2016.
- Certain 2014 transition relief is extended, including relief for non-calendar year plans.
- The requirement to offer coverage to 95 percent of full-time employees will be phased in over two years.
- Full-time status is clarified for certain groups.

Applicable large employers that have fewer than 100 full-time employees will have an additional year, until 2016, to comply with the pay or play rules.

The Affordable Care Act (ACA) imposes a penalty on large employers that do not offer minimum essential coverage to full-time employees and their dependents. Large employers that offer this coverage may still be liable for a penalty if the coverage is unaffordable or does not provide minimum value. The ACA's employer mandate provision is often referred to as the "employer shared responsibility" or "pay or play" rules.

On Feb. 10, 2014, the U.S. Treasury Department released final regulations implementing the employer shared responsibility provisions of the ACA. The regulations are effective upon publication in the Federal Register.

Delay for Medium-sized Businesses

According to the Departments, approximately 96 percent of employers are small businesses that have fewer than 50 workers and are exempt from the employer responsibility provisions. The employer shared responsibility provisions apply only to applicable large employers that have 50 or more full-time employees.

Wallstreet

the employer mandate. Applicable large employers that have fewer than 100 full-time employees will have an additional year, until 2016, to comply with the pay or play rules.

Thus, the employer shared responsibility provisions will generally apply to:

- Employers with **100 or more** full-time employees starting in **2015**; and
- Employers with **50-99** full-time employees starting in **2016**.

To qualify for this delay, the employer must provide an appropriate certification as described in the final rules.

Extension of 2014 Transition Relief

In addition to the two forms of 2015 transition relief noted earlier, a package of limited transition rules that applied for 2014 under the proposed regulations is extended to 2015 under the final regulations, including:

- ***Employers first subject to shared responsibility provisions:*** Employers can determine whether they had at least 100

- ***Non-calendar year plans:*** Employers with plan years that do not start on Jan. 1 will be able to begin compliance with the employer mandate at the start of their plan years in 2015 rather than on Jan. 1, 2015, and the conditions for this relief are expanded to include more plan sponsors.

- ***Dependent coverage:*** The policy that employers offer coverage to their full-time employees' dependents will not apply in 2015 to employers that are taking steps to arrange for such coverage to begin in 2016.

- ***Measurement and Stability Periods:*** On a one-time basis, in 2014 preparing for 2015, employers using the look-back measurement method to determine full-time status may use a measurement period of six months, even with respect to a stability period—the time during which an employee with variable hours must be offered coverage—of up to 12 months.

As these limited transition rules take effect, the Treasury and the IRS will consider whether it is necessary to further extend any of them beyond 2015.

Provisions for Businesses That Offer Coverage to Most, but Not All, Employees in 2015
Under the proposed rules, applicable large employers would need to offer coverage to at least 95 percent of their full-time employees to avoid the most significant penalties. The final rule provides transition relief that will phase in this requirement over two years, beginning in 2015.

To avoid a payment for failing to offer health coverage in **2015**, applicable large employers will need to offer coverage to **70 percent** of their full-time employees.

In **2016 and beyond**, applicable large employers will need to offer coverage to **95**

This rule is intended to provide relief to employers that, for example, may offer coverage to employees working 35 or more hours per week, but not yet to those employees who work 30 to 34 hours per week.

Various Employee Categories
The final regulations provide clarifications—many of which are based on comments on the proposed regulations—regarding whether employees of certain types or in certain occupations are considered full-time.

- ***Volunteers:*** Hours contributed by bona fide volunteers for a government or tax-exempt entity, such as volunteer firefighters and emergency responders, will not cause them to be considered full-time employees.

- ***Educational employees:*** Teachers and other educational employees will not be treated as part-time for the year simply because their school is closed or operating on a limited schedule during the summer.

- ***Seasonal employees:*** Those in positions for which the customary annual employment is six months or less generally will not be considered full-time employees.

- ***Student work-study programs***: Service performed by students under federal or state-sponsored work-study programs will not be counted in determining whether they are full-time employees.

- ***Adjunct faculty:*** Until further guidance is issued, employers of adjunct faculty are to use a method of crediting hours of service for those employees that is reasonable in the circumstances and consistent with the employer shared responsibility provisions. However, to accommodate the need for predictability and ease of administration, and consistent with the request for a "bright line" approach suggested in a number of the comments, the final

service per week for each hour of teaching or classroom time as a reasonable method for this purpose.

Full-time Employee Status Determinations
Like the December 2012 proposed regulations, the final rules allow employers to use an optional **look-back measurement method** to make it easier to determine whether employees with varying hours and seasonal employees are full-time.

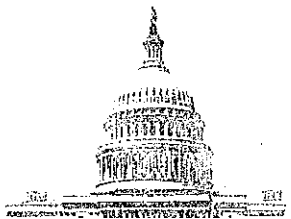
In responding to comments, the final regulations also clarify the application of this method and the alternative monthly method of determining full-time status.

Affordability Safe Harbors
Like the proposed regulations, the final rules provide safe harbors that employers can use to determine whether the coverage they offer is affordable to employees.

These safe harbors permit employers to use the wages they pay, their employees' hourly rates, or the federal poverty level in determining whether employer coverage is affordable under the ACA.

Next Steps: Final Rules Simplifying Employer Information Reporting
Many comments on the proposed employer information reporting regulations have urged that final rules provide streamlined ways to comply with employer information reporting—especially for employers that offer highly affordable coverage to all or virtually all of their full-time employees.

Others have asked for a single form for employer and insurer reporting provisions when possible. The Treasury and the IRS will issue final regulations shortly that aim to substantially simplify and streamline the employer reporting requirements.



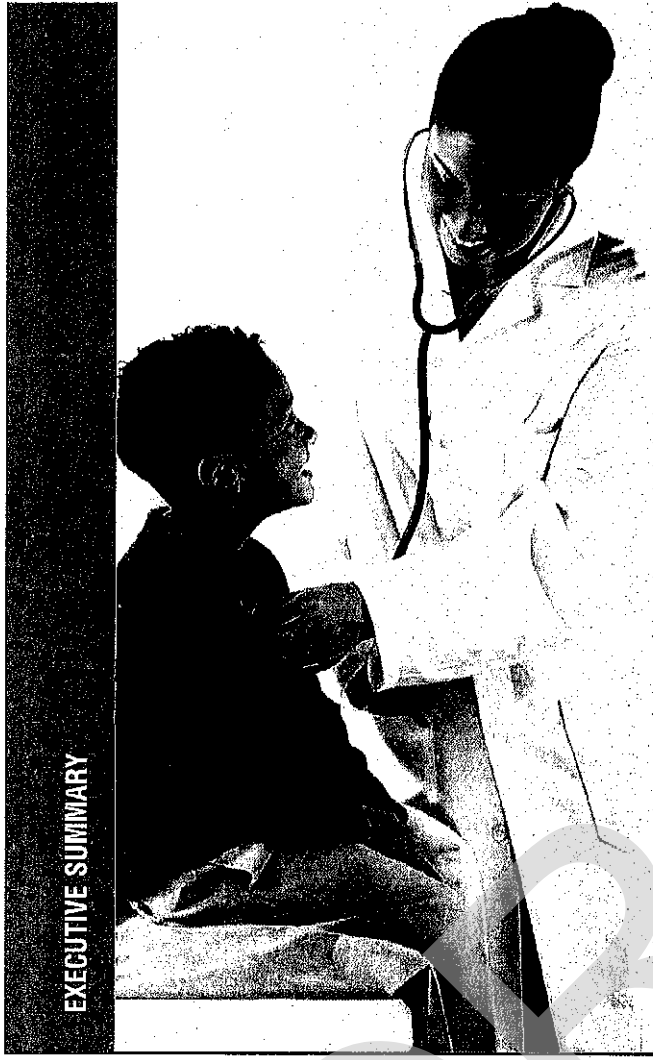
responsibility regulations, see the most recent IRS Questions and Answers.

Source: U.S. Treasury Department

TURNING HEALTHCARE DATA INTO INTELLIGENCE

Guide to the

American Health Data Institute



EXECUTIVE SUMMARY

The American Health Data Institute turns healthcare data into actionable intelligence.

WHY DO WE NEED ACTION?

Because Americans continually rank healthcare as the number one benefit of employment, and the current healthcare system faces challenges such as:

- Escalating medical costs
- Consumer entitlement
- Backlash against managed care
- Increasing burden of healthcare administration regulations

The American Health Data Institute (AHDI) was created to provide employers with a solution – demystified healthcare data. This data allows employers to direct employees to the highest quality, most cost effective healthcare providers.

Thanks to AHDI, healthcare can be purchased based on the same principles used to make decisions on most other corporate expenses.

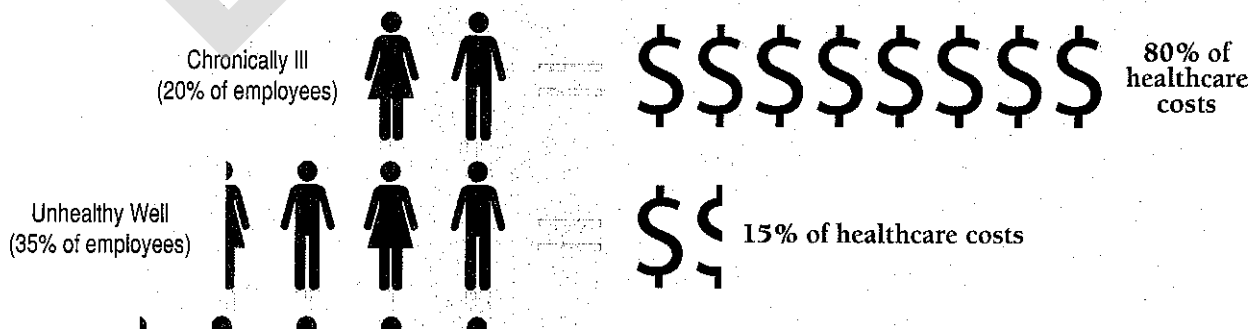
- Expected return on investment
- Targeted outcomes
- Quality & accountability defined by benchmarks
- Utilization of budget projections & financial models
- Incentives for risk and reward sharing

In short, the healthcare focus must be shifted to a managed, data driven healthcare strategy.

Turning healthcare data into intelligence and that intelligence into action.

WHO'S DRIVING YOUR HEALTHCARE COSTS?

Percentage of healthcare costs contributed by each population group.



CHRONIC DISEASE MANAGEMENT

The 80/20 rule plays a significant role in business, and in healthcare as well. How so? In the form of chronic diseases – those conditions that persist over a long period of time, affecting an individual's health and subsequent functionality.

This is why 20% of your employees will account for 80% of your healthcare costs. If you can help keep that 20% of employees healthy, the savings would be significant. AHDI identifies these individuals and establishes a minimum level of care for each of them. AHDI also helps you prevent large claims from occurring.

The goals are to create knowledgeable and motivated consumers of healthcare and to improve self-management skills and confidence. Success in these areas decreases the need for medical intervention in the short and long term.

RISK STRATIFICATION THROUGH PREDICTIVE MODELING

18-64 Year-old Insureds	Claims Range
Top 1%	$18,150 and up
4%	$7140-$18,149
5%	$4389 - $7139
5%	$3000-$4388
7%	$2000-$2999
15%	$1000-$1999
13%	$595-$999
50%	$594 or less

As defined by AHDI, risk stratification is the science of ranking individuals from those with the greatest probability of disease onset down to those with the least probability.

Each employee is assigned a Healthcare Index number. Those with the highest Healthcare Index are most likely to incur the highest healthcare bill over the next twelve months.

Since reducing large claims is a major goal for employers – this is extremely valuable information. Furthermore, it lets AHDI's Healthcare Navigator Nurses know where to most effectively spend their time to reduce your healthcare costs while giving employers the necessary information to properly utilize Pinpoint Wellness Systems.

< Expenses from Major Medical Commercial Population

- *Most insureds utilize very little in healthcare costs.*
- *Only 1% of the population spends over $18,150 on healthcare.*
- *78% of the population spends less than $2000.*

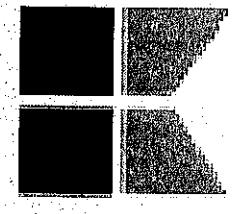
ENDORSED PROVIDERS

It is extremely important to identify physicians who are currently practicing high quality, cost effective medicine so that employees can receive the best most cost effective healthcare. AHDI can help you identify the most desirable physicians.

AHDI uses the physician profile to assist in coaching the identified chronically ill to use the highest rated physicians – those who will deliver the highest quality, most cost effective maintenance care.

The good news – 85% of physicians fall into that high quality group and are considered Endorsed Providers (EPs).

The bad news – The other 15% are driving 10% of the excess costs. Simply explained – if your



HRM

Health Risk Management℠

CAMDENTON RIII SCHOOL DISTRICT

February 21, 2014

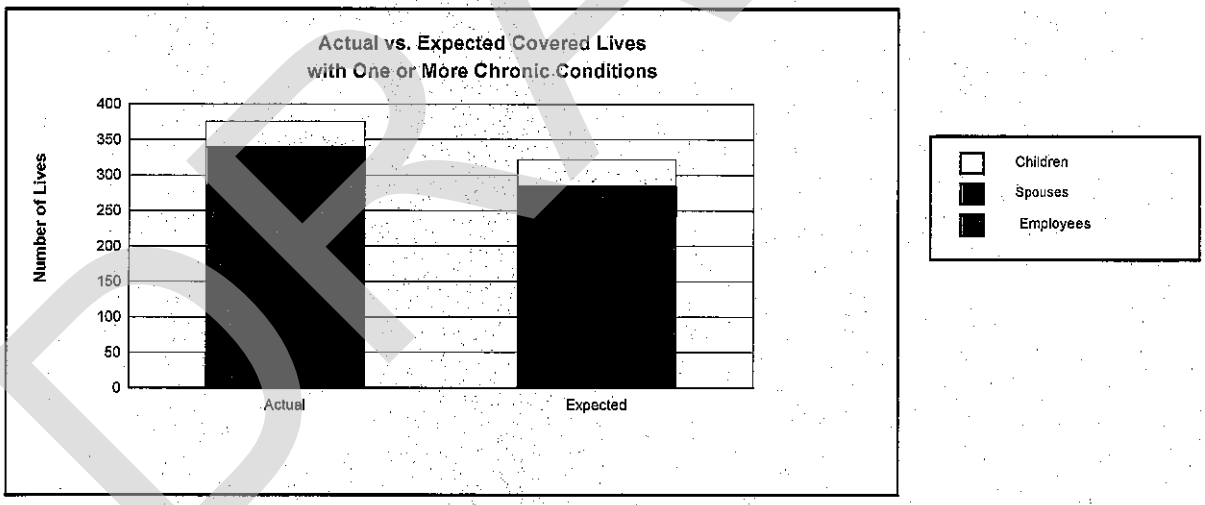
Chronic Medical Condition Evaluation of All Lives, Excluding Known False Positive Conditions

All Information in This Health Risk Management Report Is for A One Year Analysis Period Ending 02/01/2014

Except where otherwise indicated, lives counts are for last day of analysis period and include all lives regardless of length of enrollment or length of time since identification of condition.
This analysis reflects all lives without regard to their Health Economic Zone (HEZ) of residence and also the removal, following interview of patients by Healthcare Navigator nurses, of illnesses determined to have been falsely identified in claims data. The expected and normative values are based on only those employers utilizing our disease management services.

Covered Lives With At Least One Chronic Medical Condition
Compared to Norms for Your Number of Covered Lives Adjusted by Coverage Category

	Total # of Covered Lives in Group	Actual # with Conditions	Expected # with Conditions	Actual % Ill of Covered Life Group	Expected % Ill of Covered Life Group
Total Lives	1,100	376	322	34.2%	29.3%
Employee Lives	630	285	240	45.2%	38.1%
Spouse Lives	108	54	44	50.0%	40.9%
Child Lives	362	37	38	10.2%	10.5%



Your Number of Chronic Medical Conditions, Compared to Norms for Your Number of Covered Lives (Note that the total conditions is likely higher than the total lives with illness since one individual may have multiple conditions)

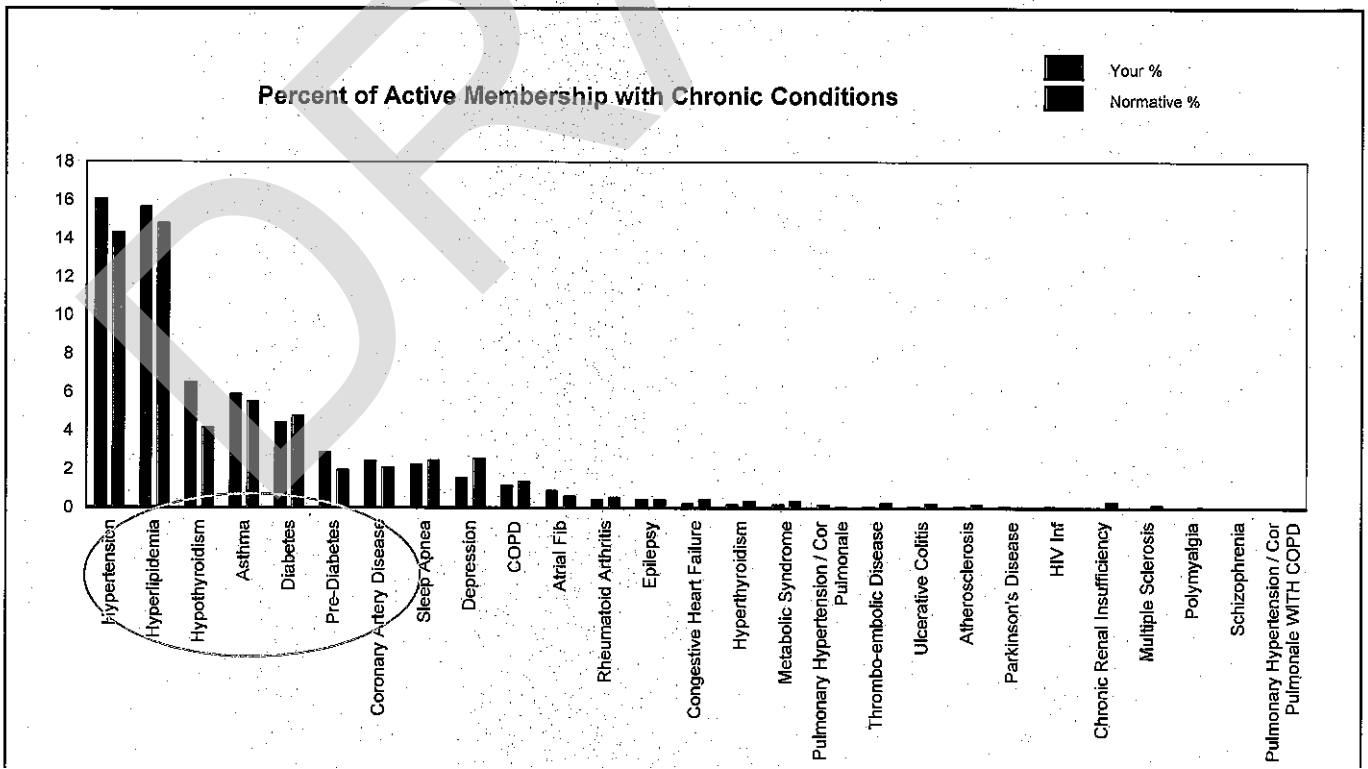
Total Conditions	Actual #	Expected #
	683	635
Employee Conditions	515	500
Spouse Conditions	125	93

Individuals with multiple chronic illness are likely to experience even higher claims costs.

Distribution of Multiple Chronic Conditions

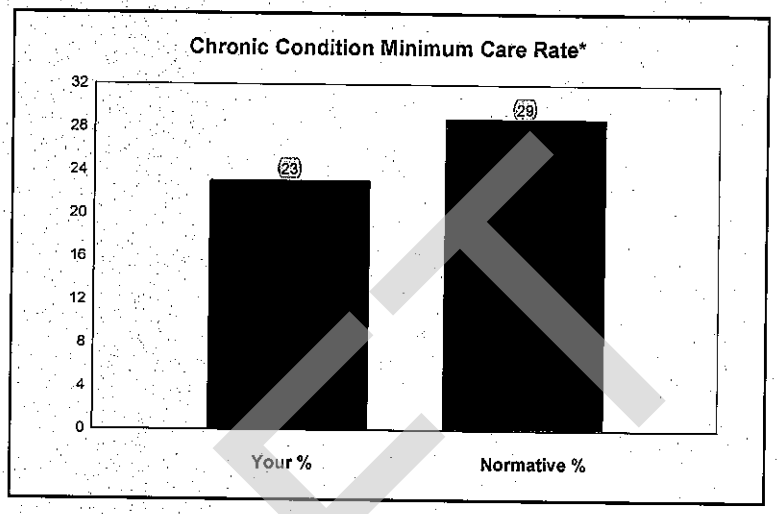
Individuals with Chronic Conditions	Current	Percent of Total Medical Lives - Current	Percent of Total Medical Lives - Norm
Number of individuals with 1 chronic condition	196	17.8%	14.2%
Number of individuals with 2 chronic conditions	95	8.6%	7.4%
Number of individuals with 3 chronic conditions	56	5.1%	4.5%
Number of individuals with 4 chronic conditions	18	1.6%	2.0%
Number of individuals with 5 chronic conditions	9	0.8%	0.8%
Number of individuals with 6 chronic conditions	2	0.2%	0.3%
Number of individuals with 7 chronic conditions	0	0.0%	0.1%
Number of individuals with 8 or more chronic conditions	0	0.0%	0.1%
Total Number of Individuals with Chronic Conditions	**376**		
Chronic Condition Patient Rate		**34.2%**	**29.5%**

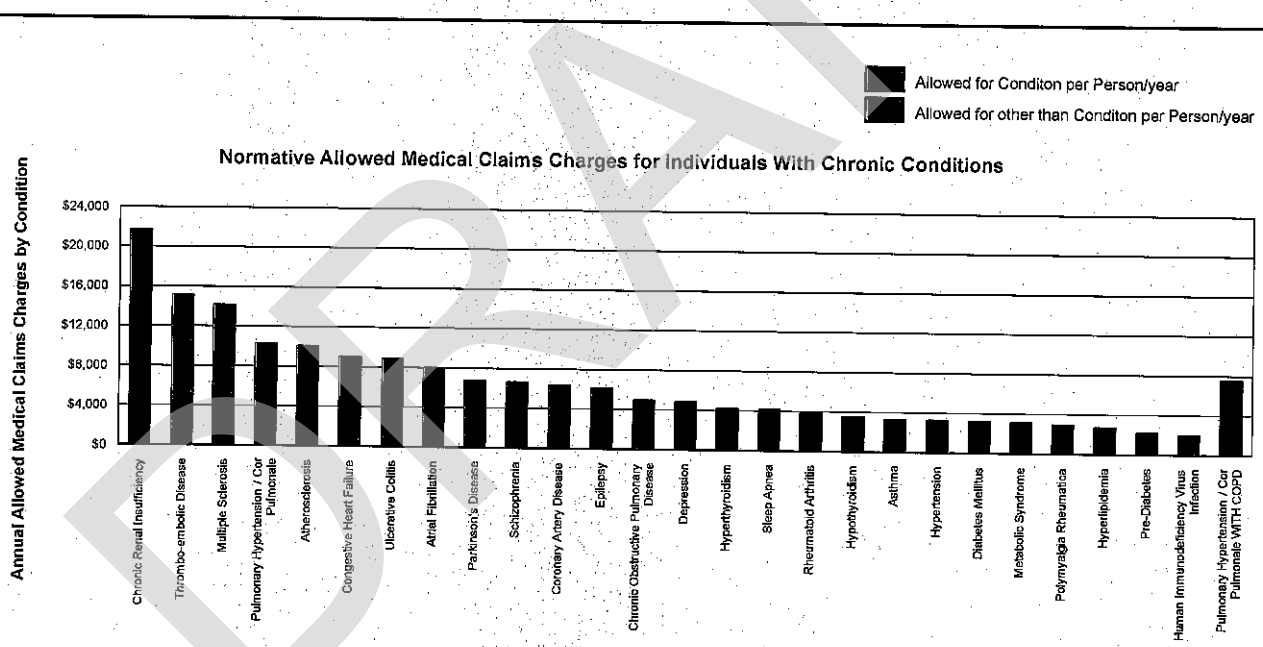
The graph below represents the percentage of your covered lives diagnosed with the chronic condition listed and the comparison to the norm.



A caveat is appropriate with respect to comparison of your value with the norm. To the extent that your population may have a higher-than-usual proportion of illnesses that require multiple services, your Minimum Care Rate is likely to be lower than the norm, even if your Service Rate is no worse than average. Likewise, if your population has a lower-than-usual proportion of illnesses that require multiple services, your Minimum Care Rate is likely to be higher than the norm, even if your Service Rate is no better than average.

* This analysis includes just those conditions that have been identified for at least a year in the CDM program - as does the "Chronic Disease Condition Detail" report. The graph shows how your Minimum Care Rate (the fraction of conditions that have satisfied all care requirements) compares to the typical rate.





	Number of Individuals with Chronic Conditions	Total Allowed Charges Spent on these Individuals Per Year	Average Allowed Charges Per Person Per Year with Chronic Conditions	Approximate Average Allowed Charges Per Person Per Year for Direct Chronic Care	Approximate Average Allowed Charges Per Person Per Year for Care of Other than Chronic Conditions
Normative			$7,431	$1,267	$6,165
Your Values	376	$3,442,902	$9,157	$438	$8,719

	Total Allowed	Total Allowed per Life**	Approximate Allowed Directly Related to Chronic Illness Care	Approximate Allowed not Directly Related to Chronic Illness Care	Total Paid	Total Paid per Life**	Approximate Paid Directly Related to Chronic Illness Care	Approximate Paid Not Directly Related to Chronic Illness Care
Amount for All Individuals with Chronic Conditions*	$3,442,902	$9,330	$164,513	$3,278,390	$2,435,071	$6,599	$106,814	$2,328,257
Amount for All Individuals without Known Chronic Conditions	$3,048,358	$4,200			$2,166,666	$2,985		
Amount for All Individuals in Plan	$6,491,261	$5,929			$4,601,736	$4,203		
Amount for All Chronically Ill Individuals as % of Plan Total*	53.0%		2.5%	50.5%	52.9%		2.3%	50.6%

* Note: Pharmacy costs usually comprise a much higher fraction of total costs for lives with chronic illness than for those without: inclusion of pharmacy costs would substantially increase the fraction of plan costs attributable to chronically ill individuals. Absence of an effective disease management program would also increase the fraction of plan costs attributable to chronically ill individuals.

** Lives count used here is the average monthly count.

In this sub-section as well as the previous two sub-sections, we attribute claims dollars to the chronic illness only if it is listed as the first diagnosis on the claim and is therefore likely the primary reason for the services in the claim. So, while the total dollar values listed are quite reliable, the division into chronic condition and other care is only an approximation. This method gives a very conservative estimate of the dollars directly related to chronic illness and a correspondingly generous estimate of the dollars not directly related.

Chronic Disease Condition Detail

All Information in This Health Risk Management Report Is for A One Year Analysis Period Ending 02/01/2014

Chronic Condition	Number of Current Active Conditions	Number of Current Active Conditions Identified for At Least 12 Months*	Annual Minimum Care Services Recommended	Total Annual Recommended Services for Conditions Identified ≥ 12 Months	Recommended Services Received During Past Year for Conditions Identified ≥ 12 Months		Conditions Receiving All Services Past Year	
					#	%	#	%
	65	42	2 E & M Visit	84	46	54.8%	4	9.5%
			1 Spirometry	42	3	7.1%		
clerosis	1	1	1 E & M Visit	1	1	100.0%	0	0.0%
			1 Lipid Panel	1	0	0.0%		
rillation	10	8	1 E & M Visit	8	6	75.0%	1	12.5%
			1 EKG	8	4	50.0%		
			6 Prothrombin Time	48	12	25.0%		
Obstructive Pulmonary Disease	13	9	2 E & M Visit	18	11	61.1%	0	0.0%
			1 Spirometry	9	1	11.1%		

Chronic Condition	Number of Current Active Conditions	Number of Current Active Conditions Identified for At Least 12 Months*	Annual Minimum Care Services Recommended	Total Annual Recommended Services for Conditions Identified ≥ 12 Months	Recommended Services Received During Past Year for Conditions Identified ≥ 12 Months		Conditions Receiving All Services Past Year		A An C P Mi S
					#	%	#	%	
nal Insufficiency	0	0	2 CBC	NA	NA	NA	0	NA	
			2 Creatinine	NA	NA	NA			
			2 E & M Visit	NA	NA	NA			
			2 Electrolytes	NA	NA	NA			
			1 Lipid Panel	NA	NA	NA			
			2 Serum Calcium	NA	NA	NA			
			2 Serum Phosphorus	NA	NA	NA			
			2 Urine Protein Total	NA	NA	NA			
Heart Failure	3	2	2 BUN	4	0	0.0%	0	0.0%	
			2 Creatinine	4	0	0.0%			
			2 E & M Visit	4	2	50.0%			
			2 Potassium	4	0	0.0%			
rtery Disease	27	22	1 Cholesterol	22	3	13.6%	1	4.5%	
			1 E & M Visit	22	20	90.9%			
			1 EKG	22	10	45.5%			
			1 Lipid Panel	22	9	40.9%			
	17	17	4 E & M Visit - Mental Health	68	0	0.0%	0	0.0%	
ellitus	49	41	2 E & M Visit	82	63	76.8%	7	17.1%	
			2 Glycohemoglobin	82	40	48.8%			
			1 Lipid Panel	41	17	41.5%			
			1 Microalbumin	41	11	26.8%			

Chronic Condition	Number of Current Active Conditions	Number of Current Active Conditions Identified for At Least 12 Months*	Annual Minimum Care Services Recommended	Total Annual Recommended Services for Conditions Identified ≥ 12 Months	Recommended Services Received During Past Year for Conditions Identified ≥ 12 Months		Conditions Receiving All Services Past Year	
					#	%	#	%
/	5	3	1 E & M Visit	3	3	100.0%	3	100.0%
Immunodeficiency Virus Infection	1	1	1 CBC	1	0	0.0%	0	0.0%
			1 E & M Visit	1	0	0.0%		
			2 HIV Quantification	2	0	0.0%		
			1 PPD	1	0	0.0%		
			1 Pap Smear (Female only)	0	0	0.0%		
			2 T Cells; Total Count	2	1	50.0%		
idemia	172	143	1 Cholesterol	143	14	9.8%	13	9.1%
			1 E & M Visit	143	103	72.0%		
			1 Lipid Panel	143	54	37.8%		
nsion	177	153	2 E & M Visit	306	194	63.4%	67	43.8%
rroidism	2	2	1 E & M Visit	2	1	50.0%	0	0.0%
			1 T4	2	0	0.0%		
			1 TSH	2	1	50.0%		
roidism	72	57	1 E & M Visit	57	43	75.4%	13	22.8%
			1 T4	57	14	24.6%		
			1 TSH	57	41	71.9%		
c Syndrome	2	2	1 E & M Visit	2	0	0.0%	0	0.0%
			1 FBS or Glycohemoglobin	2	1	50.0%		
			1 Lipid Panel	2	0	0.0%		
Sclerosis	0	0	2 E & M Visit	NA	NA	NA	0	NA

Chronic Condition	Number of Current Active Conditions	Number of Current Active Conditions Identified for At Least 12 Months*	Annual Minimum Care Services Recommended	Total Annual Recommended Services for Conditions Identified ≥ 12 Months	Recommended Services Received During Past Year for Conditions Identified ≥ 12 Months		Conditions Receiving All Services Past Year	
					#	%	#	%
on's Disease	1	1	2 E & M Visit	2	0	0.0%	0	0.0%
algia Rheumatica	0	0	1 CBC	NA	NA	NA	0	NA
			2 E & M Visit	NA	NA	NA		
			2 ESR	NA	NA	NA		
betes	32	23	1 E & M Visit	23	17	73.9%	3	13.0%
			1 FBS or Glycohemoglobin	23	16	69.6%		
			1 Lipid Panel	23	5	21.7%		
ary Hypertension / Cor Pulmonale	2	2	2 E & M Visit	4	2	50.0%	1	50.0%
ary Hypertension / Cor Pulmonale OPD	0	0	2 E & M Visit	NA	NA	NA	0	NA
			12 Months Supplemental O2	NA	NA	NA		
			1 Spirometry	NA	NA	NA		
toid Arthritis	5	5	1 CBC	5	3	60.0%	3	60.0%
			1 E & M Visit	5	5	100.0%		
irenia	0	0	6 E & M Visit - Mental Health	NA	NA	NA	0	NA
nea	25	19	1 E & M Visit	19	12	63.2%	12	63.2%
-embolic Disease	1	1	2 E & M Visit	2	1	50.0%	0	0.0%
e Colitis	1	1	1 CBC	1	1	100.0%	0	0.0%
			1 E & M Visit	1	0	0.0%		
			1 LFT	1	0	0.0%		

	Number of Current Active Conditions	Number of Current Active Conditions Identified for At Least 12 Months*		Total Annual Recommended Services for Conditions Identified ≥ 12 Months	Recommended Services Received During Past Year for Conditions Identified ≥ 12 Months		Conditions Receiving All Services Past Year		A A Ch Mi Se C
					#	%	#	%	
	683	555		1,674	791	47.3%	128	23.1%	

s are not counted here if they have been in the program for less than 12 months *even if* they have already met their Minimum Care Recommendations. Individuals who heir care recommendations within 12 months of identification *are* included in the 'Chronic Medical Condition Evaluation of All Lives, Excluding Known False Positive report section.

xtent that lives have more than one illness with overlapping service requirements, the actual total cost of minimum care services will be lower than this value.

Glossary of Minimum Recommended Care Services

ice Name	Definition and/or explanation of service
	The liver produces urea as a waste product of the digestion of protein. Urea is eliminated by the kidneys so Blood Urea (measured according to the Nitrogen it contains) can be used as a measure of kidney function. It is not as specific as creatinine, however, since the levels are dependent upon dietary protein and much more dependent upon adequate hydration.
um	One of a number of 'salts' in the blood. Often abnormal in the presence of kidney disease as well as in a number of other conditions.
	Complete Blood Count: measures of the number of red blood cells and the oxygen-carrying protein Hemoglobin that they contain, the numbers and types of white (infection-fighting) blood cells, and the number of blood platelets (part of the blood-clotting mechanism).
sterol	One of the major types of fats (lipids) in the blood, high levels are commonly associated with increased risk for coronary artery disease and other forms of atherosclerosis. It is one of the fats measured in a lipid panel (see below). Some illnesses require measurements of blood lipids more than once a year, one of which should be a full lipid panel test and one of which *may* be the less sophisticated test for cholesterol alone (but a second lipid panel, which contains measures of cholesterol, would also satisfy this requirement).
inine	Creatinine is a break-down product of muscle that is usually produced at a fairly constant rate by the body (depending on muscle mass). It is eliminated by the kidneys and the amount of creatinine in the blood is therefore a relatively sensitive measure of abnormal kidney function.
l visits	Evaluation and Management visits are physician services where thoughtful advice is the primary intent (rather than a procedure).
	Electrocardiogram (Elektro kardiogramm in German, from which the initials are derived): a tracing of the electrical activity of the heart.
olytes	A measure of the most common 'salts' in the blood: sodium, potassium, chloride, and bicarbonate. Electrolyte balance can be disturbed by some medications such as diuretics and by kidney disease (etc.).
	ESR stands for Erythrocyte Sedimentation Rate. This is a sensitive test for inflammation. This test may be very abnormal in the presence of some poorly controlled auto-immune diseases including polymyalgia rheumatica.
	FBS stands for Fasting blood sugar. This is the simplest way of assessing blood sugar control or testing for diabetes.
hemoglobin	Glycohemoglobin is sometimes called glycosolated hemoglobin or hemoglobin A1c (HgbA1c). It is a measure of the percent of hemoglobin (the oxygen-transporting protein in red blood cells) that has glucose bound to it. The level is proportional to the average blood sugar over the preceding month or so. The upper limit of normal is 6% and the closer to this value, the lower the risk of complications from poorly controlled high blood sugar in diabetic patients.

Glossary of Minimum Recommended Care Services

ice Name	Definition and/or explanation of service
uantification	Measurement of the concentration of Human Immunodeficiency Virus particles in the blood is a measure of how well anti-HIV therapy is succeeding.
	LFT stands for Liver Function Test. Ulcerative Colitis can cause severe liver disease, as can some of the medications used to treat ulcerative colitis.
Panel	A test of fats in the blood that includes not only measure of total cholesterol but a breakdown of cholesterol into High and Low-density Lipoproteins. (HDL cholesterol is sometimes called "good cholesterol" and LDL cholesterol "bad cholesterol" since the former can serve as a 'scavenger' to reduce the size of new atheromatous plaques and the higher levels of the later are associated with production of new plaques.) A lipid panel also includes a measure of Triglycerides, the other (along with cholesterol) major type of fats in the blood. Like cholesterol, elevated triglyceride levels can be associated with atherosclerotic disease. Triglycerides in blood are derived from fats eaten in foods or made in the body from other energy sources like carbohydrates. Fat ingested in a meal and not used immediately by tissues is converted to triglycerides and transported to fat cells to be stored. Hormones regulate the release of triglycerides from fat tissue so they meet the body's needs for energy between meals. Unlike cholesterol, the level of triglycerides varies widely depending upon time since the last meal, and a lipid panel should therefore be drawn while fasting.
albumin	Microalbumin is a very small size protein in the blood. Kidneys damaged by diabetes start to leak microalbumin long before they are diseased enough to cause abnormalities of creatinine or BUN. Finding microalbumin in the urine allows early treatment of diabetic kidney disease before it becomes a clinical problem.
mear	"PAP smear" is short for Papanicolaou cytology smear: the most common means of testing for cancer of the uterine cervix. Women with HIV positivity are particularly prone to this cancer.
phorus	Another 'salt' in the blood. Often abnormal in the presence of kidney disease as well as a number of other conditions.
sium	One of the most commonly measured 'salts' in the blood, potassium levels are influenced by virtually all diuretics ("water pills") as well as by kidney function. Levels too far from normal may produce dangerous irregularities of heart rhythm.
	A skin test for tuberculosis with a Purified Protein Derivative of the tuberculosis bacteria is the standard method of testing for tuberculosis exposure. Individuals with HIV positivity are particularly prone to become ill with TB if they are exposed to the germs.
rombin time	The Prothrombin Time (sometimes abbreviated PT) is the test used to measure the effect of Coumadin (warfarin) on blood clotting. Warfarin is the anti-coagulant ("blood thinner") commonly used to reduce the risk associated with abnormal clotting of blood in the heart (e.g. in atrial fibrillation) and veins (e.g. in thromboembolic disease).
metry	A basic "breathing test" measuring the speed with which air can be exhaled from the lungs as well as the total amount of air that can be exhaled.
emental O2	Individuals with lung disease may have chronically low levels of blood oxygen. These individuals benefit from breathing a higher level of oxygen (i.e. supplemental oxygen) than is present in air.
count	T-cells are a sub-type of lymphocyte and is the specific type of white blood cell responsible for coordinating the fight against infections. The T-lymphocytes are the specific type of white blood cell that are attacked by the HIV virus. The closer the T-cell count is to normal, the better controlled a Human Immunodeficiency Virus infection is.
	T4 is an abbreviation for tetra-iodothyronine (or thyroxine). It is the hormone precursor secreted by the thyroid gland. Too much of this pro-hormone produces symptoms of hyperthyroidism (overactive thyroid), too little produces symptoms of hypothyroidism (underactive thyroid).
	TSH stands for Thyroid Secreting Hormone. This hormone is produced by the pituitary gland (of the brain) and signals the thyroid gland to make more or less T4. High levels are associated with hypothyroidism (including under-treated hypothyroidism) and low levels with hyperthyroidism (or over-treated hypothyroidism).
Protein	Normal kidneys permit virtually no protein to leak from the blood out into the urine. The amount of protein in the urine is one measure of severity of kidney disease.

EMPLOYEE HEALTH PLAN DESIGN ANALYSIS
CLAIMS INCURRED 01/01/13 - 12/31/13 - PAID AS OF 02/14/2014

CURRENT PLAN DESIGN - PREVENTIVE 100%

	INDIVIDUAL	FAMILY	
OPEN ACCESS AND IN-NETWORK			
DEDUCTIBLE	$1,000	$3,000	
COINSURANCE %	20%	20%	
COINSURANCE MAXIMUM	$1,500	$4,500	
TOTAL ACTUAL PAID IN-NETWORK			**$4,243,160.50**
OUT OF NETWORK			
DEDUCTIBLE	$5,000	$15,000	
COINSURANCE %	50%	50%	
COINSURANCE MAXIMUM	$5,000	$15,000	
TOTAL ACTUAL PAID OON			**$87,283.71**
PHARMACY			**$526,582.99**
TOTAL PAID CURRENT PLAN DESIGN			**$4,857,027.20**

PROPOSED PLAN DESIGN - PREVENTIVE 100%

	INDIVIDUAL	FAMILY	
OPEN ACCESS AND IN-NETWORK			
DEDUCTIBLE	$2,000	$6,000	
COINSURANCE %	20%	20%	
COINSURANCE MAXIMUM	$4,350	$6,700	
CONTINUE WITH CARRY-OVER DEDUCTIBLE?	X		X if YES, blank if NO
CONTINUE WITH OFFICE VISIT COPAY?	X		X if YES, blank if NO
OFFICE VISIT COPAY - GENERAL	$30		
OFFICE VISIT COPAY - SPECIALIST	$40		
MAXIMUM OUT OF POCKET	$6,350	$12,700	
PHARMACY BENEFITS - KEEP SAME BENEFITS			
ESTIMATED PAID IN-NETWORK			**$3,859,061.08**
OUT OF NETWORK			
TOTAL DEDUCTIBLE	$5,000	$15,000	
COINSURANCE %	50%	50%	
TOTAL COINSURANCE MAXIMUM	$5,000	$15,000	
ESTIMATED PAID OON			**$89,584.90**
PHARMACY			**$526,582.99**
TOTAL ESTIMATED PAID PROPOSED PLAN DESIGN			**$4,475,228.97**

DECREASED COST	**($381,798.24)**
ESTIMATED PERCENT SAVINGS	**7.9%**

Note: The maximums listed below are the total for Open Access, Participating and Non-Participating Provider expenses. For example, if a maximum of 60 days is listed three times under a service (once in each column), the Calendar Year maximum is 60 days total which may be used for any combination of providers.

***DEDUCTIBLE*, PER CALENDAR YEAR**			
Per Covered Person	$1,000	$1,000	$5,000
Per Family Unit	$3,000	$3,000	$15,000

The Calendar Year deductible is waived for the following Covered Charges:
- Preventive Care- as listed
- Allergy serum & injections in a network Physician's office

COPAYMENTS			
Primary Care Physician's & urgent care office visits:	$30	$30	N/A
Specialist's office visit:	$40	$40	N/A

Note: The copayment only applies to the office visit charge, urgent care physician office visit charge and after hours visit charge. Regular Plan benefits apply to other charges. The copayment does not apply to preventive care services. Primary Care Physicians are general practitioners, family medicine, gynecologists, pediatricians and internists when providing general health services.

Prescriptions @ Pharmacy	Refer to Prescription Benefits.		
MAXIMUM *COINSURANCE* AMOUNT, PER CALENDAR YEAR			
Per Covered Person	$1,500	$1,500	$5,000
Per Family Unit	$4,500	$4,500	$15,000
MAXIMUM *OUT-OF-POCKET* AMOUNT, PER CALENDAR YEAR			
Per Covered Person	$2,500	$2,500	$10,000
Per Family Unit	$7,500	$7,500	$30,000

The Plan will pay the designated percentage of Covered Charges until out-of-pocket (deductible plus coinsurance) amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.

The following charges do not apply toward the coinsurance maximum and are never paid at 100%.

Deductible(s)
Cost containment penalties
Copayments
Amounts in excess of Usual and Customary Charge
Charges excluded as ineligible

Note: The maximum amounts an individual can contribute to the in-network deductible and coinsurance family maximums are amounts up to the in-network "Per Covered Person" maximums. Therefore, if the individual has out-of-network services, only the amount up to the in-network maximum will be counted toward reaching the family's in-network maximum.

COVERED CHARGES			
Ambulance Service			
Emergent	80% after deductible	70% after deductible	50% after deductible
Eligible non-emergent	80% after deductible	70% after deductible	50% after deductible
***Applied Behavior Analysis for Autism Spectrum Disorders**	80% after deductible	70% after deductible $40,000 Calendar Year maximum	50% after deductible

Note: This benefit is for Dependent Children up to age 19. Refer to the Medical Benefit section for further details of this benefit.

***Cardiac/Pulmonary Therapy**	80% after deductible	70% after deductible	50% after deductible
Diagnostic Testing (X-rays & Labs, including Pre-Admission Testing)	80% after deductible	70% after deductible	50% after deductible

Note: Includes mammograms and colonoscopies required for the treatment of an Illness. Refer to Preventive Care benefits for coverage of diagnostic tests when there is a family history of an Illness.

section for further details of this benefit.

***Durable Medical Equipment**	80% after deductible	70% after deductible	50% after deductible
Emergency Room Visit			
Medical Emergency	80% after deductible	70% after deductible	50% after deductible
Medical Non-Emergency Care	80% after deductible	70% after deductible	50% after deductible
***Home Health Care**	80% after deductible	70% after deductible 100 visits Calendar Year maximum	50% after deductible
Hospice Care	80% after deductible	70% after deductible	50% after deductible
Bereavement Counseling	80% after deductible	70% after deductible	50% after deductible
Hospital Services			
Room and Board	80% after deductible the semiprivate room rate	70% after deductible the semiprivate room rate	50% after deductible the semiprivate room rate
Intensive Care Unit	80% after deductible Hospital's ICU Charge	70% after deductible Hospital's ICU Charge	50% after deductible Hospital's ICU Charge
Well Newborn Nursery & Physician Care (initial Hospital confinement)	80% after deductible	70% after deductible	50% after deductible
Other Outpatient Services not listed herein	80% after deductible	70% after deductible	50% after deductible
Jaw Joint/TMJ	80% after deductible	70% after deductible $1,000 orthodontic appliances Lifetime maximum	50% after deductible

Note: Orthodontic treatment is limited to the maximum listed above. Surgical treatment is covered up to the Plan Lifetime maximum.

Mental Disorders			
Inpatient	80% after deductible	70% after deductible	50% after deductible
Outpatient	80% after deductible	70% after deductible	50% after deductible
Physician office visit and Counseling visit charge:	100% after Specialist copayment	100% after Specialist copayment	50% after deductible
***Occupational Therapy**	80% after deductible	70% after deductible	50% after deductible
***Organ Transplants**	Designated Transplant Facility: 80% after deductible		Non-Designated Transplant Facility: 50% after deductible
Transplant maximum	Part of Plan's Annual maximum		Part of Plan's Annual maximum
Donor maximum	Part of Plan's Annual maximum		Part of Plan's Annual maximum

Note: Organ and tissue transplants are covered except those which are classified as "Experimental and/or Investigational". All Organ Transplant services, including evaluation, must be preauthorized or benefits may otherwise be reduced or denied. Therefore, the Covered Person or his/her physician must call the Utilization Review Coordinator when the Physician first indicates a transplant is recommended. Retransplantation procedures must also have preauthorization. Non-authorized services rendered by a non-designated transplant facility will be excluded by this Plan.

***Orthotics**	80% after deductible	70% after deductible	50% after deductible
***Outpatient Private Duty Nursing**	80% after deductible	70% after deductible	50% after deductible
***Physical Therapy**	80% after deductible	70% after deductible	50% after deductible
Physician Services			
Inpatient visits	80% after deductible	70% after deductible	50% after deductible
Office & urgent care visits	100% after copayment on the office/ urgent care visit & after hours charge.	100% after copayment on the office/ urgent care visit & after hours charge.	50% after deductible
Specialist office visits	100% after copayment on the office visit charge.	100% after copayment on the office visit charge.	50% after deductible
Surgery	80% after deductible	70% after deductible	50% after deductible
Allergy testing	80% after deductible	70% after deductible	50% after deductible

Prescription Drugs (Inpatient, Outpatient & Physician's office)	80% after deductible	70% after deductible	50% after deductible

Note: Any ***Specialty Drug*** billed by a provider when available through the Participating Pharmacy will be covered at 70% after deductible. However, the Covered Person will remain responsible for 20% even after the maximum coinsurance amount has been met for the Calendar year. To avoid this penalty, fill the Specialty Drug through a Participating Pharmacy. Refer to Prescription Drug Benefits following this Schedule. Contact the PBM at the number on your ID card.

Preventive Care

Routine Well Adult Care	100%, deductible waived.	100%, deductible waived.	50% after deductible

Benefit restricted to services performed in conjunction with preventive services such as routine physical examination. Benefit also includes services currently recommended by the United States Preventive Services Task Force categories A and B, such as certain laboratory tests and cancer screenings. A current listing of required preventive care can be accessed at www.HealthCare.gov/center/regulations/ prevention.html. Revised recommendations by the Task Force will be made applicable to the Plan when required by law.

Additional preventive care services for women are covered with no cost-sharing when rendered by Participating Providers/Pharmacies. View a current listing of required preventive services at http://www.hrsa.gov/womensguidelines/. Contact the Pharmacy Benefit Manager at the phone number on your health care plan ID card for specific information about medications which qualify for this benefit.

Check with your local Health Department to see if immunizations are available free of charge.

Frequency limits for mammogram
Ages 35 through 39 ..... single Baseline mammogram
Ages 40 and over ..... annually

Routine Well Child Care			
-Office visit charge:	100%, deductible waived.	100%, deductible waived.	50% after deductible
-Immunizations thru age 5:	100%, deductible waived.	100%, deductible waived.	50% after deductible
-All other services:	100%, deductible waived.	100%, deductible waived.	50% after deductible

Benefit restricted to services performed in conjunction with preventive services such as routine physical examination. Benefit also includes services currently recommended by the Health Resources and Services Administration (HRSA) for Infants, Children, and Adolescents. Revised recommendations by the HRSA will be made applicable to the Plan when required by law.

Benefit restricted to services recommended by the Advisory Committee on Immunization Practices that have been adopted by the Director of the Centers for Disease Control and Prevention or as required by other federal or Missouri state law.

Check with your local Health Department to see if immunizations are available free of charge.

***Prosthetics**	80% after deductible	70% after deductible	50% after deductible
Second Surgical Opinion, Voluntary	80% after deductible	70% after deductible	50% after deductible
	Refer to Cost Management Services section for further information.		
***Skilled Nursing Facility**	80% after deductible	70% after deductible	50% after deductible
	The facility's semiprivate room rate; Within 14 days of a 3 day stay; 60 days Calendar Year maximum		
***Speech Therapy**	80% after deductible	70% after deductible	50% after deductible
Spinal Manipulation/ Chiropractic Services	80%after deductible	70%after deductible	50% after deductible
	26 visits allowed per Calendar Year with a maximum allowed of $45 per visit		

Note: All services rendered by a chiropractor are subject to these maximums.

Substance Abuse			
Inpatient	80% after deductible	70% after deductible	50% after deductible
Outpatient	80% after deductible	70% after deductible	50% after deductible
Physician office visit and Counseling visit charge:	100% after Specialist copayment	100% after Specialist copayment	50% after deductible
Replacement of **teeth**	80% after deductible	70% after deductible	50% after deductible

Note: The above Lifetime maximum applies to all services listed under this benefit in the Medical Benefits section, including complications of covered surgical procedures.

Wigs	80% after deductible	70% after deductible	50% after deductible
Note: Refer to Medical Benefits section for coverage criteria.		One wig Lifetime maximum	
All other Covered Charges not excluded or limited in this Plan Document:	80% after deductible	70% after deductible	50% after deductible

PRESCRIPTION DRUG BENEFIT		
	PARTICIPATING	**NON-PARTICIPATING**
Prescription Drug Deductible, per Calendar Year		
Per Covered Person	$50	$50
Retail Prescriptions- (Per 30-day supply)		
Generic Drugs	$10 copayment	See below.
Formulary Brand Name Drugs	$30 copayment then 20% of the balance	See below.
Non-Formulary Brand Name Drugs	$50 copayment then 20% of the balance	See below.
Specialty Drugs	10% copayment; Person responsible for a total out-of-pocket of $1,500 per Calendar Year then Plan pays 100%.	See below.
Participating MedTrak 90 Pharmacy Option- (Per 90-day supply)		
Generic Drugs	$20 copayment	Not Applicable
Formulary Brand Name Drugs	$60 copayment	Not Applicable
Non-Formulary Brand Name Drugs	$100 copayment	Not Applicable

Specialty Drugs are high-cost injectable, infused, oral or inhaled drugs that need special storage, handling and/or administration, or that generally require close supervison and monitoring of the patient's drug therapy. Al list of these durgs is available by contacting the Pharmacy Benefit Manager as stated on your health plan ID card.

Prior authorization is required for any prescription over $1,000 (30-day) or $2,000 (90-day).

Filing receipts when PBM card is not used:

If this is your primary plan, all prescriptions should be filed through the PBM. If the Pharmacy charges less than the Pharmacy's discount price through the Pharmacy Benefit Manager (PBM), purchase the prescription without the card and submit the receipt with the claim form to the PBM and state the situation on the form.

The reimbursement (based upon the network allowance less a small processing fee) will be sent to the Covered Employee if this is a copay plan. Some exceptions to the network allowance may be made for extenuating circumstances. Typically, a pharmacy can refile a claim within 14 days if a problem existed in filing the claim electronically. The MedTrak Services help desk is available six days a week to assist the pharmacy with rejected claims.

If this is your secondary plan, submit your receipt and/or explanation of benefits from your primary plan to Med-Pay. The coordination of benefits provision applies and benefits are payable under this Prescription Plan. The billed amount will be the amount listed on the receipt (total amount allowed or copayment, if total allowed is not listed).

The Med-Pay claim form may be obtained from www.med-pay.com/member/memberforms.htm. The MedTrak

	INVOICE DESCRIPTION	PO NUMBER	AMOUNT
	Lawn Roller	873-7520	10.00
[illegible]			10.00
	Argon	110-9034	164.00
	Alum Weld Rod	106-8901	12.23
[illegible]			176.23
& Pest - 201	DWE Break room		30.00
[illegible]			30.00
& Pest - 682	Pest Control		25.00
[illegible]			25.00
erapy, LLC	K-12	410-9468	2,323.75
erapy, LLC	ECSE	410-9468	1,267.50
[illegible]			3,591.25
	Capacitor		9.50
[illegible]			9.50
& Research	Registration "What's New in Children's Lit"	700-7882	235.00
& Research	Registration "What's New in Children's Lit"	700-6515	235.00
[illegible]			470.00
	Author Presentation	106-9571	3,160.27
[illegible]			3,160.27
pply Co.	Beakers	810-9135	88.35
[illegible]			88.35
les, Inc.	Graining Pads, Vinyl Spreader		41.80
[illegible]			41.80
10925	Shop Towels	110-8548	38.03
10925	Shop Towels	110-8548	38.03
[illegible]			76.06
379	Uniforms		276.59
379	Uniforms		276.59
379	Uniforms		276.59
[illegible]			829.77
	FFA Shirts	205-9530	692.30
[illegible]			692.30
	Backpack, Webcam, Wireless speaker etc	805-8430	966.00

[illegible]			366.00
Decker Equipment	Pencil Sharpeners	406-8031	51.27
[illegible]			51.27
Ellis Battery Specialists LLC	Batteries		149.90
[illegible]			149.90
Federal Express Corporation	Shipping		14.31
Federal Express Corporation	Shipping		29.47
[illegible]			43.78
Florida League of IB Schools	W Buxton FLIBS Registration	108-7560	880.00
Florida League of IB Schools	D Starkey FLIBS Registration	108-7560	880.00
[illegible]			760.00
Hummert International	Garden Supplies	110-8771	605.40
[illegible]			605.40
Infobase Learning	Facts on File	205-7675	948.48
[illegible]			948.48
J.W. Pepper	Music	105-9021	13.94
J.W. Pepper	Music	105-8794	6.95
J.W. Pepper	Music	105-9080	20.49
J.W. Pepper	Music	105-8917	69.99
J.W. Pepper	Music	105-8794	14.94
[illegible]			126.31
Jacks Sporting Goods	Bulbs		17.98
Jacks Sporting Goods	HardHat		28.18
Jacks Sporting Goods	Bulbs		25.90
Jacks Sporting Goods	Appliance Bulbs		3.18
Jacks Sporting Goods	Plumbing Supplies		5.69
Jacks Sporting Goods	Bulbs		5.88
Jacks Sporting Goods	Supplies		5.78
Jacks Sporting Goods	Supplies		8.68
Jacks Sporting Goods	Electrical Supplies		9.00
[illegible]			110.27
Janine's	Plant for funeral	700-8784	45.50
Janine's	Plant for funeral	700-8681	33.50
[illegible]			79.00

igh School	Speech/Debate Tournament	105-9353	298.00
[illegible]			[illegible]
	Meat & Cheese tray	700-8682	17.78
	Teel retirement	805-9336	25.98
	SC for lost receipt	404-8472	2.00
[illegible]			[illegible]
hool	Meat & Cheese trays	873-9134	250.20
[illegible]			[illegible]
	Cheese	110-9104	75.27
[illegible]			[illegible]
School	HS Lifeskills	410-9228	37.35
School	MS Lifeskills	410-9223	51.77
School	Ice cream cake for student voice	205-9001	28.54
School	MS Lifeskills	410-8989	56.79
School	HS Lifeskills	410-8820	24.58
School	HS Lifeskills	410-8975	28.22
School	Hospitality room	205-8721	44.00
School	HS Lifeskills	410-8821	33.12
School	MS Lifeskills	410-8823	49.35
School	HS Lifeskills	410-9227	21.34
[illegible]			[illegible]
	Cable rod slide, arrows	105-8580	150.00
			[illegible]
NEOPOST	Postage		3,000.00
[illegible]			[illegible]
a - 2018018	Family night	408-9582	106.00
[illegible]			[illegible]
s Inc.	DJ Services	205-9625	300.00
[illegible]			[illegible]
	Loose leaf rings	106-8938	53.98
	Gallon storage bags	106-8938	59.98
			[illegible]
	Mush Husky Assembly	408-9584	475.00
[illegible]			[illegible]

Schillers	Document camera	805-8345	740.64
[illegible]			[illegible]
Scholastic Inc.	Awesome Animals	402-8550	40.00
Scholastic Inc.	Baby Animals	402-8550	2.00
Scholastic Inc.	All About Winter	402-8550	12.00
Scholastic Inc.	How..Bucket for Kids	402-8550	4.00
Scholastic Inc.	Native American Bios	402-8550	10.00
Scholastic Inc.	Animals, Moonshot, Cat in Hat	402-8550	17.00
Scholastic Inc.	Bear Says Thanks	402-8550	4.00
Scholastic Inc.	Pete... Why...	402-8550	10.00
Scholastic Inc.	Pete the Cat	402-8550	4.00
Scholastic Inc.	Gingerbread, Season of Sight	402-8550	14.00
Scholastic Inc.	Guided Animal mini pack	402-8550	12.00
Scholastic Inc.	Polar Animals	402-8550	2.00
Scholastic Inc.	My Book of Space	402-8550	8.00
Scholastic Inc.	101 Animal Babies, Wild Animals	402-8550	17.00
[illegible]			[illegible]
School Specialty	Chair	105-7607	175.96
[illegible]			[illegible]
Sew Special	TShirts - OR	404-9653	1,305.60
[illegible]			[illegible]
STAM	MJoseph - Membership, banq, conf.	105-5967	104.00
STAM	TMartin - Membership, Banq, conf	105-5967	104.00
[illegible]			[illegible]
Tin Men Mechanical LLC	Air Handlers - OR Kitchen	800-9483	700.00
[illegible]			[illegible]
United States Postal Service	Postage meter		4,000.00
[illegible]			[illegible]
Wal-Mart - Hawthorn	School supplies - new students	403-8921	77.60
Wal-Mart - Hawthorn	Faculty meeting supplies	403-8585	46.88
Wal-Mart - Hawthorn	Batteries, folders, soap	403-9266	100.93
Wal-Mart - Hawthorn	Paper goods	403-9267	51.15
Wal-Mart - Hawthorn	Lantern, plaster, wire	810-8987	128.94
[illegible]			[illegible]

Check Preview Report February 25, 2014

[redacted]

ACI BOLAND ARCHITECTS

ACI/BOLAND, INC. – KANSAS CITY
1421 E 104th Street, Suite 100
Kansas City, Missouri 64131
T. 816.763.9600
F.816.763.9757

ry 18, 2014

ry Dickemann, Director of Maintenance
nton R-III School District
ox 1409
nton MO 65020

GE ORDER PROPOSAL REQUEST
ns and Alterations to
ine Deck Elementary School
Project # 3-13021

erry,

find attached Change Order Proposal Request dated January 17, 2014, in the of $31,460.00. As I'm sure you remember, at the time of the projects' bid date, as still some question as to how steep the slopes could be economically cted, as well as whether retaining walls would be a better solution, and the Slope ation study was recommended to analyze the possibilities. This Proposal es the preferred Option #4, described in the "Results" section of the report, as subsequent sections of the report. A copy of the referenced report is attached, convenience.

e reviewed this additional cost to the project with Engineering Surveys & s, and Palmerton-Parrish, find it to be reasonable, and recommend its prompt al, so as to not interfere with the Project Schedule. Should you have any ns or comments, please feel free to contact me.

ly
LAND ARCHITECTS

ith, Project Architect

Tim Hadfield; Camdenton R-III School District
Guy Augenstein, Bales Construction
Tim O'Connor, Engineering Surveys & Services
Brad Parrish, Palmerton-Parrish
Andy Ratkewicz, Norton & Schmidt
Michael Kautz/file 3-13021, ACI Boland Architects

BALES
SINCE 1939

GENERAL CONTRACTORS

PROPOSAL

Date: 1/17/2014

Bales Construction Co., Inc.
1901 Historic 66 W
Waynesville, MO 65583

Phone: (573)774-2003
Fax: (573)774-6163
Email: guy.buildbales@gmail.c

PROPOSAL SUBMITTED TO:

Attn: MR. KEN KEITH
ACI BOLAND

Phone #: 816-763-9600

WORK TO BE PERFORMED AT:

HURRICANE DECK ELEMENTARY

We hereby propose to furnish the materials and perform the labor necessary for the completion of:
Construct Rock Buttress per the detail provided by PPI as part of the Slope Stability Analysis
dated December 16, 2013 and installed as shown on Drawing C4.1 dated 12/16/2013
Material (includes 210 Tons of Rock)
Labor
Equipment
Bales Overhead and Profit

We will perform the above for the sum of: **Tota**

All materials is guaranteed to be as specified and the above work to be performed in accordance with the drawings and specifications submitted for above work and completed in a substantial workmanlike manner. **Upon Approval, please return one sign**

Respectfully submitted

Guy Augenstein

Acceptance of Proposal

BLOOMSDALE EXCAVATING
Since 1946

nuary 9, 2014

Ir. Guy Augenstein
ales Construction Co.
901 Historic Route 66
Vaynesville, MO 65583

ENT VIA EMAIL: guy.buildbales@gmail.com

E: Hurricane Deck Elementary School
Sunrise Beach, MO

)ear Mr. Augenstein:

loomsdale Excavating Company is pleased to submit the following additional pricing for
ıe above referenced project. Our price is based upon constructing the Rock Buttress per
ıe detail provided by PPI as part of the Slope Stability Analysis dated December 16, 2013
ıd is to be installed as shown on drawing C4.1 dated 12/16/13.

ump Sum Price to construct Rock Buttress ***$ 28,600.00***

lease do not hesitate to contact us if you need anything further.

espectfully,

)aniel J. Latham, PE
roject Engineer

BLOOMSDALE EXCAVATING COMPANY, INC
12211 State Route Y • P.O. Box 86 • Bloomsdale, MO 63627
573.483.2564 o • 573.483.9474 f • www.blex.com

PPI PALMERTON & PARRISH, INC.

GEOTECHNICAL & MATERIALS ENGINEERS
MATERIALS TESTING LABORATORIES
ENVIRONMENTAL SERVICES

December 16, 2013

ACI Boland Architects
1421 East 104th Street, Suite 100
Kansas City, Missouri 64131

Attn: Mr. Ken Keith

Re: Camdenton R-III School District
Hurricane Deck Elementary School – Slope Stability Analysis – Phase I
Sunrise Beach, Missouri
PPI Project Number: 218802

Dear Mr. Keith:

This letter report presents the results of the Slope Stability Analysis perfor
Palmerton & Parrish, Inc. (PPI) for slopes at the above referenced project site b
the Playing Field. This analysis was authorized by a letter proposal dated Nove
2013 and signed by Mr. Timothy Hadfield.

PROJECT BACKGROUND

As you know, our firm performed a Geotechnical Investigation for this project.
design was preliminary at the time of this Geotechnical Investigation and no
were drilled along the proposed 2H:1V slopes. These slopes bordering the Playi
are presently designed at 2H:1V with slope heights ranging from approximately
ft.

SCOPE OF SERVICES

In accordance with instructions received from Mr. Tim O'Conner with Eng
Surveys & Services, Inc., (ESS), PPI's scope of services includes:

1. A Global Stability Analysis for the presently designed 2H:1V slope as sh
the project plans bordering the Playing Field.
2. A preliminary Slope Stability Analysis for alternate methods of slope cons
which include:
   - Use of vertical segmental block walls (maximum 15 ft. height);
earth fill slopes;
   - A combination of 2:1 earth fill and 1.5:1 rock fill slopes; and
   - Other reinforced slopes that may appear to be applicable. These
use either an earth fill or rock fill material, or both.

10000 Hwy 160
Walnut Shade, MO 65771
Ph: (417) 561-8395

5616 S. 122nd East Ave., Ste. I
Tulsa, OK 74146
Ph: (918) 872-9898

nulti-phase approach was planned to accomplish the scope of services as described ove. **This is the final letter report for Phases I and II.**

ase I – Perform a slope stability analysis for 2H:1V slope as presently designed suming use of earth materials from on-site cut as new controlled fill. Conservative ength parameters will be assumed for earth materials based upon results of the otechnical borings and our experience in the site area. Secondly, prepare conceptual ss section models for review by the Project Team, which will incorporate different ree of slopes, slope materials and retaining walls.

ase II – Perform a site specific slope stability analysis for up to two (2) conceptual ss section models developed during Phase I selected by the project team. A report be prepared presenting findings, analysis approach, assumptions made in the lysis and results of the analysis will be prepared. Slope stability analysis will be formed using the limit equilibrium slope stability analysis software Slope/W. Slope bility analysis will be performed for both the end of construction and long term inage conditions. It should be emphasized that only the global stability of the pe/wall system will be analyzed under Phase II. Internal stability of retaining walls will assumed to be acceptable and will not be analyzed during this phase.

ase III – Depending upon the results of Phases I and II, final design of a slope/wall mbination may be required. It may also be apparent that additional geotechnical estigation is needed to confirm bearing capacity for retaining walls or shear strength ameters assumed during the analysis. PPI will be happy to prepare a proposal for se services, if required, after completion of Phase I and Phase II.

OPE STABILITY APPROACH

ected cross sections incorporating earth fill, rock fill, geogrid reinforcement, and MSE (maximum height of 15 ft.) were analyzed using the computer program Slope/W Spencer's Method. Topographic data for the natural ground surface and finish des within the Playing Field were provided in the grading plan transmitted tronically by ESS. This topographic data and finish grade were used to develop ss sections for the taller west slope (slope height approximately 60 ft.) and aining slopes northwest and north of the Playing Field with maximum slope heights the order of 40 ft. A copy of this topographic survey and finished contours are sented in Attachment A.

(2) representative cross sections of the "as designed" earth fill slopes at 2H:1V with and 60 ft. heights were analyzed initially using soil strength and density parameters sistent with the Geotechnical Investigation performed for the project and our firm's t experience in the site area. End of Construction Conditions utilizing undrained soil ngth parameters were analyzed, as well as long term Steady State Seepage dition utilizing drained or effective stress strength parameters. Soil strength and sity parameters used in these analyses are summarized in the following table:

Slope Condition	Earth Fill & Natural Overburden Soils			Rock Fill		
	Unit Wt. (pcf)	Cohesion (psf)	Friction Angle (Degrees)	Unit Wt. (pcf)	Cohesion (psf)	(
End of Construction	125	750	8	135	50	
Steady State Seepage Condition	125	150	28	135	50	

In addition to the above soil strength parameters, the following conditio assumed in the Stability Analysis:

- Development of a phreatic groundwater surface at a depth of approximat within the Playing Field sloping to near the toe of the embankment;
- Surcharge live load on Playing Field surface of 150 psf;
- Use of Tensar UX 1700 geogrid or equivalent;
- Proper subgrade preparation and benching of fill materials into the hillside as detailed later in this report; and
- Compaction of earth and rock fills in accordance with the Geotechnica prepared for the project under controlled conditions including on-site obs and testing by PPI.

After analysis of the 2H:1V simple slopes, differing cross sections were a incorporating rock fill or MSE walls and/or geogrid reinforcement in an at economize slopes and increase the factor of safety.

FACTOR OF SAFETY

Slope stability analysis computations yield a "Factor of Safety" for the slope a A factor of safety of less than 1.0 predicts slope failure. Factors of safety co adequate for a project depend upon the reliability of the parameters used (a parameters vs. parameters determined by laboratory tests), reliability of assu pertaining to depth to bedrock and groundwater conditions, threat to public safety and welfare, and tolerance of the Owner to risk.

As previously described, strength parameters used in this analysis were det from the Geotechnical Investigation performed for the project and PPI's past exp in the site area, but not for the specific slope area. Since groundwater and conditions are not known along the slopes, fairly conservative groundwater and conditions were assumed in the analysis. It is anticipated that no occupied st are planned along the crest of the slopes, nor at the toe. Risk of structural dam to public safety appears to be minimal. **Based upon these considerations, Factor of Safety of 1.3 is considered satisfactory for this project.**

LTS

nissible Factor of Safety of 1.3 was determined for a 40 ft. high earth slope under nd of Construction and long term Steady State Seepage Conditions regardless of er bedrock is deep or shallow. However, for the 60 ft. high slope, factors of safety y 1.1 and 1.2 were determined for deep and shallow bedrock conditions, tively and a Factor of Safety of only 1.0 for End of Construction Conditions with edrock.

attempt to economize slope construction and/or increase Factor of Safety for neights greater than 40 ft., the following slope configurations and geometries were ed:

1H:1V Geogrid Reinforced Earth Slope – This slope cross section requires the least volume of earth material. However, significant geogrid reinforcement will be required to provide satisfactory factors of safety for both shallow surface slides and deep seated slope failures. Preliminary analyses indicate factors of safety of 1.3 or greater can be achieved with this cross section. Final design and location of geogrid reinforcement will be influenced by depth to bedrock conditions. See Attachment B for a schematic of this cross section.

Rock Fill at 1.5H:1V Above 2H:1V Earth Fill – This cross section yields factors of safety of only 1.0 and 1.1 under End of Construction and Steady State Seepage Conditions even with shallow bedrock and **is not considered a viable option.**

Rock Fill at 1.5H:1V with Geogrid Reinforcement over 2H:1V Earth Fill – With incorporation of geogrid reinforcement within the rock fill, factors of safety ranging from 1.25 to 1.7 were obtained for the two (2) conditions analyzed under both deep and shallow bedrock. It is believed that a minimum factor of safety of 1.3 can be obtained using this approach. This approach requires less volume of slope material than a simple 2H:1V earth fill, but will require appreciable geogrid reinforcement within the rock fill component. A typical cross section of this slope s shown in Attachment B.

2H:1V Earth Fill with Rock Fill Buttress at Toe – This approach utilizes the simple earth fill slope at 2H:1V, but incorporates a rock fill buttress at the toe to increase safety factor and improve subsurface drainage. **As described in a later section of this report, placement of a rock fill toe drainage is recommended regardless of the slope configuration selected.** Safety factor of earth fill slopes can be increased by incorporation of a rock fill buttress. A typical cross section of this alternate is also provided in Attachment B. It is believed that safety factors on the order of 1.3 can be achieved with this approach.

2H:1V Earth Fill with MSE Wall at Crest of Slope – Although this alternate reduces the volume of material required in the slope, this slope geometry produces increased driving forces at the slope crest which reduces the factor of safety. Factors of safety of 1.0 or less were determined for this slope geometry.

However, by increasing the length of geogrid reinforcement well beyon slope crest, factors of safety on the order of 1.3 or greater can be achi Again, see Attachment B for a typical cross section.

SUMMARY

These preliminary cross sections and stability analyses are intended to provid Design Team and Owner examples of what can be achieved using differing materials. **For slopes with a height of 50 ft. or less, a simple earth slope at 2 is the more straight forward and probably the more economical appr although incorporation of rock fill, MSE walls and geogrid may als considered for 50 ft. and lower slopes to reduce the quantity of slope fill.**

For slopes ranging from 50 to 60 ft. in height (see attachments), other approaches be considered and **slope improvements must be performed to achieve an ade safety factor of 1.3.**

In addition to the above concepts for a slope cross section, the Factor of Safety m increased by lowering finish grade of the southwest end of the Playing Field. approach may be considered, as well as the above slope concepts. Shifting locati the Playing Field towards the northeast may also merit consideration.

FINAL SELECTION OF SLOPE CROSS-SECTION

It is understood that the Project Team desires the use of a simple 2H:1V slope se for this project. As described above, use of a simple 2H:1V slope should provic adequate Factor of Safety for slopes with a height of less than 50 ft. provided construction is in accordance with the Geotechnical Report for this project additional recommendations presented in the following sections of this report.

For simple 2H:1V slopes exceeding 50 ft. in height, it is recommended that a fill buttress be added to increase the slope stability Factor of Safety an reduce erosion at the toe. A detail for this rock fill buttress is show Attachment C.

ADDITIONAL SLOPE CONSTRUCTION CONSIDERATIONS

Regardless of the method of slope construction selected, the follo recommendations should be implemented in slope construction.

1. The existing hillside is fairly steep. To provide bonding of the new fill satisfactory compaction of initial fill lifts, new fill should be benched into sloping hillside. The existing hillside should be benched in a stair ste fashion to provide a level horizontal surface for placement of fill lifts a minimum 4 ft. bench into the hillside. All soft subgrade exposed in bench bot should be removed. PPI should be notified prior to commencement placement along the natural hillside. **Benching procedures should observed and approved by PPI personnel prior to fill placement.**

Erosion protection for earth fill slopes will be required, but is outside of the scope of this report and should be within the scope of the Civil Designer.

:R REPORT LIMITATIONS

tter report has been prepared in accordance with generally accepted practices of consultants undertaking similar studies at the same time and in the same ıphical area. Palmerton & Parrish, Inc. observed that degree of care and skill ılly exercised by other consultants under similar circumstances and conditions. rton & Parrish's findings and conclusions must be considered not as scientific ties, but as opinions based on our professional judgment concerning the ance of the data gathered during the course of this investigation. Other than this, ranty is implied or intended.

JRE

l you have any questions or need additional information please feel free to call ce.

ERTON & PARRISH, INC.

. Parrish, P.E.

ıment A - Topographic Survey & Finished Contours
ıment B - Typical Cross Sections
ıment C - Rock Buttress Detail

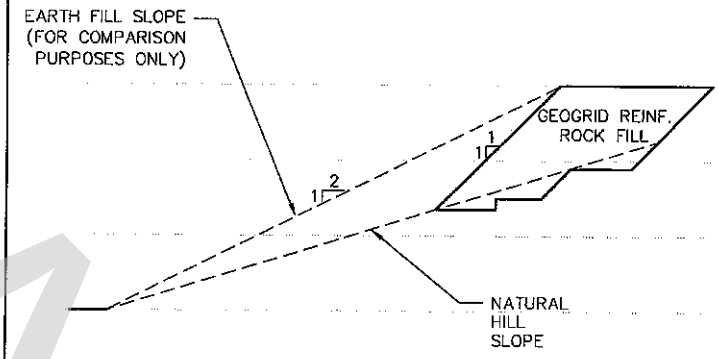
ATTACHMENT A

TOPOGRAPHIC SURVEY & FINISHED CONTOURS

HURRICANE DECK
ELEMENTARY SCHOOL
Camdenton R-III School District
16596 N. STATE HWY 5
C4
A C I

ATTACHMENT B

TYPICAL CROSS SECTIONS



Case 1 - Geogrid Reinforced 1:1 Rock Fill

Project: Hurricane Deck Elementary Sch
Client: ACI Boland Architects

Slope Stability Analysis - Cas

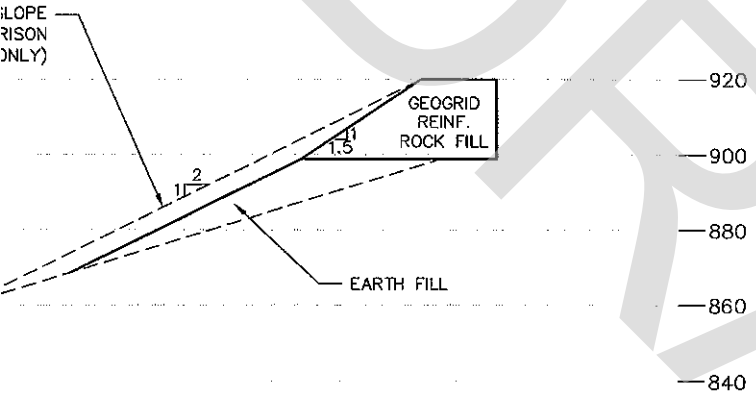
DATE: November 26, 2013

Projec

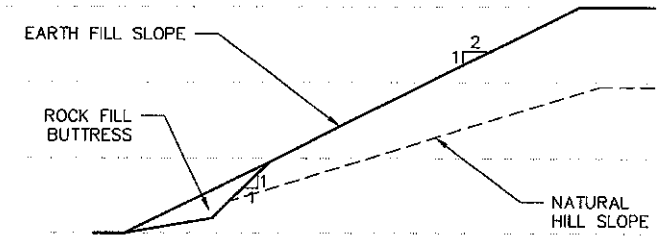
SCALE
1"=30'

PALMERTON & PARRISH, INC

GEOTECHNICAL AND MATERIALS ENGINEERS/MATERIALS TESTING LABORATORIES/ENVIRONMENTAL S



Case 3 - Geogrid Reinforced 1.5 H:1 V Rock Fill
Over 2 H:1 V Earth Fill



Case 4 - 2 H:1 V Earth Fill With Rock Fill Buttress At Toe

Project: Hurricane Deck Elementary School
Client: ACI Boland Architects

Slope Stability Analysis - Case 3

DATE: November 26, 2013 Project Number: 218802

PALMERTON & PARRISH, INC.
GEOTECHNICAL AND MATERIALS ENGINEERS/MATERIALS TESTING LABORATORIES/ENVIRONMENTAL SERVICES

FIGURE 2

SCALE
1"=30'

Project: Hurricane Deck Elementary Schoo
Client: ACI Boland Architects

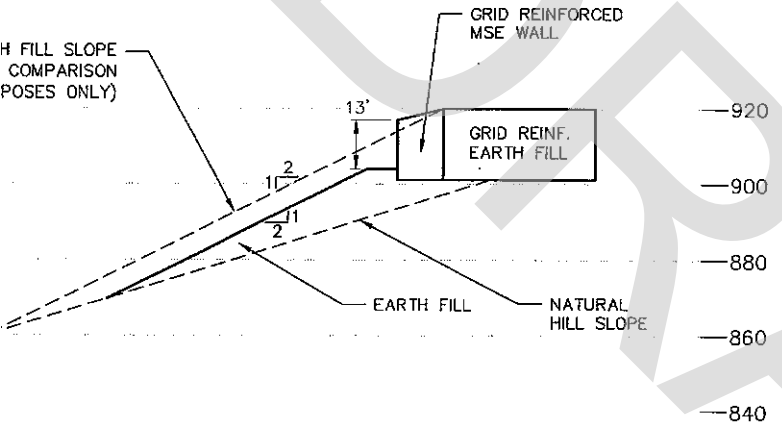
Slope Stability Analysis - Case

DATE: November 26, 2013 Project

PALMERTON & PARRISH, INC.
GEOTECHNICAL AND MATERIALS ENGINEERS/MATERIALS TESTING LABORATORIES/ENVIRONMENTAL SERV

ATTACHMENT C

ROCK BUTTRESS DETAIL



Case 5 - 2 H:1 V Earth Fill With MSE Wall And Reinforced Earth Fill At Crest

Project: Hurricane Deck Elementary School Client: ACI Boland Architects	
Slope Stability Analysis - Case 5	
DATE: November 26, 2013	Project Number: 218802
PALMERTON & PARRISH, INC. GEOTECHNICAL AND MATERIALS ENGINEERS/MATERIALS TESTING LABORATORIES/ENVIRONMENTAL SERVICES	FIGURE 4

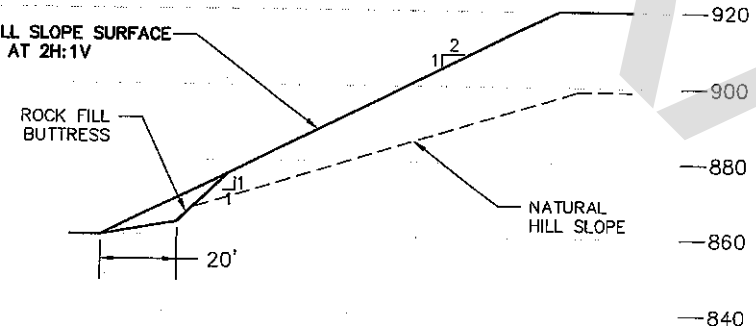
S:

CK BUTTRESS TO HAVE HORIZONTAL
20 FT AND BACKSLOPE OF 1H:1V TO
WITH NEW SLOPE FACE.

FILL GRADATION AND PLACEMENT IN
CE WITH MoDOT 203.4.17 ROCK
NT.

FABRIC MAY BE REQUIRED IF ROCK FILL
IS OPEN WITH CONSPICUOUS VOIDS.

OPE HEIGHTS EXCEEDING 50 FT.



Project: Hurricane Deck Elementary School
Client: ACI Boland Architects

Rock Buttress Detail

DATE: December 13, 2013 Project Number: 218802

PALMERTON & PARRISH, INC.
GEOTECHNICAL AND MATERIALS ENGINEERS/MATERIALS TESTING LABORATORIES/ENVIRONMENTAL SERVICES