Sample MO PPO $1,000, a PPO Product, on the Preferred-Care Blue Network

Offered by Blue Cross and Blue Shield of Kansas City

Health Benefits Certificate for:
Sample MO PPO
Group No: 77777777
PBM00000
Contract Effective Date: January 1, 2026

The Certificate 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.

Blue Cross and Blue Shield of Kansas City is an independent licensee of the Blue Cross and Blue Shield Association

Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

1400 Baltimore Ave. P.O. Box 419169 . Kansas City, MO 64141-6169 . 1-888-989-8842

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Amendments, if any, are located in the back of this Certificate.

SECTION A. DEFINITIONS

This section tells the meanings 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 an Admission, availability of care, continued stay or other Health Care Service has been reviewed and, based upon the information provided, does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is therefore denied, reduced, or terminated.

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 on whether the provider has a contract with Us and the terms of such contract.

You may be responsible for the difference between the amount that a Non-Participating Provider bills and the Allowable Charge. This is called balance billing, and the difference can be significant. Balance billing is prohibited by law in certain circumstances, such as Emergency Services and when you receive services at an In-Network Facility.

Unless otherwise specified in this Contract or governed by applicable law, the following explains what the Allowable Charge is for different types of providers:

a. For Hospitals, other institutional health care facilities, Physicians or suppliers of medical goods and services inside our Service Area which are In-Network Providers or Participating Providers, the Allowable Charge is the lesser of:

   (1) The amount negotiated and accepted by the In-Network Provider or Participating Provider; or

   (2) The In-Network or Participating Provider's billed charges.

b. For Emergency Services or post-emergency stabilization services provided by Hospitals, other institutional health care facilities, Physicians or suppliers of medical goods and services inside our Service Area which are Non-Participating Providers, the Allowable is either:

(1) The amount negotiated and accepted by the Non-Participating Provider; or

(2) If no amount has been accepted, the median contracted rate accepted by In-Network Providers and Participating Providers as required under the No Surprises Act.

c. For Non-Emergency Services provided by a Physician or supplier of medical goods and services inside our Service Area which are Non-Participating Providers at an In-Network Hospital or ambulatory surgery center, the Allowable Charge is either:

(1) The amount negotiated and accepted by the Non-Participating Provider; or

(2) If no amount has been accepted, the median contracted rate accepted by In-Network Providers and Participating Providers as required under the No Surprises Act.

d. For Non-Participating Air Ambulance Covered services, the Allowable Charge is either:

(1) The amount negotiated and accepted by the Non-Participating Provider; or

(2) If no amount has been accepted, the median contracted rate accepted by In-Network Providers and Participating Providers as required under the No Surprises Act.

e. For Non-Emergency Services provided by a Physician or supplier of medical goods and services inside our Service Area which are Non-Participating Providers at an Out-of-Network Hospital or ambulatory surgery center, the Allowable Charge is either:

(1) The amount negotiated and accepted by the Non-Participating Provider; or

(2) If no amount has been accepted, the lessor of billed charges or an amount that is based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("Medicare Fee Schedule"). This amount will be updated no less than annually. If the Medicare Fee Schedule does not include a specific fee for the

service provided, We use a gap methodology established by a third-party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location, and the resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale.

f. For ground ambulance services which are inside our Service Area provided by Non-Participating Providers, the Allowable Charge is either:

(1) The amount negotiated and accepted by the Non-Participating Provider; or

(2) If no amount has been accepted, the lessor of billed charges or an amount that is based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("Medicare Fee Schedule"). This amount but will be updated no less than annually. If the Medicare Fee Schedule does not include a specific fee for the service provided, We use a gap methodology established by a third-party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location, and the resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale.

g. For Hospitals, other institutional health care facilities, Physicians or suppliers of medical goods and services, which are outside of Our Service Area, the Allowable Charge is determined in accordance with the BlueCard Program. Please refer to the Inter-Plan Arrangement amendment for further information.

h. For In-Network pharmacies, the Allowable Charge is the rate the pharmacy has agreed to accept for Our members. If the Pharmacy has not agreed to accept a rate, the Allowable Charge is 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, including, without limitation, senior citizen's discounts, coupon discounts, non-insurance discounts, or other special discounts offered to attract customers.

For Out-of-Network pharmacies, the Allowable Charge is the pharmacy's billed charges.

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 mutually agreed upon by the Employer and Us 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 Copayment, Coinsurance, and/or Deductible requirement has been met.

Benefit Schedule Means a listing of certain Covered Services specifying Copayments, Coinsurance, Deductibles and 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 or any of its affiliates 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 chronic 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.

Certificate Means this booklet and any amendments.

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; or (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 which is defined as a normal delivery, or elective abortion.

Concurrent Review Means Utilization Review conducted during a patient'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 the day the Covered Person is discharged from the Hospital or Skilled Nursing Facility.

Contract Means the agreement between the Employer and Us that contains all of the terms of coverage. The Contract includes the Certificate, the Employer application, the Employee application, and any amendments.

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 Employee or any of the Employee's 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 other than prescription drugs a Covered Person 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. Each Covered Person must satisfy a Deductible each Calendar Year before Benefits will be paid.

If the Contract replaces the Employer's previous plan which provided similar coverage, a credit will be applied to the Deductible required by this Certificate, but only for the following conditions:

a. Deductible credit will be available only to those Covered Persons who were covered by the former plan on the day immediately prior to the Effective Date of the Contract when the Effective Date of the Contract is other than January 1; and

b. Credit will be limited to the charges for Covered Services that applied to the Deductible and were received within the 90 day period prior to the Effective Date of the Contract.

Delegate

Means an entity that We have contracted with to help Us administer Benefits, such as Our pharmacy benefit manager ("PBM"), behavioral health manager (currently Lucet), or a company performing Utilization Review services for Us.

Dependent

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

Designated Telehealth Vendor

Means a telehealth vendor designated by the Employer.

Developmental or Physical Disability

Means a severe chronic disability that:

a) Is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness or autism spectrum disorder which results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services;

b) Manifests before the individual reaches age nineteen;

c) Is likely to continue indefinitely; and

d) Results in substantial function limitations in three or more of the following areas of major life activities: (1) Self-care; (2) Understanding and use of language; (3) Learning; (4) Mobility; (5) Self-direction; or (6) Capacity for independent living.

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 the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, regardless of the final diagnosis that is given. Such a condition may include, but shall not be limited to:

a. Placing the person's health in significant jeopardy;

b. Serious impairment to a bodily function;

c. Serious dysfunction of any bodily organ or part;

d. Inadequately controlled pain; or

e. With respect to a pregnant woman who is having contractions:

(1) That there is inadequate time to effect a safe transfer to another Hospital before delivery; or

(2) That transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

Emergency Services Means health care items and services furnished or required to evaluate and treat an Emergency Medical Condition, which may include, but shall not be limited to, Health Care Services that are provided in a licensed Hospital's emergency facility by an appropriate provider.

Employee Means an eligible Employee of the Employer as provided in the Contract.

Employer Means the business organization or legal entity to which the Contract is issued.

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 on 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 (R.N.'s) 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. An Out-of-Network Hospital may or may not be a Participating Provider. 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.

d. Non-Participating Provider Hospital means an Out-of-Network 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 or other provider of medical services and supplies that has a contract to provide services at negotiated rates for Your coverage under an In-Network Provider contract with Us for the Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue network, or one of Our designated vendor's networks.

Such In-Network Provider will bill Us directly for Covered Services You receive and will not bill You for any charges above the amount agreed upon by Us and the provider except for any Copayments, Coinsurance and/or Deductible amounts for which You are responsible.

Initial Enrollment Period

Means the period of time during which a person is first eligible to enroll under the Contract. It starts on the date of the person's initial date of eligibility and ends 31 days later.

Late Enrollee

Means a person who requests Coverage under the Contract following his Initial Enrollment Period and who does not qualify to enroll under a Special Enrollment Period, unless either of the following apply:

a The Employer offers multiple health benefit plans and the person elects a different health benefit plan during an Annual Enrollment Period without a lapse in coverage; or

b A court ordered coverage to be provided for a minor child.

Lifetime Maximum

Means that when Benefits for a Covered Services total this amount, no more Benefits will be paid for a Covered Person under the Contract.

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, 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.

Our determinations regarding Medical Necessity, just like 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 Means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders except for Substance Abuse.

Non-Participating Provider Means an Out-of-Network Hospital, health care facility, Physician, or other provider of medical care or supplies, which has not entered into a contract that defines the method We will use to determine the Allowable Charges for Covered Services. Non-Participating Providers have not agreed to accept our Allowable Charge as payment in full for Covered Services and may require You to pay the difference between what the Non-Participating Providers bills and the payment We will make for Covered Services. You are also responsible for amounts incurred for Non-Covered Services, amounts in excess of any Benefit limits of the Contract, and any applicable Cost-Sharing.

Organ Transplant Means surgically removing an organ or tissue from one person (donor) and placing it in another person (recipient) or 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 for the Preferred-Care Blue network.

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 an Out-of-Network Non-Participating outpatient facility or in an Out-of-Network 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;

Amounts You pay for Covered Services administered by a Pharmacy Benefit Manager that are processed under the Contract are included in the Out-of-Pocket Maximum.

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 Out-of-Pocket Maximum.

Participating Provider

Means an Out-of-Network Hospital, health care facility, Physician, 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 the payment of any Copayment, Coinsurance and Deductible amounts, non-Covered Services and amounts in excess of any Benefit maximums of the Contract.

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 (M.D.) or Doctor of Osteopathy (D.O.). 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 state insurance 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.

Physicians are classified as follows:

a. In-Network Provider Physician. See the definition of In-Network Provider.

b. Out-of-Network Provider Physician. An Out-of-Network Provider Physician may or may not be a Participating Provider Physician. See the definition of Out-of-Network Provider.

c. Participating Provider Physician means a Physician who, by a contract with a Blue Cross and/or Blue Shield Plan, agrees to accept the Allowable Charge as full payment for Covered Services. Any applicable Copayments, Coinsurance and/or Deductible for Covered Services are Your responsibility.

d. Non-Participating Provider Physician means a Physician that does not have a Participating Provider Physician contract with Us.

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

Pre-Service Claim Means a request for 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.

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.

Prospective Review Means Utilization Review conducted prior to an Admission or a course of treatment.

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

Retrospective Review Means Utilization Review of Medical Necessity that is conducted after services have been provided to a patient, but 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 the initial proposed health services.

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.

Skilled Nursing Facility

Means a facility that:

a. Operates pursuant to law;

b. Provides 24-hour nursing services by registered nurses (R.N.'s) on duty or on call; and

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.

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

Skilled Nursing Facility also means an extended care facility, convalescent care facility, intermediate care facility or long-term illness facility.

Skilled Nursing Facilities are classified as follows:

a. Participating Provider Skilled Nursing Facility means a Skilled Nursing Facility that contracts with Us or any Blue Cross and/or Blue Shield Plan to provide the Skilled Nursing Facility Covered Services, if any, described in the Contract and accepts the Allowable Charge as full payment for Covered Services except for Copayments, Coinsurance and/or Deductibles if any.

b. Non-Participating Provider Skilled Nursing Facility means a Skilled Nursing Facility which does not have a contract with Us or any Blue Cross and/or Blue Shield Plan.

Special Enrollment Period

Means a period of time during which a new Dependent may enroll for coverage. It also means a period of time during which an individual who did not enroll for coverage during the individual's Initial Enrollment Period may be eligible to enroll for coverage.

Specialist

Means Doctors of Medicine (M.D.), Doctors of Osteopathy (D.O.), except Primary Care Physicians, and 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.

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.

Substance Abuse Means the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

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

Totally Disabled Means:

a. A Covered Person has a condition which prevents him from performing the material and substantial duties of his occupation; or

b. A nonworking Dependent has a condition which prevents him from performing activities normally associated with a person of the same sex and age;

c. and such condition is a result of a sickness or injury.

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, Prospective Review, Second Opinion, Certification, Concurrent Review, case management, Discharge Planning or Retrospective Review. Utilization Review shall not include elective requests for clarification of coverage.

Waiting Period Means the length of time an Employee must continuously work for the Employer before he is eligible to enroll for coverage under the Contract.

The terms of any eligibility condition or Waiting Period imposed will not exceed 90 days in a manner that violates the Affordable Care Act.

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 Lucet), or a company performing Utilization Review services for Us.

You, Your Refers to the Covered Person.

SECTION B. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

1. Employee Eligibility To be eligible to enroll as an Employee, a person must be:

a. In an eligible class of Employees listed in the Contract and satisfy any Waiting Periods required by the Employer; and

b. A legal alien residing in the United States, or a United States citizen.

2. Dependent Eligibility To be eligible to enroll as a Dependent, a person must be:

a. The Employee's legal spouse;

b. The Employee's or Employee's 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 Employee for the purpose of adoption for whom the Employee has a legal obligation to support; or

(4) a child under the age of 18 who has been placed under the Employee's legal guardianship.

Coverage for a Dependent child under this section will apply without regard to whether such child (defined above) is: married, a tax dependent of the Employee or Employee's spouse, a student, actively employed, or residing with or receiving financial support from the Employee or Employee's legal spouse.

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

c. For disabled dependents, if the Social Security Administration ("SAA") 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.

d. The Employee's or Employee's legal spouse's, unmarried Dependent child (defined above) who has reached the Dependent 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 the Dependent reached the Dependent Limiting Age and the Dependent must have been continuously covered by Us or a prior health plan at the time of reaching the Dependent Limiting Age.

We must receive satisfactory proof of the Dependent's handicap within 31 days after the Dependent reaches the Dependent Limiting Age, or within 31 days after the Dependent is enrolled for coverage under the Contract to continue coverage beyond the Dependent Limiting Age]. In addition, We must receive such satisfactory proof annually following the Dependent's attainment of the Dependent Limiting Age.

It is the Employee's responsibility to see that Dependent information is kept current. If necessary Dependent information is not in Our files, claims will be rejected for such individuals.

Dependents will not be eligible for coverage unless the Employee is covered under the Contract.

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3. Enrollment

a. Annual Enrollment Period

If an Employee has elected coverage under another health plan offered by his Employer, such Employee and his Dependents will not be eligible for coverage under this Contract unless they enroll during the Annual Enrollment Period. During the Employer designated Annual Enrollment Period, an individual who is eligible for coverage as an Employee or Dependent may apply for coverage by submitting to Us a completed Employee application. A Late Enrollee may enroll for coverage during an Annual Enrollment Period.

b. Initial Enrollment Period for a Newly Eligible Employee

A person who first becomes eligible as an Employee may enroll by submitting to Us a completed Employee application and any Premium due within 31 days of becoming eligible. If a new Employee and/or his Dependent(s) do not enroll within 31 days of becoming eligible, then that Employee and/or his Dependent(s) will be considered a Late Enrollee(s).

c. Special Enrollment Periods

(1) New Dependents: If a new Dependent is acquired by an Employee due to marriage, birth of a child, adoption of a child, or placement for adoption of a child, the new Dependent, the spouse of an Employee and/or an Employee who previously declined coverage may enroll during this Special Enrollment Period, even if coverage was previously declined. To enroll during this Special Enrollment Period, an Employee must submit to Us a completed Employee application and any additional Premium due within 31 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 Employee previously has elected Dependent coverage and such coverage is in effect on the date of the newborn child's birth, then the Employee's newborn child will be covered automatically 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 Employee must submit to Us a completed Employee application requesting coverage for such newborn to be added within 31 days of the child's birth in order to continue such child's coverage beyond the initial 31 days. Coverage for such a newborn will be subject to all of the terms and conditions of the Contract.

If You notify Our Customer Service Department of the birth either verbally or in writing within 31 days of the date of birth, We must:

(i) Provide the Employee with forms and instructions; and

(ii) Allow an additional 10 days from the date on which enrollment forms and instructions were provided for the Employee to complete and return the enrollment materials for the newborn.

If a child placed for adoption is not legally adopted, coverage for such child will end on the date on which the Employee's legal support obligation for the child ends.

If the new Dependent does not enroll within 31 days of becoming eligible, then the Dependent will be considered a Late Enrollee.

(2) Loss of Other Coverage: If an Employee has previously declined coverage for himself and/or his Dependent(s) and the Employee and/or his Dependent(s) were covered under another health plan (including Medicaid, Children's Health Insurance Plan (CHIP), and nationalized health insurance provided by a foreign government), the Employee and/or his Dependent(s) may enroll if any of the following conditions are satisfied:

a. (i) The employer's contributions toward such coverage were terminated;

(ii) The Employee's and/or his Dependent's COBRA or state continuation coverage has been exhausted; or

(iii) The Employee's and/or his Dependent's coverage terminated as a result of loss of eligibility for coverage. Loss of eligibility for coverage does not include termination due to untimely payment of Premiums or termination for cause. Events that could result in a loss of eligibility for coverage include:

1. Legal separation, divorce, no longer qualifying as a dependent under the other coverage, death of an Employee, termination of employment or reduction in the number of hours of employment.

2. Reaching a Lifetime Maximum on all Benefits under coverage offered by an Employer.

3. An Employer no longer offers any health coverage to a class of similarly situated individuals.

b. Except as provided below, the Employee must submit to Us a completed Employee application and any additional Premium due within 31 days after the loss of such other coverage and provide appropriate documentation verifying the loss of such other coverage, if requested.

c. If the Employee and/or Dependent lost Medicaid or CHIP coverage, the Employee must submit to Us a completed Employee application and any additional Premium due within 60 days after the loss of such coverage and provide appropriate documentation verifying the loss of such coverage, if requested.

(3) Eligibility for Premium Assistance under Medicaid or CHIP. Except as provided below, if an Employee 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, the eligible Employee and/or his eligible Dependents may enroll during this Special Enrollment Period, even if coverage was previously declined. To enroll during this Special Enrollment Period, an Employee must submit to Us a completed Employee application and any additional Premium due within 60 days after eligibility is determined and provide appropriate documentation verifying the eligibility, if requested.

(4) Coverage Options: The Employee and/or his Dependents may enroll in any health benefit plan offered by his Employer subject to any qualified employer coverage requirements under the premium assistance rules for Medicaid or CHIP.

d. Guardianship

A child placed with an Employee for legal guardianship may enroll by submitting to Us a completed Employee application, a copy of the court order awarding guardianship, and any additional Employee Premium due within 31 days of the effective date of the court order. If the Employee does not enroll the child within 31 days of the date of the court order awarding guardianship, then the child will be considered a Late Enrollee.

e. Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued, We must receive a completed Employee application and any additional Employee Premium due within 31 days of the date of the court order. If the child is not enrolled within 31 days of the date of the court order, then the child will be considered a Late Enrollee.

f. Employee Application

Employees must fully and accurately complete and sign the Employee 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.

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4. Effective Date of Coverage

Coverage is effective at 12:01 a.m. on the following specified dates subject to all of the terms and conditions of the Contract and the payment of applicable Premium, as follows:

a. Annual Enrollment Period

If You are eligible for coverage on the Effective Date of the Contract, Your coverage will become effective on that date.

If You enroll during any subsequent Annual Enrollment Period, the Effective Date of coverage is the Contract anniversary date.

b. Initial Enrollment Period for a Newly Eligible Employee

The Effective Date of coverage of a person who first becomes eligible as an Employee will be the first day of the month following satisfaction of the Waiting Period, if any. If an Employee has

Dependents on the date the Employee's coverage becomes effective, coverage for those Dependents will begin on the Employee's coverage Effective Date, provided the Employee requested coverage for the Dependents on the Employee application when the Employee enrolled.

c. Special Enrollment Period

(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, the date of the marriage.

(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 of the child; (ii) the date the petition for adoption was filed; or (iii) on the child's date of placement. Date of placement means the date You assume the legal obligation for total or partial support of the child to be adopted in connection with formal adoption proceedings.

(2) Loss of Other Coverage: If an individual enrolls under the Special Enrollment Period due to a loss of coverage, coverage is effective on the first day following the date the other coverage terminates.

(3) Eligibility for Premium Assistance under Medicaid or CHIP. If an individual enrolls under the Special Enrollment Period due to becoming eligible for premium assistance under Medicaid or CHIP, coverage is effective on the first day following the date that eligibility for the premium assistance subsidy is determined or as otherwise required by law.

d. Late Enrollees

The Effective Date of coverage for an individual who is a Late Enrollee is the next Contract anniversary date.

e. Guardianship

In the case of a child placed for guardianship, the Effective Date of coverage is the date the court order awarding guardianship is legally effective.

f. Qualified Medical Child Support Order

Notwithstanding any provision in the Contract to the contrary, children who are the subject of a "Qualified Medical Child Support Order" will

be eligible for coverage in accordance with such order, provided the order is "qualified" in accordance with Section 609 of ERISA.

In the event a medical child support order is received, the Employer will:

(1) Promptly notify the participant and each alternate recipient of such order and the procedures for determining whether an order is a Qualified Medical Child Support Order;

(2) Within a reasonable period after receipt of such order, determine whether such order is a Qualified Medical Child Support Order and notify the participant and each alternate recipient of such determination; and

(3) Permit an alternate recipient to designate a representative for receipt of copies of notices that are sent to the alternate recipient with respect to a medical child support order.

Coverage for such child will be provided in accordance with the requirements of the order, applicable federal laws, and all other terms and conditions of the Contract.

g. Extension of Benefits from Prior Plan

If You are covered under an extension of benefits under a prior plan, coverage under the Contract will become effective in accordance with the above provisions. Services or supplies that are covered, or required to be covered, under an extension of benefits provision under the prior plan will be covered under the Contract subject to the Coordination of Benefits section.

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5. Dual Coverage

For the same Employer-sponsored coverage, an individual cannot be covered under this Contract simultaneously as an Employee and a Dependent, nor can an individual be covered under this Contract simultaneously as a Dependent of more than one Employee.

If an eligible Employee and/or Dependent declines coverage under this Contract due to having Dependent coverage under the “other” Employee’s coverage and subsequently ceases to be an eligible Dependent under such “other” Employee’s coverage, such individual may be eligible for Employee coverage, and, if applicable, Dependent coverage subject to the Special Enrollment Periods section of this Contract.

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6. Section 125 Eligibility

The eligibility provisions of Your Employer’s Section 125 plan are incorporated into this Section provided such provisions are consistent with the final permitted mid-year election changes outlined under Treas. Reg.

§1.125-4 and §1.125-3. Your Employer will determine who is eligible under this provision and will advise Us of such person's eligibility and Effective Dates of coverage.

SECTION C. 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 Deductible, Copayment, and Coinsurance requirements and the limitations and exclusions of the Contract.

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 or other properly licensed provider;

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;

Benefits

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

Benefits are different depending on whether Covered Services are received from an In-Network Provider or an Out-of-Network Provider. 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.

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 a combination of covered family members have satisfied the family Deductible for a Calendar Year, the Deductible will be considered satisfied for all covered family members. No Covered Person is allowed to contribute more than his own individual Deductible to the family Deductible per Calendar Year.

You must satisfy the Deductible requirement for services received from In-Network Providers and a separate Deductible requirement for services received from Out-of-Network Providers. Amounts You pay towards satisfaction of the Deductible requirement for Emergency Services will

apply to Your In-Network Provider Deductible, regardless of whether services are received from an In-Network or Out-of-Network Provider.

Copayments

Copayments are a specified charge that You must pay each time You receive a service of a particular type or in a designated setting. Whenever a Copayment applies towards a Covered Service, the Deductible does not apply, except as specified for Emergency Services.

Copayments are shown in the Benefit Schedule.

Out-of-Pocket Maximum

After a combination of covered family members have satisfied the family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be considered satisfied for all covered family members.

There are separate Out-of-Pocket Maximums for In-Network Providers and Out-of-Network Providers. The amount You pay for Covered Services received from In-Network Providers or Out-of-Network Providers will apply to the Out-of-Pocket Maximum for each other.

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

Please see the definition of Out-of-Pocket Maximum for a listing of expenses that do not apply to the Out-of-Pocket Maximum.

Prior Authorization

Services that must be Prior Authorized by Us will state so in the applicable Covered Service provision. Please visit www.bluekc.com/pa for the current list of services that must be Prior Authorized. The following explanation outlines Your responsibilities for obtaining such approval and the consequences of obtaining such services when they have not been Prior Authorized.

Services Received from In-Network Providers Inside Our Service Area – If these services are not Prior Authorized, the admitting Physician, provider and/or Hospital will be responsible for the cost associated with such services, regardless of Medical Necessity.

Services Received from Out-of-Network Providers or In-Network Providers Outside Our Service Area – If these services are not Prior Authorized, You will be responsible for the cost associated with such services, regardless of Medical Necessity.

In the case of a maternity or an inpatient Admission due to an Emergency Medical Condition, You or Your provider must notify Us within 48 hours of the Admission or as soon thereafter as reasonably possible.

Benefits will be limited to the length of stay approved by Us. When the approved length of stay must be extended for Medically Necessary reasons, You or Your attending Physician, on Your behalf, must contact Us in advance to obtain Our approval for the additional days. Failure to provide such notice or obtain Prior Authorization for additional days may result in You being responsible for the cost of the service regardless of Medical Necessity.

The following information provides a detailed description of Covered Services:

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1. 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 and 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, unless the medical condition of the Covered Person prevents treatment from being rendered within 12 months of the date of the Accidental Injury.

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

We provide Benefits for:

Tooth Extractions

Extraction of the tooth (teeth) and services related to such extraction(s) when performed in conjunction with the treatment of head and/or neck tumor(s).

Dental Implants

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 tooth (teeth) due to an Accidental Injury; and

f. Correction of a defect diagnosed within 31 days of birth.

Dental prostheses over an implant are not covered unless the dental implant was due to an Accidental Injury or due to a correction of a defect diagnosed within 31 days of birth.

Dental implants and bone grafts must be Prior Authorized by Us.

Orthognathic Surgery

We provide Benefits for orthognathic surgery for the following conditions:

a. Correction of a congenital birth defect or abnormality diagnosed within 31 days of birth; 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, unless the medical condition of the Covered Person prevents treatment from being rendered within 12 months of the date of the Accidental Injury.

c. For the treatment of medically diagnosed cleft lip, cleft palate, ectodermal dysplasia, non-dental lesions, and incision/drainage of infection of soft tissue (not including odontogenic cysts or abscesses).

d. Correction of other medical conditions according to Our medical policy (such as difficulty swallowing, speech abnormalities, intraoral trauma related to malocclusion, masticatory dysfunction or malocclusion, or obstructive sleep apnea.

Temporomandibular Joint Disorder

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

Complications of Dental Treatment

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

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2. Allergy

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

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3. Ambulance Services

We provide Benefits for transportation by a licensed Ambulance service 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 ambulance services provided by ground, water, and air Ambulance.

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

Benefits for a ground Ambulance may be limited to a maximum allowable charge for each usage if indicated in the Benefit Schedule.

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4. 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).

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

Dental

We provide Benefits for general anesthesia materials their administration, and medical care facility charges for dental care if provided 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;

whether such services are provided in a Hospital, surgical center, or office. Covered Services must be provided by a Physician, Certified Registered Nurse Anesthetist (CRNA) or Dentist.

FOR MISSOURI RESIDENTS ONLY.

5. Autism Spectrum Disorder

The following definitions apply to this section:

Autism Spectrum Disorders (ASD) means a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise

Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior. Applied Behavior Analysis does not include cognitive therapies or psychological testing, personality assessment, intellectual assessment, neuropsychological assessment, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, family therapy and long-term counseling as treatment modalities.

Autism Service Provider means:

a. Any person, entity, or group that provides diagnostic or treatment services for Autism Spectrum Disorders who is licensed or certified by the state in which services were rendered to provide health care services; or

b. Any person who is licensed under chapter 337 by the state in which services were rendered as a board certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board certified behavior analyst.

Diagnosis of Autism Spectrum Disorders means medically necessary assessments, evaluations, or tests in order to diagnose whether an individual has an Autism Spectrum Disorder.

Habilitative or rehabilitative care means professional, counseling, and guidance services and treatment programs, including Applied Behavior Analysis, that are necessary to develop the functioning of an individual.

Line therapist means an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment plan, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst;

Pharmacy care means medications used to address symptoms of an autism spectrum disorder prescribed by a licensed physician, and any health-related services deemed medically necessary to determine the need or effectiveness of the medications only to the extent that such medications are included in the insured's health benefit plan;

Psychiatric care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

Psychological care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

Therapeutic care services means services provided by licensed speech therapists, occupational therapists, or physical therapists;

Treatment for Autism Spectrum Disorders means care prescribed or ordered for an individual diagnosed with an Autism Spectrum Disorder by a licensed physician or licensed psychologist, including equipment medically necessary for such care, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, including, but not limited to:

(a) Psychiatric care;

(b) Psychological care;

(c) Habilitative or rehabilitative care, including Applied Behavior Analysis therapy;

(d) Therapeutic care;

(e) Pharmacy care.

We provide Benefits for the diagnosis and treatment of Autism Spectrum Disorders (ASD) when prescribed or ordered for an individual diagnosed with an Autism Spectrum Disorder by a licensed physician or licensed psychologist, including equipment medically necessary for such care including but not limited to: (a) Psychiatric care; (b) Psychological care; (c) Habilitative or rehabilitative care, including Applied Behavior Analysis therapy; (d) therapeutic care; a€(e) pharmacy care.

Coverage for Applied Behavior Analysis is limited to Medically Necessary treatment ordered by the treating physician or psychologist in accordance with the treatment plan. An ABA therapy treatment plan must include all elements necessary for Us to pay the claim. Except for inpatient services, We have the right to review the treatment plan once every six months, unless the treating physician agrees a more frequent review is necessary.

Benefits will be paid at the In-Network Provider level only if Autism Spectrum Disorders are provided by an Autism Service Provider in the network. Services provided by an Autism Service Provider (ASP) for Speech Therapy, Occupational Therapy, or Physical Therapy will not be subject to any visit limits.

These services must be Prior Authorized by Lucet.

FOR KANSAS RESIDENTS ONLY.

The following definitions apply to this section:

Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior. Applied Behavior Analysis does not include cognitive therapies or psychological testing, personality assessment, intellectual assessment, neuropsychological assessment, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, family therapy and long-term counseling as treatment modalities.

Autism Service Provider means:

a. Any person, entity, or group that provides diagnostic or treatment services for Autism Spectrum Disorders who is licensed or certified by the state in which services were rendered to provide health care services;

b. In states that do not have licensure and/or certification requirements, any person who is a Behavioral Analyst with national certification from the Behavior Analyst Certification Board; or

c. Any person who is licensed, trained and qualified to provide such services or an autism specialist or an intensive individual service provider as such terms are defined by the Kansas Department of Aging and Disability Services Autism Waiver

Autism Spectrum Disorders means a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder as defined within the DSM-IV.

Diagnosis of Autism Spectrum Disorders means medically necessary assessments, evaluations, or tests performed by a licensed physician, licensed psychologist, or licensed specialist clinical social worker in order to diagnose whether an individual has an Autism Spectrum Disorder.

Treatment for Autism Spectrum Disorder means care prescribed or ordered for an individual diagnosed with an Autism Spectrum Disorder by a licensed physician or licensed psychologist or licensed specialist clinical social worker, including equipment medically necessary for such care, pursuant to the powers granted under such licensed physician's or licensed psychologist's license.

We provide Benefits for the diagnosis and treatment of Autism Spectrum Disorders when prescribed or ordered for an individual diagnosed with an Autism Spectrum Disorder by a licensed physician or licensed psychologist, including equipment medically necessary for such care.

The Benefits for Applied Behavior Analysis are subject to the same Cost-Sharing as All Other Covered Services as specified in the Benefit Schedule. Benefits for ABA therapy will be provided to the extent that such coverage is the better of:

a. The Benefits for Applied Behavior Analysis are subject to the same Cost-Sharing as All Other Covered Services and are limited to a Calendar Year Maximum for Covered Persons. Such maximum benefit limit may be exceeded, upon prior approval by Lucet, if the provision of ABA therapy beyond the maximum limit is Medically Necessary for a Covered Person.; or

b. The Benefits for Applied Behavior Analysis are subject to the same Cost-Sharing as All Other Covered Services. For Covered Persons diagnosed with an Autism Spectrum Disorder between birth and five years of age, ABA coverage is limited to 1,300 hours per Calendar Year for the first four years of such coverage. After the first four years of coverage, and for Covered Persons diagnosed with an Autism Spectrum Disorder after five years of age, ABA coverage is limited to 520 hours per Calendar Year until reaching age12.

Coverage for Applied Behavior Analysis is limited to Medically Necessary treatment ordered by the treating physician or psychologist in accordance with the treatment plan for Covered Persons under the age of 19. An ABA therapy treatment plan must include all elements necessary for Us to pay the claim. Except for inpatient services, We have the right to review the treatment plan once every six months unless the treating physician agrees a more frequent review is necessary.

Notwithstanding any provision in the Certificate to the contrary, services provided by an Autism Service Provider for Speech Therapy, Occupational Therapy or Physical Therapy will not be subject to any visit limits and shall not be subject to the age limitations described in this subsection, except for Applied Behavior Analysis.

ABA services must be Prior Authorized by Lucet.

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6. 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.

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7. Chemotherapy

We provide Benefits for chemotherapy, including oral chemotherapy drugs.

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8. Chiropractic Services

We provide Benefits for Chiropractic Services. Coverage includes initial diagnosis and clinically appropriate and Medically Necessary services to treat the diagnosed disorder.

Office Visit	You must pay the office visit Copayment if indicated in the Benefit Schedule for each office visit to a Chiropractor. This Copayment applies to the office visit charge only.
Skeletal Manipulations	Skeletal manipulations performed in a Chiropractor's office are subject to the In-Network Provider Deductible and Coinsurance level indicated in the Benefit Schedule. Please refer to the Physical Therapy section of the Outpatient Therapy Benefit for information on skeletal manipulations provided by a Doctor of Osteopathy (D.O.)
Other Procedures	Lab services that are drawn and processed in the Chiropractor's office will be covered at 100% of the Allowable Charge after Your office visit Copayment. Other procedures, including x-ray and other radiology procedures, performed in a Chiropractor's office are subject to the In-Network Provider Deductible and Coinsurance level indicated in the Benefit Schedule.

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9. Clinical Trials

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

a. National Institute of Health (NIH);

b. Center for Disease Control and Prevention (CDC);

c. Agency for Health Care Research and Quality;

d. Centers for Medicare and Medicaid Services;

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.

Covered Services for Routine Patient Care Costs are provided when the available clinical or pre-clinical data give a reasonable expectation that the treatment will be superior to non-investigational treatment alternatives.

Routine Patient Care Costs are defined as follows:

a. Drugs and devices that have been approved for sale by the FDA, regardless of whether 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; and

c. All other items and services that are otherwise generally available in the clinical trial, except:

   i. The Investigational item, device, or service itself;

   ii. 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;

   iii. Costs for services clearly inconsistent with widely accepted and established standards of care for a particular diagnosis, or

   iv. 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 Us.

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10. Cochlear Implants

We provide Benefits for cochlear implants. Covered Services include the initial cochlear 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.

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11. Cranial (head) Remodeling Devices

We provide Benefits for cranial (head) remodeling devices, including but not limited to Dynamic Orthotic Cranioplasty ("DOC Bands") when Medically Necessary for the treatment of congenital birth defects and birth

abnormalities.

12. Diabetes

We provide Benefits for the treatment of diabetes. Covered Services are limited to self-management training (including diet counseling from a registered dietician or certified diabetes educator) and Physician prescribed Medically Necessary equipment and Tier 1 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 pair of inserts for the diabetic shoes per Covered Person per Calendar Year.

13. Diagnostic Services

We provide Benefits for diagnostic services including x-ray examinations, laboratory services, other diagnostic procedures and tests required to diagnose an illness, injury, or other Covered Service. Covered Services do not include screening examinations or routine physical examinations unless these services 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.

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 and will be paid at the In-Network Provider Coinsurance level.

MRI, MRA, CT, Ultrasound, PET, Nuclear Medicine, Cardiac Nuclear Medicine. These specified tests are subject to the Deductible requirements of the Contract as indicated in the Benefit Schedule.

MRI, MRA, CT, Ultrasound, PET, Nuclear Medicine, Cardiac Nuclear Medicine must be Prior Authorized by Us.

Prostate Specific Antigen (PSA) Tests, Pap Smears, and Mammograms

The lab and x-ray services related to Prostate Specific Antigen (PSA) tests, pap smears, and mammograms will be covered at 100% of the Allowable Charge when provided by an In-Network Provider.

Outpatient Colorectal Cancer Exams and lab tests

Outpatient Colorectal cancer diagnostic services consisting of a digital rectal exam, fecal occult blood tests; flexible sigmoidoscopy; colonoscopy; double contrast barium enema, laboratory tests, pathology and related physician services will be covered at 100% of the Allowable Charge when provided by an In-Network Provider. The office visit Copayment will apply if applicable.

Computed Tomography (CT), Computed Tomography Angiography (CTA), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiogram (MRA), Positron Emission Tomography (PET), Nuclear Medicine, Cardiac Nuclear Medicine, Echo, and Stress Echo must be Prior Authorized by Us.

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14. Dialysis

We provide Benefits for hemodialysis and peritoneal dialysis services.

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15. Durable Medical Equipment

We provide Benefits for the rental or purchase of durable medical equipment (DME) for use outside a Hospital subject 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 and 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 which meets the minimum specifications which are 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); and

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 patient care 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, including but 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.

We provide Benefits for pediatric gait trainers (including posterior, anterior, and upright gait trainers, as well as other assistive walking devices), when Medically Necessary, for Covered Persons under age 19. **These services must be Prior Authorized by Us.**

Covered Services do not include repair or replacement required as a result of abuse or misuse of DME. Covered Services also do not include repair or replacement required as the result of 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; nor items for comfort or convenience, such as but not limited to spas, whirlpools, Jacuzzis, hot tubs, humidifiers, dehumidifiers and air conditioners. Covered Services also do not include DME that would normally be provided by a Skilled Nursing Facility. Benefits are not provided for replacement of items still functional and/or under warranty. If the item(s) work as intended, replacement will be patient responsibility. See the Exclusions section of the Contract for additional exclusions which may apply.

DME must be Prior Authorized by Us.

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16. Elective Sterilization

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

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17. Electrical Stimulation

We provide Benefits for central and peripheral nervous system stimulation based on medical necessity:

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

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18. Emergency Services And Supplies

We provide Benefits for the treatment of Emergency Medical Conditions. You must pay the Emergency Services and Supplies Copayment if indicated in the Benefit Schedule for each visit to an emergency room.

This Copayment will not apply if You are admitted to an In-Network Provider Hospital for the same condition within 24 hours.

You must notify Us of any emergency Admission within 48 hours of the time of the Admission or as soon as is reasonably possible.

Emergency Services are subject to the Deductible and Coinsurance requirements of the Contract in addition to Your emergency room Copayment, if any.

Note: If You are kept at the Hospital for observation (usually less than 24 hours), the emergency room Copayment will apply.

The emergency room Copayment will be waived if a Covered Person is admitted to either an In-Network Provider or Out-of-Network Provider Hospital for the same condition within 24 hours.

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19. Formula and Food Products for Phenylketonuria (PKU)

We provide Benefits for formula and low protein modified food products recommended by a Physician for the treatment of Phenylketonuria (PKU) or any inherited disease of amino and organic acids. Covered Services may be limited to a Calendar Year Maximum if indicated in the Benefit Schedule.

Low protein modified food products are limited to those products specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

These Benefits are subject to the same Copayment or Coinsurance provisions as other Covered Services, but in no case shall Your Coinsurance or Copayment be greater than 50% of the cost of the formula or food product.

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20. Gender Affirmation Services

We provide Benefits for gender affirmation services. The Covered Person must be diagnosed with gender identity disorder (GID), and an active participant in a recognized gender identity program.

Covered Services are limited to services and supplies for gender affirmation and surgery when ordered by a Physician including Medically Necessary treatment related to GID or gender affirmation, counseling by a mental health professional for GID, hormone therapy, and other related surgical/medical procedures that are necessary for gender affirmation. Such services include but are not limited to room and board, general nursing care, supplies, laboratory services, x-rays, and related office visits when such services are Medically Necessary in accordance with our policies for gender affirmation. Covered Surgical/medical procedures may require that the Covered Person be over the age of 18. Please see the criteria as defined in Our medical policy.

Surgeries considered cosmetic would not be covered.

These services must be Prior Authorized by Us.

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21. Genetic Testing

We provided Benefits for genetic testing in accordance with Our Medical Necessity criteria. Certain genetic tests for women who have a family history associated with an increased risk for mutations in the BRCA1 or BRCA2 genes are Covered Services under the Routine Preventive Care Benefit.

Genetic Testing must be Prior Authorized by Us.

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22. Hearing Aids

We provide Benefits for hearing aids and implantable bone conduction and bone anchored hearing aids, including but not limited to initial amplifications for newborns. Covered Services include the initial implant and related implant services.

Hearing aids include parts and attachments or accessories as well as ear molds. Hearing aids do not include batteries, cords, or receivers. Repairs or replacements are Covered Services only when necessary, because of a change in the physiological condition of the patient.

Covered Services do not include repair or replacement as the result of lost, stolen, destroyed or damaged implants or hearing aids.

Charges for deluxe implants or hearing aids are not covered, except for those devices that are Medically Necessary for the Covered Person.

Coverage for hearing aids will be provided subject to Cost-Sharing indicated in the Benefit Schedule and may be subject to a Benefit Maximum. Initial amplification for newborns are not subject to any Calendar Year Maximum.

Covered services do not include over-the-counter hearing aids, or hearing aids that do not require a physician’s order.

23. Home Health Services

We provide Benefits for home health services provided in the home or other outpatient setting. Covered Services may be limited to a Calendar Year Maximum if indicated in the Benefit Schedule and are subject to all of the following 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; and

c. Your Physician determines that You need home health care and designs a home health care plan for You.

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, and homemaker services.

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24. Hospice Services

We provide Benefits for Hospice services if a Physician certifies that 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.

Home Hospice

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.

   (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 such as, but not limited to, the execution of a will.

(3) Services received in a free standing Hospice facility, a Hospital-based Hospice, or provided to a Hospital bed patient except that 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.

(5) Services received from Hospice organizations that do not have a contract with a Blue Cross and/or Blue Shield Plan to provide such services to Covered Persons.

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 and also include the following services.

(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.

(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 such as, but not limited to, the execution of a will.

(3) Services received by persons other than the Covered Person or his Immediate Family Members.

(4) Services received from Hospice organizations that do not have a contract with a Blue Cross and/or Blue Shield Plan to provide such services to Covered Persons.

(5) Respite care.

Covered Services may be limited to a lifetime maximum if indicated in the Benefit Schedule.

Inpatient Hospice services must be Prior Authorized by Us.

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25. Immunizations for Children

We provide Benefits for routine and necessary childhood immunizations for covered Dependent children. Covered Services include: (1) at least 5 doses of vaccine against diphtheria, pertussis, tetanus; (2) at least 4 doses of vaccine against polio, Haemophilus Influenza Type b (Hib); (3) at least 3 doses of vaccine against Hepatitis B; (4) 2 doses of vaccine against measles, mumps, and rubella; (5) 2 doses of vaccine against varicella; (6) at least 4 doses of vaccine against pediatric pneumococcal (PCV7); (7) 1 dose of vaccine against influenza; (8) at least one dose of vaccine against Hepatitis A; (9) 3 doses of vaccine against Rotavirus; and (10) such other vaccines and dosages as may be prescribed by the State Department of Health. Covered Services are limited to immunizations administered to each covered Dependent child age 6 and under.

Covered Services for routine and necessary immunizations will be provided at 100% of the Allowable charge and will not be subject to any Cost-Sharing requirements.

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 regardless of whether received from an In-Network or Out-of-Network Provider.

Any office visit charges incurred in conjunction with these immunizations will be subject to the office visit Copayment, Coinsurance, and Deductible requirements of the Contract, the same as any other services.

For information regarding Benefits for other immunizations, if any, see the Routine Preventive Care Benefit in the Covered Services Section.

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26. Infusion Therapy and Injectables

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 and provided by an infusion therapy provider or Physician licensed to provide such services; and

c. **Services are Prior Authorized by Us.**

Injectable

We provide Benefits for injectables administered in the Physician's office or in the home setting. **These services may require Prior Authorization by Us.** Covered Services for growth hormones are limited to treatment for pediatric growth deficiency. Most injectables are processed under Your Outpatient Prescription Drug Benefit; however, selected injectables may be processed under Your medical benefit. Please refer to the Prescription Drug List for a listing of injectables that are processed under Your medical benefit or visit Our website at www.BlueKC.com for a current listing. This list is subject to change without prior notice and is based on the recommendations of community Physicians and pharmacists. Covered Services for infusion therapy also include Remicade.

Allergy injections and insulin are not Covered Services under this Benefit. See the Allergy and Diabetes Benefits in the Contract for a description of how allergy injections and insulin are covered.

Covered Services for infusion therapy and injectables are subject to the home health Benefit visit limit, if any, when provided by a Home Health Agency in conjunction with home health services that have been Prior Authorized by Us.

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

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27. 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. **Personal care or convenience items are not covered.**

All Admissions, except maternity and emergency Admissions, must be Prior Authorized by Us. We require notification of emergency and maternity Admissions within 48 hours of the Admission or as soon as reasonably possible.

Benefits for services received from an Out-of-Network Non-Participating Provider Hospital inside Our Service Area will not be subject to any Deductible and Coinsurance requirements.

The amount You pay for services received in an Out-of-Network Non-Participating Provider Hospital inside Our Service Area will not apply to and will not be limited by Your Out-of-Pocket Maximum.

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28. 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. Only one office visit Copayment shall apply for Physician obstetrical services per pregnancy. This Copayment will be assessed at the time of delivery and will be in addition to any applicable Deductible and Coinsurance. You must pay Your office visit Copayment for each visit to a Physician for Complications of Pregnancy.

Covered Services include an inpatient stay of at least 48 hours for a covered mother and a covered 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 for 2 visits (at least 1 visit in home) 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; and, appropriate chemical tests and submission of a metabolic specimen to the state laboratory.

Services provided for a covered newborn child and routine Hospital nursery services provided during the Hospital Confinement, are eligible for Benefits under the newborn child's Dependent coverage. Benefits shall also include coverage during the confinement for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If both the mother and newborn child are covered under this Contract, the routine Hospital nursery services are not subject to the child's Deductible. If Your plan

provides coverage for routine Physician examinations, the Physician services associated with the routine Hospital nursery stay will be subject to the child's Deductible. The list of Covered Services under the Routine Preventive Care benefit will include Physician examinations if You have coverage for such Physician Services.

Dependent daughters are not covered for maternity services.

If a child is adopted by a covered Employee 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. Such services must be provided by an In-Network Provider.

Complications of Pregnancy

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

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29. Mental Illness and Substance Abuse

We provide Benefits for the treatment of Mental Illness and Substance Abuse as indicated in the Benefit Schedule. Lucet performs intake services designed to provide crisis intervention, assessment, benefits management and referral services. Covered Services for outpatient evaluation and treatment are limited to crisis intervention, stabilization and therapy for conditions which Lucet and We determine will substantially benefit You. 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.

Inpatient and Residential Mental Illness and Substance Abuse Services must be Prior Authorized by Lucet.

Mental Illness and Substance Abuse Services:

Mental Illness and Substance Abuse Services rendered by In-Network Providers are provided as follows:

a. Outpatient Treatment

Services for outpatient treatment will be covered to the same extent as any other illness as indicated in the Benefit Schedule.

Covered Services include non-residential services, such as partial outpatient hospitalization and intensive outpatient services. These services will be subject to the Cost-Sharing indicated for All Other Covered Services.

b. Inpatient Treatment (including Residential Treatment)

Services for inpatient treatment will be covered to the same extent as any other illness.

Mental Illness and Substance Abuse Services rendered by Out-of-Network Providers are limited as follows:

a. Outpatient Treatment

Services for outpatient treatment will be covered to the same extent as any other illness as indicated in the Benefit Schedule.

Notwithstanding any provision to the contrary, outpatient therapy services provided for a Mental Illness or Substance Abuse Disorder diagnosis for Physical Therapy, Occupational Therapy, or Speech and Hearing Therapy will not be subject to any Calendar Year visit limits.

b. Inpatient Treatment (including Residential Treatment)

Services for inpatient treatment will be covered to the same extent as any other illness.

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30. Nutritional/Diet Counseling

We provide Benefits for office visits for nutritional or diet counseling for any diagnosis when received at a facility or from a Physician.

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31. Organ Transplants

Notwithstanding any provision to the contrary, we provide Benefits for all Organ Transplants that are clinically appropriate and Medically Necessary in accordance with our medical policies for transplantation services. **These services must be Prior Authorized by Us.** If it appears that You may need an Organ Transplant, We encourage You to review these Covered Services with Your Physician.

Covered Organ Transplant Services

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:

- Liver
- Cornea
- Kidney
- Pancreas
- Autologous Islet Cell
- Small Bowel
- Heart
- Lung(s)
- Kidney and Pancreas
- Small Bowel and Liver
- Small Bowel and Liver and Pancreas

- Small Bowel and Liver and Stomach
- Small Bowel and Liver and Colon
- Small Bowel and Liver and Pancreas and Stomach
- Small Bowel and Liver and Pancreas and Colon
- Small Bowel and Liver and Stomach and Colon
- Small Bowel and Liver and Pancreas and Stomach and Colon
- Heart and Lung(s)
- Allogenic and Autologous Bone Marrow and Stem Cell Transplants

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. Designated Transplant Providers will be determined by Us and may or may not be located within Our Service Area.

In-Network Providers

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

Out-of-Network Providers

If Organ Transplant services are provided at a provider that is NOT a Designated Transplant Provider, Covered Services will be subject to the following limitations:

a. Benefits will be provided at the Out-of-Network Provider level.

b. The Coinsurance level for Organ Transplant services received from Out-of-Network Providers will always be paid at the Out-of-Network Benefit level.

c. Covered Services do not include Travel Expenses.

Any amount for Covered Services incurred at a non-Designated Transplant Provider will not apply to and will not be limited by Your Out-of-Pocket Maximum.

Physician Services

Physician services received in connection with Organ Transplants will be paid according to the Physician's network status.

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, Covered Services received by the donor and recipient will be provided.

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. Covered Services provided to a donor will be applied towards the recipient's Benefit limits under the Contract.

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. No Covered Services will be provided to a transplant recipient who is not covered under the Contract.

d. If any organ or tissue is sold rather than donated to a recipient covered under the Contract, no Covered Services will be provided for the purchase price of such organ or tissue. 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. Such Benefits do not apply toward and are not limited by Your prescription drug Calendar Year Maximum, if any.

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 including, but not limited to, adherence to medication regimens and abstinence from the use of alcohol and drugs. **All retransplantations must be Prior Authorized by Us.**

Exclusions

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

You have no Benefit for transplant services which are Experimental or Investigative.

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

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32. Osteoporosis

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

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33. Outpatient Prescription

Drugs

Introduction/Prior Authorization:

We provide Benefits for drugs and medicines for use outside a Hospital 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 Us a statement of Medical Necessity. 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.

We permit the early refill of prescription eye drops at a retail pharmacy when 25% or less of the Covered Person's prescription remains or through a mail-order pharmacy when 50% or less of the Covered Person's prescription remains. Earlier refills of prescription eye drops may be permitted if Prior Authorization is obtained.

In the event You are presently taking a prescription drug, We will notify You electronically, or in writing, upon Your request at least 30 days prior to the deletion of such prescription drug.

For Out-of-Network Participating Providers, You must always pay the lower of either: (1) Your applicable Prescription Drug Copayment, specified in the Benefit Schedule; or, (2) the Allowable Charge.

Call customer service for a copy of the Prescription Drug List or visit Our website at www.bluekc.com for the most current information. The list of drugs is subject to change without prior notice based on the recommendations of community Physicians and pharmacists.

Covered Services include diabetic continuous glucose monitors and the associated supplies.

Drug Rebates and Credits:

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

Under the agreement, 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 pay administrative fees to PBM in connection with PBM's services of administering, invoicing, allocating, and/or collecting rebates. Such administrative fees retained by PBM in connection with its rebate program

do not exceed the greater of (i) 4.58% of the Average Wholesale Price, or (ii) 5.5% of the wholesale acquisition cost of the products. AWP does not represent a true wholesale price, but rather is a fluctuating benchmark provided by third party pricing sources. PBM may also receive other service fees from manufacturers as compensation for various services unrelated to rebates or rebate-associated administrative fees.

In addition, We and the PBM also contract with pharmacies to provide prescription products at discounted rates for Our Members. The discounted rates paid by PBM and Us to these pharmacies differ among pharmacies within a network, as well as between networks. For pharmacies that contract with the PBM, We pay a uniform 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. We also guarantee 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 to be 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, 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.

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

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, and that has 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.

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

d. Insulin, syringes, needles, lancets, test strips, oral anti-diabetic agents and glucometers

e. Oral and injectable contraceptive drugs

f. Contraceptive devices and implants which require a Physician's prescription;

g. Smoking cessation agents by prescription only.

h. Diabetic continuous glucose monitors and the associated Supplies.

Covered Services are limited to drugs and medicines that have been approved for use in the United States by the Federal Food and Drug Administration (FDA) 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.

The following Medication-assisted Treatment (MAT) medications will be subject to the Cost-Sharing indicated for Tier 1 Drugs: Buprenorphine tablets; Methadone; Naloxone; Extended-release injectable naltrexone; and Buprenorphine/naloxone combination.

Calendar Year Maximum: Covered Services may be limited to a Calendar Year Maximum for each Covered Person if indicated in the Benefit Schedule. Selected outpatient prescription drugs may not apply to the Calendar Year Maximum. Please refer to the Prescription Drug List for a listing of drugs that do not apply toward the Calendar Year Maximum.

Short-Term Supplies:

In-Network Pharmacies: When a prescription is purchased at an In-Network pharmacy, You must pay the applicable Copayment and/or any applicable Coinsurance for each prescription 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 In-Network pharmacies.

Short-term prescriptions are for up to a 34 day supply. You must pay a Copayment and/or any applicable Coinsurance for each short-term prescription obtained from an In-Network pharmacy if indicated in the Benefit Schedule.

Only one Copayment will apply for a prescription even if the prescription requires dispensing in a combination of different manufactured dosage amounts. If You are required to pay more than one Copayment at the pharmacy, You must submit a claim to Us for reimbursement.

Out-of-Network Pharmacies: When a prescription is purchased at an Out-of-Network pharmacy, You must pay the pharmacy for the cost of the prescription and submit a claim form to Us. You will be reimbursed as follows:

a. The amount You paid the pharmacy for the drug will be reduced by the applicable Copayment and/or any applicable Coinsurance amount.

b. Your Benefits will be 50% of the remaining balance (after the Copayment amount is subtracted).

Long-Term Supplies:

Mail Order Prescription Drugs:

We provide Benefits for 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.

You must pay a Copayment and/or any applicable Coinsurance for each long-term prescription if indicated in the Benefit Schedule.
Call customer service for a copy of the Prescription Drug List or visit our website at www.bluekc.com for the most current information. The list of drugs is subject to change without prior notice based on the recommendations of community Physicians and pharmacists.

Specialty Pharmaceuticals:

We provide Benefits for Specialty Pharmaceuticals when obtained from a designated specialty pharmacy. Refer to the Prescription Drug List for a listing of Specialty Pharmaceuticals and 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. Specialty Pharmaceuticals are limited to a 34 day supply and are subject to the applicable Prescription Drug Copayment, or any applicable Coinsurance if indicated in the Benefit Schedule.

Exclusions:

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

a. New pharmaceutical product/medical therapies for the first 6 months following FDA approval (including new indications) unless a shorter exclusions period is recommended by a Pharmacy and Therapeutics Committee.

b. Appetite suppressants, anorexiants and anti-obesity drugs

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

d. Experimental, Investigative or unproven services and medications; medications used for Experimental indications and/or dosage regimens determined by Us to be Experimental (including, but not limited to those labeled "caution - limited by federal law to investigational use" and drugs found by the Food and Drug Administration to be ineffective)

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

f. Non-prescription/over-the-counter medications for smoking cessation or smoking deterrents (such as but not limited to nicotine replacement or other pharmacological agents used for smoking cessation)

g. Medications and other items available over-the-counter, including any medication that is equivalent to an over-the-counter medication, that do not require a prescription order or refill by federal or state law (whether provided with or without a prescription, except as otherwise specified in the Routine Preventive Care Benefit).

h. Any medication that is equivalent to an over-the-counter medication

i. Medications with no approved FDA indications

j. Immunization agents

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

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

m. Anabolic steroids, anti-wrinkle agents, dietary supplements, Fluoride supplements, growth hormones prescribed for anyone over age 18, except as specifically provided in the Contract, blood or blood plasma, irrigational solutions and supplies

n. Lifestyle enhancing drugs, unless otherwise specified

o. Fertility drugs

p. Impotency medications and devices

q. Drugs and Devices that are intended to induce an abortion

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

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34. Outpatient Surgery We provide Benefits for outpatient surgery provided under the direction of

And Services

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 require Prior Authorization. Please contact customer service or visit http://www.bluekc.com/pa for the current list of outpatient surgeries and services that must be Prior Authorized.

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35. Outpatient Therapy

We provide Benefits for Speech Therapy, Hearing Therapy, Physical Therapy and Occupational Therapy provided on an outpatient basis. For Covered Persons age 65 and older with a history of falls, please see the Routine Preventive Care Benefit for physical or occupational therapy. Physical or occupational therapy provided under Routine Preventive Care will not be subject to the visit limits stated in the Benefit Schedule.

Notwithstanding any provision to the contrary, the Calendar year Maximum as indicated in the Benefit Schedule for Physical Therapy, Occupational Therapy, and Speech and Hearing Therapy shall not apply when such services are provided in connection with a Developmental or Physical Disability diagnosed by a licensed physician or licensed psychologist.

Notwithstanding any provision to the contrary, outpatient therapy services provided for a Mental Illness or Substance Abuse Disorder diagnosis for Physical Therapy, Occupational Therapy, or Speech and Hearing Therapy will not be subject to any Calendar Year visit limits.

Speech Therapy and Hearing Therapy

This is treatment for the loss or impairment of speech or hearing disorders 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 (ASHA), or both, and which 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. Benefits for Speech Therapy are covered only when the Speech Therapy is being requested as the result of illness; injury; permanent, moderate to severe, bilateral sensorineural hearing loss; and /or birth defects such as cleft lip and cleft palate.

Covered Services do not include screening examinations or services arranged by, or received under any health plan offered by, any governmental body or entity including school districts for their students. See the Exclusions section of the Contract for other exclusions which may apply.

While services for the treatment of Autism, Mental Illness or Substance Abuse Disorder or a developmental or physical disability are not subject to or limited by the Calendar Year Maximum, speech and hearing therapy for the treatment of Autism or a developmental or physical disability must be Prior Authorized if the Speech and Hearing Therapy Calendar Year maximum has been met.

Physical Therapy

Physical Therapy Services provided by a Physician, Registered Physical Therapist (R.P.T.) or Licensed Physical Therapist (L.P.T.) are covered when these services are expected to result in significant improvement in a Covered Person's condition.

Please refer to the Chiropractic Services Benefit for information on skeletal manipulations provided by a Chiropractor.

While services for the treatment of Autism, Mental Illness or Substance Abuse Disorder or a developmental or physical disability are not subject to or limited by the Calendar Year Maximum, physical therapy for the treatment of Autism or a developmental or physical disability must be Prior Authorized if the Physical Therapy Calendar Year maximum has been met.

Occupational Therapy

Occupational Therapy Services provided by a Physician or Registered Occupational Therapist (O.T.R.) are covered when these services are expected to result in significant improvement in a Covered Person's condition. Occupational therapy is provided only for purposes of training Covered Persons to perform the activities of daily living. Covered Services do not include occupational therapy provided on a routine basis as part of a standard program for all patients.

While services for the treatment of Autism, Mental Illness or Substance Abuse Disorder or a developmental or physical disability are not subject to or limited by the Calendar Year Maximum, Occupational Therapy for the treatment of Autism or a developmental or physical disability must be Prior Authorized if the Occupational Therapy Calendar Year maximum has been met.

Covered Services for therapy services (including evaluation) may be limited to a Calendar Year Maximum if indicated in the Benefit Schedule. **This limit will not apply to speech, physical or occupational therapy services provided by a Home Health Care Agency pursuant to a home health plan of treatment Prior Authorized by Us.** Such services will be subject to the limit, if any for Home Health Services.

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36. Physician Services

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

a. Office visits.

You must pay the PCP office visit Copayment if indicated in the Benefit Schedule for each visit to a Primary Care Physician. This Copayment applies to the office visit charge only. You must pay the Specialist Office Visit Copayment if indicated in the Benefit Schedule for visits to a Specialist.

Lab services that are drawn and processed in the Physician's office, except for allergy testing, will be covered at 100% of the Allowable Charge after Your office visit Copayment. Other procedures, including allergy testing, x-ray and other radiology procedures, performed in a Physician's office are subject to the In-Network Provider Deductible and Coinsurance level indicated in the Benefit Schedule.

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 and 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 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 if the reason for the visits is 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 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.

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37. 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 lower limbs. Routine foot care means the paring and removal of corns and calluses or trimming of nails.
Bone Surgery	We provide Benefits for bone surgery on the foot.

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38. Pre-Surgery Testing

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

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39. Prosthetic and Orthotic Appliances

We provide Benefits for prosthetics and orthotics other than foot orthotics (including shoes). Please see the Diabetes Benefit in the Contract for a description of how diabetic shoes are covered.

Covered Services are limited to the purchase and fitting of prosthetic and orthotic devices that are Medically Necessary as a result of congenital defects, injury or sickness. 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; or

c. The condition of the device requires repairs and 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) and may include one or more temporary prostheses when Medically Necessary.

Repairs and replacements 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 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. Activities of daily living include bathing, dressing, eating, continence, toileting, transferring and/or ambulating. Charges for deluxe prosthetic or orthotic devices are not covered, except for those prosthetic or orthotic devices that are Medically Necessary for the Covered Person.

See the Reconstructive Surgery/Prosthetic Devices Following a Mastectomy Benefit in the Contract for a description of how prosthetic bras are covered.

Prosthetic and orthotic devices must be Prior Authorized by Us.

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40. 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 Us.

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41. 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: 1) reconstructive surgery on the breast on which the mastectomy was performed; 2) reconstructive surgery on the unaffected breast that is required to produce a symmetrical appearance; and 3) breast prostheses. No time limit will be imposed on a Covered Person for the receipt of a prosthetic device or reconstructive surgery following a mastectomy.

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42. Routine Preventive Care

We provide Benefits for routine preventive care as required by state or federal law. These services are not limited and do not apply to the Calendar Year Maximum indicated in the Benefit Schedule. Covered

Services are limited to the following and may be received from In-Network or Out-of-Network Providers:

a. Prostate exams and prostate specific antigen (PSA) tests, in accordance with the current American Cancer Society guidelines,

b. Pelvic exams and pap smears, including those performed at the direction of a Physician in a mobile facility certified by Centers for Medicare and Medicaid Services (CMS), in accordance with the current American Cancer Society guidelines,

c. Mammograms if ordered by a Physician, including those performed at the direction of a Physician in a mobile facility certified by CMS, in accordance with the current American Cancer Society guidelines,

d. Colorectal cancer exams and laboratory tests, in accordance with the current American Cancer Society guidelines, consisting of a digital rectal exam and the following:

   (1) fecal occult blood test;

   (2) fecal colon cancer tests;

   (3) flexible sigmoidoscopy;

   (4) colonoscopy;

   (5) double contrast barium enema,

e. Newborn hearing screening, audiological assessment and follow-up, and initial amplifications,

f. Childhood immunizations as referenced in the Immunizations for Children Benefit of this Contract,

g. Lead testing, and

h. The related office visit.

We also provide Benefits for routine preventive care received from **In-Network or Out-of-Network Providers** to evaluate and manage a well person's health status according to the Covered Person's age. Covered Services are limited to a Calendar Year Maximum if indicated in the Benefit Schedule.

Covered Services are limited as follows:

a. Physician Examinations

b. Additional examinations, testing and services:

(1) Hemoglobin/Complete Blood Count (CBC)

(2) Metabolic screening

(3) Hearing exams

(4) Immunizations:

Covered Immunizations are limited to the parameters recommended by the Advisory Committee on Immunization Practices and/or adopted by the Center for Disease Control.

i. Catch-up for Hepatitis B

ii. Catch-up for varicella

iii. Catch-up for MMR

iv. Tetanus boosters as necessary, including tetanus, diphtheria and pertussis; diphtheria and tetanus; and tetanus only

v. Pneumococcal vaccine

vi. Influenza virus vaccine

vii. Meningococcal vaccine

viii. Catch-up for Hepatitis A

ix. HPV vaccine

x. Zoster vaccine

xi. COVID-19 Vaccine

xii. Polio vaccine

xiii. Haemophilus Influenza Type b (Hib) vaccine

(5) Urinalysis

(6) Glucose screening

(7) Thyroid stimulating hormone screening

(8) Lipid cholesterol panel

(9) HIV Screening

(10) HPV Testing

(11) Chlamydia Trachomatis Testing

(12) Gonorrhea Testing

(13) Electrocardiogram (EKG)

(14) Chest X-ray

Benefits for Routine Preventive Services are paid the same as any other service unless otherwise indicated in the Benefits Schedule.

In addition, Covered Services do not include any of the following:

- Examinations or testing for or in connection with extracurricular school activities or any recreational activities; exercise programs or equipment such as, but not limited to, bicycles or treadmills;

- Examinations and testing for or in connection with entering school, licensing, employment, insurance, adoption, immigration and naturalization, premarital blood testing;

- For immunizations unless specifically covered under the Contract, including but not limited to, immunizations required only for travel, work-related immunizations, Anthrax vaccine and Lyme Disease vaccine.

Covered Services include preventive care services that are evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Task Force ("USPSTF"). With respect to women, Benefits are provided for evidence-informed preventive care and screenings described in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), as long as they are not otherwise addressed by the recommendations of the USPSTF. This includes bone density screenings for women.

This also includes coverage for contraceptives that require a prescription to obtain and elective sterilization for women. Such contraceptives are limited to Tier 1 (generic) drugs, unless a generic version is not available or Prior Authorization has been obtained for a Tier 2 or Tier 3 drug. If a generic version is available or Prior Authorization is not obtained, Tier 2 or Tier 3 drugs are Covered Services under the Outpatient Prescription Drug Benefit.

Covered Services also include evidence-informed preventive care and screenings for infants, children, and adolescents provided for in the HRSA comprehensive guidelines. Covered Services include immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

The recommended list of required preventive care services described above may change periodically. When the list of recommended preventive care services changes, We will modify Your coverage when required to do so by PPACA. A complete list of the covered preventive care services can be located at www.BlueKC.com or by contacting Us at the telephone number listed on Your ID card.

If the PPACA required preventive care services are received from an In-Network Provider, such services will not be subject to any Copayment, Deductible, and/or Coinsurance in a manner consistent with PPACA. A Copayment, Deductible, and/or Coinsurance will not apply to an office visit billed in conjunction with the preventive care services. However, if the primary reason for Your office visit is not for preventive care services, the office visit will be subject to the applicable Copayment, Deductible, and/or Coinsurance listed in the Benefit Schedule.

If the PPACA required preventive care services are received from an Out-of-Network Provider, such services will be subject to the applicable Copayment, Deductible, and/or Coinsurance as indicated in the Benefit Schedule.

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43. Skilled Nursing Facility

We provide Benefits for services and supplies furnished by a Skilled Nursing Facility for the treatment of a medical or surgical condition when authorized by Your Physician. Covered Services may be limited to a Calendar Year Maximum if indicated in the Benefit Schedule. These services are limited to those You are eligible to receive as a Hospital bed patient and that would otherwise require Confinement in a Hospital.

These Benefits are not available unless Prior Authorized by Us. No Benefits are available under this provision for custodial care or for the care of a nervous or mental condition, drug addiction, alcoholism or Substance Abuse.

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44. Urgent Care Center

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

You must pay the Urgent Care Copayment if indicated in the Benefit Schedule for each visit to an Urgent Care Center. This Copayment applies to the urgent care visit charge only. Lab Services that are drawn and processed in the urgent care center, except for allergy testing, will be covered at 100% of the Allowable Charge after Your Urgent Care Copayment. Other procedures, including allergy testing, x-ray and other radiology procedures, performed in an Urgent Care Center are subject to the In-Network Provider Deductible and Coinsurance level indicated in the Benefit Schedule.

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45. Vision Care

We provide Benefits for vision care provided by an optometrist or Physician. Covered Services are limited to one complete eye exam per Calendar Year, including refraction, which is used to determine if You need prescription lenses. You must pay a vision care In-Network Provider Copayment for these services if indicated in the Benefit Schedule. All services received from Out-of-Network Providers are subject to the Deductible and Coinsurance requirements of the Contract.

We provide Benefits for either the first pair of eyeglasses or non-disposable contact lenses or refractive keratoplasty, only following cataract surgery, and for eye exams including refraction, needed as a result of a covered medical illness or Accidental Injury.

Benefits are limited to the amount available for a basic (standard) pair of eyeglasses which 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.

We also provide benefits for Medically Necessary orthoptic training for convergence insufficiency for children under the age of 18. This Benefit is subject to a Lifetime Maximum of 12 visits.

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46. Weight Loss Services

We provide Benefits for office visits and labs associated with the treatment of obesity and will be subject to the applicable Cost-Sharing as indicated in the Benefit Schedule.

SECTION D. EXCLUSIONS AND LIMITATIONS

Covered Services do not include, and no Benefits will be provided for any of the following services, supplies, equipment or care; or for any complications, related to, or received in connection with, such services, supplies, equipment or care that are:

1. For services or supplies received if there is no legal obligation for payment or for which no charge had been made; or 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 Deductible, Coinsurance or Copayment amounts.

2. Subject to Our Prior Authorization requirement and such approval was not obtained.

3. For injuries or illnesses related to Your job to the extent You are covered or are required to be covered by a state or Federal workers' compensation law for work-related injuries 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.

4. Not Medically Necessary.

5. Not specifically covered under the Contract.

6. Experimental or Investigative as determined by Us except as specifically provided under Clinical Trials and Outpatient Prescription Drugs for off-label use of drugs.

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

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

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

10. For music therapy, remedial reading, recreational therapy, and other forms of education or special education except as specified under the Diabetes benefit.

11. For marital counseling or counseling to assist in achieving more effective intra or interpersonal development except as specifically provided under the Autism Spectrum Disorder Benefit; dietary counseling, except as specifically provided; decisional; social; or educational development except as specifically provided under the Autism Spectrum Disorder Benefit; vocational development; or work hardening programs.

12. For cosmetic purposes, except as specifically provided under the Contract. Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Cosmetic rhinoplasty whether an independent procedure or done in conjunction with any other surgical procedure. Cosmetic is defined as surgery, procedure or therapy intended to: 1) improve or alter an individual's appearance, self-esteem, where functional impairment is not present; or 2) treat an individual's psychological symptoms or psychosocial complaint related to the individual's appearance.

13. For any equipment or supplies that condition the air, including environmental evaluations; heating pads; cooling pads (circulating or non-circulating), including hot water bottles; personal care items; wigs and their care. For items for comfort and convenience, such as spas; whirlpools; Jacuzzis; and any other primarily nonmedical equipment. For stethoscopes; blood pressure devices; and Durable Medical Equipment that would normally be provided by a Skilled Nursing Facility. Repairs and replacement of prosthetic and orthotic devices are Covered Services only when Medically Necessary and necessitated by normal anatomical changes or when necessitated as indicated in the Covered Services section.

14. For hypnotism, hypnotic anesthesia, acupuncture, acupressure, biofeedback (including neurofeedback), rolfing, massage therapy, and/or any services provided by a massage therapist, aromatherapy, wilderness, adventure, camping, outdoor, other similar programs and other forms of alternative treatment, regardless of diagnosis.

15. For genetic testing unless specifically covered under the Contract; or examinations or treatment ordered by a court.

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

17. Provided by You, Your Immediate Family Members or members of Your immediate household.

18. For vision services and hearing care services and cochlear implants, except as otherwise specifically provided in the Contract, including but not limited to hearing aids, pleoptic training, and orthoptic training eyeglasses, contact lenses, and the examination for fitting of these items.

19. For over-the-counter hearing aids that can be purchased without a physician’s order.

20. Unless specifically covered under the Contract, for all dental services, complications of dental treatment; temporomandibular joint disorder; and orthognathic surgery. Injections for treatment of pain that are in close proximity to the teeth or jaw and due to a dental cause. For orthodontic treatment and surgical correction of a malocclusion. For dental splints, dental prostheses, extractions or any treatment on or to the teeth, gums or jaws and 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.

21. For drugs and medicines that do not require a prescription for their use, except as otherwise specified in the Routine Preventive Care Benefit, or prescription drugs purchased from a Physician for self-administration outside a Hospital.

22. 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.

23. For staff consultations required by Hospital rules and regulations.

24. For the treatment of obesity or morbid obesity, except as otherwise specified in the Contract. For services including but not limited to Mason Shunt, banding, gastroplasty, intestinal bypass, gastric balloons, stomach stapling, jejunal bypass, wiring of the jaw, skin reduction or revision following weight loss surgery regardless of medical necessity. For related office visits, laboratory services, prescription drugs, vitamins, medical weight reduction programs, nutrients, nutritional/diet counseling (except as specifically provided) and health services of a similar nature whether or not it is part of a treatment plan for another illness, except as specified in the Contract. This exclusion also applies to any complications arising from any of the above, except for Emergency Medical Conditions.

25. For surgical procedures on the cornea including 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.

26. For hairplasty or hair removal, regardless of reason or diagnosis except as specifically provided for under the Contract or in connection with gender affirming care.

27. For, or related to the surgical insertion of a penile prosthesis including the cost of the prosthesis, unless required for approved gender reassignment surgery.

28. For orthotics unless otherwise specified.

29. For foot orthotics, including shoes except as specifically covered under the Contract.

30. For support/surgical stocking (for the lower extremities), including but not limited to custom made stockings.

31. For corrective shoes unless permanently attached to a brace.

32. For routine foot care, unless specifically covered under the Contract.

33. For, or related to an Organ Transplant not specifically covered in the Contract.

34. For lodging or travel to and from a health professional or health facility except as specifically provided for under the contract.

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

36. Provided for an Emergency Medical Condition Admission in excess of the first 48 hours if We are not notified within 48 hours of the Admission, or as soon as reasonably possible.

37. Health services and associated expenses for megavitamin therapy; psychosurgery; nutritional-based therapy for alcoholism, chemical dependency, or other medical conditions; services and supplies for smoking cessation programs and treatment of nicotine addiction, unless otherwise stated in the Outpatient Prescription Drug benefit.

38. Health services which are related to complications arising from treatments or services otherwise excluded under the Contract except for complications related to maternity care as indicated in the Contract.

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

    For any services required by a diversion agreement or by order of a court to attend an alcohol or drug safety action program, or for evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, child custody, or child visitation proceedings.

40. For personal care and convenience items.

41. Occupational therapy provided on a routine basis as part of a standard program for all patients.

42. Received for, or in preparation for, any treatment (including drugs) for infertility by any name called and any related complications. '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, egg collection and/or preservation, 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, surrogate parenting (which includes donating ovum or ova, or carrying the fetus to term for another woman), not Medically Necessary amniocentesis, and any other experimental fertilization procedure or fertility drugs.

43. For health services and associated expenses for elective pregnancy termination, except when the life of the mother would be endangered if the fetus was carried to term.

44. Received for or in preparation for any diagnosis or treatment (including drugs) of impotency and any related complications.

45. For growth hormone therapy for the diagnosis of idiopathic or genetic short stature, intrauterine growth retardation or small for gestational age. Testing for growth hormone deficiencies in Covered Persons ages 19 or older, except as specifically provided under the Contract.

46. For cranial (head) remodeling devices, including but not limited to Dynamic Orthotic Cranioplasty ("DOC Bands") except as otherwise specifically provided in the Contract.

47. Screening examinations or services available, arranged by, or received from any governmental body or entity, including school districts.

48. For speech therapy for vocal cord training/retraining due to vocational strain and/or weak cords, conceptual handicap, and psychosocial speech.

49. Except as specifically provided under the Contract, Physician Services charges incurred as a result of virtual office visits on the Internet, including those for prescription drugs. A virtual office visit on the Internet occurs when a Covered Person was not physically seen or physically examined.

50. For services or supplies received from any 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.

51. For sales tax.

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

53. For extracorporeal shock wave therapy (TENS) due to musculoskeletal pain or musculoskeletal conditions and for electrical stimulation, except as specifically provided in the Contract.

54. For nutritional assessment testing and saliva hormone testing.

55. For Applied Behavior Analysis services received as part of any Part C early intervention program or provided by any school district.

56. For measurement of exhaled nitric oxide or exhaled breath condensate in the diagnosis and management of asthma and other respiratory diseases.

57. For mental illness and substance abuse services 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.

58. Screening examinations or services available, arranged by, or received from any governmental body or entity, including school districts.

59. For certain infusion therapy/injectables unless obtained from a designated specialty pharmacy or designated home infusion vendor.
60. New pharmaceutical product/medical therapies drugs for the first 6 months following FDA approval (including new indications) unless a shorter exclusions period is recommended by a Pharmacy and Therapeutics Committee.

61. 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.

62. 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.

Limitations: If an individual is enrolled in Medicare, Benefits for Covered Services will be coordinated with any benefits paid by Medicare. This limitation will not apply if the Employer, by law, is not permitted to allow the Contract to be secondary to Medicare.

SECTION E. HOW TO FILE A CLAIM

1. Claim Procedures

We are responsible for evaluating all Claims under the Contract. We may secure independent medical or other advice and require such other evidence, as We deem necessary to decide Your Claim.

If We deny, in whole or in part, Your Pre-Service Claim or Post-Service Claim, You will be furnished with a written notice of the denial setting forth:

a. The reason or reasons for the denial,

b. Reference to the specific Contract provision on which the denial is based,

c. A description of any additional material or information necessary for You to complete Your Claim and an explanation of why such material or information is necessary, and

d. Appropriate information as to the steps to be taken if You wish to appeal Our decision, including Your right to file suit under the Employee Retirement Income Security Act "ERISA" (if Your plan is subject to ERISA) with respect to any Claim denial after appeal of Your Claim.

2. Post-Service Claims

a. Hospital and other Facility Services

(1) For care received *inside* Our Service Area.

(a) In-Network or Participating Providers will file Your Post-Service 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, Deductible, Copayment or Coinsurance amounts.

(b) If You receive care from an Out-of-Network Provider that is Non-Participating, it will be Your responsibility to make payment arrangements with the facility. Some Out-of-Network Providers that are Non-Participating will submit Your Post-Service Claim for You. If not, You can obtain a Post-Service Claim form from Our Customer Service Department. The form will give You instructions for filing the Post-Service Claim. If such forms are not furnished to You within 15 days after Your requesting the forms, You will have complied with the requirements of this Contract as to proof of loss upon submitting, within the required time period herein mentioned for filing Claims, such other written proof covering the occurrence, the character, and the extent of the loss for which Claim is made.

(2) For care received *outside* Our Service Area.

Post-Service Claims should be filed directly with Us. If a Hospital or other facility will not file Your Post-Service Claim for You, You can obtain a Post-Service Claim form from Our Customer Service Department. The form will give You instructions for filing the Post-Service Claim. If such forms are not furnished to You within 15 days after Your requesting the forms, You will have complied with the requirements of this Contract as to proof of loss upon submitting, within the required time period herein mentioned for filing Claims, such other written proof covering the occurrence, the character, and the extent of the loss for which Claim is made.

b. Physician Services

(1) For care received *inside* Our Service Area.

(a) In-Network or Participating Providers will file Your Post-Service 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, Deductible, Copayment or Coinsurance amounts for which You are responsible.

(b) Out-of-Network Physicians who are Non-Participating will sometimes file Your Post-Service Claim for You. If an Out-of-Network Physician who is Non-Participating declines to file Your Post-Service Claim for You, You can obtain a Post-Service Claim form from Our Customer Service Department. The form will give You instructions for filing the Post-Service Claim. If such forms are not furnished to You within 15 days after Your requesting the forms, You will have complied with the requirements of this Contract as to proof of loss upon submitting, within the required time period herein mentioned for filing Claims, such other written proof covering the occurrence, the character, and the extent of the loss for which Claim is made.

(2) For care received *outside* Our Service Area.

If You ask, a Physician outside Our Service Area will frequently file Your Post-Service Claim for You. Post-Service Claims must be filed with Us. If the Physician declines to file Your Post-Service Claim for You, You can obtain a Post-Service Claim form from Our Customer Service Department. The form will give You instructions for filing the Post-Service Claim. If such forms are not furnished to You within 15 days after Your requesting the forms, You will have complied with the requirements of this Contract as to proof of loss upon submitting, within the required time period herein mentioned for filing Claims, such other written proof covering the occurrence, the character, and the extent of the loss for which Claim is made.

c. Services Received From Providers Other Than Hospitals, Physicians and Facilities

It is necessary for You to file a completed Post-Service Claim form with Us for these services. Contact Our Customer Service Department for the proper Post-Service Claim forms. The form will give You instructions for filing the Post-Service Claim. If such forms are not furnished to You within 15 days after Your requesting the forms, You will have complied with the requirements of this Contract as to proof of loss upon submitting, within the required time period herein mentioned for filing Claims, such other written proof covering the occurrence, the character, and the extent of the loss for which Claim is made. The presentation of a prescription at an In-Network Pharmacy is not a Claim. If You disagree with the amount of Copayment, Coinsurance or whether the prescription would be covered under the Contract, You must file a completed Post-Service Claim form with Us.

d. Time Limits for Filing Post-Service Claims

We must receive proof of a Post-Service Claim for reimbursement for Covered Services no later than 365 days after the end of the Calendar Year in which the service was received, except if it was not reasonably

possible to give notice of proof within this time. We will deny any Post-Service Claim not received within this time limit.

e. Processing of the Filed Post-Service Claim

We will process Your Post-Service Claim as soon as reasonably possible but in no more than thirty (30) calendar days after receipt. We will notify You within thirty (30) calendar days after receipt if additional information is necessary to process the Post-Service Claim. You have forty-five (45) calendar days from the date You receive Our request to provide Us with the additional information. Upon receipt of the additional information, We will process Your Post-Service Claim within fifteen (15) calendar days. If You fail to provide Us with the additional information within forty-five (45) calendar days of receipt of Our request, We will deny Your Post-Service Claim.

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3. Pre-Service Claims

Requests for Pre-Service Claims must be made in accordance with the Utilization Review Section. The presentation of a prescription at a Pharmacy is not a Claim. If You disagree with whether the prescription would be covered under the Contract, You must request Prior Authorization in accordance with the Utilization Review Section.

SECTION F. COORDINATION OF BENEFITS (COB)

1. The Purpose of COB

Many people have group medical coverage through more than one Plan at the same time. Because these people usually have their claim for medical services sent to every Plan that covers them, most Plans include 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. This helps to keep down the increasing costs of health care coverage.

2. Definitions Applicable to this Section

a. *Allowable Expense* means a medical expense or service that is covered at least 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 outpatient prescription drug coverage. 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, and In-Network provider arrangements. When the HMO Plan is primary, this provision will not be used by a secondary Plan to refuse to pay benefits because an HMO member has elected to have medical services provided by a Non-HMO provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services.

If a Covered Person is covered under two 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 then any amount in excess of the lowest fee is not an Allowable Expense.

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

(1) Group or blanket coverage, except for student accident coverage;

(2) Group practice, individual practice, HMOs and other prepayment coverage on a group basis;

(3) Prepayment coverage under labor-management trustee plans, employer organization Plans, union welfare Plans, self-funded Plans, or employee benefit organization Plans;

(4) Any "no fault" contracts and traditional automobile "fault" contracts sold on a group basis, by whatever name called. This Contract is always secondary to benefits provided under any mandatory No-Fault Auto Insurance Act in the state in which the Covered Person resides; and

(5) Group or group-type Plans designed to pay a fixed dollar benefit per day while the individual is confined in a Hospital, provided however, COB will be applied only to the portion of the daily benefit which exceeds $200 per day.

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.

c. *Claim Determination Period* means a period of not less than 12 consecutive months, over which Allowable Expenses shall be compared with total benefits payable in the absence of COB, to determine whether over insurance exists and how much each Plan will pay or provide.

The Claim Determination Period is usually a calendar year, but a Plan may use some other period of time that fits the coverage of the group contract. A person is covered by a Plan during a portion of a Claim Determination Period if that person's coverage starts or ends during the Claim Determination Period.

As each claim is submitted, each Plan determines its liability and pays or provides benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period. That determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

3. Order of Benefit Determination Rules

Plans use COB to determine which Plan should pay first (primary Plan) for the medical service. Benefits payable under another Plan include the benefits that would have been payable if You had filed a claim for them.

The order of benefit determination is based on the first of the following rules which applies:

a. Employee/Dependent:

The benefits of a Plan which covers the person as an Employee, will be determined before the benefits of a Plan which covers such person as a Dependent.

b. Dependent Child/Parents <u>not</u> 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, and the rule set forth in the Plan which does not have the provisions of this paragraph b. shall determine the order of benefits.

c. 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:

(1) First, the Plan of the parent with custody of the child;

(2) Then, the Plan of the spouse of the parent with custody of the child; and

(3) Finally, the Plan of the parent not having custody of the child.

Notwithstanding (1), (2) and (3) above, if there is a court decree which would otherwise establish financial responsibility for the medical expenses with respect to the child, 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.

d. 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 b. above for a Dependent child of parents who are not separated or divorced.

e. **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.

f. **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:

(1) First, the Plan covering the person as an Employee (or as that person's Dependent); and

(2) 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.

g. **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 date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

To determine the length of time a member has been covered under the plan, two successive plans will be treated as one if the Covered Person was eligible under the second plan within twenty-four hours after coverage under the first plan ended.

h. **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 and this Coordination of Benefits section shall not apply.

i. **Plans without COB Provisions:**

If a Plan does not have a COB provision, it will always be considered as the primary Plan.

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4. 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 during a Claim Determination Period are not more than 100% of total Allowable Expenses. The difference between the benefit payments that this Plan would have paid had it been the primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by this Plan to pay any Allowable Expenses, not otherwise paid during the Claim Determination Period. As each claim is submitted, this Plan will:

(1) Determine its obligation to pay or provide benefits under its Contract;

(2) Determine whether a benefit reserve has been recorded for the Covered Person; and

(3) Determine whether there are any unpaid Allowable Expenses during that Claim Determination Period.

If there is a benefit reserve, the secondary Plan will use the Covered Person's benefit reserve to pay up to 100% of the total Allowable Expenses incurred during the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero. A new benefit reserve must be created for each new Claim Determination Period.

5. 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 needed by Us to coordinate those Benefits.

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6. 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 G. PREMIUM PAYMENT, GRACE PERIOD AND CHANGES

1. Premium Payment

Initial Premiums are due and payable by Your Employer on or before the Contract effective date. Subsequent Premiums are due and payable by Your Employer on or before the monthly Due Date.

2. Grace Period

The Employer shall have a grace period of 31 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 on the last day of the period for which Premiums have been paid if the grace period expires and any Premium remains unpaid.

3. Reinstatement

If coverage under the Contract is terminated for nonpayment of Premiums, We have the right to decide whether or not to reinstate the Contract. Such decision will occur only after resubmission of a new application and payment of a reinstatement fee.

4. Changes in Premiums

After the initial term of the Contract, We reserve the right to change Premiums upon 31 days prior written notice to the Employer. Notwithstanding the foregoing, We may change the Premiums at any time upon 31 days prior written notice whenever the terms of the Contract are changed.

If We find that Your Employer falls into a different risk classification due to a misrepresentation made by You in Your application, We may change the amount of Your Employer's Premiums. If Your Employer's Premiums would have been higher had We known the correct information, Your Employer will owe Blue KC the difference between what Your Employer Premiums would have been and the Premiums Your Employer was charged. This amount will be calculated from the effective date of Your Employer's Contract.

If under the Contract, Your Premiums are age rated, We will automatically change the amount of Your Premiums on the first day of the month in which the birthday occurs which places the Covered Person into the next age classification upon which Premiums are based.

If under the Contract, Your Premiums are age rated and Your age has been misstated, We will adjust the Premium for Your coverage under the Contract in a subsequent statement sent to Your Employer.

We may change the amount of Your Premiums on any monthly Due Date if the Premiums of Your entire age classification are changed and We give the Employer 31 days prior written notice.

SECTION H. TERMINATION AND EXTENSION OF COVERAGE

1. Terminating a Covered Person's Coverage

We may terminate a Covered Person's coverage on the earliest of the dates specified below.

a. On the date the Contract is terminated. The Employer is responsible for notifying You of the termination of the Contract. Failure of the Employer to notify the Employee of termination will not continue coverage beyond the effective date of termination of this Contract;

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

c. On the last day of the month following the date the Employee ceases to meet the eligibility requirements set forth in the "Employee Eligibility" provision of the "Eligibility, Enrollment and Effective Date" section of the Contract;

d. On the last day of the month that 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;

e. On the date a Covered Person becomes covered under another health plan sponsored by the Employer;

f. 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 Employee application;

g. On the date a Covered Person allows an unauthorized person to use the Covered Person's identification card, or files a fraudulent claim; or

h. On the date a Covered Person chooses Medicare as primary coverage, and the Employer, by law, is not permitted to allow the Contract to be secondary to Medicare.

When a Covered Person's coverage terminates, he may have continuation of coverage or conversion rights. See "Continuation and Conversion" section of the Contract.

2. Extension of Coverage If a Covered Person is Totally Disabled on the date the Contract is terminated, the Covered Person's coverage will be extended without payment of Premium. Coverage under this extension will only be for Covered Services directly related to the Total Disability, including related complications. The Extension does not apply to maternity or dental services.

The extended coverage will terminate on the earlier of the following:

a. The end of a 12 month period following the date the Contract is terminated; or

b. The date the Covered Person is no longer considered Totally Disabled.

SECTION I. CONTINUATION AND CONVERSION

1. Continuation of Coverage

Certain persons whose group health coverage would otherwise be terminated as a result of a qualifying event may be allowed to continue that coverage for a limited time, in accordance with state or federal COBRA laws.

The federal COBRA law applies to most Employers with 20 or more Employees. (It does not apply to Employers with fewer than 20 Employees, plans for federal Employees or church plans.) If an Employer is subject to the federal law, the federal law takes precedence over the state law. If an Employer is not subject to the federal law, state law applies. In general, if Your Employer has fewer than 20 Employees, then state law applies. (State law also applies to church groups, regardless of size.) **Contact Your Employer to determine whether state or federal continuation is available.**

2. Continuation of Coverage under Federal Law ("COBRA") or under State Law

For Employers subject to COBRA, the continuation provisions of the Contract will conform with the minimum requirements of COBRA law, provided that the Employer and Covered Persons comply with COBRA requirements. For Employers not subject to COBRA, the continuation provisions of the Contract will conform with the minimum requirements of state law, provided that the Employer and Covered Persons comply with the requirements below. Coverage under the Contract will not be continued if the Employer or the Covered Person(s) do not comply with COBRA requirements, if applicable or the requirements below.

a. Qualifying Events

If coverage is terminated for an Employee or a Dependent as a result of one of the following "qualifying events," any of those individuals may elect to continue their group health coverage regardless of whether the Employee or Dependent is currently covered by another group health plan or entitled to Medicare. The qualifying events are:

1. Termination of employment (other than for gross misconduct);
2. Reduction in work hours;
3. Death of the Employee;
4. The Employee becomes entitled (eligible and enrolled) to Medicare Benefits;
5. Divorce or legal separation;

6. A Dependent child ceases to qualify as a Dependent under the terms of the Plan; or

7. The Employer files for Chapter 11 bankruptcy, but only for a retired Employee and his covered Dependents.

8. The contract terminates and is not replaced by similar group coverage within 31 days; provided the Employee or Dependent was continuously covered under the Contract (or any similar group contract it replaced) for at least 3 months immediately prior to termination.

The Employee, or the covered Dependents must notify the Employer (or their designated Plan Administrator) within 60 days of a divorce, legal separation, or a child's ceasing to be a Dependent child under the terms of the Contract or within 60 days of the date coverage under the Contract terminates as a result of one of these events, if later. If such timely notice is not received, the provisions of this section will not apply with respect to that event. Consult the Employer for information on the procedures to comply with these notice requirements.

b. Qualified Beneficiary

A qualified beneficiary is any individual who, on the day before a qualifying event, is covered under the Contract or any child who is born to or placed for adoption with a covered Employee during a period of continuation coverage. If a child is born to or placed for adoption with the Employee during the continuation period, the child is considered a qualified beneficiary only when the initial qualifying event is termination or reduction in hours of the covered Employee's employment. The Employee has the right to elect continuation coverage for the child, provided the child satisfies the plan eligibility requirements. The Employee must notify the Employer or plan administrator within 30 days of the birth or placement for adoption. A qualified beneficiary does not include an individual who marries any qualified beneficiary on or after the date of the qualifying event and a newborn or adopted child (other than one born to or placed for adoption with a covered Employee).

c. Maximum Coverage Period

If coverage is terminated because of the Employee's termination of employment or reduction in work hours, the qualified beneficiary may continue coverage for up to 18 months after that qualifying event. However, if the Employee became entitled to Medicare within 18 months before the termination or reduction of hours, the qualified beneficiaries (other than the Employee) may continue coverage up to 36 months after the date of Medicare entitlement.

If coverage is terminated as a result of the Employee's death, Medicare entitlement, divorce or legal separation, or a child ceasing to be a Dependent child under the Contract, qualified beneficiaries may continue coverage for up to 36 months after that qualifying event.

If coverage is terminated because the Contract was terminated and not replaced by similar group coverage within 31 days and the Employee or Dependent was continuously covered under the Contract for at least 3 months immediately prior to such termination, the qualified beneficiary may continue coverage for up to 18 months after that qualifying event.

d. Second Qualifying Event

If continuation coverage is elected following the Employee's termination of employment or reduction in work hours, and then another qualifying event occurs during that continuation period, covered Dependents (including Dependents born or adopted within the original 18-month continuation period) may continue their coverage for up to 36 months, rather than only 18 months. Such 36-month period will be measured from the date of the termination of employment or reduction in work hours, rather than from the date of the second event. Only an event giving rise to a 36-month maximum coverage period can be considered a second qualifying event. Therefore, termination of employment that follows a reduction in hours of employment is <u>not</u> considered a multiple qualifying event.

In addition, if during the continuation period the former Employee becomes entitled to Medicare Benefits and such event would not have resulted in coverage termination, such second event shall not be considered a second qualifying event.

Covered Dependents must notify the Employer (or its designated Plan Administrator) within 60 days of any second qualifying event. If such timely notice is not received, the provisions of this section will not apply with respect to that event. Consult the Employer for information on the procedures to comply with these notice requirements.

e. Social Security Disability

A special rule applies if a qualified beneficiary is found to have been disabled during the first 60 days of continuation coverage. All qualified beneficiaries may be eligible to continue coverage for up to 29 months. The determination of disability must be made by the Social Security Administration, and must be issued within the disabled individual's initial 18 months of continuation coverage. That individual must then notify the Employer of the Social Security Administration's disability determination as follows: (1) within 60 days of the later of the date after the determination is issued, the date of the qualifying event, or the date

coverage under the Contract is terminated as a result of termination of employment or a reduction in hours; and (2) within the individual's first 18 months of continuation coverage. This extension applies for all qualified beneficiaries, including a qualified beneficiary born or adopted during the continuation period, if notice is given within 60 days of such birth or adoption.

If the Social Security Administration later determines that an individual is no longer disabled, that individual must notify the Employer within 30 days after the date of that second determination. The individual and other qualified beneficiaries' right to the 11-month extension of continuation coverage will terminate as of the first day of the month that begins more than 30 days after the second determination is issued. However, if another qualifying event occurs giving rise to 36 months of continuation coverage during the 11 month disability extension, the qualified beneficiaries receive the full 36 months of coverage beginning from the initial date of continuation coverage. This extension cannot be shortened if disability ceases.

f. Electing Continuation Coverage

An individual who wishes to continue coverage must complete a continuation election form that is postmarked within 60 days after the person's coverage would terminate due to the Qualifying Event; or, if subject to Federal COBRA, 60 days after the Employer or plan administrator sends notice of the continuation right; whichever is later. An individual must then pay the initial Premium within 45 days after electing continuation. To continue state coverage (not Federal COBRA), obtain a continuation election form from Your Employer.

For Federal COBRA, if an Employee or Covered Dependent contacts Us regarding a qualifying event, such contact does not constitute notice to the Employer or its designated Plan Administrator, and We will not be obligated to provide continuation of coverage to a Covered Person as a result of any such contact from the Employee or Covered Dependent.

For Federal COBRA, in no event shall We be obligated to provide continuation of coverage to a Covered Person if the Employer or its designated plan administrator fails to notify the Covered Person in a timely manner of his right to continuation of coverage; or, if they fail to notify Us in a timely manner, of the Covered Person's election of continuation of coverage.

g. Effective Date of Continuation Coverage

Upon receipt of both the first month's Premium and the election form, Continuation Coverage will be effective on the date Coverage would have otherwise terminated.

h. Coverage Changes

If the terms of the Contract or Covered Services are changed, the continuation coverage is also subject to the amended terms of the Contract or Covered Services.

The qualified beneficiary has the same right to change benefit programs as the active Employees. If the active Employee is allowed to change to another benefit program during the Employer Annual Enrollment Period or under a Special Enrollment Period under the Health Insurance Portability and Accountability Act (HIPAA), a qualified beneficiary is allowed the same opportunity.

If the Employer changes insurance carriers during the period of continuation, the continuation covered individual for that Employer will be terminated as to the coverage under this Contract and become the responsibility of the new insurance carrier or health plan.

i. Termination of Continuation Coverage

Continuation coverage will end on the earliest of the following dates:

1. 18 months from the date continuation began if coverage ended because of the Employee's termination of employment or reduction in hours worked or 36 months for qualified beneficiaries (other than the Employee) after the date of Medicare entitlement if the Employee became entitled to Medicare within 18 months before the termination or reduction of hours;

2. 29 months from the date continuation began for a qualified beneficiary who is totally disabled in accordance with the Social Security Disability provisions above;

3. 36 months from the date continuation began if coverage ended because of the Employee's death, divorce, legal separation or a child's loss of Dependent status;

4. The date coverage terminates under the Contract for failure to make timely payment of the required Premium; if the individual fails to make the required Premium payment within the grace period (payment of Premium must be postmarked no later than last day of the grace period);

5. The date the individual first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise). However, an individual who becomes covered under a group health plan which has a preexisting condition limit must be allowed to continue coverage for the length of a preexisting

condition or to the continuation maximum coverage period, if less. Continuation coverage may be terminated if the individual becomes covered under a group health plan with a preexisting condition limit, if the preexisting condition limit does not apply to (or is satisfied by) the individual by reason of HIPAA, ERISA or the Public Health Services Act;

6. The date the Covered Person becomes entitled to Medicare Benefits, if after the date of continuation coverage election;

7. For retirees, in the case of a qualifying event that is the Chapter 11 bankruptcy of an Employer, the earlier of the date of the qualified beneficiary's death or the date that is 36-months after the death of the retired covered Employee.

8. The date any Covered Person allows someone other than an eligible Dependent to use his or her identification card, or submits a fraudulent claim; or

9. The date the Contract terminates.

j. Extension of COBRA Continuation for Spouses

Divorced or surviving spouses (of a deceased Employee), who are age 55 or older at the time their Federal COBRA continuation coverage terminates, may be eligible to continue their group health coverage until age 65. Persons entitled to extend their continuation coverage are limited to:

1. A surviving spouse (and Dependent children) whose coverage would otherwise terminate due to the death of the Employee, if the surviving spouse is 55 or older at the time the surviving spouse's federal COBRA continuation coverage expires. Within thirty days of the death of an Employee whose surviving spouse is eligible for such continuation of coverage, or prior to the expiration of a thirty-six month federal COBRA continuation period covering such surviving spouse (and Dependent children), if such spouse has elected and maintained such COBRA coverage, the Employer shall provide Us written notice of the death and of the mailing address of the surviving spouse; or,

2. A divorced or legally separated spouse (and Dependent children) whose coverage would otherwise terminate due to the divorce or legal separation, if the spouse is 55 or older at the time their federal COBRA continuation coverage expires. Within sixty days of legal separation or the entry of a decree of dissolution of marriage, or prior to the expiration of a thirty-six month federal COBRA continuation period covering a legally

separated or divorced spouse (and Dependent children), if such spouse has elected and maintained such COBRA coverage, a legally separated or divorced spouse eligible for such continuation of coverage shall provide Us written notice of the legal separation or dissolution. The notice shall include the mailing address of the legally separated or divorced spouse.

This extension of continuation coverage will terminate upon the earliest of the following dates:

1. The date coverage terminates under the Contract for failure to make timely payment of the required Premium; if the individual fails to make payment on any Due Date;

2. The date the Contract terminates except if a different group policy is made available to all other Covered Persons. In this instance, the legally separated, divorced or surviving spouse will be eligible for continuation of coverage under such different group policy as if coverage under the Contract had not been terminated.

3. The date the person becomes covered under any other group health plan; or

4. The spouse's 65th birthday

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3. Continuation Coverage under Uniformed Services Employment and Reemployment Act of 1994 (USERRA)

The following USERRA continuation provisions apply to all Employers regardless of size. The USERRA provisions of the Contract conform with the minimum requirements of the USERRA law, provided that the Employer and Covered Person(s) comply with the USERRA requirements. Coverage under this Contract will not be continued if the Employer or the Covered Person(s) do not comply with the USERRA requirements.

Apart from other rights to continued coverage provided under the Contract, if coverage would terminate for an Employee due to a leave for uniformed service, the Employee and his covered Dependents may be entitled to up to 24 months of continuation of such coverage, and certain reinstatement rights following a period of uniformed service.

a. Eligibility

An Employee who is absent from employment from his Employer due to uniformed service may continue his Employee and Dependent coverage beginning on the date on which the Employee is first absent from employment by reason of uniformed service.

Any election made by an Employee applies to the Employee and the Employee's Dependents who otherwise would lose coverage under the

Contract. No separate election may be made by any Dependent. The coverage that Employees are allowed to continue on behalf of themselves and their Dependents will be the same as that provided to Employees and their Dependents under the Contract. Except in connection with circumstances that permit other Employees to make changes, an Employee may continue only the type of coverage that he or she was receiving on the day before the Employee first was absent from employment.

b. Electing USERRA Continuation Coverage

An Employee who wishes to continue coverage must complete an election form that is postmarked within 60 days after the Employee's coverage would terminate due to a leave for qualified uniformed service, or 60 days after the Employer or plan administrator sends notice of the USERRA continuation rights; whichever is later. An individual must then pay the initial Premium within 45 days after electing USERRA continuation coverage.

In no event shall We be obligated to provide USERRA continuation of coverage to a Covered Person if the Employer or its designated plan administrator fails to notify the Covered Person in a timely manner of his right to USERRA continuation coverage; or, if they fail to notify Us in a timely manner, of the Covered Person's election of USERRA continuation coverage.

c. Coverage Changes

If the terms of the Contract are changed, the USERRA coverage is also subject to the amended terms of the Contract.

If the Employer changes insurance carriers during the period of USERRA continuation, the USERRA covered individuals for that Employer will be terminated as to the coverage under this Contract and become the responsibility of the new insurance carrier or health plan.

d. Premium Payment

The premium charged for USERRA continuation coverage will be the same for all similarly situated Employees electing coverage under this provision. When the period of uniformed service is less than 31 days, the Employer is required to pay its normal share of the Premium for coverage. When the period of uniformed service is 31 days or more, the Employee will be responsible for both the Employee's portion and Employer's portion, determined in the same manner as COBRA continuation coverage under the Contract.

e. Termination of USERRA Coverage

Coverage will end on the earliest of the following dates:

(1) 24 months from the date USERRA continuation coverage began;

(2) The date the Employee fails to apply for or return to a position of employment;

(3) The date coverage terminates under the Contract for failure to make timely payment of the required Premium; if the individual fails to make the required Premium payment within the grace period (payment of Premium must be postmarked no later than the last day of the grace period); or

(4) The date the Contract terminates.

f. COBRA and USERRA Continuation Rights

You may be eligible for both COBRA and USERRA continuation rights simultaneously.

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4. Continuation of Coverage Pursuant to a Leave of Absence

If an Employee's coverage would terminate because of a leave of absence approved by the Employer (including absences under the Family and Medical Leave Act (FMLA), if eligible), coverage may be continued if the Employer:

1. forwards the Premium for such continued coverage; and

2. provides continued coverage to all Employees in the same class as the Employee whose coverage would otherwise terminate because of an approved leave of absence.

Such continuation of coverage shall terminate no later than:

1. 90 days after the Employee's coverage would have otherwise terminated were it not for this continuation coverage; or

2. If an Employee is eligible for FMLA leave to care for an injured or ill service member, 180 days after the Employee's coverage would have otherwise terminated were it not for this continuation coverage; or

3. If an Employee is eligible for FMLA leave for service member-related qualified exigencies, 90 days after the Employee's coverage would have otherwise terminated were it not for this continuation coverage.

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5. Conversion Coverage

The following individuals are entitled to convert to Our conversion plan designed for the classification applicable to them provided they have been covered as an Employee or Dependent under the Contract for 3 months, (except that a surviving Dependent of a deceased Employee will be offered an opportunity to enroll in Our conversion plan without regard to the 3 month coverage requirement if the Dependent was covered under the Employee's family coverage at the time of the Employee's death):

a. Employees and Dependents whose coverage under the Contract is ending because the Contract is terminated and is not reinstated or replaced within 31 days.

b. Employees or Dependents who have continued coverage for the maximum time allowed under state law or federal law (COBRA), whichever is applicable.

c. Persons whose continuation coverage terminates because the Contract is discontinued and not replaced within 31 days by similar group coverage.

Any waiting period required under the new contract will be reduced by the period of time You had been continuously covered under the Contract. If You had no required Waiting Periods under the Contract, then You have no required waiting period under the conversion coverage.

A Covered Person has 31 days after termination of such group coverage to apply for conversion coverage and to make the required Premium payment for the period beginning with the day following the date coverage would otherwise terminate. No gap in coverage will be permitted.

SECTION J. GENERAL INFORMATION

1. Terms and Conditions of the Contract

The Contract is subject to amendment, modification or termination in accordance with any provision hereof by mutual agreement with Us and the Employer without Your consent or concurrence. 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.

A Certificate shall be issued to the Employer setting forth the insurance protection to which You are entitled, to whom the insurance benefits are payable, and a statement as to any Dependent's coverage. The Employer will provide such Certificate to You. You may also visit www.bluekc.com or contact Customer Service for a copy of such Certificate.

2. Statements

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

3. 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. The Covered Person must pay for any medical examination required to restore his Lifetime Maximum.

4. 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. This authorization constitutes a waiver of any provision of law forbidding such disclosure. Your records will be maintained with strict confidentiality.

5. Reimbursement to Us

a. Workers' Compensation

As a Covered Person, You agree to reimburse Us for any Benefits We paid to You or on Your behalf for claims paid or payable for injuries or illnesses related to Your job to the extent You are covered or are required to be covered by a state or Federal workers' compensation law whether or not You file a claim. In addition, if You enter into a settlement giving up Your right to recover past or future medical benefits under a workers' compensation law, You agree to reimburse Us for any Benefits paid to You or on Your behalf for claims paid or

payable for any past or future medical benefits that are the subject of or related to that settlement.

If You are covered by a workers' compensation program that limits certain authorized providers, You agree to reimburse Us for any Benefits We paid to You or on Your behalf for claims paid or payable for services You receive from providers, authorized or unauthorized, by Your workers' compensation program.

Even if You fail to make a claim under a workers' compensation plan, and You could have received payment under such plan if You had filed, reimbursement must still be made to Us. We have the right of setoff in all case.

b. Errors

We have the right to correct Benefits paid in error. Hospitals, Physicians, other providers and/or You have the responsibility to return any overpayments to Us. We have the responsibility to make additional payment if an underpayment is made.

c. Recovery of Overpayment

If we determine that an erroneous payment for Benefits has been made, You (or any other person or entity receiving the erroneous payment on Your behalf) agree to return to Us the erroneous payment. In the event You (or any other person or entity receiving the erroneous payment on Your behalf) do not return to Us the erroneous payment, We shall have the equitable right to recoup such erroneous payment. 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, and such defenses are hereby disclaimed.

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6. 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.

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7. Conformity with State Laws

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

8. 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: (1) any Hospital or Hospital's agent or employee; (2) any Physician or Physician's agent or employee; (3) any other providers of services or their agent or employee; or (4) the Employer or the Employer's agent or employee.

9. Clerical Errors

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

10. Notice

Written notice given by Us to an authorized representative of the Employer is deemed notice to all affected Employees and their covered Dependents in the administration of the Contract, including termination of the Contract. The Employer is responsible for giving notice to Employees.

11. Authority to Change the Contract

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

12. Assignment

The Contract and all the 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 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. We will make benefit payments directly to Participating Providers for Covered Services. If You use a Non-Participating Provider, however, we may make benefit payments to You or to the Non-Participating Provider.

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 the 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.

We shall reimburse the Part C Early Intervention System for claims for early intervention services (i.e. speech and language therapy, occupational therapy, physical therapy, and assistive technology devices) provided to Covered Persons under the age of three who are Missouri residents and are identified as eligible for services under Part C of the Individuals with Disabilities Education Ac. Claims for early intervention services will be subject to the same Cost-Sharing as other Covered Services, and reimbursement for each Covered Person is limited to $3,000 per year and not to exceed $9,000 per lifetime. Early intervention services must be provided and billed by the Department of Elementary and Secondary Education (DESE). Any payment made to the Part C Early Intervention System will satisfy Our liability to extent of that payment.

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13. 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.

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14. ERISA Statement of Rights

The following applies to Employee Welfare Benefit Plans subject to the Employee Retirement Income Security Act (ERISA).

As a participant in this plan, You are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). As noted in this Contract, these rights and protections are personal to You, and are not assignable to any third party, with the sole exception that Your right to payment under the Contract to In-Network Participating Providers, BlueCard Program Providers, or other providers with whom We contract to the extent services are received from those providers.

ERISA provides that all plan participants shall be entitled to:

a. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the plan with the United States Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The plan administrator may charge a reasonable fee for the copies.

c. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of You and other plan participants and beneficiaries. No one, including Your Employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit, or exercising Your rights under ERISA. If Your claim for a welfare benefit is denied or ignored in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denials, all within certain time schedules.

d. Continue health care coverage for Yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or Your Dependents may have to pay for such coverage. Review Your Summary Plan Description and the documents governing the plan on the rules governing Your COBRA continuation coverage rights.

e. Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If You have a claim for Covered Services which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, You may file suit in Federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the United States Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

If You have any questions about the plan, You should contact the plan administrator. If You have any questions about this statement or Your rights under ERISA, or if You need assistance in obtaining documents from the plan administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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15. Authority to construe Terms of the Contract

The Employer has no discretion to determine eligibility or construe plan Benefits. This function is Our responsibility. We reserve full discretion and authority to interpret and apply the provisions of Your Contract to the extent permitted by law. Should You disagree with any of the decisions We have made relating to the above provisions, You may file a Complaint or Grievance as provided in the Complaint and Grievance Procedures Section.

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16. Plan Sponsor and Plan Administrator

For Employee Welfare Benefit Plans subject to the Employee Retirement Income Security Act (ERISA), the Employer is the plan sponsor and the named plan administrator (unless You receive written notice from the Employer that someone else is fulfilling those roles). We are not the plan sponsor or plan administrator.

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17. 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 at Our discretion.

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18. Independent Licensee

The Contract constitutes a Contract solely between Employer 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 the Employer for any of Blue Cross and Blue Shield of Kansas City's obligations to the Employer 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.

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19. Gender

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

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20. Titles

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

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21. Entire Contract

The Employer application, Employee applications, and Certificate(s) issued to the Employee are incorporated by reference in this document and made a part of the Contract. Any conflict between the Contract and the Certificate(s) will be resolved according to the terms which are most favorable to the Covered Person. The definitions contained in the Certificate(s) 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 and 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.

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22. Time Limit on Certain Defenses

In the absence of fraud, all statements made by the Covered Person are considered representations and not warranties and no statement made by the Covered Person voids the coverage or reduces Benefits unless the statement was material to the risk assumed and contained in the written application. Furthermore, 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 the Employee.

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23. 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.

24. PPO Provider Directory

At no additional cost, PPO Provider Directories are provided by Us and upon request when You call Our Customer Service Department. In addition, You may access Our PPO Provider Directory on Our website at www.BlueKC.com.

25. Right to Recover Payment

If the amount of Our Benefit payment exceeds the amount needed to satisfy Our obligation, We have the right to recover the excess amount from one or more of the following:

a. Any persons to, or for, or with respect to whom such payments were made;

b. Any insurance companies or service Plans; or

c. Any other organizations

Notwithstanding the above, We will not request a refund against a claim from a provider more than twelve months after We have paid a claim except in cases of fraud or misrepresentation by the provider.

26. 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.

27. Inter-Plan Arrangement

I. Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area We serve, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of Our service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in

that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how We pay both kinds of providers.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by Us to provide the specific service or services.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, We will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive Covered Services outside Our service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price We have used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, We may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) made available to Us by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, you will incur no liability, other than any related patient cost sharing under this contract.

C. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Us through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If We have entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer on your behalf, We will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, We will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

E. Nonparticipating Providers Outside Our Service Area

1. Member Liability Calculation

When Covered Services are provided outside of Our service area by nonparticipating providers, the amount you pay for such services will

normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In certain situations, We may use other payment methods, such as billed charges for Covered Services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount We will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment We will make for the Covered Services as set forth in this paragraph.

F. Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

  In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered

Services. **You must contact Us to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

  When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Us, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

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28. Surprise Billing

What is "Surprise Billing" (sometimes called "balance billing"):

When you see a doctor or other health care provider, You may owe certain out-of-pocket costs, like a Copayment, Coinsurance, or Deductible. You may have additional costs or have to pay the entire bill if You see a provider or visit a health care facility that isn't in Your Plan's network.

"Out-of-Network" means providers and facilities that haven't signed a contract with Your health Plan to provide Covered Services in your network. In some situations, Out-of-Network Providers may be allowed to bill You for the difference between Our Allowable Charge and the full amount charged for a service. This is called balance billing. This amount is likely more than In-Network costs for the same service and might not count toward your Plan's Deductible or Annual Out-of-Pocket Maximum.

Surprise Billing is an unexpected balance bill. This can happen when You cannot control who is involved in Your care, like when You require Emergency Services or when You schedule a service at an In-Network Hospital or ambulatory surgical center (ASC), but are unexpectedly treated by an Out-of-Network Provider.

To the extent Covered Services are provided by Out-of-Network Providers under the Consolidated Appropriations Act of 2021, You will not be

subject to balance billing.

The No Surprises Act protects You from balance billing for:

1. Emergency Services

If You have an Emergency Medical Condition and Emergency Services are provided by an Out-of-Network Provider or Facility (including air, but not ground ambulance), the most You can be billed is Your Plan's In-Network Cost-Sharing amount (i.e., Copayments, and applicable Coinsurance) and You cannot be balance billed. This includes services You may get after you're in stable condition, unless you give written consent and give up Your protections not to be balanced billed for these post-stabilization services.

Missouri law provides similar protections if you receive Emergency Services from an Out-of-Network Provider at an In-Network Hospital in Missouri, any Cost-Sharing payments made with respect to your Emergency Service will be counted towards your In-Network Deductible and Your Out-of-Pocket Maximum

2. Out-of-Network Covered Services provided at an In-Network Hospital or ambulatory surgical center ("ASC").

If You receive a Covered Service at an In-Network Hospital or ASC, but services are provided by an Out-of-Network Provider, Covered Services for the Out-of-Network Provider will be processed as In-Network Cost-Sharing and will apply to Your In-Network Out-of-Pocket Maximum. The Out-of-Network Provider involved in Your service at an In-Network Hospital or ASC cannot balance bill You unless You give written consent and give up Your protections.

Ancillary providers, including: Emergency Services; anesthesiology; pathology; radiology; neonatology; diagnostic services; assistant surgeons; hospitalists; intensivists; and others described by law are prohibited from requesting Your consent. As such, these protections will always apply to ancillary providers.

You are never required to give up your protection from balance billing. You also are not required to get Out-of-Network care. You can choose a provider or facility in your Plan's network.

When balance billing isn't allowed, You also have these protections:

- You are only responsible for paying Your Cost-Sharing (like the Copayments, Coinsurance, and Deductible that You would pay if the provider or facility was In-Network). Your Plan will pay any additional costs to Out-of-Network Providers and Facilities directly.

- Generally, Your Plan must:
    - Cover Emergency Services without requiring You to get approval for services in advance (also known as "Prior Authorization").
    - Cover Emergency Services by Out-of-Network Providers.
    - Base what You owe the provider or facility (Cost-Sharing) on what it would pay an In-Network Provider or Facility and show that amount in your Explanation of Benefits.
    - Count any amount You pay for Emergency Services or Out-of-Network services toward your In-Network Deductible and Out-of-Pocket Maximum.

If You think You have been wrongly billed, contact member services by calling the number on the back of Your member ID card.

At any point You can contact the state or federal agencies listed below. However, contacting Blue KC first is recommended for a more efficient and consumer-friendly experience.

The federal phone number for information and complaints is: 1-800-985-3059 or www.cms.gov/nosurprises/consumers.

Missouri Department of Insurance can be contacted at 1-800-726-7390.

Kansas Department of Insurance Consumer Hotline is 800-432-2484.

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29. 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; contributions to a health savings or reimbursement account; 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.

SECTION K. UTILIZATION REVIEW

Utilization Review is undertaken for all medical/surgical inpatient Admissions, including acute care, skilled nursing and medical rehabilitation. Such review is performed using nationally licensed medical criteria. Our toll free telephone number for Utilization Review is on Your identification card. You must call the number on Your identification card or submit the request in writing to Our Medical Management Department.

1. Initial Determination

For initial determinations, We will make the determination within thirty-six hours, which shall include one working day, of obtaining all necessary information regarding a proposed Admission, procedure or service requiring Prior Authorization.

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

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

We will notify the provider rendering the service within 24 hours for Urgent Care Services and within 5 working days for non-Urgent Care Services after Our receipt of the request for Prior Authorization if the request was incorrectly filed or additional information is needed. If additional information is needed in order to make a determination, You have 48 hours from the time You are notified to provide Us with the requested information for Urgent Care Services, and 45 calendar days from the date You are notified to provide Us with the requested information for non-Urgent Care Services.

Failure to provide the information within 48 hours for Urgent Care Services and within 45 calendar days for non-Urgent Care Services will result in the denial of Your request. Upon receipt of the requested information, We will make the determination within 48 hours.

Urgent Care Services are:

a. Those services that if not provided could seriously jeopardize Your life, health or the ability to regain maximum function; or

b. Those that in the opinion of a physician with knowledge of Your medical condition would subject You to severe pain that cannot be adequately managed without the requested care or treatment.

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2. 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 the provider rendering the service within one working day of making the Certification, and provide written or electronic confirmation to the Covered Person and the provider within one working day after the telephone 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 the provider rendering the service within 24 hours of making the Adverse Determination, and provide written or electronic notification to the Covered Person and the provider within one working day of the telephone notification. The service will be continued without liability to the Covered Person until the Covered Person has been notified of the determination.

If additional information is needed in order to make a determination, We will notify You as soon as possible but no later than 24 hours after receipt of the request for additional services.

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3. Reconsideration

In the case of an initial 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.

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4. 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.

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5. 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 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 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 alternate 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, and only when and for so long as it is determined that the extension of Benefits for Covered Services or provision of other Medically Necessary services is appropriate, Medically Necessary and cost effective. Such Benefits shall count toward a Covered Person's Calendar Year Maximum (if applicable) and the Lifetime Maximum.

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

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, nor shall it be construed as a waiver of Our right to thereafter administer the Covered Service in strict accordance with the terms of the Contract.

SECTION L. 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, and 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 and 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.

1. Definitions Applicable to this Section

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

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

Grievance - A written Complaint submitted by or on behalf of a Covered Person to Our Appeals Department regarding: (a) the availability, delivery or quality of Covered Services, including a Complaint regarding an Adverse Determination made pursuant to Utilization Review; (b) Post-Service 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 - 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: (a) would seriously jeopardize the life or health of a Covered Person; (b) would jeopardize the Covered Person's ability to regain maximum function; or (c) in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the requested care or treatment. However, for purposes of the Grievance register requirements, the request will not be considered a Grievance unless the request is submitted in writing.

2. 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 identification (I.D.) card for a toll-free number to call for instruction or any questions.

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.

An adverse determination also includes claims protected under the federal No Surprises Act and any rescission of coverage. A rescission of coverage is not eligible for external review.

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3. Procedures for Filing a First Level Grievance

If You prefer to file a formal Grievance, You may do so by requesting a Member Grievance form from Our Customer Service Department, and submitting the form to Us. In order to request a first level Grievance, Your request must be filed within three hundred sixty-five (365) days from the date: (a) You received notice of an Adverse Determination made pursuant to Utilization Review, or (b) for Post-Service Claims, You received the Explanation of Benefits. For Employee Welfare Benefit Plans subject to the Employee Retirement Income Security Act (ERISA) You must file a first level Grievance before You can bring a civil action under ERISA Section 502(a). Call Your Employer to find out if You are subject to ERISA.

The Grievance Form must be sent to the attention of the Appeals Department. We will acknowledge receipt of the Grievance in writing 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 other information relating to the Claim for Benefits. You have the opportunity to submit written comments, documents, records and 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 comments, documents, records and other information from You or Your authorized representative, regardless of whether the information was considered in the initial benefit determination.

We will conduct a complete investigation of the Grievance within 20 working days or 30 calendar days, whichever is less, 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 Your representative and the person who submitted the Grievance, provided such disclosure does not violate Title II of HIPAA, in writing of Our decision

within 5 working days from the day We make a determination. If the denial is upheld, the notification will include the principal reason for the denial and any clinical rationale. The notification will also explain the member's right to request a second level review and rights to complain to the State Department of Insurance.

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4. Procedures for Filing a Second Level Grievance

If You are dissatisfied with Our first level Grievance decision, You may request a second level review by a Grievance Advisory Panel (the "Panel"). In order to request a second level Grievance, Your request must be filed within three hundred sixty-five (365) days from the later of the date: (a) You are allowed to file a first level Grievance; or (b) You or Your representative, were sent notification of Our first level Grievance decision.

Please note that the second level review is voluntary and We waive Our right to assert that You have failed to exhaust administrative remedies because You did not elect to pursue a second level review. In addition, We agree that any statute of limitations or other defense based on timeliness is tolled during the time that You pursue a second level review. Furthermore, Your decision as to whether or not to submit a Benefit dispute to a second level review will have no effect on Your right to any other Benefit under the Contract. We will not charge You any fee if You elect to pursue a second level review and You have the right to representation at Your own expense.

Your written Grievance must be sent to the attention of the Appeals Department. We will acknowledge receipt of the second level 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 other information relevant to Your Claim for Benefits, not previously provided during the first level Grievance. You have the opportunity to submit written comments, documents, records and other information relating to the Claim for Benefits. We must receive such documents prior to the Panel's review of Your Claim. We will take into account all comments, documents, records and other information from You or Your authorized representative, regardless of whether the information was considered in the initial benefit determination or first level Grievance. The Panel will consist of one or more enrollees and representatives of Ours who have not been involved in the circumstances giving rise to the Grievance..

Where the grievance involves a clinical adverse determination, and the Panel makes a preliminary decision that the determination should be upheld, We shall submit the grievance for review to two independent clinical peers in the same or similar specialty as would typically manage the case being reviewed who were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance. In the event that both independent reviews

concur with the Panel's preliminary decision, the Panel's decision shall stand. In the event that both independent reviewers disagree with the Panel's preliminary decision, the initial adverse determination shall be overturned. In the event that one of the two independent reviewers disagrees with the Panel's preliminary decision, the Panel shall reconvene and make a final decision in its discretion.

If We obtain advice from a medical or vocational expert in connection with a benefit determination, We will provide You with the identification of the expert upon written request. The Second Level Grievance process will adhere to the same time frames associated with the First Level Grievance process. We will notify You in writing of the Panel's decision within 5 working days from the day the Panel makes a determination and of the right to file an appeal with the Insurance Director's Office.

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5. Procedures to Request an Expedited Review

If the time frame of the standard Grievance procedure: (a) would seriously jeopardize the life or health of the Covered Person; (b) would jeopardize the Covered Person's ability to regain maximum function; or (c) in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the requested care or treatment, 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 calendar days of providing oral notification of Our decision.

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6. External Review Of Adverse Determination

You or Your representative has the right to file a grievance concerning an Adverse Determination with the Missouri Department of Insurance ("Department"). If the Department determines a grievance is unresolved after completion of its consumer complaint process, the Department will refer the unresolved grievance to an independent review organization ("IRO").

A. Assignment to an IRO

The Department will provide the IRO with copies of all medical records and any other relevant documents. You and/or Your representative also may submit additional information to the Department which will be forwarded to the IRO. All additional information must be received within 15 working days from the postmark date the Department mailed the information to the IRO. The Department may, but is not required, to accept additional information after the 15 working days.

The IRO will review all the documents and provide the Department its opinion of the issues reviewed within 20 calendar days after the IRO receives the request for the external review. The IRO can request an extension of time, not to exceed five (5) calendar days.

B. IRO Decision

After the Department receives the IRO's opinion, it will issue a decision which will be binding upon You and Us. The decision will be in writing and provided to You and Us within 25 calendar days of receiving the opinion. In no event will the time between the date the IRO receives the request and the date of the Department's decision be longer than 45 days.

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

a. You have exhausted all available review procedures listed above, unless You have an Expedited Review 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 external review organization 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 granted, the external review organization 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 external review organization 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 Insured's medical condition or circumstances require.

In no event shall the Insured be held responsible for any portion of the external review organization'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 beginning on the date of the initial request for external review.

You may contact the Kansas Insurance Department by mail or telephone at 420 SW 9th Street, Topeka, KS 66612-1678 or toll-free at 1-800-432-2484.

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7. Exhaustion of Claims and Appeals Procedures

In the case of a claim for disability benefits, You will be deemed to have exhausted all claims and appeals procedures if We do not strictly adhere to Our procedures. However, You will not be deemed to have exhausted all claims and appeals procedures when the following are all true:

a. Our violation was a minor violation;

b. The violation does not cause and is not likely to cause harm or prejudice to You;

c. The violation is attributable to a good cause or matters beyond Our control;

d. The violation is during the ongoing good-faith exchange of information between You and Us; and

e. Not reflective of a pattern or practice of non-compliance by Us.

You may request a written explanation of Our rationale for asserting We meet this standard. We must provide this within 10 days of Your request.

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8. Expedited External Review

A. Request for an Expedited External Review

You or Your representative may be eligible to request an expedited external review if You receive:

1. An Adverse Determination that involves an admission, availability of care, continued stay, or Covered Service for which You received Emergency Services, but have not been discharged from the facility; or

2. An Adverse Determination that involves a medical condition for which the delay of the standard external review would jeopardize Your life or health or would jeopardize Your prognosis or ability to regain maximum function.

B. Preliminary Review

As soon as possible upon receipt of a request for an expedited external review, the IRO will issue its opinion as to whether the Adverse Determination should be upheld or reversed and submit its opinion to the Department. Within 72 hours after the receipt of the request, the Department shall issue a notice to You and Us of the IRO's determination. If the notice is not in writing, the Department must provide the written decision within 48 hours after the date of notice.

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9. Denial of Coverage for Experimental or Investigational

If a request for external review of an Adverse Determination involves a denial of coverage based on a determination that a health care service or treatment recommended or requested is Experimental or Investigational, the following requirements must be met.

A. The IRO shall make a preliminary determination as to whether the requested health care service or treatment is a Covered Service under this Contract except for the fact that We determined that the service or treatment is Experimental or Investigational for a particular medical condition; and is not explicitly listed as an exclusion under this Contract.

B. The request for external review of an Adverse Determination involving a denial of coverage based on Our determination that the health care service or treatment is Experimental or Investigational must include a certification from Your Physician that:

1. Standard health care services or treatments have not been effective in improving Your condition; or

2. Standard health care services or treatments are not medically appropriate for You; or

3. There is no available standard health care service or treatment covered under the Contract that is more beneficial than the recommended or requested health care service or treatment; and

The request shall also include documentation (a) that Your Physician has recommended a health care service or treatment that the Physician certifies, in writing, is likely to be more beneficial to You, in the Physician's opinion, than any available standard health care services or treatments; or (b) Your Physician, who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat Your condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by You is likely to be more

beneficial to You than any available standard health care services or treatments.

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10. Department of Insurance

You may also contact the Missouri Department of Commerce & Insurance, P.O. Box 690, Jefferson City, MO 65102-0690 or call them toll free at 1-800-726-7390, for assistance at any time with a Complaint or Grievance or for any other matter.

AMENDMENT ISSUED BY
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

AMENDMENT: PPO-209-23-M

In Section C. Covered Services, the following is deleted:

Nutritional/Diet Counseling

We provide Benefits for office visits for nutritional or diet counseling for any diagnosis when received at a facility or from a Physician.

And replaced as follows:

Nutritional/Diet Counseling

We provide Benefits for nutritional or diet counseling for all diagnosis including obesity and morbid obesity when received at a facility or from a Physician.

For the treatment of certain chronic conditions, We provide Benefits for nutritional counseling under the Routine Preventive Care benefit. Such counseling must be provided by a Physician or at a facility.

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

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

AMENDMENT ISSUED BY
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

AMENDMENT: PPO-208-23-M

In Section C. Covered Services, the following is added:

Cryopreservation for Impending Infertility

We provide Benefits for fertility preservation when a Covered Member anticipates becoming infertile as a result of planned gonadotoxic treatments (most often chemotherapy or radiation) or surgery for a medical diagnosis that requires gonadotoxic treatments or surgical removal of reproductive organs. These services must be prior authorized by Us.

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

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

AMENDMENT ISSUED BY
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

AMENDMENT: PPO-204-24-M

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

In Section C. Covered Services, subsection Diagnostic Services, the following is added;

Interventional Radiology (IR) and Interventional Cardiac Radiology (CR) must be Prior Authorized by Us.

Radiology services may require Prior Authorization by Us.

Cardiac Services may require Prior Authorization by Us.

Visit Bluekc.com for a complete list of services that require Prior Authorization.

COVERED MEDICAL SERVICES	COST-SHARING AND LIMITATIONS AT IN-NETWORK PROVIDERS	COST-SHARING AND LIMITATIONS AT OUT-OF-NETWORK PROVIDERS
Interventional Radiology	Deductible then 30% Coinsurance **These Services must be Prior Authorized by Us**	Deductible then 40% Coinsurance
Interventional Cardiac Radiology	Deductible then 30% Coinsurance **These Services must be Prior Authorized by Us**	Deductible then 40% Coinsurance

This amendment is attached to and made a 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 and Blue Shield of Kansas City

AMENDMENT ISSUED BY
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

AMENDMENT: PPO-211-23-M

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

COVERED MEDICAL SERVICES	COST-SHARING AND LIMITATIONS AT IN-NETWORK PROVIDERS	COST-SHARING AND LIMITATIONS AT OUT-OF-NETWORK PROVIDERS
Diagnostic Mammography	No Copayment	No Copayment
Ultrasound of the Breast, MRI of the Breast	No Copayment **Breast MRI must be Prior Authorized.**	No Copayment
Diagnostic Testing	*See section Diagnostic Mammography, Ultrasound of the Breast, MRI of the Breast for those services.*	
High-Tech Diagnostic Testing	*See section Diagnostic Mammography, Ultrasound of the Breast, MRI of the Breast for those services.*	

In Section C. Covered Services, 51. Routine Preventive Care the Following is deleted:

(2) c. Mammograms if ordered by a Physician, including those performed at the direction of a Physician in a mobile facility certified by CMS.

And replaced as follows:

c. Mammograms, including those performed in a mobile facility certified by CMS.

In Section C. Covered Services, 51. Routine Preventive Care the Following is deleted:

(4) c. One mammogram per Calendar Year or more frequently if ordered by a Physician, including those performed at the direction of a Physician in a mobile facility certified by CMS

And replaced as follows:

c. One mammogram per Calendar Year, including those performed in a mobile facility certified by CMS.

In Section C. Covered Services, 15. Diagnostic Services the Following is added:

Diagnostic Mammography, Ultrasound of the Breast and MRI of the Breast will be covered at 100% of the Allowable Charge for Out-of-Network Providers when Medically Necessary.

This amendment is attached to and made a 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 and Blue Shield of Kansas City

AMENDMENT ISSUED BY
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

AMENDMENT: PPO-212-23-M

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

In Section L. COMPLAINT AND GRIEVANCE PROCEDURES, subsection 4. Procedures for Filing a Second Level Grievance is deleted in its entirety and replaced as follows:

If You are dissatisfied with Our first level Grievance decision, You may request a second level review by a Grievance Advisory Panel (the "Panel"). In order to request a second level Grievance, Your request must be filed within three hundred sixty-five (365) days from the later of the date: (a) You are allowed to file a first level Grievance; or (b) You or Your representative, were sent notification of Our first level Grievance decision.

Please note that the second level review is voluntary and We waive Our right to assert that You have failed to exhaust administrative remedies because You did not elect to pursue a second level review. In addition, We agree that any statute of limitations or other defense based on timeliness is tolled during the time that You pursue a second level review. Furthermore, Your decision as to whether or not to submit a Benefit dispute to a second level review will have no effect on Your right to any other Benefit under the Contract. We will not charge You any fee if You elect to pursue a second level review and You have the right to representation at Your own expense.

Your written Grievance must be sent to the attention of the Appeals Department. We will acknowledge receipt of the second level 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 other information relevant to Your Claim for Benefits, not previously provided during the first level Grievance. You have the opportunity to submit written comments, documents, records and other information relating to the Claim for Benefits. We must receive such documents prior to the Panel's review of Your Claim. We will take into account all comments, documents, records and other information from You or Your authorized representative, regardless of whether the information was considered in the initial benefit determination or first level Grievance. The Panel will consist of one or more enrollees and representatives of Ours who have not been involved in the circumstances giving rise to the Grievance.

Where the grievance involves a clinical adverse determination, and the Panel makes a preliminary decision that the determination should be upheld, We shall submit the grievance for review to two independent clinical peers in the same or similar specialty as would typically manage the case being reviewed who were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance. In the event that both independent reviews concur with the Panel's preliminary decision, the Panel's decision shall stand. In the event that both independent reviewers disagree with the Panel's preliminary decision, the initial adverse determination shall be overturned. In the event that one of the two independent reviewers disagrees with the Panel's preliminary decision, the Panel shall reconvene and make a final decision in its discretion.

If We obtain advice from a medical or vocational expert in connection with a benefit determination, We will provide You with the identification of the expert upon written request. The Second Level Grievance process will adhere to the same time frames associated with the First Level Grievance process. We will notify You in writing of the Panel's decision within 5 working days from the day the Panel makes a determination and of the right to file an appeal with the Insurance Director's Office.

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

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

AMENDMENT ISSUED BY
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

AMENDMENT: BCBSKC-206-19-MK

In Section A., Definitions, Medically Necessary (Medical Necessity) is deleted in its entirety and replaced as follows:

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 or treatment of a medical or surgical condition;

b. In accordance with Our local medical policies and the medical policies of Our Delegates;

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;

e. Reasonably calculated to result in the improvement of the Covered Person's physiological and psychological functioning; and

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, just like any other determination, may be appealed pursuant to the grievance procedure.

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

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

The following pages are not a part of this Certificate, 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 healthcare provider from those available as listed in your managed care plan directory or from any non-participating physician or other healthcare 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 healthcare plan, its services, and the practitioners and providers providing care, as well as have the opportunity to make recommendations about your rights and responsibilities.

i. Communicate any concerns with your PPO managed healthcare 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 to:

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 healthcare 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 healthcare 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 healthcare plan properly.

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

NOTICE OF
PROTECTION PROVIDED BY
MISSOURI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
RSMo 376.715, et. seq.

This notice provides a brief summary of the Missouri Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Missouri law, which determines who and what is covered and the amounts of coverage.

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 Missouri law, with funding from assessments paid by other insurance companies.

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 as follows:

- $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance

- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance

- $5,000,000 to one policy owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Missouri law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mo-iga.org, or contact:

Missouri Life and Health
Insurance Guaranty Association
994 Diamond Ridge, Suite 102
Jefferson City, Missouri 65109
Ph.: 573-634-8455
Fax: 573-634-8488

Missouri Department of Insurance
301 W. High St., Room 530
Jefferson City, MO 65101
Ph.: 573-522-6115

Insurance companies and agents are not allowed by Missouri law to use the existence of the Association or its coverage to encourage You to purchase any form of insurance. When selecting an insurance company, You should not rely on Association coverage. If there is any inconsistency between this notice and Missouri law, then Missouri law will control.

Discrimination is Against the Law

Blue Cross and Blue Shield of Kansas City ("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 (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). Blue KC does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue KC:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact 816-395-3558 (local) or 888-989-8842.

Blue KC's Section 1557 Coordinator can be reached by contacting: Section 1557 Coordinator, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@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.

This notice is available at Blue KC's website: https://www.bluekc.com/consumer/non-discrimination-information/

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 1-844-395-7126

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, ທ່ານມີສິດທ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະໍຂ້ ມູ ນຂ່ າວສານ ທ່ເປ ັນພາສາຂອງທ່ານ ໍ ບ ມ ຄ ່ າໃຊ ້ จ ่ าย. ການໂອ ້ 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

Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association