Spira EPO Product, on the BlueSelect Plus Network

Offered by Blue Cross and Blue Shield of Kansas City

DIRECT ENROLLMENT
Health Benefits Contract for:
PPK4001A

NOTICE

The application, which You completed was delivered to You as a part of the Contract. The Contract was issued on the basis that answers to all questions and information shown on the application is correct and complete. Please read over Your copy of the application and carefully check it.

You may return this Contract within 10 days of its receipt for full refund of any Premiums paid if, after examining it, You are not satisfied for any reason. Write to Us within 10 days if any information shown on it is not correct and complete.

The Contract describes the Benefits for Health Care Services covered by Blue Cross and Blue Shield of Kansas City and the extent to which Benefits may be limited. EPO plans cover health care services only when provided by a doctor or facility who participates in the network. If you receive services from an Out-of-Network doctor or other health care provider, you will have to pay all of the costs for the services, except that emergency services must be covered regardless of whether they are delivered by an In-Network provider and Covered Service include 2 visits per Calendar Year for the diagnosis or assessment of Mental Illness to an Out-of-Network Provider acting within the scope of their license. The Contract may be terminated by Us as described in the Contract.

Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

2301 Main . P.O. Box 419169 . Kansas City, MO 64141-6169 . 1-888-989-8842

Discrimination is Against the Law
Blue KC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue KC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue KC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service, 844-395-7126 (Toll free), languagehelp@bluekc.com.

If you believe that Blue KC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: the Appeals Department, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you, or someone you're helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-844-395-7126.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue KC, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-989-8842

Chinese: 如果您，或是您正在協助的對象，有關於 Blue KC 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話1-844-395-7126。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-395-7126

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-395-7126 an.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue KC 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-395-7126 로 전화하십시오.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-844-395-7126.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-395-7126.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue KC, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-395-7126.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue KC, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-395-7126.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue KC, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-395-7126.

Laotian: ຖ້າທ່ານ, ຫຼືຄົນທ່ານກໍາລັງຊ່ວຍເຫຼືອ, ມໍຄາຖາມກ່ຽວກັບ Blue KC, ທ່ານມີສິດ ທ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະໍຂ້ ມ ູ ນຂ່າວສານ ທ່ເປັ ນພາສາຂອງທ່ານ ໍ ່ ບມ ຄ ່ າໃຊ້ ຈ ່ າຍ. ການໂອ້ ລ ົ ມກ ັ ບນາຍພາສາ, ໃຫ ້ ໂທຫາ 1-844-395-7126.

Pennsylvanian Dutch: Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Blue KC, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-844-395-7126 uffrufe.

Persian:
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue KC ، داشته باشید حق این را دارید که کمکو اطالعات به زبان خود را به طور رایگان دریافت نمایید 1-844-395-7126 .تماس حاصل نمایید.

Cushite: Isin yookan namni biraa isin deeggartan Blue KC irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-844-395-7126 tiin bilbilaa.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue KC, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-395-7126

For TTY services, please call 1-816-842-5607

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Amendments/Riders, if any, are located in the back of this Contract.

WELCOME TO BLUE KC

This Contract describes the services covered, the services not covered, and other important information You need to know. **Please read this Contract carefully to better understand how Your care will be provided.**

Your healthcare product is an EPO. EPO is an abbreviation for *Exclusive Provider Organization*.	In-Network Providers participate in the **BlueSelect Plus network**. In-Network pharmacies are in the **RxPremier network**. Services provided by Out-of-Network Providers (including providers that participate in other Blue Cross and Blue Shield of Kansas City networks) are generally **not** covered.
What that means to You is services **must** be provided by an In-Network Provider to be covered except for Emergency Services and certain Mental Health office visits. You may pay 100% of the Out-of-Pocket Cost up to Your Out-of-Pocket Maximum for these limited Covered Services provided by Out-of-Network Providers.	
Your healthcare product provides direct access to the **Spira Care Center**. All Covered Services provided at the Spira Care Center are provided at no cost to You. You are required to pay for Covered Services provided by In-Network Providers up to Your Out-of-Pocket maximum.	

When accessing health care services, there are many items to consider to determine if the services will be covered by your plan.

1. The service must be considered a Covered Service and not excluded. See Section D. Covered Services for a description of what is covered and Section E. Exclusions and Limitations for a description of what is excluded.
2. The service must be considered Medically Necessary for You. Please see Section K. Terms You Should Know for a description of Medical Necessity. A service may be covered under Your plan, but if the service is not considered Medically Necessary for You, then the service will be excluded.
3. The service must be provided by an In-Network Provider.
4. The service may be subject to other rules when your claim processes. Examples of such rules may include clinical edits (i.e. if the service is appropriate for your age or gender), medical policy limits, or provider reimbursement rules.

If a health care service is covered, You may still be required to pay Cost-Sharing for that service. Cost-Sharing may include a Deductible, Coinsurance, or Copayment.

- Deductible is the amount You will pay for a service before Blue KC will pay.
- Coinsurance is a percentage You will pay for a service. This is based on the Allowable Charge.
- Copayment is a flat dollar amount that You will pay for a service.

Your Cost-Sharing will stop once You reach Your Out-of-Pocket Maximum for the year (i.e. the most You will be required to pay for Covered Services in a single Calendar Year).

Need help? If You have any questions, comments or concerns, call Blue KC Customer Service at the phone number listed on Your member ID card. They are available Monday through Friday from 8 a.m. to 8 p.m. Central Time.

WELCOME TO BLUE KC

Need help? If You have any questions, comments or concerns, call Blue KC Customer Service at the phone number listed on Your member ID card. They are available Monday through Friday from 8 a.m. to 8 p.m. Central Time.

In addition, You are encouraged to register with **MyBlueKC.com** as a member today. It's quick and easy. Simply use the information from Your Blue KC member ID card to gain access to Your MyBlueKC.com portal. Your portal allows You to manage Your personalized information and take advantage of the tools and resources available from Blue KC to help You achieve your best health.

SECTION A. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

Eligibility

To be eligible to enroll, the Contractholder must live within Johnson or Wyandotte County.

Dependent Eligibility

To be eligible to enroll as a Dependent a person must be:

a. The Contractholder's legal spouse

b. The Contractholder's or his legal spouse's child. Such child includes:

(1) A child by birth.
(2) An adopted child.
(3) A child under the age of 18 who has been placed with the Contractholder for the purpose of adoption. The Contractholder must have a legal obligation to support the child. Or
(4) A child under the age of 18 who has been placed under the Contractholder's legal guardianship.

Coverage for a Dependent child under this section will apply whether such child (defined above) is: married, a tax dependent of the Contractholder or his legal spouse, a student, actively employed, or residing with or receiving financial support from the Contractholder or his legal spouse.

Coverage will be provided until the end of the Calendar Year in which such child reaches the Dependent limiting age.

c. The Contractholder's or his legal spouse's unmarried Dependent child (defined above) who has reached the limiting age but who cannot support himself because of a physical or mental handicap. The Dependent's handicap must have started before the end of the Calendar Year in which he reached the limiting age. The Dependent must have been continuously covered by Us or a prior health plan at the time of reaching the limiting age.

We must receive satisfactory proof of the Dependent's handicap. We must receive this within 31 days before the child reaches the Dependent limiting age, or within 31 days after the child is enrolled for coverage under the Contract to continue coverage beyond the limiting age.

For disabled dependents, if the Social Security Administration ("SSA") determines that such dependent is totally disabled, then such determination will be accepted as proof for a disabled dependent without further review. For disabled dependents with no SSA determination, or a determination of partial disability, an affidavit is required to be submitted as proof of the disability. The affidavit includes a physician attestation regarding the health of the dependent, as well as criteria regarding the duration of the disability and ability of the dependent to be gainfully employed.

The Contractholder is responsible for ensuring Dependent information is current. If necessary information is not in Our files, claims will be rejected for such individuals.

Enrollment

Annual Enrollment Period

A Contractholder may choose coverage for himself or himself and his Dependents. He must submit a properly completed and signed application.

Special Enrollment Periods

a. New Dependents

If a new Dependent is acquired by the Contractholder due to marriage, birth, adoption, or placement for adoption (so long as the Contractholder retains physical custody of such child), the new Dependent may enroll during this Special Enrollment Period. To do so, the Contractholder must submit to Us a completed application and any additional Premium due within 60 days after the date of marriage, birth, adoption, or placement for adoption. Documentation verifying the event must be provided, if requested.

Notwithstanding the above paragraph, if the Contractholder has previously elected Dependent coverage and such coverage is in effect on the date of the newborn child's birth or the date the petition for adoption is filed, then the newborn child will be covered automatically. Coverage will apply for 31 days from the moment of birth. No additional Premium will be assessed for coverage for these 31 days. If additional Premium is due, the Contractholder must submit to Us a completed application. The application must request coverage for such newborn to be added within 60 days of the child's birth in order to continue such child's coverage beyond the initial 31 days. Additional Premium may be due upon adding the child after the initial 31 days. Coverage for such newborn will be subject to all of the terms and conditions of the Contract.

If You notify Us of the birth verbally or in writing within 60 days of the date of birth, We must:

(1) Provide the Contractholder with forms and instructions.
(2) Allow an additional 10 days from the date on which enrollment forms and instructions were provided for the newborn enrollment materials to be completed and returned.

If a child placed for adoption is not legally adopted, coverage for such child will end the earlier of the date on which the Contractholder's legal support obligation for the child ends or 280 days after such child's date of placement.

If the new Dependent for whom additional premium is due is not enrolled as a Dependent within 60 days of becoming eligible, then such Dependent will be considered a Late Enrollee.

b. Loss of Minimum Essential Coverage.

If the Contractholder and/or his Dependents had Minimum Essential Coverage under another health plan and are no longer eligible for such coverage, they may enroll during the Special Enrollment Period. This is provided such loss of coverage was not due to failure to pay premiums for the coverage or Rescission.

The Contractholder must submit to Us a completed Contractholder application and any additional Premium due within 60 days after the loss of such other coverage. He must provide appropriate documentation verifying the loss of such other coverage, if requested.

c. Eligibility for Government Assistance.

(1) If a Contractholder and/or his Dependent become eligible for premium assistance under Medicaid or CHIP and the coverage provided under the Contract is not a high deductible health plan as defined under IRS Code §223, they may enroll during this Special Enrollment Period. To do so, a Contractholder must submit to Us a completed Contractholder application and any additional

Premium due within 60 days after eligibility is determined. He must provide appropriate documentation verifying the eligibility, if requested.

(2) If the Contractholder and/or his Dependents gain or lose eligibility for government assistance for Premiums or Cost-Sharing, they may be able to enroll during this Special Enrollment Period. To do so, a Contractholder must submit to Us a completed Contractholder application and any additional Premium due within 60 days after eligibility is determined. He must provide appropriate documentation verifying the eligibility, if requested.

d. Error in Enrollment.

If the Contractholder and/or his Dependents enroll or fail to enroll due to an error, misrepresentation, or inaction by Us or a governmental entity, they may enroll during this Special Enrollment Period. To do so, a Contractholder must submit to Us a completed Contractholder application and any additional Premium due within 60 days of becoming aware of the error.

e. Material Violation of Contract.

If a Contractholder and/or his Dependents adequately demonstrate that We or another entity substantially violated a material provision of the health benefit contract in which he is enrolled, they may enroll during this Special Enrollment Period. To do so, a Contractholder must submit to Us a completed Contractholder application and any additional Premium due within 60 days of becoming aware of the violation.

f. Permanent Move.

If a Contractholder and/or his Dependents gain access to coverage as the result of a permanent move, they may enroll during this Special Enrollment Period. To do so, a Contractholder must submit to Us a completed Contractholder application and any additional Premium due within 60 days after the permanent move.

Contractholder Application.

The Contractholder must fully and accurately complete and sign the Contractholder application. Coverage for all Covered Persons may become null and void from inception if it is determined that You intentionally misrepresented material facts or committed fraud.

Effective Date of Coverage

a. Annual Enrollment.

Coverage is effective at 12:01 a.m. on January 1st. Coverage is subject to Our receipt of the required Premium.

b. Special Enrollment.

(1) New Dependents.

If an individual enrolls during a Special Enrollment Period due to acquiring a new Dependent, coverage is effective as follows:

(a) In the case of marriage, no later than the first day of the month following enrollment.
(b) In the case of the birth of a child, the date of such birth.
(c) In the case of adoption of a child, the earlier of:

(i) The moment of birth for a newborn child if a petition for adoption was filed within 31 days of the birth.
(ii) The date the petition for adoption was filed. Or
(iii) The child's date of placement. Date of placement means the date the Contractholder assumed the legal obligation for total or partial support of the child to be adopted in connection with formal adoption proceedings.

(2) Loss of Minimum Essential Coverage.

If an individual enrolls during a Special Enrollment Period due to loss of Minimum Essential Coverage, coverage is effective no later than the first day of the month following enrollment.

(3) Eligibility for Government Assistance.

If an individual enrolls under the Special Enrollment Period due to becoming eligible or ineligible for government assistance, coverage is effective on the first day of the month following enrollment if enrollment occurs between the first and fifteenth of the month. The effective date is the first day of the second month following enrollment if enrollment occurs between the sixteenth and the last day of the month.

(4) Error in Enrollment.

If an individual enrolls under the Special Enrollment Period due to an error in enrollment, coverage is effective on the first day of the month following enrollment if enrollment occurs between the first and fifteenth of the month. The effective date is the first day of the second month following enrollment if enrollment occurs between the sixteenth and the last day of the month.

(5) Material Violation of Contract.

If an individual enrolls under the Special Enrollment Period due to a material violation of contract, coverage is effective on the first day of the month following enrollment if enrollment occurs between the first and fifteenth of the month. The effective date is the first day of the second month following enrollment if enrollment occurs between the sixteenth and the last day of the month.

(6) Permanent Move.

If an individual enrolls under the Special Enrollment Period due to a permanent move, coverage is effective on the first day of the month following enrollment if enrollment occurs between the first and fifteenth of the month. The effective date is the first day of the second month following enrollment if enrollment occurs between the sixteenth and the last day of the month.

Other Changes in Coverage

If You want to change Your coverage because of a divorce, the change will be effective on the date of the divorce.

If You are a surviving Dependent of a deceased Contractholder, You have the right to continue coverage under the Contract. The change will be effective on the day after the date of death.

If the Contractholder terminates coverage because he became covered under a Medicare supplement or Medicare Advantage policy with Us, any other Covered Person has the right to continue coverage under this Contract. The change will be effective on the effective date of the Medicare supplement policy.

When a Dependent child reaches the limiting age as provided in the Benefit Schedule, he will be issued his own coverage under a similar direct enrollment Contract. He will not be required to complete an application if he has been covered under the Contract and currently resides within Our Service Area. When this occurs, any references in the Contract to the individual having to complete an application will not apply. Such coverage will be effective the day following the date of termination of his previous coverage. This applies only if he pays the required Premium for his new Contract within 60 days of the termination of his previous coverage. Any Dependents added later to his new coverage will be subject to all the provisions of the Contract.

SECTION B. PREMIUM PAYMENT, GRACE PERIOD, AND CHANGES

Premium Payment

Initial Premiums are due and payable on or before the Contract effective date. Subsequent Premiums are due and payable on or before the monthly Due Date. Premium payments received will be applied first to the oldest month due.

Premiums are owed by the Contractholder. Premiums may not be paid by third parties unless related to the Contractholder by blood or marriage. We will not accept premium payments by third parties, unless we are required by law to do so. Third parties include but are not limited to Ryan White HIV / AIDS Programs, Indian tribes, tribal organizations, or urban Indian organizations, State and Federal Government Programs, hospitals, pharmacies, physicians, automobile insurance carriers, or other insurance carriers. We may have previously accepted a premium from an unrelated third party. This does not mean that We will accept premiums from these parties in the future.

Grace Period

You shall have a grace period of 28 calendar days for the payment of any Premium, during which time the Contract shall continue in force. In no event shall the grace period extend beyond the date the Contract terminates. Coverage under the Contract will automatically terminate at 11:59 p.m. on the last day of the period for which Premiums have been paid if the grace period expires and any Premium remains unpaid.

Reinstatement

Reinstatement for Nonpayment of Premium

Except as provided below, if coverage under the Contract is terminated for nonpayment of Premiums, We have the right to decide whether or not to reinstate such Contract. Such a decision will occur in writing within 45 days of receiving Your resubmission of a new application, if one is required, as well as payment of any outstanding Premium. Any Premiums that are owed to Blue KC for previous coverage within the previous twelve (12) months at the time of re-application for coverage may be required to be paid in order to enroll in any Blue KC product. Failure to make the required Premium payment may result in a denial of coverage.

Reinstatement for Individuals Deployed in Military Service

If You terminate coverage as a result of Your or Your Dependent spouse's activation to military service, You may request Reinstatement of Your Contract for You and Your eligible Dependents who were covered under the Contract on the day before the Contract was terminated. You must request Reinstatement of Your Contract within 30 days following the deactivation or loss of coverage under the federal government sponsored health insurance program. You must provide proof of loss of coverage, including the termination date, under the program.

Notwithstanding the above, if a new Dependent child is acquired by the Contractholder due to the birth of a child or adoption of a child during the period of military activation, the new Dependent child may be enrolled for coverage under the Contract. To enroll, the Contractholder must submit to Us a completed application and any additional Premium due. These must be submitted along with the request for Reinstatement of coverage.

Reinstatement rights will not be available for You or Your Dependents if You are discharged from the military under other than honorable conditions.

The Effective Date of the reinstated Contract will be the first of the month following receipt of the notice requesting
Reinstatement.

SECTION C. TERMINATING THE CONTRACT

Terminating a Covered Person's Coverage

We may terminate the Contract and/or a Covered Person's coverage on the earliest of the dates specified below:

a. On the last day of the month for which Premium has been paid if You fail to pay any required Premium. We may recover from You Benefits We paid subsequent to the date of termination.

b. On the last day of the month a Dependent ceases to meet the eligibility requirements set forth in the "Dependent Eligibility" provision of the "Eligibility, Enrollment and Effective Date" section of the Contract, except as otherwise indicated for Dependent children.

c. On the date indicated in writing to You by Us if a Covered Person performs an act of fraud or makes an intentional misrepresentation of a material fact in connection with the coverage. Such termination will only occur if written notice was provided 30 days in advance.

d. On the original Effective Date of coverage if coverage is terminated by Us due to a Covered Person committing fraud or intentionally misrepresenting a material fact on the application.

e. On the last day of the month in which the Contract is terminated because the Contractholder no longer resides in Our Service Area.

f. On the last day of the year in which the Contract is terminated because the Contractholder changes his place of residence within Our Service Area to the state of Missouri. You may contact Us for other coverage that may be available to You.

g. On the last day of the month in which coverage under the Contract is terminated because We cease offering the particular type of coverage provided by this Contract in accordance with applicable laws and regulations. If We discontinue offering this particular type of coverage, We will provide You 90 days written notice prior to the date coverage is discontinued. We will offer You, on a guaranteed issue basis, the option to purchase any other individual health insurance coverage that We are currently offering.

h. On the last day of the month in which the Contract is terminated because We cease offering all individual health insurance coverage in Kansas in accordance with applicable laws and regulations. If We discontinue all individual health insurance coverage in Kansas, We will provide You 180 days written notice prior to the date all such coverage will terminate.

SECTION D. COVERED SERVICES

This section describes the Benefits for Covered Services available under the Contract. All Covered Services are subject to the conditions, limitations and exclusions of the Contract.

Covered Services

Covered Services under the Contract are set forth in this section. All Covered Services are subject to the Cost-Sharing requirements and the limitations and exclusions of the Contract.

What is a Covered Service?

The specified services and supplies will be Covered Services only if they are:

a. Incurred for a Covered Person while coverage is effective;
b. Performed, prescribed or ordered by a Physician;
c. Medically Necessary for the treatment of Your injury or illness, except for specifically listed routine preventive or diagnostic services;
d. Not excluded under the Contract. And
e. Received in accordance with the requirements of the Contract.
f. Received from In-Network Providers, except as described in the Emergency Services provision or Mental Health provision, or services from an Out-of-Network Provider Prior Authorized by Us due to a life threatening condition or disabling degenerative disease.

Covered Services do not include any services or supplies received from a provider in a country where the terms of any sanction, embargo, boycott, Executive Order, or other legislative or regulatory action taken by the Congress, President or an administrative agency of the United States would prohibit payment or reimbursement by Us for such services.

Benefits

We provide Benefits for Covered Services in excess of Cost-Sharing. All Covered Services are subject to the maximums and other limits and conditions specified in the Contract.

Benefits for Covered Services will be greater if Covered Services are received from In-Network Providers. **It is Your responsibility to ensure that You use In-Network Providers to receive the maximum Benefits.** Failure to do so will increase Your financial responsibility.

Services from Out-of-Network Providers Prior Authorized by Us

If You have a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of these may require specialized medical care over a prolonged period of time. In such a case, You may receive services from an Out-of-Network specialty care center with expertise in treating such condition when such services are Prior Authorized by Us. We or Your In-Network Provider, in consultation with one of Our Medical Directors, may determine that Your care would be most appropriately provided by a specialty care center. If so, We shall Prior Authorize these services from such a center. Such services shall be pursuant to a treatment plan that is developed by the specialty care center. Such services shall be approved by Us, in consultation with the In-Network Provider, if any, or a Specialist as designated previously, as well as You or Your designee.

If We Prior Authorize in advance services from a specialty care center which is not an In-Network Provider, services provided pursuant to the approved treatment plan shall be provided at no greater cost to You than if such services were obtained from an In-Network Provider. A specialty care center shall mean only such centers accredited or designated by an agency of the state or federal government or by a voluntary national health

organization as having special expertise in treating such condition or disease for which it is accredited or designated.

Deductible

The Deductible is applied each Calendar Year. Except as specifically provided, the Calendar Year Deductible must be satisfied before we will provide Benefits for Covered Services. After 2 covered family members have satisfied the individual Deductible for a Calendar Year, the Deductible will be considered satisfied for all family members. No Covered Person is allowed to contribute more than his own individual Deductible to the family Deductible per Calendar Year.

Amounts You pay towards satisfaction of the Deductible requirement for Emergency Services and limited Covered Services from Out-of-Network Providers where specified, including the 2 visits per Calendary Year for the diagnosis or assessment of Mental Illness to an Out-of-Network Provider, will apply to Your In-Network Provider Deductible. This is so regardless of whether services are received from an In-Network or Out-of-Network Provider.

Copayments

Copayments are a specified amount that You must pay each time You receive a service of a particular type or in a designated setting. Whenever a Copayment applies toward a Covered Service, the Deductible does not apply, except as specified in the Benefit Schedule.

Copayments, if any, are indicated in the Benefit Schedule.

Out-of-Pocket Maximum

After 2 or more covered family members have satisfied the individual Out-of-Pocket Maximum for a Calendar Year, the Out-of-Pocket Maximum will be considered satisfied for all family members.

Cost-Sharing for Emergency Services will apply to Your In-Network Provider Out-of-Pocket Maximum. This is so regardless of whether services are received from an In-Network or Out-of-Network Provider.

Expenses that do not apply toward the Out-of-Pocket Maximum are indicated in the Out-of-Pocket Maximum definition.

Prior Authorization

Services that must be Prior Authorized by Blue KC or its Delegates are identified in the applicable Covered Service subsection.

In the case of a maternity or an inpatient Admission due to an Emergency Medical Condition, You must notify Us within 24 hours of the Admission or as soon after as reasonably possible.

Benefits will be limited to the length of stay approved by Us. When the length of stay must be extended for Medically Necessary reasons, You must contact Us in advance to obtain Our approval for the additional days. Your attending Physician may contact Us on Your behalf.

Failure to provide such notice or obtain Prior Authorization or approval for additional days will result in You being responsible for the cost of the service. This is so regardless of Medical Necessity.

The following information provides a detailed description of Covered Services:

Accident-Related and Other Dental Services

Accidental Injury

We provide Benefits for dental services only when such services are for treatment of an Accidental Injury. Covered Services are limited to treatment of natural teeth, as well as the purchase, repair, or replacement of dental prostheses needed as a direct result of an Accidental Injury (except injury resulting from biting or chewing). Treatment must be completed within 12 months of the date of the Accidental Injury to be considered a Covered Service. This may be extended if the medical condition of the Covered Person prevents treatment from being rendered within 12 months of the Accidental Injury.

Covered Services do not include health and dental services resulting from Accidental Injuries arising out of a motor vehicle accident. This applies only to the extent that such services are payable under any expense payment provisions (by whatever terminology used, including such benefits mandated by law) of any automobile insurance policy.

Covered Services also include treatment of jaw fractures or complete dislocations, as well as diagnostic x-rays in connection with these.

Tooth Extractions

We provide Benefits for the extraction of teeth and related services when performed in conjunction with the treatment of head or neck tumors.

Dental Implants

We provide Benefits for dental implants and bone grafts for the following conditions:

a. The repair of defects in the jaw due to tumor/cyst removal;
b. Severe atrophy in a toothless arch;
c. Exposure of nerves;
d. Non-union of a jaw fracture;
e. Loss of teeth due to an Accidental Injury; and
f. Correction of a defect.

Dental prostheses over an implant are only covered if the dental implant was due to an Accidental Injury or due to a correction of a defect.

Dental implants and bone grafts must be Prior Authorized by Blue KC of its Delegates.

Orthognathic Surgery

We provide Benefits for Orthognathic surgery for:

a. Correction of a congenital birth defect or abnormality; or
b. Correction of a defect due to an Accidental Injury. Treatment for correction of a defect due to an Accidental Injury must be completed within 12 months of the date of the Accidental Injury to be considered a Covered Service. This may be extended if the medical condition of the Covered Person prevents treatment from being rendered within 12 months of the date of the Accidental Injury.

Temporomandibular Joint Disorder

We provide Benefits for the surgical treatment of temporomandibular joint disorder. We provide Benefits for the medical or dental management of this disorder only in connection with acute dislocation of the mandible due to accidental bodily injury, fractures, or tumors.

Temporomandibular joint disorder must be Prior Authorized by Blue KC of its Delegates.

Complications of Dental Treatment

We provide Benefits for inpatient Hospital services that are required as a result of complications of dental treatment. Covered Services are limited to those that cannot be adequately provided in an outpatient setting.

Allergy

We provide Benefits for allergy services provided in a Physician's office. Covered Services are limited to office visits as well as Medically Necessary testing, injections, and allergy antigens.

Ambulance Service

We provide Benefits for transportation by a licensed Ambulance service, whether via ground or water Ambulance, when it is Medically Necessary to transport You from the place where an Accidental Injury or other Emergency Medical Condition occurred to the nearest facility where appropriate treatment can be obtained**.**

Covered Services include transportation by an air Ambulance only when it is Medically Necessary. Benefits and will be limited to transportation to the nearest facility where appropriate treatment can be obtained.

Anesthesia

Medical

We provide Benefits for anesthesia materials and their administration if the surgical, orthopedic, diagnostic, or obstetrical service requiring the anesthesia is covered. Covered Services must be provided by a Physician (other than the operating Physician) or Certified Registered Nurse Anesthetist (CRNA).

Dental

We provide Benefits for general anesthesia materials, their administration, and medical care facility charges for dental care. Benefits will be provided only when such services are provided in a Hospital, surgical center, or office.

Who is eligible to receive dental anesthesia?

Benefits are limited to the following Covered Persons:

a. Children age 5 and under;
b. Persons who are severely disabled; or
c. Persons who have medical or behavioral conditions requiring hospitalization or general anesthesia when dental care is provided.

Covered Services must be provided by a Physician, Certified Registered Nurse Anesthetist (CRNA) or Dentist.

Bone Marrow Testing

We provide Benefits for bone marrow testing. Covered Services are limited to Human Leukocyte Antigen testing for A, B and DR antigens used in bone marrow transplantation.

Chemotherapy

We provide Benefits for chemotherapy. This includes oral chemotherapy drugs.

These services must be Prior Authorized by Blue KC of its Delegates.

Clinical Trials

We provide Benefits for Routine Patient Care Costs as the result of a Phase I, II, III, or IV clinical trial. The trial must be for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition. The treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient number of patients. The trial must be approved by one of these entities:

a. National Institute of Health (NIH).
b. CDC.
c. Agency for Health Care Research and Quality.
d. Centers for Medicare and Medicaid Services (CMS).
e. A cooperative group or center of those listed in a. through d., or of the Department of Defense or Veteran Affairs.
f. A qualified non-research entity identified in the guidelines issued by the NIH.
g. If certain conditions are met, the Department of Veteran Affairs, the Department of Defense, or the Department of Energy.
h. The FDA in the form of an investigational new drug application.
i. A drug trial that is exempt from the requirement of a FDA new drug application.

Routine Patient Care Costs are defined as follows:

a. Drugs and devices that have been approved for sale by the FDA. This applies whether or not they have been approved by the FDA for use in treating the patient's particular condition.
b. Reasonable and Medically Necessary services needed to administer a drug or device under evaluation in a clinical trial.
c. All other items and services that are otherwise generally available in the clinical trial, except:

    (1) The Investigational item, device, or service itself.
    (2) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
    (3) Costs for services clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
    (4) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

These services must be Prior Authorized by Blue KC of its Delegates.

Cochlear Implants

We provide Benefits for cochlear implants. Covered Services include the initial implant, Medically Necessary repairs and replacements that are no longer covered under warranty, and related implant services (including batteries).

Initial and replacement cochlear implants must be Prior Authorized by Us. Implant repairs and replacement parts (including batteries) do not require Prior Authorization.

Diabetes

We provide Benefits for the treatment of diabetes. Covered Services include self-management training (including diet counseling from a registered dietician or certified diabetes educator) Covered Services also include Physician prescribed Medically Necessary equipment and supplies used in the management and treatment of diabetes. Benefits are available only for Covered Persons with gestational, type I or type II diabetes. Insulin, oral anti-diabetic agents, syringes, test strips, lancets, needles and glucometers are Covered Services under the Outpatient Prescription Drug Benefit.

We provide Benefits for one pair of diabetic shoes and up to a maximum of 3 pairs of inserts for these shoes per Covered Person per Calendar Year.

Diagnostic Services

We provide Benefits for diagnostic services. These include x-ray examinations, laboratory services, and other diagnostic procedures and tests required to diagnose an illness, injury, or other Covered Service. Covered Services include Echocardiogram and Stress Echocardiogram. Covered Services do not include screening examinations or routine physical examinations unless they are specifically listed as Covered Services under the Routine Preventive Care Benefit in this section. Benefits for diagnostic services may vary based on where the services are rendered as indicated in the Benefit Schedule.

MRI, MRA, Nuclear Medicine, Cardiac Nuclear Medicine, CT, CTA, and PET scans are Covered Services under the High-Tech Diagnostic Benefit.

We also provide Benefits for lab tests, x-rays, and other necessary diagnostic tests and exams ordered by Your Physician prior to a covered outpatient or inpatient surgery.

Radiology services and pathology services provided in an In=Network facility will be subject to the In-Network Provider Deductible and Out-of-Pocket Maximum provisions of the Contract. Such services will be paid at the In-Network Provider Coinsurance level.

Echocardiograms and Stress Echocardiograms must be Prior Authorized by Blue KC or its Delegates.

Dialysis

We provide Benefits for hemodialysis and peritoneal dialysis services.

Durable Medical Equipment and Related Supplies

We provide Benefits for the rental or purchase of durable medical equipment (DME) for use outside a Hospital.

Are there restrictions to approved DME?

Benefits are limited to the following conditions:

a. Use of DME will be authorized for a limited period of time;
b. We retain the right to possess the equipment. You agree to cooperate with Us in arrangements to return the equipment following Your authorized use; and
c. We have the right to stop covering the rental when the item is no longer Medically Necessary.

Covered Services are limited to the basic DME that meets the minimum specifications and is Medically Necessary. Covered Services include:

a. Hand-operated wheelchairs.
b. Hand-operated hospital-type beds.
c. Oxygen and the equipment for its administration.
d. Mechanical equipment for the treatment of chronic or acute respiratory failure (ventilators and respirators).
e. Oral appliances for sleep apnea.

When Medically Necessary, an electrically operated bed or wheelchair may be covered.

The wide variety of DME and continuing development of equipment makes it impractical to provide a complete listing. Covered DME includes those items covered by Medicare unless otherwise specified.

Covered Services include some warning or monitoring devices. These include but are not limited to home apnea monitors for infants, 24 hour event monitors (not including 24 hour blood pressure devices), 24 hour ECG monitors ("Holter"), and home oximetry monitors.

Covered Services do not include repair or replacement required as a result of abused, misused, stolen, lost, destroyed or damaged DME. If repair or replacement of DME is authorized, We retain the option to determine whether to repair or replace the equipment. Covered Services do not include muscle stimulators; portable paraffin bath units; sitz bath units; stethoscopes, or blood pressure devices. Covered Services do not include items for comfort or convenience, such as spas, whirlpools, Jacuzzis, hot tubs, humidifiers, dehumidifiers, and air conditioners. Covered Services do not include support/surgical stocking (for the lower extremities), including, but are not limited to, custom made stockings. Covered Services also do not include DME that would normally be provided by a Skilled Nursing Facility. See the Exclusions section of the Contract for additional exclusions which may apply.

DME and related supplies must be Prior Authorized by Blue KC of its Delegates.

Elective Sterilization

We provide Benefits for elective sterilization and for reversal of non-elective sterilizations. Elective sterilization services for women and men are Covered Services under the Routine Preventive Care Benefit.

Reversal of Non-Elective Sterilizations must be Prior Authorized by Blue KC or its Delegates.

Electrical Stimulators and Other Stimulators

We provide Benefits for certain types of stimulators. Covered Services are limited to:

a. spinal cord stimulator and bone growth stimulator:
b. spine stimulator as an adjunct to spinal fusion and sacral nerve neuromodulation
c. spinal cord stimulator for chronic pain unresponsive to standard therapies;
d. bone growth stimulator for fracture nonunions or congenital pseudoarthroses;
e. bone growth stimulator of the spine as an adjunct to spinal fusion;
f. sacral nerve neuromodulation for urinary dysfunction;
g. vagus nerve stimulator for the treatment of refractory or intractable seizures;
h. phrenic nerve stimulator;
i. deep brain stimulator for tremor associated with Parkinson's or essential tremor;
j. hypoglossal nerve stimulator; or
k. tumor treating fields therapy, as a form of electrical stimulator, for the treatment of glioblastoma multiforme.

We provide Benefits for electrical stimulator when provided by a physician for the treatment of chronic or acute pain as well as for wound healing. Covered Services include unattended and manual electrical stimulator, as well as Iontophoresis. This does not include home based electrical stimulator or durable medical equipment except as otherwise specified, e.g., TENS.

Certain Stimulator services must be Prior Authorized by Us. Please contact Us or visit www.bluekc.com for a complete list.

Emergency Services and Supplies

We provide Benefits for the treatment of Emergency Medical Conditions.

You must notify Us of any emergency Admission within 24 hours of the time of the Admission or as soon as is reasonably possible.

Services will be covered under this Benefit to evaluate or treat an Emergency Medical Condition. If You become stabilized and Your health condition no longer meets the definition of an Emergency Medical Condition, then any subsequent admission to the hospital will be covered under the Inpatient Hospital Services benefit. If received at an In-Network Provider Hospital.

What is an Emergency Medical Condition?

An Emergency Medical Condition means a medical condition manifesting itself by an unexpected onset of symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a. Serious impairment to a bodily function;
b. Serious dysfunction of any bodily organ or part; or
c. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

Genetic and Molecular Testing

We provide Benefits for the genetic testing for colorectal cancer and the following genetic tests for breast cancer: BRCA1, BRCA2, and Oncotype DX. We also provide Benefits for genetic testing when such testing is required to determine the Medical Necessity of certain prescription drugs or a bone marrow transplant. Covered Services are limited to selected genetic tests and the associated pre-test and post-test genetic counseling in accordance with Our Medical Necessity criteria. Certain genetic testing for women who have a family history that is associated with an increased risk for mutations in the BRCA1 or BRCA2 genes is a Covered Service under the Routine Preventive Care Benefit.

Genetic and Molecular Testing must be Prior Authorized by Us.

High-Tech Diagnostic Testing

We provide Benefits for High-Tech Diagnostic Testing. Covered Services include MRI, MRA, Nuclear Medicine, Cardiac Nuclear Medicine, CT, CTA, and PET scans. X-rays, radiology, and other diagnostic procedures are Covered Services under the Diagnostic Services Benefit.

These services must be Prior Authorized by Blue KC of its Delegates.

Home Health Services

We provide Benefits for home health services. These include 3 educational visits, provided in the home or other outpatient setting. Covered Services are subject to these conditions:

a. Covered Services are limited to part-time skilled nursing care, part-time services from home health aides, private duty nursing, physical therapy, occupational therapy or speech therapy.
b. The services are received as an alternative to inpatient Confinement in a Hospital or Skilled Nursing Facility.
c. Your Physician determines that You need home health care and designs a home health care plan for You.

Limitations: A visit is defined as no more than 2 hours. If private duty nursing is approved, services exceeding the 2 hour limit will accumulate as one or more additional visits.

Covered Services do not include meals delivered to Your home, custodial care, companionship, or homemaker services.

These services must be Prior Authorized by Blue KC of its Delegates.

Hospice Services

Home Hospice

We provide benefits for home hospice services if a Physician certifies You are Terminally Ill. Covered Services are limited to palliative care. If We determine the care provided is not palliative care, Benefits under Hospice Services are not Covered Services.

a. Covered Services are limited to the following home Hospice services:
   (1) Assessment and initial testing;
   (2) Family counseling of Immediate Family Members;
   (3) Non-prescription pharmaceuticals;
   (4) Medical supplies;
   (5) Respite care;

(6) Professional, medical, social, and pastoral counseling services provided by salaried employees of the Hospice; and
(7) Supportive services to the bereaved family members for up to 3 months following the death of the Covered Person.

b. Covered Services do not include:
(1) Services for which there is no charge;
(2) Services related to organization or dispensation of nonmedical, personal, legal, and financial affairs. For example: the execution of a will;
(3) Services received in a free standing Hospice facility or a Hospital-based Hospice, or provided to a Hospital bed patient. However, Covered Services will be provided for an assessment visit, family counseling and supportive services to the bereaved Immediate Family Members;
(4) Services received by persons other than the Covered Person or his Immediate Family Members.

Home Hospice services must be Prior Authorized by Blue KC of its Delegates.

Inpatient Hospice

We provide Benefits for Inpatient Hospice.

a. Covered Services are limited to services and supplies furnished by an Inpatient Hospice. Covered Services are limited to those You are eligible to receive as a Hospital bed patient and that would otherwise require confinement in a Hospital or Skilled Nursing Facility. The following services are also included:

(1) Assessment and initial testing;
(2) Family counseling of Immediate Family Members;
(3) Professional, medical, social, and pastoral counseling services provided by salaried employees of the Hospice; and
(4) Supportive services to the bereaved family members for up to 3 months following the death of the Covered Person.

b. Covered Services do not include:

(1) Services for which there is no charge;
(2) Services related to organization or dispensation of nonmedical, personal, legal, and financial affairs. For example: the execution of a will;
(3) Services received by persons other than the Covered Person or his Immediate Family Members;
(4) Respite care.

Inpatient Hospice services must be Prior Authorized by Blue KC of its Delegates.

Infertility

We provide Benefits for services received for (or in preparation for) any diagnosis of infertility. Treatment of infertility is limited to prescription drugs as indicated in the Benefit Schedule. Other Covered Services related to infertility are provided under this Benefit.

Covered Services do not include any services received for (or in preparation for) any diagnosis or treatment of sexual dysfunction (including drugs and prosthesis) as well as any related complications, unless the Covered Person has a documented disease resulting in impotence.

These services must be Prior Authorized by Blue KC of its Delegates.

Infusion Therapy and Self-Injectables, and Other Drugs Administered under the Medical Benefit

Infusion Therapy

We provide Benefits for infusion therapy services and supplies.

Infusion therapy is the administration of drugs or nutrients using specialized delivery systems which otherwise would have required You to be hospitalized. Infusion therapy in Your home or a Physician's office will be a Covered Service only if all of the following conditions are met:

a. If You did not receive infusion therapy at home or in Your Physician's office, You would have to receive such services in a Hospital or Skilled Nursing Facility.
b. The services are ordered by a Physician. They are provided by an infusion therapy provider or Physician licensed to provide such services.

These services must be Prior Authorized by Blue KC of its Delegates.

Injectables

We provide Benefits for injectables administered in the Physician's office or in the home setting**.** Covered Services include growth hormones, subject to the criteria defined in Our medical policy. Most injectables are covered under Your Outpatient Prescription Drug Benefit. However, certain injectables may be covered under this medical Benefit. Please refer to the Prescription Drug List for a listing of injectables that are covered under this medical Benefit. You may also visit Our website at www.BlueKC.com for a current listing. This list is subject to change without prior notice. It is based on the recommendations of community Physicians and pharmacists.

These services must be Prior Authorized by Blue KC of its Delegates.

Please contact Us at the telephone number listed on Your ID card for the current list of injectables that must be Prior Authorized.

Allergy injections and insulin are Covered Services under the Allergy and Diabetes Benefits.

Certain infusion therapy / injectable drugs may not be Medically Necessary when received in an outpatient hospital facility. However, such drugs may be covered when received at certain outpatient hospital facilities, a designated specialty pharmacy, or designated home infusion vendor. Please contact Customer Service for a list of such drugs and facilities.

Inpatient Hospital Services

We provide Benefits for inpatient services at a Hospital for evaluation or treatment of conditions that cannot be adequately treated in an outpatient setting. Covered Services include room and board; general nursing care; intensive care services; operating and treatment rooms and their equipment; drugs, medications, and biologicals; durable medical equipment; emergency rooms and their equipment and supplies; dressings, splints, and casts; electroshock or drug-induced shock therapy; blood and the administration of blood and blood products. We may approve a lower level setting (such as Skilled Nursing Facility) in lieu of a Hospital through Case Management. **Personal care or convenience items are not covered.**

All Admissions, including, but not limited to, acute, planned, and post-acute Admissions, except maternity and emergency Admissions, must be Prior Authorized by Blue KC or its Delegates. We require notification of emergency and maternity Admissions within 24 hours of the Admission or as soon as reasonably possible.

Maternity Services and Related Newborn Care

We provide Benefits for maternity services. Covered Services include a nuchal translucency scan at 12-14 weeks gestation and a routine obstetrical ultrasound at 20 weeks. Covered Services are limited to pre-natal, obstetrical and postpartum services. Covered Services also include genetic testing of fetal tissue. Covered Services do not include carrier genetic testing.

Covered Services include an inpatient stay of at least 48 hours for a covered mother and newborn child following any vaginal delivery or 96 hours following a cesarean section delivery. If the attending Physician, after consulting with the mother, authorizes a shorter inpatient Confinement, We will provide Benefits for post discharge care. If the mother and newborn child are discharged early, Covered Services include post-discharge care for a covered mother and a covered newborn child. Care must be provided by a Physician or registered professional nurse with experience in maternal and child health nursing.

Such services include, but are not limited to: Physical assessment of the mother and newborn child. Parent education. Assistance and training in breast or bottle feeding. Education and services for immunizations. Appropriate chemical tests and submission of a metabolic specimen to the state laboratory.

Services provided for a child and routine Hospital nursery services provided during the Hospital Confinement are eligible for Benefits. If the newborn child is added to the Contract as a Dependent, Benefits will be applied. Benefits shall also include coverage during the confinement for injury or sickness. This includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

If a child is adopted by You within 90 days of birth, Covered Services include obstetrical and delivery expenses only for the birth mother incurred at the time of the birth of such child.

We require notification of maternity Admissions within 24 hours of the Admission or as soon as reasonably possible.

Complications of Pregnancy

Covered Services include care (medical or surgical) required for medical Complications of Pregnancy resulting from or occurring during a pregnancy.

Covered Services do not include elective pregnancy termination. Elective pregnancy termination does not include spontaneous abortion or services to prevent the death of the mother upon whom the procedure is performed.

Mental Illness and Substance Abuse

We provide Benefits for the treatment of Mental Illness and Substance Abuse as indicated in the Benefit Schedule. New Directions Behavioral Health ("New Directions") performs intake services designed to provide crisis intervention, assessment, benefits management and referral services. Covered Services are provided for Medically Necessary outpatient evaluation and treatment of Mental Illness and Substance Abuse. For coverage for psychotherapeutic drugs, please see the Outpatient Prescription Drugs Benefit. Services for outpatient treatment will be covered to the same extent as any other illness as indicated in the Benefit Schedule. Covered Services for inpatient services are limited to Hospital and Physician services when You are confined in any Hospital or other residential facility licensed to provide such treatment. Services for inpatient treatment will be covered to the same extent as any other illness as indicated in the Benefit Schedule.

Covered Services include 2 office visits per Calendar Year for the diagnosis or assessment of Mental Illness to an Out-of-Network Provider acting within the scope of their license. Benefits will be provided for the purpose of diagnosis or assessment. Benefits will not, though, be dependent upon the findings of such practitioner. Benefits for these 2 office visits are not subject to Prior Authorization. Such Benefits will be subject to the applicable Cost-Sharing as indicated in the Benefit Schedule.

Inpatient and Residential Mental Illness and Substance Abuse Services must be Prior Authorized by Blue KC or its Delegates. Outpatient Mental Illness and Substance Abuse Services must be Prior Authorizaed by Blue KC or its Delegates.

Organ Transplants

We provide Benefits for Organ Transplants**. These services must be Prior Authorized by Us.** In the event that You need an Organ Transplant, We encourage You to review these Covered Services with Your Physician.

Covered Services are limited to services and supplies for Organ Transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ procurement, and ancillary services. Coverage is limited to the following transplants only when such transplants are Medically Necessary in accordance with Our Policies for transplantation services:

Benefits will be paid at the In-Network Provider level only if Organ Transplant services are provided at a Designated Transplant Provider.

If Organ Transplant Services are provided at a provider that is not a Designated Transplant Provider, Benefits will be provided at the Out-of-Network Provider level.

Designated Transplant Provider

A Designated Transplant Provider is a provider who has entered into an agreement with Us, or through a national organ transplant network with which We contract to render Organ Transplant Services if designated by Us. Designated Transplant Providers will be determined by Us. Such providers may or may not be located within Our Service Area.

Donor Covered Services

The following apply when a human Organ Transplant is provided from a living donor to a transplant recipient:

a. When both the recipient and the donor are covered under the Contract, Health Care Services received by the donor and recipient will be covered.
b. When only the recipient is covered under the Contract, both the donor and the recipient are entitled to the Covered Services of the Contract. The donor's Covered Services are limited to

only those benefits which are not provided by or available to the donor from any other source. This includes but is not limited to, other health care plan coverage or any government program.

c. When only the donor is covered under the Contract, Covered Services are limited to only those services which are not provided by or available to the donor from any other source. This includes, but is not limited to, other health care plan coverage or any government program. Covered Services will only be provided to a transplant recipient who is a Covered Person.
d. Covered Services do not include any organ or tissue that is sold rather than donated to a recipient covered under the Contract. However, other costs related to evaluation and organ "Procurement Services" are covered.

As used herein, "Procurement Services" are the services provided to match the human organ donor to the transplant recipient, surgically remove the organ from the donor and transport the organ to the location of the recipient within 24 hours after the match is made.

Immunosuppressant Drugs

We provide Benefits for immunosuppressant drugs required as a result of a covered Organ Transplant under the Outpatient Prescription Drug Benefit. To determine the applicable category and respective Cost-Sharing level for a drug, call the telephone number listed on Your ID card for a copy of the Prescription Drug List. You may also visit Our website at www.BlueKC.com for the most current information.

Limitations

A Covered Person is eligible for Benefits for retransplantation as deemed Medically Necessary and appropriate by Us. Review for a retransplantation request will include review of the Covered Person's compliance with relevant transplant selection criteria. This includes, but is not limited to, adherence to medication regimens and abstinence from the use of alcohol and drugs.

All retransplantation must be Prior Authorized by Blue KC or its Delegates.

Exclusions

You have no Benefit for a nonhuman or mechanical Organ Transplant.

You have no Benefit for testing, typing, or screening when the person does not become a transplant or tissue donor.

You have no Benefit for transportation and lodging expenses associated with a transplant.

Osteoporosis

We provide Benefits for the diagnosis, treatment and appropriate management of osteoporosis. This includes bone density studies if Medically Necessary. Bone density studies for screening (non-symptomatic or no medical history) purposes are not covered, except as otherwise specified.

Outpatient Prescription Drugs

Introduction/Prior Authorization

We provide Benefits for drugs and medicines for use outside a Hospital, and/or obtained at a pharmacy, that require a Physician's prescription.

Certain medications or classes of medication may require Prior Authorization. To receive Prior Authorization, Your Physician will need to submit to Blue KC or its Delegates a statement of Medical Necessity.

Drug Rebates and Credits

We contract with a pharmacy benefit manager ("PBM") for certain prescription drug administrative services. These include prescription drug rebate administration and pharmacy network contracting services. Please see the General Information section of the Contract for more details.

Covered Drugs

We provide Benefits for Outpatient Prescription Drugs as identified in the Benefit Schedule. These include psychotherapeutic drugs. To determine the applicable category and respective Cost-Sharing level for a drug, call the telephone number listed on Your ID card for a copy of the Prescription Drug List. You may also visit Our website at www.BlueKC.com for the most current information. The list of drugs is subject to change without prior notice. Any changes will be based on the recommendations of community Physicians and pharmacists.

What are Covered Drugs?

Covered Services are limited to:

a. Legend drugs that, by federal law, can only be dispensed upon written prescription from an authorized prescriber.
b. Compound medications that contain at least one legend drug in a therapeutic amount are a Covered Service when Medically Necessary. Certain compound medications may be subject to Prior Authorization. Please contact Customer Service to find out if Your compound medication must be Prior Authorized.
   Compound medications are available to You only at a designated pharmacy. Please contact Customer Service to determine where these medications will be available, or whether they may be shipped directly to You.
c. Off-label use of prescription drugs when treatment of the indication is recognized in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature. Your Physician must submit documentation supporting the proposed off-label use or uses if requested by Us.

   For this specific Benefit, the following terms are defined as follows:

   "Peer-reviewed medical literature" means a published scientific study in a journal or other publication in which original manuscripts have been published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. The manuscript must have been determined by the international committee of medical journal editors to have met the uniform requirements for manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

   "Off-label use of prescription drugs" means prescribing prescription drugs for treatments other than those stated in the labeling approved by the Food and Drug Administration (FDA).

   "Standard reference compendia" means the United States pharmacopoeia drug information, the American Hospital formulary service drug information, or the American Medical Association drug evaluation. This may also include other sources that We deem credible.

Covered Services are limited to drugs and medicines that have been approved for use in the United States by the FDA. This limitation applies regardless of where the drugs are obtained. Drugs or medicines approved by the FDA for Experimental or Investigative Services are not covered. We may impose administrative limits on the quantity or frequency by which a drug may be dispensed. These limits will be based on recommendations of the drug manufacturer or by community Physicians and pharmacists.

Benefits for prescription drugs are subject to the exclusions started in the Exclusions section of the Contract. In addition, Covered Services do not include any of the following.

a. Drugs or medications which are not on the formulary drug list;
b. Drugs or medications obtained from an Out-of-Network Provider pharmacy, except for Emergency Services; or
c. Immunization agents.

Short-Term and Long-Term Supplies

Short-term prescriptions are for up to a 34 day supply. If Your Physician prescribes a prescription for more than a 34 day supply, You must obtain a refill for any quantity above the 34 day supply. The pharmacy will then file the claim for the prescription. See Your provider directory for a listing of participating pharmacies.

We provide Benefits for certain long-term prescriptions when obtained from a designated mail order prescription drug program. Call Us for instructions and forms for obtaining prescription drugs through the mail. Long-term prescriptions are for a 35 to 102 day supply.

If the prescription is dispensed in a combination of different manufactured dosage amounts, You are only subject to Cost-Sharing for one prescription as indicated in the Benefit Schedule. If you are required to pay more than the Cost-Sharing for one prescription indicated in the Benefit Schedule at the pharmacy, You must submit a claim to Us for reimbursement.

Specialty Pharmaceuticals

We provide Benefits for Specialty Pharmaceuticals. Please refer to the Prescription Drug List for a listing of these drugs as well as specialty pharmacies. In some cases, these drugs will be delivered to Your home.

Specialty Pharmaceuticals means biotechnology drugs or other drug products that may require special ordering, handling, clinical monitoring and/or customer service. These drugs are limited to a 34 day supply.

If You obtain Your specialty drug from a retail pharmacy, You will be required to pay higher Cost-Sharing for all fills of that drug at a retail pharmacy, as indicated in the Benefit Schedule. Certain specialty drugs are required to be obtained from a designated specialty pharmacy. Please contact Customer Service for a list of such drugs.

Maintenance Drugs

We provide Benefits for prescription maintenance drugs. Maintenance drugs are those that must be used on a continuing basis to treat a chronic condition. Maintenance drugs may be obtained from a retail pharmacy on a short-term basis. They may also be obtained from a designated mail order prescription drug program under the long-term supply prescription drug benefit.

If You obtain Your maintenance drug from a retail pharmacy, then after obtaining Your second refill of that specific drug, You will be required to notify Us, and/or Our pharmacy benefit manager (PBM),

whether You intend to continue to obtain the drug from the retail pharmacy, or if You would like to begin obtaining such drug from a designated mail order pharmacy. Subsequent refills of the drug must be obtained using Your designated method.

If You do not notify Us, and/or Our PBM, of Your preferred method after the second refill, You may be responsible for the entire cost of the medication.

You may change Your preferred method by notifying Us, and/or Our PBM prior to obtaining Your next maintenance drug refill.

Maintenance Drugs

We provide Benefits for prescription maintenance drugs. Maintenance drugs are those that must be used on a continuing basis to treat a chronic condition. Such drugs may be obtained from a retail pharmacy or a designated mail order prescription drug program.

If You obtain Your maintenance drug from a retail pharmacy, then after obtaining Your second refill of that specific drug, You will be required to pay higher cost-sharing for all subsequent refills of that specific drug at a retail pharmacy. This will be 2 times the copayment indicated in the Benefit Schedule for short-term supplies.

If You obtain Your maintenance drug through a designated mail order prescription drug program, You must pay the Cost-Sharing indicated in the Benefit Schedule for long-term supplies.

Outpatient Surgery and Services

We provide Benefits for outpatient surgery provided under the direction of a Physician at a Hospital or an outpatient facility. Covered Services are limited to the same services You would receive under the same conditions in a Hospital as a bed patient, except for the Hospital daily service charge.

Certain outpatient surgeries and services, such as pain management, sleep procedures and devices, and spinal procedures, must be Prior Authorized by Blue KC or its Delegates in order to be Covered Services. Please contact Us at the telephone number listed on Your ID card for the current list.

Pediatric Dental

We provide Benefits for dental services for children until the end of the Calendar Year in which such Covered Person reaches age 19.

Basic Services

We provide Benefits for Basic Services. These include oral evaluations, x-rays, teeth cleanings, fluoride treatments, sealant treatments, and space maintainers.

Limitations: Oral evaluations and prophylaxes (teeth cleanings) are limited to 2 per Calendar Year. Complete mouth survey x-rays or panoramic x-rays are limited to 1 every 3 Calendar Years. Bitewing x-rays are limited to 2 occurrences per Calendar Year. Fluoride treatments are limited to 3 per Calendar Year. Topical application of sealant on a posterior tooth is limited to no more than 1 treatment per tooth every 12 months.

Intermediate Services

We provide Benefits for Intermediate Services. These include fillings, recementation, sedative fillings, root canal therapy, endodontics, tooth extractions, alveoloplasty and general anesthesia.

Limitations: Benefits are not available for more than 1 direct pulp cap per tooth. Benefits are limited to 1 course of root canal therapy per tooth.

Major Services

We provide Benefits for Major Services. These include crowns, inlays, onlays, bridges, dentures, partial dentures, maintenance of prosthodontics, and periodontics.

Limitations: Payment will not be provided for the relining of a denture if less than 6 months has elapsed since the date of insertion. Only 1 relining of a denture will be provided during any 2 Calendar Year period. Occlusal guard appliances (biteguards) will be provided only after active periodontal treatment and are limited to 1 every Calendar Year. These are limited to 1 per tooth every 60 months. Prefabricated posts and cores that are in addition to a crown are limited to 1 per tooth every 60 months. Dentures are limited to 1 every 60 months.

Major Services include orthodontics only in the case of severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or traumatic facial injury resulting in serious health impairment to the Covered Person.

Accident-related and other dental services for all Covered Persons are Covered Services under the Accident-Related and Other Dental Services Benefit.

These services for orthodontics must be Prior Authorized by Blue KC or its Delegates.

Pediatric Vision

We provide Benefits for vision services when provided to a Covered Person age 18 and under. Coverage will be provided until the end of the Calendar Year in which such Covered Person reaches age 19.

Covered Services include routine eye exams, eyeglasses, and contact lenses when received in lieu of eyeglasses. Services may be limited as indicated in the Benefit Schedule.

Covered Services also include fitting for contact lenses. Such services will be subject to the applicable Cost-Sharing indicated for All Other Covered Services in the Benefit Schedule.

Covered Services for eyewear will be limited to the eyewear that meets the minimum specifications and is Medically Necessary. Covered Services do not include non-prescription (Plano) lenses, two pairs of eyeglasses in lieu of bifocals, or services/supplies that are cosmetic in nature. Covered Services do not include replacement of lost or stolen eyewear.

Physician Services

We provide Benefits for Physician services unless otherwise noted. Covered Services are limited to the following:

a. Office visits.
b. Surgical and orthopedic services. Covered Services are limited to cutting and other operative procedures for treating illness or injury.
c. Surgical assistant services provided by a Physician. Covered Services are limited to the assistance at the operating table which is given to the operating Physician by another Physician. This assistance must be

Medically Necessary, as determined by Us and in connection with procedures that normally require assistance. Covered Services do not include any activities of internship or residency, or any type of training.

d. Inpatient Specialist services. Covered Services are limited to those that are provided when a Covered Person has a medical condition that is not in the attending Physician's specialty and the attending Physician asks the opinion of a Physician with that specialty. Covered Services do not include staff consultations required by Hospital rules and regulations.
e. Hospital bed patient care by a Physician.

(1) General care. Covered Services are limited to a Physician's visits to a Covered Person if the reason for the Hospital stay is strictly to treat a medical condition. No surgical, orthopedic or obstetrical services are performed during that Confinement.
(2) Preoperative care. Covered Services are limited to visits by a Physician with a specialty different from that of the operating Physician, assistant surgeon or anesthesiologist. The visits must be for treatment of a condition unrelated to surgery.
(3) Postoperative care. Covered Services are limited to visits by a Physician other than the operating Physician, assistant surgeon or anesthesiologist. The reason for the visits must be to treat a Covered Person for an acute phase of a medical condition a Covered Person either had before the surgical services, or that first began during the postoperative period.
(4) Intensive care. Covered Services are limited to visits by a Physician treating a Covered Person. Treatment must be for a medical condition that requires constant attendance or frequent visits in a short period of time.
(5) Inpatient Hospice. Covered Services are limited to visits by a Physician treating a Covered Person for a medical condition while in an Inpatient Hospice Setting.

f. Home visits by a Physician.
g. Telehealth services for medical information exchanged from one site to another via electronic communication to the extent the same service would be covered if provided through face to face diagnosis, consultation, or treatment. Covered Services do not include site origination fees, technological fees, or costs for the provision of telehealth services. Telehealth services will be subject to the same Cost-Sharing that would be applicable if the service were provided face to face.

Podiatry

Routine Care

We provide Benefits for routine foot care only if the Covered Person has a disease such as diabetes that can potentially affect circulation and/or the loss of feeling in the lower limbs. Routine foot care means the paring and removal of corns and calluses or trimming of nails. This does not include corrective shoes unless permanently attached to a brace.

Bone Surgery

We provide Benefits for bone surgery on the foot.

Prosthetic and Orthotic Devices

We provide Benefits for prosthetics and orthotics, other than foot orthotics (including shoes).

Covered Services are limited to the purchase and fitting of prosthetic and orthotic devices. These must be necessary as a result of congenital defects, injury or sickness.

When will repairs and replacements of prosthetics be covered?

When will repairs and replacements of prosthetics be covered?

Repairs or replacement of prosthetics are Covered Services only when necessary because of any of the following:

a. A change in the physiological condition of the patient.
b. An irreparable change in the condition of the device.
c. The condition of the device requires repairs. The cost of such repairs would be more than 60% of the cost of a replacement device.

Purchase and fitting means the entire process necessary to provide a Covered Person's prosthesis (whether paid by Us or someone else). This may include one or more temporary prostheses, when Medically Necessary.

Repairs and replacement are not Covered Services if the need for repair or replacement is due to misuse or abuse of the device, or to the extent the device is covered under any warranty. Covered Services also do not include repair or replacement required as the result of stolen, lost, destroyed, or damaged devices. Covered Services also do not include replacement of prosthetic and orthotic devices due to changes in technology. Prosthetics that may enhance function after initial purchase are not Covered Services.

Benefits are limited to the amount available for a basic (standard) item which meets the minimum specifications to allow for necessary activities of daily living. These include bathing, dressing, eating, continence, toileting, transferring and/or ambulating. Charges for deluxe prosthetic or orthotic devices are only covered for those devices that are Medically Necessary for the Covered Person.

Orthotics and foot orthotics (including shoes) are not covered unless otherwise specified. Diabetic shoes are Covered Services under the Diabetes Benefit.

Prosthetic and orthotic devices must be Prior Authorized by Blue KC or its Delegates.

Radiation Therapy

We provide Benefits for treatment of a medical condition with x-ray, radium, or radioactive isotopes.

These services must be Prior Authorized by Blue KC or its Delegates.

Reconstructive Surgery and Cosmetic Repair

We provide Benefits for reconstructive surgery and cosmetic repair to correct birth defects or a defect incurred through an Accidental Injury.

We also provide Benefits for reconstructive surgery when a functional impairment is present. A functional impairment is the inability of a body part or organ to perform its specific purpose.

These services must be Prior Authorized by Blue KC or its Delegates.

Reconstructive Surgery / Prosthetic Devices Following a Mastectomy

We provide Benefits for prosthetic devices and/or reconstructive surgery following a mastectomy. Covered Services are limited to:

a. Reconstructive surgery on the breast on which the mastectomy was performed.

b. Reconstructive surgery on the unaffected breast that is required to produce a symmetrical appearance.
c. Breast prostheses and physical complications in all stages of mastectomy, including lymphedemas. No time limit will be imposed on a Covered Person for the receipt of a prosthetic device or reconstructive surgery following a mastectomy.

No time limit will be imposed on a Covered Person for the receipt of a prosthetic device or reconstructive surgery following a mastectomy. Benefits for 4 mastectomy bras are available under the Durable Medical Equipment Benefit.

These services must be Prior Authorized by Blue KC or its Delegates.

Rehabilitative and Habilitative Services

We provide Benefits for physical therapy, occupational therapy, speech therapy, and hearing therapy provided on an outpatient basis. These services may be subject to a Calendar Year Maximum as indicated in the Benefit Schedule.

Physical Therapy

Physical therapy services, including skeletal manipulations, provided by a Physician, Registered Physical Therapist or Licensed Physical Therapist are covered. Such services are covered only when they are expected to result in significant improvement in a Covered Person's condition.

Occupational Therapy

Occupational therapy services provided by a Physician or Registered Occupational Therapist are covered when these services are expected to result in significant improvement in a Covered Person's condition. Occupational therapy is provided only for the purposes of training Covered Persons to perform the activities of daily living.

Speech and Hearing Therapy

This is treatment for the loss or impairment of speech or hearing disorders. Such treatment must be provided by a speech pathologist, speech/language pathologist or audiologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association, or both. The treatment must fall within the scope of such license or certification. Covered Services include examination, evaluation, counseling, and any testing required to diagnose any loss or impairment of speech or hearing.

Covered Services do not include screening examinations or services arranged by or received under any health plan offered by any governmental body or entity. These include screenings provided by school districts for their students.

Routine Preventive Care

We provide Benefits for routine preventive care as required by state or federal law. Routine Preventive Benefits required by federal law include evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force ("USPSTF"). These benefits also include certain preventative care and screenings described in Health Resources and Services Administration ("HRSA") guidelines, as well as immunizations recommended from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention (CDC). This includes childhood immunizations as provided by the Missouri Department of Health and Senior Services.

The recommended list of required preventive care services described above may change periodically. We will modify Your coverage when required to do so by federal law. A complete list of the preventive care services can be located at https://www.bluekc.com/routinepreventativecare.

You may also contact Us at the telephone number listed on Your ID card.

We provide Benefits for routine preventive examinations and the related office visit, as well as all associated labs, in accordance with the current American Cancer Society guidelines, at a minimum. As part of such office visit, Benefits will be provided for screening for gestational diabetes in pregnant women identified to be at high risk for diabetes, as well as screening and counseling for interpersonal and domestic violence and abuse.

Covered Services also include evidence-informed preventive care, as well as screenings for infants, children, and adolescents provided for in the HRSA comprehensive guidelines. Newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification are also included.

Covered Services include catch-up immunizations for a Dependent child over the age of 6 who has not previously received the immunization. Catch-up immunizations for Covered Persons over the age of 6 will not be subject to any Cost-Sharing when received from an In-Network Provider.

Urgent Care Center and Retail Health Clinics

We provide Benefits for urgent care services that are obtained at urgent care centers and retail health clinics. Urgent care services are Health Care Services that are required in order to prevent serious deterioration of Your health as a result of an unforeseen sickness or injury. Urgent care services that are provided in a Physician's office on an urgent basis are covered under the Physician Services Benefit.

Vision Care

We provide Benefits for non-routine vision care.

Eyewear following Surgery

We provide Benefits for either the first pair of eyeglasses or non-disposable contact lenses or refractive keratoplasty, only following cataract surgery. Benefits are limited to the amount available for a basic (standard) pair of eyeglasses. These must meet the minimum specifications to allow for necessary vision correction. Charges for eyeglasses which exceed a basic pair of eyeglasses are not covered, beyond the extent allowed for basic eyeglasses.

Orthoptic Training

We provide benefits for orthoptic training. Covered Services are limited to the treatment of convergence insufficiency for Covered Persons under the age of 18. This Benefit is subject to a Lifetime Maximum of 12 visits.

Eye Exam

We also provide Benefits for eye exams, including refraction, that are needed as a result of a covered medical illness or Accidental Injury. Vision care services for Covered Persons age 18 and under are Covered Services under the Pediatric Vision Benefit.

SECTION E. EXCLUSIONS AND LIMITATIONS

The following describes services that are not covered under the plan. These exclusions are organized in three categories: A. General, B. Medical, and C. Prescription Drugs.

Covered Services do not include any of the following services, supplies, equipment or care. No Benefits will be provided for them, or for any complications related to, or received in connection with them. Exclusions listed under the General section also apply to medical services and prescription drugs.

A. General

A1. For services or supplies received if there is no legal obligation for payment or for which no charge had been made. For services or supplies received where a portion of the charge has been waived. This includes, but is not limited to full or partial waiver of any applicable Cost-Sharing.

A2. For injuries or illnesses that are related to Your job to the extent You are covered or are required to be covered by a state or federal workers' compensation law or any comparable benefit that provides medical coverage for work-related injuries or illness. This applies whether or not You file a claim. If You enter into a settlement giving up Your right to recover past or future medical benefits under a workers' compensation law, We will not pay past or future medical benefits that are the subject of or related to that settlement. In addition, if You are covered by a workers' compensation program that limits benefits to certain authorized providers, We will not pay for services You receive from providers, authorized or unauthorized, by Your workers' compensation program.

A3. Not Medically Necessary.

A4. Not specifically covered under the Contract.

A5. Experimental or Investigative as determined by Us, except as specifically provided under the Clinical Trials Benefit.

A6. For military service connected disabilities or conditions for which You are legally entitled to services and for which You have no obligation to pay.

A7. For losses due in whole or in part to war or any action of war.

A8. For services that are provided by You, Your Immediate Family Members or members of Your immediate household

A9. For staff consultations that are required by Hospital rules and regulations.

A10. For lodging or travel to and from a health professional or health facility.

A11. For interest charges, document processing or copying fees, mailing costs, collection fees, or telephone consultations. For charges when no direct contact is provided. These include but are not limited to Physician team conferences, charges for missed appointments, charges for completion of forms, or other non-medical charges

A12. Provided for an Emergency Medical Condition Admission in excess of the first 24 hours if We are not notified within 24 hours of the Admission, or as soon as reasonably possible.

A13. Obtained in an emergency room which are not Emergency Services.

A14. For screening examinations or services that are available, arranged by, or received from any governmental body or entity. These include but are not limited to school districts.

A15. For sales tax, to the extent it exceeds Our Allowable Charge.

A16. For any services, supplies, equipment or care received in connection with a non-covered service, supply, equipment or care.

A17. For services and supplies to the extent they are payable by Medicare. For services and supplies covered by Medicare Part A, Part B, or Part C (Medicare Advantage). This applies whether or not You are actually enrolled in Medicare. This exclusion applies to all Covered Persons who are eligible to enroll under Medicare Part A, Part B, or Part C (Medicare Advantage), or who are otherwise entitled to Medicare benefits. This exclusion applies from the date of their eligibility or entitlement to Medicare benefits. This exclusion also includes Covered Persons who do not enroll or otherwise make application for Medicare benefits.

A18. For laboratory services performed by an independent laboratory that is not approved by Medicare.

A19. Amounts for services or supplies billed by Out-of-Network Providers that are Non-Participating that are not eligible for separate reimbursement according to Our payment policy.

A20. Amounts for non-Emergency services billed by Out-of-Network Providers that are Non-Participating when proof of service is not established or supported by Your medical record.

B. Medical

B1. For Custodial, convalescent, or respite care except as specifically provided under the Hospice benefit. This includes but is not limited to meals delivered to Your home, companionship, and homemaker services, that do not require services of licensed professional nurses in Our opinion. This applies even if the care is provided by skilled nursing personnel.

B2. For music therapy, remedial reading, and recreational therapy. For other forms of education or special education except as specified under the Diabetes Benefit or Routine Preventive Care.

B3. For marital counseling or counseling to assist in achieving more effective intra or interpersonal development. For dietary counseling, except as specifically provided under the Diabetes benefit. For decisional, social, or educational development. For vocational development or work hardening programs.

B4. For removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. For cosmetic rhinoplasty, whether it is an independent procedure or done in conjunction with any other surgical procedure.

B5. For cosmetic repair or reconstructive surgery, except as specifically provided for under the Reconstructive Surgery and Cosmetic Repair Benefit.

B6. For any equipment or supplies that condition the air. These include but are not limited to environmental evaluations, heating pads, cooling pads (circulating or non-circulating), hot water bottles, personal care items, items for comfort and convenience, spas, whirlpools, Jacuzzis, and any other primarily nonmedical equipment. These also include stethoscopes, blood pressure devices, and Durable Medical Equipment that would normally be provided by a Skilled Nursing Facility.

B7. For the repairs and replacement of prosthetic and orthotic devices, except when necessitated as indicated in the Prosthetic and Orthotic Devices Benefit.

B8. For wigs and their care.

B9. For biofeedback, including neurofeedback.

B10. For court ordered services. These include but are not limited to assessments, examinations, diagnostic tests, and genetic testing.

B11. For the collection and storage of autologous (self-donated) blood, umbilical cord blood, or any other blood or blood product. This exclusion only applies in the absence of a known disease or planned surgical procedure.

B12. For vision services, except as specifically provided under the Vision Care benefit. This includes but is not limited to pleoptic training, orthoptic training that is not for convergence insufficiency, eyeglasses, and contact lenses. This also includes the examination for fitting of these items.

B13. For hearing care services, except as specifically provided under the Speech and Hearing Therapy or Routine Preventive Care benefits. These include, but are not limited to, hearing aids, as well as the examination for fitting of these items.

B14. Unless specifically covered under the Accident-Related and Other Dental Services benefit, for all dental services; complications of dental treatment; except when such services are received for an Emergency Medical Condition; temporomandibular joint disorder; and orthognathic surgery. For injections for treatment of pain that is in close proximity to the teeth or jaw and due to a dental cause. For orthodontic treatment. For surgical correction of a malocclusion.

B15. Unless specifically covered under the Accident-Related and Other Dental Services benefit, for dental splints, dental prostheses, extractions or any treatment on or to the teeth, gums, or jaws. For all other services customarily provided by a dentist. Services related to injuries caused by or arising out of the act of biting or chewing are also excluded.

B16. For chemosurgery, laser dermabrasion, chemical peel, salabrasion, collagen injections or other skin abrasion procedures associated with the removal of scars, tattoos and/or which are performed as a treatment of scarring secondary to acne or chicken pox.

B17. For the treatment of obesity or morbid obesity. This includes but is not limited to Mason Shunt, banding, gastroplasty, intestinal bypass, gastric balloons, stomach stapling, jejunal bypass, and wiring of the jaw, as well as related office visits. This also includes laboratory services, prescription drugs, medical weight reduction programs, nutrients, diet counseling, (except as specified under the Diabetes Benefit) and Health Care Services of a similar nature. This exclusion applies whether or not the treatment is part of a treatment plan for another illness. This exclusion also applies to any complications arising from any of the above, except for Emergency Medical Conditions.

B18. For surgical procedures on the cornea. These include but are not limited to radial keratotomy and other refractive keratoplasty procedures, except when used to correct medical conditions other than refractive errors (such as nearsightedness) or following cataract surgery.

B19. For hairplasty or hair removal, regardless of reason or diagnosis.

B20. For or related to an Organ Transplant, except as specifically provided under the Organ Transplant Benefit.

B21. For Health Care Services which are related to complications arising from treatments or services that are otherwise excluded under the Contract. This exclusion shall not apply when such services are received for an Emergency Medical Condition, or for complications related to maternity care as indicated in the Outpatient Prescription Drugs Benefit.

B22. For Health Care Services which are related to complications arising from treatments or services that are otherwise excluded under the Contract. This exclusion shall not apply when such services are received for an Emergency Medical Condition, or for complications related to maternity care as indicated in the Contract.

B23. For Mental Illness and/or Substance Abuse services received from a Non-Participating Provider that are provided in connection with or to comply with involuntary inpatient commitments after the Covered Person has been screened and stabilized. The exclusion shall not apply if the Covered Person cannot be safely transferred, or if there is not an In-Network Provider who will accept the transfer.

For any assessment, evaluation, diagnostic test, or genetic test required by a diversion agreement or by order of a court to attend an alcohol or drug safety action program.

B24. For assessments, evaluations, diagnostic tests, and genetic tests ordered or requested in connection with criminal actions, divorce, child custody, or child visitation proceedings.

B25. For mental illness and substance abuse services that are received at a residential facility that does not provide for individualized treatment. Mental illness and substance abuse services provided by a residential facility that is not licensed or certified by the state in which such services are provided will not be covered.

B26. For non-prescription enteral feedings. For any other nutritional and electrolyte supplements..

B27. For personal care and convenience items.

B28. For occupational therapy that is provided on a routine basis as part of a standard program for all patients.

B29. For speech therapy for vocal cord training or retraining due to vocational strain and/or weak cords.

B30. Received for (or in preparation for) any treatment for infertility (except for drugs, as provided under the Contract) by any name called and any related complications, except as specifically provided for under the Infertility Benefit. 'Infertility' as used here means any medical condition causing the inability or diminished ability to reproduce. Treatment for infertility shall include, but not be limited to, reversal of sterilization, all artificial means of conception including but not limited to sperm collection and/or preservation, sperm and egg and/or inseminated egg procurement and processing, banking of sperm and inseminated eggs, artificial insemination, in vitro fertilization, in vivo fertilization, embryo transplants, gamete intra fallopian transplant (GIFT), zygote intra fallopian transplant (ZIFT), and related tests and procedures. Also included are surrogate parenting (which includes donating ovum or ova, or carrying the fetus to term for another woman), amniocentesis that is not Medically Necessary, and any other experimental fertilization procedure or fertility drugs.

B31. For Health Care Services and associated expenses for elective pregnancy termination. This does not include spontaneous abortion or services to prevent the death of the mother.

B32. Received for (or in preparation for) any diagnosis or treatment of sexual dysfunction (including drugs and prosthesis) and any related complications. This exclusion will not apply if the Covered Person has a documented disease resulting in impotence.

B33. For cranial (head) remodeling devices, including but not limited to Dynamic Orthotic Cranioplasty ("DOC Bands") This exclusion does not apply to post-operative care or the treatment of congenital birth defects or birth abnormalities that are caused by synostotic plagiocephaly and craniosynostosis.

B34. Except as specifically provided under Physician Services, for charges incurred as a result of virtual office visits on the Internet. These include but are not limited to those for prescription drugs. A virtual office visit on the Internet occurs when a Covered Person was not physically seen or physically examined.

B35. For extracorporeal shock wave therapy due to musculoskeletal pain or musculoskeletal conditions. For electrical stimulation, except as specifically provided in the Electrical Stimulator Benefit.

B36. For nutritional assessment testing. For saliva hormone testing.

B37. For services and materials that do not meet accepted standards of optometric practice.

B38. For the measurement of exhaled nitric oxide or exhaled breath condensate in the diagnosis and management of respiratory disorders.

B39. For acupuncture, acupressure, rolfing, services provided by a massage therapist, and aromatherapy. For all other forms of alternative treatment.

B40. For Applied Behavioral Analysis.

C. Prescription Drug

C1. Appetite suppressants, anorexiants and anti-obesity drugs.

C2. Compounded medications with ingredients that do not require a prescription.

C3. Experimental, Investigative or unproven services and medications. Medications used for indications and/or dosage regimens determined by Us to be Experimental. (These include, but are not limited to, those labeled "caution - limited by federal law to Investigational use." These also include drugs found by the FDA to be ineffective).

C4. Medications for cosmetic purposes, such as but not limited to isotretinoin, tretinoin (Retin-A), topical minoxidil, and finasteride.

C5. Non-prescription/over-the-counter medications for smoking cessation or smoking deterrents. (These include but are not limited to nicotine replacement or other pharmacological agents used for smoking cessation).

C6. Medications and other items available over-the-counter. These include any medication that is equivalent to an over-the-counter medication, and that does not require a prescription order or refill by federal or state law (whether provided with or without a prescription).

C7. Medications with no approved FDA indications.

C8. Drugs related to treatment that is not a Covered Service under the Contract.

C9. Prescription drugs that are not Medically Necessary unless otherwise specified.

C10. Anabolic steroids, anti-wrinkle agents, dietary supplements, Fluoride supplements, blood or blood plasma, or irrigational solutions and supplies.

C11. Lifestyle enhancing drugs, unless otherwise specified.

C12. Medications and devices used for the treatment of impotency.

C13. Tier 2 and Tier 3 drugs for the first 6 months following FDA approval unless a shorter exclusion period is recommended by Our Pharmacy and Therapeutics Committee, which includes community physicians and pharmacists.

C14. Drugs and devices that are intended to induce an abortion.

C15. Drugs obtained outside the United States for consumption in the United States.

C16. For drugs and medicines that do not require a prescription for their use, except as otherwise specified in the Routine Preventive Care Benefit.

Utilization Review is undertaken for all medical/surgical inpatient Admissions. These include acute care, skilled nursing, and medical rehabilitation. Such a review is performed using nationally licensed medical criteria. Our toll-free telephone number for Utilization Review is on Your identification card.

Determination

For determinations, We will make the determination within 2 working days of obtaining all necessary information regarding a proposed Admission, a procedure, or a service requiring Prior Authorization.

In the case of a determination to certify an Admission, a procedure or a service, We will notify the provider rendering the service by telephone or electronically within 24 hours of making the the determination. We will provide written or electronic confirmation of the telephone or electronic notification to the Covered Person and provider within 2 working days of making the determination.

In the case of an Adverse Determination, We will notify the provider rendering the service by telephone or electronically within 24 hours of making the Adverse Determination. We will provide written or electronic confirmation of the telephone or electronic notification to the Covered Person and the provider within one working day of making the Adverse Determination.

Concurrent Review Determination

For Concurrent Review determinations, We will make the determination within one working day of obtaining all necessary information.

In the case of a determination to certify an extended stay or additional services, We will notify by telephone or electronically the provider rendering the service within one working day of making the Certification. We will provide written or electronic confirmation to the Covered Person and the provider within one working day after the telephone or electronic notification. The written notification will include the number of extended days or next review date, the new total number of days or services approved, and the date of Admission or initiation of services.

In the case of an Adverse Determination, We will notify by telephone or electronically the provider rendering the service within 24 hours of making the Adverse Determination. We will provide written or electronic notification to the Covered Person and the provider within one working day of the telephone or electronic notification. The service will be continued without liability to the Covered Person until the Covered Person has been notified of the determination. A written notification of the Adverse Determination will include the principal reason or reasons for the determination, including the clinical rationale, and the instructions for initiating an appeal or reconsideration of the determination. We shall provide the clinical rationale in writing, including any clinical review criteria used to make the determination, to the provider and any party who received notice of the Adverse Determination.

Reconsideration

In the case of a determination or a Concurrent Review determination the provider may request a reconsideration of an Adverse Determination. This reconsideration will occur within one working day of the receipt of the request.

Retrospective Review Determinations

For Retrospective Review determinations, We will make the determination within 30 working days of receiving all necessary information. We will provide notice in writing of Our determination to the Covered Person within 10 working days of making the determination.

Case Management

Case Management focuses primarily on providing an appropriate level of care in a non-acute setting. The intent of Case Management is to ensure the provision of Medically Necessary care in the most appropriate setting for a Covered Service.

Case Management may approve an extension of Covered Services' Benefits beyond the limits that are specified in the Contract. In addition to the Covered Services specified in the Contract, Case Management may approve other Medically Necessary services when warranted by the Covered Person's particular needs.

It may also include any plan of care set forth to promote health and prevent illness and injury of the Covered Person. This Case Management plan is not designed to extend Covered Services' Benefits or provide any other Medically Necessary services to persons who do not meet the Case Management plan standards and criteria. We may elect to provide Benefits furnished by any provider pursuant to Our approved treatment plan for Case Management.

We shall provide any extension of Covered Services' Benefits or other Medically Necessary services when We determine the person meets the appropriate standards and criteria. An extension will be provided only when and for so long as it is determined that the extension is appropriate, Medically Necessary, and cost effective. Such Benefits shall count toward a Covered Person's Calendar Year Maximum (if applicable).

The implementation of a Case Management plan shall require the approval of the affected Covered Person or of his legal representative. Approval of the affected person's Physician is also required.

If We elect to extend Benefits for Covered Services or provide other Medically Necessary services for a Covered Person in one instance, it shall not obligate Us to provide the same or similar services for any Covered Person in any other instance. It shall not be construed as a waiver of Our right to thereafter administer the Covered Service in strict accordance with the terms of the Contract.

Outpatient Prescription Drug Utilization Programs

Certain medications are subject to utilization programs that require You to try to use a therapeutic alternative before another medication will be considered a Covered Service. Your Physician may submit to Us a statement of Medical Necessity if the utilization program is not appropriate for Your medical condition.

Certain medications may be subject to a utilization program that limits the dispensed quantity of prescription medications in compliance with FDA-approved dosage guidelines.

SECTION G. HOW TO FILE A CLAIM

Hospital and Other Facility Services

In-Network or Participating Providers will file Your Claims for You. We will pay the facility directly. You may be asked to make arrangements with such facility to pay for any non-Covered Services or Cost-Sharing amounts.

If You receive care from an Out-of-Network Provider that is Non-Participating Provider, it will be Your responsibility to make payment arrangements with the facility. Some of these Providers will submit Your Claim for You. If not, You can obtain a Claim form from Us. You can do so by calling the telephone number listed on Your ID card. The form will give You instructions for filing the Claim.

Physician Services

In-Network or Participating Providers will file Your Claim for You. We will pay the Physician directly. After the Physician receives Our payment, the Physician may bill You for any non-Covered Services or Cost-Sharing amounts for which You are responsible.

Out-of-Network Physicians who are Non-Participating Physicians will sometimes file Your Claim for You. If such a Physician declines to file Your Claim for You, You can obtain a Claim form from Us. You can do so calling the telephone number listed on Your ID card. The form will give You instructions for filing the Claim.

Service Received From Providers Other Than Hospitals, Physicians and Facilities

It is necessary for You to file a completed claim form with Us for these services. Contact Us at the telephone number listed on Your ID card for the proper Claim forms. The form will give You instructions for filing the Claim.

Time Limits for Filing Claims

We must receive proof of a claim for payment for Covered Services no later than 365 days after the end of the Calendar Year in which the service is received. We will deny any Claim not received within this time limit. We will extend the 365 day limit if it was not reasonably possible to give notice of proof within this time.

Processing of the Filed Claim

We make Our claim payment decisions based on the information We have when We receive a Claim. We make every effort to process claims as quickly as possible. Claims will be paid immediately upon receipt of due written proof of loss. If We deny all or part of Your Claim, We will send You an Explanation of Benefits form or a letter. This will explain why it was denied under the terms of the Contract. We will also notify You if additional information is necessary to process the Claim. Payment of Claims for Covered Services received from Non-Participating Providers will be payable to the Covered Person.

Claim Forms

You may request Claim forms from Us by calling the telephone number listed on Your ID card. If such forms are not furnished to You within 15 days after You request them, You shall be deemed to have complied with the requirements of this policy as to proof of loss if You submit written proof within the Time Limits for Filing Claims. This proof must cover the occurrence, the character, and the extent of the loss for which the Claim is made.

SECTION H. COORDINATION OF BENEFITS (COB)

Individuals typically send their claims for medical services to every Plan that covers them. As a result, most plans have a Coordination of Benefits (COB) provision. A COB provision allows Plans to work together so that the total amount of all payments by all Plans will never be more than the Allowable Expense.

Definitions Applicable to this Section

Allowable Expense

Allowable Expense means a medical expense or service including Deductibles, Coinsurance or Copayments that is covered in full or in part by one or more of the Plans covering the person for whom the claim is made. An Allowable Expense does not include dental coverage or group-type accident only coverage. If a Plan is advised that all plans covering a Covered Person are high-deductible health plans and the Covered Person intends to contribute to a health savings account, the primary high-deductible health plan's deductible is not an Allowable Expense, except for any health care expense incurred that is not subject to the deductible as described in Section 223(c)(2)(C) of the Internal Revenue Code of 1986. A medical expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense unless the private room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

When benefits are reduced under a primary Plan because a Covered Person did not comply with the Plan provisions, the amount of that reduction will not be considered an Allowable Expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services, or the Covered Person having a lower benefit because they did not use an In-Network Provider.

If the primary Plan is a Closed Panel Plan and the secondary Plan is not a Closed Panel Plan, the secondary Plan will pay or provide benefits as if it were primary when a Covered Person uses a non-Closed Panel provider. This does not apply for Emergency Services or authorized referrals that are paid or provided by the primary Plan.

A Covered Person may be covered under 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology. In this case, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an Allowable Expense.

A Covered Person may be covered under 2 or more Plans that provide benefits or services on the basis of negotiated fees or if one Plan calculates its benefits or services on the basis of usual, customary and reasonable fees and another Plan provides its benefit on the basis of negotiated fees. In this case, any amount in excess of the highest of the Plan's fees is not an Allowable Expense.

Closed Panel Plan

A Closed Panel Plan means a plan that provides health benefits to covered persons primarily in the form of services through a panel or provider that have contracted with or are employed by the plan. A closed panel plan also limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Plan

A Plan means any arrangement that provides coverage for medical services. COB applies to only the following Plans:

a. Group coverage, including insured, self-funded, accident only, or Closed Panel Plans.
b. Individual coverage, including insured or Closed Panel Plans, issued on or after January 1, 2014.
c. Coverage under any governmental program(s) to include any coverage required or provided by statute(s). Benefits available from Part A and Part B of Medicare are included. However, benefits under a state Medicaid program are not included.
d. The medical care components of group long-term care contracts, such as skilled nursing care.

The term "Plan" applies separately to each policy, contract, or other arrangement for medical services. The term "Plan" also applies separately to that part of any such policy, contract, or other arrangement for medical services that coordinates its benefits with other Plans and to that part that does not.

Order of Benefit Determination Rules

1. Non-Dependent

The benefits of a Plan which covers the person as other than a Dependent will be determined before the benefits of a Plan which covers such person as a Dependent.

2. Dependent Child/Parents not Separated or Divorced

Except for a Dependent child whose parents are separated or divorced, the benefits of a Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. The word birthday refers only to the month and day in a Calendar Year, not the year in which the person was born.

If a Plan does not have the provisions of this paragraph b. regarding Dependents, which results either in each Plan determining its benefits before the other or each Plan determining its benefits after the other, the provisions of this paragraph b. shall not apply. The rule set forth in the Plan which does not have the provisions of this paragraph b. shall determine the order of benefits.

3. Dependent Child/Parents Separated or Divorced

In the case of a Dependent child whose parents are separated or divorced, benefits for the child are determined in this order.

a. First, the Plan of the parent with custody of the child.
b. Then, the Plan of the spouse of the parent with custody of the child.
c. Then, the Plan of the parent not having custody of the child.
d. Finally, the Plan of the spouse of the noncustodial parent.

Notwithstanding (1), (2), (3) or (4) above, there may be a court decree which would otherwise establish financial responsibility for the medical expenses with respect to the child. In this case, the benefits of a Plan which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a Dependent child. If a court decree states both parents have financial responsibility for the medical expenses, then the provisions of paragraph b. of this subsection apply.

4. Dependent Child/Joint Custody

If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the medical expenses of the child, the Plans covering the child shall follow the rules outlined in paragraph b. above for a Dependent child of parents who are not separated or divorced.

5. Dependent Child of Non-Parents

In the case of a Dependent child covered under more than one plan of individuals wo are not the parents of the child, the order of benefits shall be determined, as applicable, under paragraph b. or c. of this subsection as if those individuals were parents of the child.

6. Dependent Child / Spouse Coverage
   If a person has coverage as a Dependent child under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the Plans shall follow the rules outline in paragraph i. below. If the coverage under the Plans began on the same date, the order of benefits shall be determined by applying the birthday rule outlined in paragraph b. above to the dependent's parent(s) and spouse.

7. Active/Inactive Employee
   The benefits of a Plan which covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired Employee (or as that Employee's Dependent). If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

8. Continuation Coverage
   If a person whose coverage is provided under continuation of coverage pursuant to federal or state law is also covered under another Plan, benefits are determined in the following order:

   a. First, the Plan covering the person as other than a Dependent (or as that person's Dependent); and
   b. Second, the benefits under the continuation coverage.

   If the other Plan does not have this rule and if as a result, the Plans do not agree on the order of benefits, this rule is ignored.

9. Longer/Shorter Length of Coverage
   If the above rules do not establish an order of benefit determination, the benefits of a Plan which has covered the person for a longer period of time shall be determined before the benefits of a Plan which has covered such person for a shorter period of time.

   The claimant's length of time covered under a Plan is measured from his first date of coverage under that Plan. If that date is not readily available, the length of time shall be measured from the date the claimant first became a member of the group.

10. Medicare
    When benefits under the Contract are being coordinated with any benefits available by Medicare, the Federal Medicare Secondary Payor Rules in effect at that time will apply. This Coordination of Benefits section shall not apply.

11. Plans without COB Provisions
    If a Plan does not have a COB provision, it will always be considered as the primary Plan**.**

12. Plans Share Equally
    If none of the above rules determine the primary Plan, the Allowable Expenses shall be shared equally between the Plans.

Effect on the Benefits of this Plan

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans for the claim does not exceed 100% of the total Allowable Expense for that claim. In determining the amount to be paid for any claims, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage. The plan will apply that calculated amount to any allowable expense under its plan that is unpaid by the

Primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and the other Closed Panel Plan.

Right to Receive and Release Necessary Information

In order to decide if this COB section (or any other Plan's COB section) applies to a claim, We (without the consent of or notice to any person) have the right to:

a. Release to any person, insurance company or organization, the necessary claim information.
b. Receive from any person, insurance company or organization, the necessary claim information.

Any person claiming Benefits under the Contract must give Us any information We need to coordinate those Benefits.

Facility of Payment

If another Plan makes a benefit payment that should have been made by Us, then We have the right to pay that other Plan any amount necessary to satisfy Our obligation.

SECTION I. COMPLAINT AND GRIEVANCE PROCEDURES

We have a formal process that gives You the right to express Complaints, either by telephone or in writing, regarding Our Claim payment decisions or other aspects of Our service. You have the right to receive a response from Us explaining Our actions. This feedback is a valuable tool that helps Us enhance the quality of Our products and services. It also helps us serve You as effectively as possible. The following procedures will be used to address any Complaints that You or any other Covered Person may have.

Definitions Applicable to this Section

Inquiry

An Inquiry means a question or request for information or action. Usually an Inquiry can be resolved on initial contact with no follow-up action required.

Complaint

A Complaint means an oral allegation made by a Covered Person of improper or inappropriate action, or an oral statement of dissatisfaction with Covered Services, Claims payment, or policies that do not fall within the definition of a Grievance.

Grievance

A Grievance means a written Complaint submitted by or on behalf of a Covered Person regarding.

a. The availability, delivery or quality of Covered Services, including a Complaint regarding an Adverse Determination made pursuant to Utilization Review;
b. Claims payment, handling or reimbursement for Health Care Services; or
c. Matters pertaining to the contractual relationship between a Covered Person and Us.

A Grievance may be submitted by a Covered Person, a Covered Person's representative, or a provider acting on behalf of a Covered Person.

Expedited Review

An Expedited Review means the procedure for the review of a Grievance (which may be submitted either orally or in writing) involving a situation where the time frame of the standard Grievance procedure would seriously jeopardize the life or health of a Covered Person or would jeopardize the Covered Person's ability to regain maximum function. For purposes of the Grievance register requirements, the request will only be considered a Grievance if it is submitted in writing.

Expedited Review Emergency Medical Condition

An Expedited Review Emergency Medical Condition is:

a. The sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part or would place a person’s health in serious jeopardy;
b. a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the insured or would jeopardize the insured’s ability to regain maximum function; or
c. a medical condition for which coverage has been denied based on a determination that the recommended or requested Health Care Service or treatment is experimental or investigational, if the insured’s treating physician certifies, in writing, that the recommended or requested Health Care Service or treatment for the medical condition would be significantly less effective if not promptly initiated.

Complaint Procedures

Our customer service representatives are available to answer Inquiries about claims and Benefits. However, You are encouraged to discuss Complaints concerning medical care with the Physician or other health care provider.

A Covered Person should refer to his ID card for a toll-free number to call for instruction or any questions regarding Benefits, Claims, appeals or Grievance procedures.

Your provider may file a Grievance with Us on Your behalf if You have granted written permission to such provider.

We will ensure the independence and impartiality of the decision making process related to claims or appeals.

Procedures for Filing a Grievance

If You prefer to file a formal Grievance, You may do so by requesting a Member Grievance form from Us. You may request this form by calling the telephone number listed on Your ID card. You may then submit the form to Us. In order to request a Grievance, Your request must be filed within three hundred sixty-five (365) days from: (a) the date You received notice of an Adverse Determination made pursuant to Utilization Review, or (b) for Post-Service Claims, the date You received the Explanation of Benefits.

The Grievance form must be sent to the attention of the Appeals Department. We will acknowledge receipt of the Grievance within 10 working days unless it is resolved within that period of time. Upon request, We will provide You with copies of all documents, records, and any other information relating to the Claim for Benefits. You have the opportunity to submit written comments, documents, records and any other information relating to the Claim for Benefits. We must receive such documents prior to Our review of Your Claim. We will take into account all information from You or Your authorized representative. This applies whether or not the information was considered in the initial Benefit determination.

We will conduct a complete investigation of the Grievance within the lesser of 20 working days or 30 calendar days after receipt of the Grievance for Pre-Service Claims, and within 20 working days after receipt of the Grievance for Post-Service Claims, unless the investigation of the Post-Service Claim cannot be completed within this period of time. If the investigation for Post-Service claims cannot be completed within the 20 working days, We will notify You in writing before the 20th working day. The notice will state the reasons for which additional time is needed for the investigation. The investigation will be completed within 30 working days thereafter, but no more than 60 calendar days after receipt of the Grievance for Post-Service Claim. We will notify You and/or Your representative in writing of Our decision within 5 working days from the day We make a determination. We will also notify the person who submitted the Grievance, provided such disclosure does not violate Title II of HIPAA, If the denial is upheld, the notification will include the principal reason for the denial and any clinical rationale. The notification will also explain Your additional appeal rights.

Procedures to Request an Expedited Review

If the time frame of the standard Grievance procedure would jeopardize the life or health of the Covered Person, a request for an Expedited Review may be submitted orally or in writing. We will notify You orally within 72 hours after receiving a request for an Expedited Review of Our decision. We will send written confirmation of Our decision within 3 working days of providing oral notification of Our decision. In the case of urgent care situations, You may initiate an Expedited External Review at the same time as an Expedited Review.

External Review of Adverse Determination

You have the right to request an independent external review of an Adverse Determination by the external review organization (ERO) established by the Commissioner of Insurance. Your right to request such a review applies only if:

a. You have exhausted all available review procedures listed above, unless You have an Emergency Medical Condition in which case the Expedited Review is utilized; or
b. You have not received a final decision from Us within 60 days of seeking the above available review procedures, except to the extent that the delay was requested by You.

Within 120 days of receiving a notice of an Adverse Determination, You, Your Provider with Your written authorization, or Your legally authorized representative may request an external review in writing to the Commissioner of Insurance. Your request shall include all information in Your possession pertaining to the Adverse Determination, an appeal form and a fully executed medical records release for the Commissioner of Insurance and the ERO to obtain any necessary medical records.

The Commissioner of Insurance will determine whether Your request for an external review will be granted within 10 business days after receiving all necessary information. If it is granted, the ERO will issue a written decision regarding Your Adverse Determination to You within 30 business days. In the event that an Expedited Review Emergency Medical Condition exists, the ERO will issue such decision not more than 72 hours after the date of receipt of the request for an expedited external review, or as expeditiously as the Covered Person's medical condition or circumstances require.

In no event shall the Covered Person be held responsible for any portion of the ERO's fee for performance.

Only 1 external review is available for any request arising out of the same set of facts during a period of 12 consecutive months. This 12 month period begins on the date of the initial request for external review. If We fail to strictly adhere to all appeal procedure requirements as prescribed by law, then You shall be deemed to have exhausted all available review procedures. You have the right to request an independent external review of an adverse decision when any error We committed was de minimis.

The decision of the ERO may be reviewed directly by the district court at the request of You or Us. The review by the district court shall be de novo.

Department of Insurance

You may also contact the Kansas Insurance Department by mail or telephone at 1300 SW Arrowhead Rd. Topeka, KS 66604 or toll free at 1-800-432-2484.

SECTION J. GENERAL INFORMATION

Terms and Conditions of the Contract

The Contract is subject to amendment, modification or termination. The Contract may be modified at any time by Us as necessary to comply with state or federal laws or regulations. By electing coverage under the Contract, You agree to all terms, conditions and provisions hereof.

Statements

No statement made by a Covered Person in the application for coverage shall void coverage or be used in any legal proceeding against the Covered Person unless the application (or an exact copy) is included in or attached to the Contract or has been furnished to the Covered Person.

Medical Examination

To fulfill the obligations under the Contract, We may require a Covered Person to have a medical examination by a Physician of Our choice and at Our expense.

Release of Records

During the processing of Your Claim, We may need to review Your health records.

As a Covered Person, You hereby authorize the release to Us of all physical or mental health records related to Your Claim. Such authorization shall remain valid for no more than 24 months. This authorization constitutes a waiver of any provision of law forbidding such disclosure. Your records will be maintained with strict confidentiality.

Reimbursement to Us

Errors

We have the right to recover Benefits paid in error. These include any Benefits We paid that exceed the amount needed to satisfy Our obligation. We have the right to recover the excess amount from You. We have the right to recover the excess amount from any other persons to, or for, or with respect to, whom such payments were made; any insurance companies or services plans; and/or any other organizations. Such individual or organization has the responsibility to return any overpayments to Us. We have the responsibility to make additional payment if an underpayment is made.

Recovery of Overpayment

If We determine that an erroneous payment for Benefits has been made, We have the right to correct Benefits paid in error. These include any Benefits We paid that exceed the amount needed to staisfy Our obligation. We have the right to recover the excess amount from You or any other person or entity receiving the erroneous payment on Your behalf. Such individual or organization has the responsibility to return any overpayments to Us. In the event the erroneous payment is not returned to us, We shall have the equitable right to recoup such erroneous payment. We have the responsibility to make additional payment if an underpayment is made. Our right of recoupment provided in this section shall not be diminished, restricted, or limited in any manner whatsoever by any defenses, either in law or in equity, that the person or entity subject to Our claim of recoupment may otherwise have. Such defenses are hereby disclaimed

Misrepresentations

We have the right to recover payments from You for Claims submitted on behalf of You or any Covered Person under the Contract in the event that We rescind Your Contract due to fraud or intentional misrepresentation of material fact by Your or any Covered Person in Your application.

Legal Actions

No action at law or equity shall be brought prior to the expiration of 60 days after written proof of loss has been furnished or after the expiration of 5 years after the time written proof of loss is required to be furnished.

Conformity with Laws

If any provision of the Contract conflicts with federal law or the laws of the state in which this Contract was issued for delivery, those provisions are automatically changed to conform to at least the minimum requirements of such laws.

Commission or Omission

No Hospital, Physician or other provider of service will be liable for any act of commission or omission by Us. We will not be liable for any act of commission or omission by:

a. Any Hospital or Hospital's agent or employee;
b. Any Physician or Physician's agent or employee;
c. Any other providers of services or their agent or employee; or
d. You.

Clerical Errors

Clerical errors shall not deprive any individual of coverage under the Contract or create a right to additional coverage.

Notice

Written notice given by Us to the Contractholder is deemed notice to the Contractholder and the Contractholder's covered Dependents in the administration of the Contract. Includes termination of the Contract.

Authority to Change the Contract

None of Our agents, employees or representatives, other than the President and Chief Executive Officer or the Board of Directors, are authorized to change the Contract or waive any of its provisions.

Assignment

The Contract and all rights, responsibilities, and Covered Services under it are personal to You, including any legal cause of action, or remedy, derived therefrom. Except for assignment of claim payment to In-Network or Out-of-Network Participating Providers, You may not assign them in whole or in part, either before or after services have been received, to any other person, firm, corporation or entity.

However, any Covered Services provided under the Contract and furnished by a facility of the uniformed services of the United States will be paid to that facility if a proper Claim is submitted by the provider. Such Claim will be paid with or without an assignment from You.

In addition, any Covered Services provided under the Contract and furnished by a public Hospital or clinic will be paid to that public Hospital or clinic if a proper Claim is submitted by the provider and processed before We have made Our payment. Such Claim will be paid with or without an assignment from You.

No payment for Covered Services will be made to the public Hospital or clinic if payment for Covered Services has been made to You prior to Our receipt of a Claim from the public Hospital or clinic. Any payment made to the public Hospital or clinic will satisfy Our liability to the extent of that payment.

Medicaid

The Covered Services provided under the Contract shall in no way be excluded, limited or restricted because Medicaid benefits, as permitted by title XIX of the Social Security Act of 1965, are or may be available for the same accident or illness.

Special Programs

As an individual covered under the Contract, You may have the opportunity to take advantage of special programs offered at no additional costs to You. These programs are designed to help You with Your health care and/or related expenses. Special features of these programs are described in separate material provided to You.

These programs are made possible through arrangements with various providers and cooperating businesses. Changes in these arrangements and/or their discontinuance may occur at any time in the future. Changes will be at Our discretion.

Outpatient Prescription Drugs: Drug Rebates and Credits

We contract with a pharmacy benefit manager ("PBM") for certain prescription drug administrative services, including prescription drug rebate administration and pharmacy network contracting services.

Under the agreement, the PBM obtains rebates from drug manufacturers based on the utilization of certain prescription products by You and other Covered Persons, and PBM retains the benefit of the rebate funds prior to disbursement. In addition, pharmaceutical manufacturers may pay administrative fees to the PBM in connection with PBM's services of administering, invoicing, allocating, and/or collecting rebates, and the PBM retains the benefit of such amounts prior to disbursement. PBM may also receive other service fees or discounts from manufacturers as compensation for various services unrelated to rebates or rebate-associated administrative fees.

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

We are not acting as a fiduciary with respect to rebate administration, pharmacy network management, or the prescription drug plan. We receive rebates from the PBM and may receive positive margin in connection with the pharmacy network, as well as other financial credits, administrative fees and/or other amounts from network pharmacies, drug manufacturers or the PBM (collectively "Financial Credits"). We retain sole and exclusive right to all Financial Credits, which constitute Our property (and are not plan assets), and We may use such Financial Credits in Our sole and absolute discretion, including, for example, to help stabilize Our overall rates and to offset expenses, and We do not share Financial Credits with You.

Without limitation to the foregoing, the following ("Financial Credit Rules") apply: (1) You have no right to receive, claim or possess any beneficial interest in any Financial Credits; (2) Applicable drug benefit Copayment, Coinsurance, and/or maximum allowable benefits (including without limitation Calendar Year Maximum and Lifetime Maximum benefits) are in no way adjusted or otherwise affected as a result of any Financial Credits, except as may be required by law; (3) Any Coinsurance that you must pay for prescription drugs is based upon the Allowable Charge at the pharmacy, and does not change as a result of any Financial Credits, except as may be required by law; and (4) Amounts paid to pharmacies or any prices charged at pharmacies are in no way adjusted or otherwise affected as a result of any Financial Credits.

Independent Licensee

The Contract constitutes a Contract solely between Contractholder and Blue Cross and Blue Shield of Kansas City. Blue Cross and Blue Shield of Kansas City is an independent corporation operating under an agreement with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Blue Cross and Blue Shield of Kansas City to use the Blue Cross and Blue Shield Service Mark in a portion of the States of Missouri and Kansas. Blue Cross and Blue Shield of Kansas City is not contracting as the agent of the Association. No person, entity, or organization other than Blue Cross and Blue Shield of Kansas City shall be held accountable or liable to Contractholder for any of Blue Cross and Blue Shield of Kansas City's obligations to Contractholder created under the Contract. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Kansas City other than those obligations created under other provisions of the Contract.

Gender

Any use of the male pronoun in the Contract shall also apply equally to the female gender.

Titles

Titles used throughout the Contract are for convenience purposes only. They do not change the terms of the Contract.

Second Opinion Policy

You have the right to seek a second medical opinion from an In-Network or Out-of-Network Provider. Benefits will be provided at the same level as for any other Covered Service rendered by that provider.

Entire Contract

The applications are incorporated by reference in this document and made a part of the Contract. The definitions contained in the Contract will have the defined meaning when used in this document with the first letter capitalized. The Contract and any amendments or riders thereto constitute the entire agreement between the parties. Any change in the Contract must be signed by an officer of the Company to be valid. No agent or representative has the authority to change the Contract or waive any of the provisions.

Time Limit on Certain Defenses

In the absence of fraud, all statements made by the Covered Person are considered representations and not warranties No statement made by the Covered Person voids coverage or reduces Benefits unless the statement is material to the risk assumed and contained in the written application. After the Covered Person's coverage has been in force for two (2) years from the Effective Date, no statement except fraudulent statements he has made will void the coverage or reduce the Benefits. A copy of the written application form is provided to You.

Cancellation by You

In the absence of fraud, all statements made by the Covered Person are considered representations and not warranties. No statement made by the Covered Person voids coverage or reduces Benefits unless the statement is material to the risk assumed and contained in a written application. After the Covered Person's coverage has been in force for two (2) years from the Effective Date, no statement except fraudulent statements he has made will void the coverage or reduce the Benefits. A copy of the written application form is provided to You.

Provider Directory

At no additional cost, PPO Provider Directories are provided by Us and upon request when You call Us at the telephone number listed on Your ID card. In addition, You may access Our PPO Provider Directory on Our website at www.BlueKC.com.

Power of Attorney

Because a provider's interests are distinct from, and potentially in conflict with, those of the Covered Person, the Covered Person may not, through a power of attorney, authorize a provider to act on his or her behalf, including as an agent, in connection with any legal cause of action or remedy derived from the rights, responsibilities, and Benefits for Covered Services under this plan. Nothing in this provision shall prevent a provider from acting as an authorized representative in connection with an appeal of an Adverse Determination in accordance with the provisions of this plan governing authorized representatives.

Incentives

We are committed to ensuring Your health and wellness. We may offer incentives to encourage You to access certain medical services and/or to participate in various wellness or disease management programs. Incentives may include, but are not limited to: services / supplies provided at no or minimal cost to You; gift cards; entries for a prize drawing; and/or merchandise. Eligibility for these incentive programs may be limited to Covered Persons with particular health factors. Participation in such programs has the potential to promote better health and to help prevent disease

Certain incentives may be considered taxable income. You may wish to consult with Your tax advisor or legal counsel for further guidance.

Mindful by Blue KC

The Mindful by Blue KC initiative provides a set of tools and resources to promote whole person wellness, including a limited number of well-being resource visits and access to Mindful Advocates. The well-being resource visits help with major life events (divorce, adoption, loss), stress, financial issues, childcare, and other everyday challenges through lifestyle coaching. These visits are limited to [3] per issue for each Blue KC member every calendar year. Well-being resource visits are not considered Covered Services. Mindful Advocates are licensed clinicians and social workers who match members to providers and guide care plans. They act as a single point of contact for listening, connecting, crisis management, benefits guidance, navigating care, and follow-up.

SECTION K. TERMS YOU SHOULD KNOW

This section explains the meaning of some of the more important words used in the Contract. Please read this section carefully. It will help You to understand the rest of the Contract. All of these defined words are capitalized when used in the Contract.

Accidental Injury

Means accidental bodily injury sustained by a Covered Person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause.

Admission

Begins the first day a Covered Person becomes a registered Hospital bed patient or a Skilled Nursing Facility patient and continues until he is discharged.

Adverse Determination

Means a determination by Us that a proposed or delivered Health Care Service which would otherwise be covered under the Contract is not or was not Medically Necessary or the health care treatment has been determined to be Experimental/Investigative and:

a. The requested service is provided in a manner that leaves the Covered Person with a financial obligation to the provider or providers of such service; or

b. The Adverse Determination is the reason for the Covered Person not receiving the requested services.

Allowable Charge

Means the dollar amount upon which Benefits will be determined. Any amounts for Covered Services (other than Copayments) a Covered Person is required to pay will be based on this Allowable Charge. Benefit limits, if any, will also be based on this Allowable Charge. The Allowable Charge may vary depending upon whether or not the provider has a contract with Us to participate in the BlueSelect Plus network and the terms of such contract. Providers are identified as In-Network and Out-of-Network.

You may be responsible for the difference between the amount that the Out-of-Network Provider bills and the payment We will make for the Covered Services as set forth in this paragraph. This practice is called balance billing and the difference can be significant.

Unless otherwise specified the following explains what the Allowable Charge is for different providers:

a. For Hospitals, other institutional health care facilities, Physicians or suppliers of medical goods and services which are In-Network Providers-

   The Allowable Charge is the lesser of:

   (1) The amount the provider has agreed to accept as payment in full as of the date of service.
   (2) The provider's billed charges.

b. For non-Emergency Services provided by Hospitals, other institutional health care facilities, Physicians or suppliers of medical goods and services which are Out-of-Network Providers inside Our Service Area-

   The Allowable Charge is the lesser of:

(1) The amount the provider has agreed to accept as payment in full as of the date of service.
(2) An amount that is based on 150% of the Medicare fee schedule. This percentage will be periodically evaluated and adjusted if deemed appropriate by Blue KC. If the fee schedule does not include a specific code for the service provided, Blue KC will apply the same methodology used to establish an Allowable Charge for an Out-of-Network.
(3) The provider's billed charges.

c. For Emergency Services provided by Hospitals, other institutional health care facilities, Physicians or suppliers of medical goods and services which are Out-of-Network Providers inside Our Service Area.

The Allowable Charge is the lesser of:

(1) The median amount negotiated with in-network providers.
(2) An amount that is based on 150% of the Medicare fee schedule. This percentage will be periodically evaluated and adjusted if deemed appropriate by Blue KC. If the fee schedule does not include a specific code for the service provided, Blue KC will apply the same methodology used to establish an Allowable Charge for an Out-of-Network Provider.

d. For Ambulance services provided by Out-of-Network inside Our Service Area –

The Allowable Charge is the lesser of:

(1) The amount the provider has agreed to accept as payment in full as of the date of service; or
(2) An amount that is based on 150% of the Medicare fee schedule. This percentage will be periodically evaluated and adjusted if deemed appropriate by Blue KC. If the fee schedule does not include a specific code for the service provided, Blue KC will apply the same methodology used to establish an Allowable Charge for an Out-of-Network Participating Provider.
(3) The provider's billed charges.

e. For In-Network pharmacies-

The Allowable Charge is the lesser of:

(1) The amount the pharmacy has agreed to accept as payment in full as of the date of service; or
(2) The Usual and Customary Charge.

For purposes of this paragraph, Usual and Customary Charge means the amount that the participating pharmacy would have charged You if You were a cash paying customer. Such amount includes all applicable discounts, such as senior citizen's discounts, coupon discounts, non-insurance discounts, or other special discounts offered to attract customers.

f. For Out-of-Network pharmacies –

The Allowable Charge is the provider's billed charges.

g. For pediatric vision eyewear provided by In-Network, Out-of-Network, or Non-Participating Providers -

The Allowable Charge is the lesser of:

(1) The amount the provider has agreed to accept as payment in full as of the date of service.
(2) The provider's billed charges.

(3) Standard eyeglass frames and any additional lens services/features or an annual supply of standard contact lenses provided in lieu of eyeglasses. Standard frames are those frames priced at $300 or less. Standard contact lenses are also those contacts priced at $300 or less.

Ambulance
Means a vehicle designed and operated to provide medical services and that is licensed by state and local laws.

Ambulatory Review
Means Utilization Review of Health Care Services performed or provided in an outpatient setting.

Annual Enrollment Period
Means a period of time each Calendar Year during which eligible persons who have not enrolled with Us may do so.

Authorized Representative
Means an individual (including a provider) whom a Covered Person designates, in writing, to act on his or her behalf to file a claim for benefits or to appeal an Adverse Determination.

Benefits
Means the amount of Allowable Charges We pay for Covered Services after the Cost-Sharing requirements have been met.

Benefit Schedule
Means a listing of certain Covered Services specifying Copayments, Coinsurance, Deductibles and visit limitations under the Contract.

Blue Cross and Blue Shield of Kansas City
Means the company legally responsible for providing the Benefits under the Contract. Blue Cross and Blue Shield of Kansas City is referred to as "We," "Us" and "Our."

Calendar Year
Means January 1 through December 31 of the same year.

Calendar Year Maximum
Means a maximum dollar amount or a maximum number of days, visits, or sessions for which Benefits for Covered Services are provided for a Covered Person in any one Calendar Year. Once a Calendar Year Maximum for a specific Covered Service is met, no more Benefits for such Covered Services will be provided during the same Calendar Year.

If the Contract replaces any health plan issued by Blue Cross and Blue Shield of Kansas City under which a Covered Person was covered, then this maximum will be reduced by the amount of Benefits a Covered Person received through the previous plan(s) during that Calendar Year.

Case Management
Means a method of review whereby a Covered Person’s health, or catastrophic or complex health problem or general health is evaluated and a plan of care is developed and implemented which meets that Covered Person’s particular needs and is the most cost-effective.

Certification

Means a determination by Us that an Admission, availability of care, continued stay or other Health Care Service has been reviewed and, based on the information provided, satisfies Our requirements for Medical Necessity, appropriateness, health care setting, level of care and effectiveness.

Claim
Means a request for: (1) services that require Prior Authorization made in accordance with the procedures outlined in the Utilization Review Section. (2) payment for Covered Services rendered in accordance with the procedures outlined in the How to File a Claim Section. (3) an appeal of a benefit determination ("Grievance") made in accordance with the procedures outlined in the Complaint and Grievance Procedures Section.

Coinsurance
Means the percentage of an Allowable Charge that You must pay for a Covered Service.

Complications of Pregnancy
Means non-routine care (medical or surgical) required due to medical complications occurring as a result of or during the pregnancy. This does not include the actual obstetrical procedure itself. That procedure is defined as a normal delivery, cesarean section, miscarriage, or elective pregnancy termination.

Concurrent Review
Means Utilization Review conducted during a Covered Person's Hospital stay or course of treatment.

Confinement
Means an uninterrupted stay following formal Admission to a Hospital or Skilled Nursing Facility. It starts with the Admission and ends when the Covered Person is discharged from the facility.

Contract
Means the agreement between the Contractholder and Us that contains all of the terms of coverage. The Contract includes this booklet, Your application for coverage, and any amendments/riders.

Contractholder
Means the person who originally applies for and is accepted for coverage by Us under the Contract.

Copayment
Means the dollar amount of a charge that a Covered Person must pay for certain Covered Services.

Cost Sharing
Means the applicable Copayment, Coinsurance, or Deductible that must be paid by the Covered Person for a Covered Service. Cost-Sharing does not include Premiums, amounts incurred for non-Covered Services, or any amount above the Allowable Charge.

Covered Person
Means the Contractholder or any of their Dependents whose coverage is in effect under the Contract.

Covered Services
Means services, supplies, equipment and care specifically listed in the "Covered Services" section of the Contract.

Custodial Care
Means care furnished mainly to train or assist in personal hygiene or other activities of normal daily living such as dressing, feeding, and walking, rather than to provide medical treatment.

Deductible
Means the portion of Allowable Charges for Covered Services You must pay each Calendar Year before We will provide Benefits unless otherwise specified. The application of the Deductible during any Calendar Year will be based upon the date when Covered Services were actually received. Except as specifically provided, each Covered Person must satisfy a Deductible each Calendar Year before Benefits will be paid.

Applicable Cost Sharing amounts paid for or reimbursed by pharmaceutical manufacturers, for Specialty Prescription Drugs processed under Your Outpatient Prescription Drug Benefit, do not accumulate toward Your Deductible. This includes payments made through any discount programs, coupon programs, or similar arrangements.

Delegate
Means an entity that We have contracted with to help Us administer Benefits. For example: Our pharmacy benefit manager ("PBM"), behavioral health manager (currently New Directions Behavioral Health), or a company performing Utilization Review services for.

Dependent
Means a person in the Contractholder's family who meets the Dependent eligibility requirements of the "Eligibility, Enrollment and Effective Date" section of the Contract.

Designated Chronic Care Management Vendor
Means a chronic care management vendor designated by Us.

Designated Telehealth Vendor
Means a telehealth vendor designated by Us.

Discharge Planning
Means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

Due Date
Means the first day of each month when Premiums are due and payable.

Effective Date
Means the date coverage begins for a Covered Person under the Contract.

Emergency Medical Condition
Means a medical condition manifesting itself by an unexpected onset of symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a. Serious impairment to a bodily function;
b. Serious dysfunction of any bodily organ or part; or
c. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

Emergency Services

Means Ambulance services and health care items and services furnished or required to evaluate and treat an Emergency Medical Condition, as directed or ordered by a Physician.

Experimental / Investigative Services

We will use the following criteria to determine whether drugs, devices and medical treatment or procedures and Related Services and Supplies are Experimental or Investigative.

A drug, device or medical treatment or procedure is Experimental or Investigative if:

a. The drug or device cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

b. Reliable evidence shows that the drug, device or medical treatment or procedure:

   (1) Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the maximum tolerated dose, safety, toxicity, or efficacy as its objective;
   (2) Is provided pursuant to a written protocol or other document that lists an evaluation of its safety, toxicity, or efficacy as its objective; or
   (3) Is Experimental/Investigative per the informed consent document utilized with the drug, device, or medical treatment.

c. The national Blue Cross and Blue Shield Association's uniform medical policy (as amended from time to time) has determined the device or medical treatment or procedure ("technology") is investigational based on the following criteria:

   (1) Final approval from the appropriate governmental regulatory bodies has not been received; or
   (2) Scientific evidence does not permit conclusions concerning the effect of the technology on health outcomes; or
   (3) The technology does not improve the net health outcome; or
   (4) The technology is not as beneficial as established alternatives; or
   (5) The improvement is not attainable outside the investigational settings; or

d. To the extent paragraphs a., b., and c. above do not apply, the drug, device, medical treatment, or procedure and Related Services and Supplies will still be considered Experimental or Investigative if:

   (1) We, utilizing additional authoritative sources of information and expertise, have determined that the technology does not meet the criteria listed in paragraph c. 1-5 above; or
   (2) There is not sufficient evidence based peer reviewed studies published in medical literature to establish the safety and efficacy of the technology.

"Related Services and Supplies" for the purposes of this definition shall mean any service or supply that We determine is primarily related to the application or usage of a drug, device, medical treatment or procedure that is Experimental or Investigative.

Health Care Service

Means a service for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

Home Health Agency

Means an organization or entity that is licensed to provide Health Care Services in the home.

Hospice
Means an organization or entity that furnishes medical services and supplies only to patients who are considered to be Terminally Ill.

Hospital
Means a facility that:

a. Operates pursuant to law.
b. Provides 24-hour nursing services by Registered Nurses on duty or call. And
c. Provides Health Care Services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of a Physician or a staff of Physicians.

Hospitals are classified as follows:

a. In-Network Provider Hospital. See definition of In-Network Provider.
b. Out-of-Network Provider Hospital. See definition of Out-of-Network Provider.
c. Participating Provider Hospital means a Hospital that contracts with Us or any Blue Cross and/or Blue Shield Plan to provide the Hospital services described in the Contract and accepts the Allowable Charge as full payment for Covered Services except for Copayments, Coinsurance and Deductibles, if any. A Participating Provider Hospital may or may not be an In-Network Provider Hospital.
d. Non-Participating Provider Hospital means a Hospital that does not have a Participating Provider Hospital contract with Us.

Hospital does not include residential or nonresidential treatment facilities; health resorts; nursing homes; Christian Science sanatoria; institutions for exceptional children; Skilled Nursing Facilities; places that are primarily for the care of convalescents; clinics; Physicians' offices; private homes; ambulatory surgical centers; or Hospices.

We have the right to determine whether a facility is a Hospital.

Immediate Family Member
Means a parent, spouse, child, or sibling and such person's spouse.

In-Network Provider
Means a Hospital, Physician, Spira Care Center Provider or other provider of medical services and supplies participating under a contract with Us through a Preferred Provider Organization (PPO) as named in the provider directory.

Such In-Network Provider will bill Us directly for Covered Services You receive. However, You are responsible for amounts incurred for Non-Covered Services, or in excess of any Benefit limits of the Contract, as well as any applicable Cost-Sharing

Late Enrollee
Means a person who requests coverage under the Contract following the Annual Enrollment Period and who does not qualify to enroll under a Special Enrollment Period.

Medically Necessary (Medical Necessity)

Means services and supplies which We, utilizing additional authoritative sources of information and expertise, determine are essential to the health of a Covered Person and are:

a. Appropriate and necessary for the symptoms, diagnosis and treatment of a medical or surgical condition;
b. In accordance with Our local medical policies, and the medical policies of Our Delegates which are consistent with acceptable medical practice according to the national Blue Cross and Blue Shield Association's uniform medical policy (as amended from time to time);
c. Not primarily for the convenience of the Covered Person, nor the Covered Person's family, Physician or another provider;
d. Consistent with the attainment of reasonably achievable outcomes; and,
e. Reasonably calculated to result in the improvement of the Covered Person's physiological and psychological functioning.
f. If more than one service or supply would meet the requirements a through e above, furnished in the most cost-effective manner which may be provided safely and effectively to the Covered Person.

Our determinations regarding Medical Necessity, as any other determination, may be appealed pursuant to the grievance procedure.

Medicare
Means Part A or Part B of the insurance program established by Title XVIII, of the United States Social Security Act, as amended.

Mental Illness Substance Abuse
Means any disorder as such terms are defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994).

Minimum Essential Coverage
Means one of the following: (1) medical coverage under a specified government sponsored program (e.g. Medicare, Medicaid, CHIP, etc.); (2) medical coverage under an eligible employer-sponsored plan; (3) medical coverage under a health plan offered in the individual market within a State (excluding short-term limited duration policies); (4) coverage under a grandfathered health plan; or (5) other medical coverage that the Secretary of Health and Human Services, in coordination with the Secretary of the Treasury Department, recognizes for purposes of section 5000A(f).

Non-Participating Provider
Means a provider who does not meet the definition of a Participating Provider.

Organ Transplant
Means surgically removing an organ or tissue from one person (donor) and placing it in another person (recipient). Can mean returning the organ or tissue from the donor to the donor (same person), an autologous Organ Transplant.

Out-of-Network Provider
Means a Hospital, Physician or other provider of medical services and supplies that does not have a contract to provide services at negotiated rates for Your coverage under an In-Network Provider contract with Us.

Out-of-Pocket Maximum
Means the total amount of Cost-Sharing a Covered Person must pay each Calendar Year before amounts incurred for Covered Services will be paid in full. The Out-of-Pocket Maximum does not include.

a. Any amount that is above the Allowable Charge.

b. Any amount that exceeds a specific maximum for Benefits.
c. Any amount for Covered Services incurred in a Non-Participating outpatient facility or in a Non-Participating Provider Hospital in Our Service Area, except for Emergency Services.
d. Any amount for Covered Services incurred at a non-Designated Transplant Provider for an Organ Transplant.
e. Any amount for services received from an Out-of-Network Provider, except for Emergency Services.

Amounts You pay for non-Covered Services and for services that are denied by Us as not Medically Necessary will not apply to the Out-of-Pocket Maximum.

Applicable Cost-sharing amounts paid for or reimbursed by pharmaceutical manufacturers, for Specialty Prescription Drugs processed under Your Outpatient Prescription Drug Benefit, do not accumulate toward Your Deductible or Out-of-Pocket Maximum. This includes payments made through any discount programs, coupon programs, or similar arrangements

Outpatient Prescription Drug Out-of-Pocket Maximum

Means the total amount of any Cost-Sharing a Covered Person must pay each Calendar Year for covered outpatient prescription drugs before amounts incurred for outpatient prescription drugs will be paid in full. Notwithstanding the Cost-Sharing described in Your Benefit Schedule, You will not be subject to any Cost-Sharing for prescription drugs covered under your outpatient prescription drug benefit after the Prescription Drug Out-of-Pocket Maximum has been satisfied. The Prescription Drug Out-of-Pocket Maximum does not include:

a. Any amount that is above the Allowable Charge;
b. Any amount that exceeds a specific maximum for Benefits;
c. Any amounts for prescription drugs covered under Your medical benefit. Amounts for drugs covered under Your medical benefit will apply toward Your Out-of-Pocket Maximum for other Covered Services.

Amounts You pay for non-Covered Services and for services that are denied by Us as not Medically Necessary cannot be used to meet the Prescription Drug Out-of-Pocket Maximum.

Applicable Cost-sharing amounts paid for or reimbursed by pharmaceutical manufacturers, for Specialty Prescription Drugs processed under Your Outpatient Prescription Drug Benefit, do not accumulate toward Your Deductible or Out-of-Pocket Maximum. This includes payments made through any discount programs, coupon programs, or similar arrangements.

Participating Provider

Means a Hospital, health care facility, Physician, Spira Care Center Provider or other provider of medical care or supplies, which has entered into a contract that defines the method We will use to determine the Allowable Charges for Covered Services. Participating Providers have agreed to accept Our Allowable Charge as payment in full for Covered Services. However, You are responsible for amounts incurred for Non-Covered Services, amounts in excess of any Benefit limits of the Contract, and any applicable Cost-Sharing.

Physician

Means anyone qualified and licensed to practice medicine and surgery by the state in which services are rendered who has the degree of Doctor of Medicine or Doctor of Osteopathy. Physician also means Doctors of Dentistry and Podiatry as well as Optometrists, Chiropractors and Psychologists when they are acting within the scope of their license.

By use of this term and when We are required by law, We recognize and accept, to the extent of Our obligations under the Contract, other practitioners of medical care and treatment when the services performed are within the lawful scope of the practitioner's license and are provided pursuant to applicable laws.

Physician Extender
Means a Nurse Practitioner, Physician Assistant, Certified Registered Nurse Anesthetist, or Mid-wife.

Services received from a Physician Extender will be subject to the Cost-Sharing applicable to the place of service where the service was rendered. (E.g. services provided in a Specialist's office will be subject to the Cost-Sharing for a Specialist.)

Post-Service Claim
Means a request for payment for Health Care Services rendered.

Pre-Service Claim
Means a request for Health Care Services that require Prior Authorization.

Premiums
Means the amount paid on a periodic basis for Your coverage under the Contract.

Primary Care Physician (PCP)
Means an internist, family practitioner, general practitioner or pediatrician. This includes an internist, family practitioner, general practitioner, or pediatrician designated as a designated as Spira Care Center Provider.

Prior Authorization or Prior Authorized
Means the procedure whereby We determine: (a) based on medically recognized criteria, whether or not an Admission to a Hospital as an inpatient is reasonable for the type of services to be received; or, (b) whether any service to be performed is reasonable and Medically Necessary for the condition being treated and the type of services to be provided, or (c) a certification made pursuant to a Prior Authorization Review or notice as required by Us or utilization review entity prior the provision of health care services.

Prospective Review
Means Utilization Review conducted prior to an Admission or a course of treatment, including but not limited to pre-admission review, pretreatment review, Utilization Review, and Case Management.

Reinstatement
Means restoring a Contract that has been terminated. (For example, because of nonpayment of Premiums.)

Rescission
Means a retroactive cancellation or discontinuance of coverage under a health benefit plan, unless the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums. A Rescission qualifies as an Adverse Determination.

Retrospective Review
Means Utilization Review of Medical Necessity that is conducted after services have been provided to a patient. Does not include the review of a Claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Second Opinion
Means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of that service.

Service Area
(Sometimes referred to as "Our Service Area") Means the geographic area served by Us. Contact Us to determine the geographic area We serve. Our Service Area includes the following counties in Kansas: Johnson and Wyandotte. Our Service Area includes the following counties in Missouri: Clay, Jackson, Platte, Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Ray, Saint Clair, Saline, Vernon, and Worth.

Skilled Nursing Facility
Means a facility that:

a. Operates pursuant to law.
b. Provides 24-hour nursing services by Registered Nurses on duty or on call.
c. Provides convalescent and long-term illness care with continuous nursing and other Health Care Services by, or under the supervision of, a staff of one or more Physicians and registered nurses.

A Skilled Nursing Facility may be operated either independently or as part of an accredited general Hospital.

Also means an extended care facility, convalescent care facility, intermediate care facility or long-term illness facility.

Special Enrollment Period
Means a period of time during which eligible persons may enroll in coverage.

Specialist
Means Doctors of Medicine (M.D.), Doctors of Osteopathy (D.O.), except Primary Care Physicians. Includes other medical practitioners when the services performed are within the lawful scope of the practitioner's license, including, but not limited to, optometrists, chiropractors and psychologists.

Spira Care Center
Means a designated healthcare facility that has contracted with Us to provide primary care and care coordination services exclusively to Covered Persons in Our Service Area as indicated in the Benefit Schedule.

Spira Care Center Provider
Means any individuals or entities who are 1) Performing covered services in a Spira Care Center, including Primary Care Physicians, Physician Extenders, or behavioral health providers; 2) Performing lab tests or other analyses when the lab was drawn and ordered in a Spira Care Center; and 3) Certain designated providers operating outside a Spira Care Center to provide certain additional Covered Services. A complete list of designated Spira Care Center providers may be obtained by contacting Us at the telephone number listed on your ID card.

Stabilize
Means with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely to result or occur before an individual may be transferred.

Terminally Ill
Refers to a Covered Person that a Physician has certified has 6 months or less to live.

Utilization Review

Means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, Health Care Services, procedures, or settings. Techniques may include Ambulatory Review, Prior Authorization Review, Second Opinion, Certification, Concurrent Review, Case Management, Discharge Planning or Retrospective Review. Utilization Review shall not include elective requests for clarification of coverage.

We, Us, Our

Means Blue Cross and Blue Shield of Kansas City, the company legally responsible for providing the Benefits for Covered Services under the Contract, either acting on its own or through one of its Delegates, such as its pharmacy benefit manager ("PBM"), behavioral health manager (currently New Directions Behavioral Health), or a company performing Utilization Review services for Us.

You, Your

Refers to the Covered Person.

The following pages are not a part of this Contract, but contain important information and are provided here for your convenience in locating this information if needed.

COVERED PERSON'S RIGHTS AND RESPONSIBILITIES

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1. You have the right to:

a. Receive considerate and courteous care with respect and recognition of personal privacy, dignity and confidentiality.

b. Have a candid discussion of medically necessary and appropriate treatment options or services for your condition from any participating physician, regardless of cost or benefit.

c. Receive Medically Necessary and appropriate care or services from any participating Physician or other participating health care provider from those available as listed in Your managed care plan directory or from any Non-Participating physician or other health care provider.

d. Receive information in clear and understandable terms, and ask questions to ensure You understand what You are told by Your Physician and other medical personnel.

e. Participate with practitioner in making decisions about Your health care, including accepting and refusing medical or surgical treatments.

f. Give informed consent to treatment and make advance treatment directives, including the right to name a surrogate decision maker in the event You cannot participate in decision making.

g. Discuss Your medical records with Your Physician and have health records kept confidential, except when disclosure is required by law or to further Your treatment.

h. Be provided with information about Your PPO managed health care plan, its services and the practitioners and providers providing care as well as the opportunity to make recommendations about your rights and responsibilities.

i. Communicate any concerns with Your PPO managed health care plan regarding care or services You received, receive an answer to those concerns within a reasonable time, and initiate the complaint and grievance procedure if You are not satisfied.

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2. You have the responsibility:

a. Respect the dignity of other members and those who provide care and services through Your PPO managed health care plan.

b. Ask questions of Your treatment Physician or treatment provider until You fully understand the care You are receiving and participate in developing mutually agreed upon treatment goals to the degree possible.

c. Follow the mutually agreed upon plans and instructions for care that you have discussed with your health care practitioner, including those regarding medications. Comply with all treatment follow-up plans, and be aware of the medical consequences of not following instructions.

d. Communicate openly and honestly with Your treatment provider regarding Your medical history, health conditions, and the care You receive.

e. Keep all scheduled health care appointments and provide advance notification to the appropriate provider if it is necessary to cancel an appointment.

f. Know how to use the services of Your PPO managed health care plan properly.

g. Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

AMENDMENT ISSUED BY
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

AMENDMENT: PPOI-206-16-K

It is mutually understood and agreed that the Contract is amended as follows:

In Section C., Covered Services, *Elective Sterilization* is deleted in its entirety and replaced as follows:

Elective Sterilization We provided Benefits for elective sterilization. Elective sterilization services for women and men are Covered Services under the Routine Preventive Care Benefit.

In Section C., Covered Services, *Electrical Stimulation* is deleted in its entirety and replaced as follows:

Electrical Stimulation We provide Benefits for certain types of electrical stimulation. Covered Services are limited to:

a. Spinal cord electrical stimulation and electrical stimulation for bone growth;

b. electrical stimulation of the spine as an adjunct to spinal fusion and sacral nerve neuromodulation;

c. spinal cord stimulation for chronic pain unresponsive to standard therapies;

d. electrical bone growth stimulation for fracture nonunions or congenital pseudoarthroses;

e. electrical bone growth stimulation of the spine as an adjunct to spinal fusion;

f. sacral nerve neuromodulation for urinary dysfunction;

g. vagus nerve stimulation for the treatment of refractory or intractable seizures;

h. Phrenic nerve stimulation; or

i. Deep brain stimulation for tremor associated with Parkinson's or essential tremor.

In Section C., Covered Services, the following is added under *Routine Preventive Care*:

Covered Services include catch-up immunizations for a Dependent child over the age of 6 who has not previously received the immunization. Catch-up immunizations for Covered Persons over the age of 6 will not be subject to any Cost-Sharing when received from a Preferred Provider.

In Section D., Exclusions, the following is added:

For certain infusion therapy/injectables unless obtained from a designated specialty pharmacy or designated home infusion vendor.

In Section L, Complaint and Grievance Procedures, the following is added:

Your provider may file a Grievance with Us on Your behalf if You have granted written permission to such provider.

This amendment is attached to and made part of Your Contract. Except as specifically stated, nothing contained in this amendment will be deemed to alter any of the provisions of Your Contract.

Erin Stucky
President and Chief Executive Officer
Blue Cross Blue Shield of Kansas City

GENERAL PURPOSES AND LIMITATIONS OF THE
KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
K.S.A. 40-3001, et. seq.

DISCLAIMER

THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR ALL OR A PORTION OF THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS AND EXCLUSIONS, AND IS CONDITIONED UPON RESIDENCY IN THIS STATE. THEREFORE, YOU SHOULD NOT RELY UPON COVERAGE BY THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELLING YOU ANY FORM OF AN INSURANCE POLICY, OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU HAVE REGARDING THIS DOCUMENT.

Kansas Life and Health Insurance Guaranty Association
2909 SW Maupin Lane
Topeka, KS 66614
Ph.: 785-271-1199
Fax: 785-272-0242

Kansas Insurance Department
420 SW 9th Street
Topeka, KS 66612
Ph.: 785-296-3071

This is a brief summary of the Kansas Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. If there is any inconsistency between this notice and Kansas law, then Kansas law will control.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Kansas law, with funding from assessments paid by other insurance companies. This safety net was created under Kansas law, which determines who and what is covered and the amounts of coverage. The basic protections provided by the Association are:

- **Life Insurance**
  $300,000 in death benefits
  $100,000 in cash surrender or withdrawal values
- **Health Insurance**
  $500,000 in hospital, medical and surgical insurance benefits
  $300,000 in disability insurance benefits
  $300,000 in long-term care insurance benefits
  $100,000 in other types of health insurance benefits
- **Annuities**
  $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits, as well as certain aggregate limits.

BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Our Privacy Practices

We may use and disclose your medical information, without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We may disclose to your employer whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose summary health information to your employer for certain limited purposes. We may disclose your medical information to your employer to administer your group health plan if your employer explains the limitations on its use and disclosure of your medical information in the plan document for your group health plan.

We will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

Contact Information

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Office.

Contact Office: Privacy Office
Blue Cross and Blue Shield of Kansas City
P. O. Box 417012
Kansas City, MO 64141

Telephone: 816-395-3784 or toll free at 1-800-932-1114
Fax: 816-395-2862
E-Mail: privacy@bluekc.com

Organizations Covered by this Notice

This notice applies to the privacy practices of the organizations listed below. They may share with each other your medical information, and the medical information of others they service, for the health care operations of their joint activities.

Blue Cross and Blue Shield of Kansas City

Good Health HMO, Inc.

Blue-Advantage Plus of Kansas City, Inc.

Missouri Valley Life and Health Insurance Company

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 1, 2006 and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our health plan subscribers at the time of the change.

Uses and Disclosures of Your Medical Information

Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Your Employer: We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan. Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the summary health information as yours.

We may disclose your medical information and the medical information of others enrolled in your group health plan to your employer to administer your group health plan. Before we may do that, your employer must amend the plan document for your group health plan to establish the limited uses and disclosures it may make of your medical information. Please see your group health plan document for a full explanation of those limitations.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Your Rights

If you wish to exercise any of the rights set out in this section, you should submit your request in writing to our Privacy Office. You may obtain a form by calling Customer Service at the phone number on the back of your ID card to make your request.

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Office for information about our fees.

Disclosure Accounting: You have the right to a list of instances after April 13, 2003, in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to your additional requests. Contact our Privacy Office for information about our fees.

Amendment: You have the right to request that we amend your medical information.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. Any agreement we may make to a request for restriction must be in writing signed by a person authorized to bind us to such an agreement.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request.

We will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Electronic Notice: If you receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Privacy Office to obtain this notice in written form.

Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information, you may complain to our Privacy Office.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.