$3,500, a Spira EPO Product, on the BlueSelect Plus Network

Employee Health Plan Sponsored by UNIFIED SCHOOL DISTRICT NO 500

Benefit Booklet for:
UNIFIED SCHOOL DISTRICT NO 500

32076000
January 1, 2022

Welcome to Your Employer-sponsored healthcare plan (Plan) administered by Blue Cross and Blue Shield of Kansas City (Blue KC).

Enclosed is Your Benefit Booklet. The Benefit Booklet describes Your benefits, provisions, and programs offered by this Plan, as well as Your rights and responsibilities.

Please read this Benefit Booklet carefully to better understand how Your benefits work.

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

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

Your good health and well-being are important to Blue KC. Thank You for choosing this comprehensive healthcare coverage to help keep You happy and healthy.

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

	Effective Date: January 1, 2022
Group Name: UNIFIED SCHOOL DISTRICT NO 500	**Dependent Limiting Age:** 26

The Covered Services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the Plan.

Similar to other health provider patient dismissal policies, You may not be able to access services at Spira Care Centers if You exhibit any threatening, disruptive, or abusive behavior or language directed toward any medical or office associates or other patients.

		IN-NETWORK PROVIDER
Covered Services		**Copayment, Deductible, Coinsurance and Limitations**
Calendar Year Deductible (Individual/Family)		$3,500/$7,000
Out-of-Pocket Maximum (Individual/Family) ***Includes Deductible***		$3,500/$7,000
Office Visit – Spira Care Center Provider Office Visit/Physician Services (includes Office Visit and related services unless otherwise specified)		No Copayment *For this Copayment to apply, You must receive services from a designated Spira Care Center Provider.* *Procedures performed in a Physician's office are covered at 100% of Allowable Charge*
Physician Services		Deductible
Telehealth – Blue KC Virtual Care	Office Visits	No Copayment
	Therapy	Deductible
Lab drawn and processed in a Spira Care Center Provider Physician's Office (excluding allergy testing)		No Copayment
X-ray and other Radiology Procedures Performed in a Spira Care Clinic Provider's Office (unless otherwise specified)		No Copayment
X-ray and other Radiology Procedures		Deductible
Routine Preventive Care – (See the Routine Preventive Care Benefit under the Covered		No Copayment

	IN-NETWORK PROVIDER
Covered Services	**Copayment, Deductible, Coinsurance and Limitations**
Services Section for a description of Routine Preventive Services for which you have Benefits)	
Urgent Care	Deductible
Diagnostic and Routine Preventive Mammograms, Pap Smears and PSA Tests	No Copayment
Emergency Services	Deductible
Ambulance	Deductible
Inpatient Hospital Services	Deductible
Outpatient Surgery/Services in Hospital or other Outpatient Facility	Deductible
Durable Medical Equipment	Deductible
Diabetes Self-Management Education and Training	No Copayment
Formula and Food Products for Phenylketonuria	Deductible *$5,000 Calendar Year Maximum*
Inpatient Hospice Facility	Deductible *14 day Lifetime Maximum*
Home Health Services	Deductible *60 visit Calendar Year Maximum*
Skilled Nursing Facility	Deductible *30 day Calendar Year Maximum*
Outpatient Therapy Includes Speech, Hearing, Physical, Occupational and Skeletal Manipulations	Covered
Speech and Hearing Therapy	Deductible **Speech and Hearing Therapy:** *Combined 20 visit Calendar Year Maximum*
Physical Therapy when performed by a Health	Deductible

	IN-NETWORK PROVIDER
Covered Services	**Copayment, Deductible, Coinsurance and Limitations**
Care or Facility-based Provider **Physical Therapy** when performed in a Physician's office	Deductible **Physical Therapy, Occupational Therapy and Skeletal Manipulations:** *Combined 60 visit Calendar Year Maximum.*
Occupational Therapy when performed by a Health Care or Facility-based Provider **Occupational Therapy** when performed in a Physician's office	Deductible Deductible **Occupational Therapy, Physical Therapy and Skeletal Manipulations:** *Combined 60 visit Calendar Year Maximum*
Outpatient Mental Illness Provided by a Spira Care Center Provider Office Visit	No Copayment
Outpatient Mental Illness Office Visit	Deductible
Outpatient Mental Illness Therapy	Deductible
Inpatient Mental Illness	Deductible
Outpatient Substance Abuse Provided by a Spira Care Center Provider Office Visit	No Copayment
Outpatient Substance Abuse Office Visit	Deductible
Outpatient Substance Abuse Treatment	Deductible
Inpatient Substance Abuse	Deductible
Organ Transplant	*Subject to the applicable Cost-Sharing*
Elective Sterilization	Covered under Routine Preventive Services

		IN-NETWORK PROVIDER
Covered Services		**Copayment, Deductible, Coinsurance and Limitations**
Outpatient Prescription Drugs includes oral and injectable contraceptives, and contraceptive devices and implants		*Calendar Year Maximum*
Outpatient Prescription Contraceptives *If a generic version is not available or Prior Authorization is obtained, Tier 2 and Drugs Tier 3 Drugs will be subject to the Cost-Sharing indicated for Tier 1 Drugs.*	**Tier1**	No Copayment
	Tier 2	$50 Copayment
	Tier 3	Deductible
Short-Term Supplies	**Tier 1**	$15 Copayment
	Tier 2	$50 Copayment
	Tier 3	Deductible
Long-Term Supplies (Mail Order)	**Tier 1**	$15 Copayment
	Tier 2	$125 Copayment
	Tier 3	Deductible
Prescription Oral Chemotherapy Drugs Short-Term Supplies	**Tier 1**	No Copayment
	Tier 2	No Copayment
	Tier 3	No Copayment
All Other Covered Services		Deductible

SECTION A. DEFINITIONS

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

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

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

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

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

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

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

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

(1) The amount the provider has agreed to accept as payment in full as of the date of service: or

(2) The provider's billed charges.

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

The Allowable Charge is the l**esser** of:

(1) The amount the provider has agreed to accept as payment in full as of the date of service; or

(2) An amount that is based on 100% of the Medicare fee schedule. This percentage will be periodically evaluated and adjusted if deemed appropriate by Blue KC. If the fee schedule does not include a specific code for the service provided, Blue KC will apply the same methodology used to establish an Allowable Charge for an Out-of-Network Participating Provider; or

(3) The provider's billed charges.

c. For Emergency Services provided by Hospitals, other institutional health care facilities, Physicians or suppliers of medical goods and services which are Out-of-Network Providers [[7]inside Our Service Area-

The Allowable Charge is the **greater** of:

(1) The median amount with in-network providers or

(2) An amount that is based on 100% of the Medicare fee schedule. This percentage will be periodically evaluated and adjusted if deemed appropriate by Blue KC. If the fee schedule does not include a specific code for the service provided, Blue KC will apply the same methodology used to establish an Allowable Charge for an Out-of-Network Provider.

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

The Allowable Charge is the **lesser** of:

(1) The amount the provider has agreed to accept as payment in full as of the date of service; or

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

(3) The provider's billed charges.

e. For In-Network pharmacies-

The Allowable Charge is the **lesser** of:

(1) The negotiated rate the pharmacy has agreed to accept for Our members; or

(2) The Usual and Customary Charge

For purposes of this paragraph, Usual and Customary Charge means the amount that the participating pharmacy would have charged You if You were a cash paying customer. Such amount includes all applicable discounts, including, without limitation, senior citizen's discounts, coupon discounts, non-insurance discounts, or other special discounts offered to attract customers.

f. For Out-of-Network pharmacies–

The Allowable Charge is 50% of the balance of the provider's billed charges after Your Cost-Sharing has been applied.

g. For BlueCard PPO Program providers inside the BlueCard PPO Program Service Area-

When You obtain Covered Services inside the BlueCard PPO Program Service Area through the BlueCard PPO Program, the amount You pay is calculated on the lesser of:

(1) The provider's billed charges; or

(2) The negotiated price that the Host Blue passes on to the Service Organization.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with Your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with Your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for overestimation or underestimation of past prices. However, the amount You pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate that Your liability calculation method differ from the usual BlueCard PPO Program method noted above or require a surcharge, the Service Organization would then calculate Your liability for any Covered Services in accordance with the applicable state statute in effect at the time You received Your care.

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 established by the Plan Sponsor during which eligible persons who have not enrolled with the Plan may do so.

Appeal Means a written Complaint submitted by or on behalf of a Covered Person to the Service Organization's 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 relationship between a Covered Person and the Service Organization. An Appeal may be submitted by a Covered Person, a Covered Person's representative, or a provider acting on behalf of a Covered Person.

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.

Benefit Booklet Means this booklet and any amendments.

Benefits Means the amount of Allowable Charges the Plan pays 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 Plan.

BlueCard PPO Program Means a national Preferred Provider program offered by the Service Organization and other participating Blue Cross and/or Blue Shield Plans across the country. This program offers the highest level of Benefits to Covered Persons when they obtain Covered Services from any Physician, Hospital or other health care provider designated as a Preferred Provider in the BlueCard PPO Program.

BlueCard PPO Program Service Area Means any other area outside of the Service Organization's Service Area served by another Blue Cross and/or Blue Shield Plan participating in the BlueCard PPO Program. Please call the 1-800 number on Your identification card for more information on the Blue Cross and/or Blue Shield Plans participating in the BlueCard PPO Program.

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 Plan replaces any health plan issued or administered by the Service Organization 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.

Certification Means a determination by the Service Organization that an Admission, availability of care, continued stay or other Health Care Service has been reviewed and, based on the information provided, satisfies the Service Organization's 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; or (2) payment for Covered Services rendered in accordance with the procedures outlined in the How to File a Claim Section.

Coinsurance	Means the percentage of an Allowable Charge that You must pay for a Covered Service.
Complaint	Means 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 an Appeal
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.
Contribution(s)	Means the amount paid on a periodic basis for Your coverage, and that of any Covered Dependents, under the Plan.
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 Contributions, 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 Plan.
Covered Services	Means services, supplies, equipment and care specifically listed in the "Covered Services" section of the Plan.
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 the Plan 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.

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

If the Plan replaces the Plan Sponsor's previous plan which provided similar coverage, a credit will be applied to the Deductible required by this Plan, 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 Plan when the Effective Date of the Plan 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 Plan.

Delegate Means an entity that the Service Organization has contracted with to help the Service Organization administer Benefits, such as Our pharmacy benefit manager ("PBM"), behavioral health manager (currently New Directions Behavioral Health), or a company performing Utilization Review services for the Service Organization.

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 Plan.

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 Contributions are due and payable

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

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

a. Serious impairment to a bodily function;

b. Serious dysfunction of any bodily organ or part; or

c. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy

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

Employee Means an eligible Employee of the Plan Sponsor as provided in the Plan.

Employee Contribution Means the amount that You pay on a periodic basis for Your Coverage, and that of any Covered Dependents, under the Plan.

Employer Means the Plan Sponsor.

Expedited Review Means the procedure for the review of an Appeal (which may be submitted either orally or in writing) involving a situation where the time frame of the standard Appeal 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 Appeals register requirements, the request will not be considered an Appeal unless the request is submitted in writing.

Experimental/ Investigative Services The Service Organization 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; or

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) The Service Organization, utilizing additional authoritative sources of information and expertise, has 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 the Service Organization determines is primarily related to the application or usage of a drug, device, medical treatment or procedure that is Experimental or Investigative.

FMLA Leave Means leave authorized by the Family and Medical Leave Act of 1993. The Plan Sponsor maintains a written FMLA policy. All references made to the FMLA policy herein shall be subject to the terms of said policy.

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 the Service Organization or any Blue Cross and/or Blue Shield Plan to provide the Hospital services described in the Plan and accepts the Allowable Charge as full payment for Covered Services except for Copayments, Coinsurance and Deductibles, if any. A Participating Provider Hospital may or may not be an In-Network Provider Hospital.

d. Non-Participating Provider Hospital means a Hospital that does not have a Participating Provider Hospital contract with the Service Organization.

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.

The Service Organization has 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 the Service Organization for the BlueSelect Plus network, or one of the Service Organization's designated vendor's networks.

In-Network Provider also includes providers outside the Service Organization's Service Area who participate in other designated Blue Cross and/or Blue Shield Plan networks in the BlueCard program.

Such In-Network Provider will bill the Service Organization directly for Covered Services You receive and will not bill You for any charges above the amount agreed upon by the Service Organization 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 Plan. It starts on the date of the person's initial date of eligibility and ends 31 days later.

Inquiry

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

Late Enrollee

Means a person who requests Coverage under the Plan 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 Plan Sponsor 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 Plan.

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.

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

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 the Service Organization for the BlueSelect Plus 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 services received from an Out-of-Network Provider,

except for Emergency Services.

d. Any amount for Covered Services incurred in a Non-Participating outpatient facility or in a Non-Participating Provider Hospital in the Service Organization's Service Area, except for Emergency Services;

e. Any amount for Covered Services incurred at a non-Designated Transplant Provider for an Organ Transplant;

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

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

Participating Provider

Means a Hospital, health care facility, Physician, Spira Clinic or other provider of medical care or supplies, which has entered into a contract that defines the method the Service Organization will use to determine the Allowable Charges for Covered Services. Participating Providers have agreed to accept the Service Organization's 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 Plan.

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 the Service Organization is required by state insurance law, the Service Organization recognizes and accepts, to the extent of the Service Organization's obligations under the Plan, 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. Spira Clinic Provider. See the definition of Spira Clinic Provider.

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

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

d. 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. A Participating Provider Physician may or may not be an In-Network Provider Physician.

e. Non-Participating Provider Physician means a Physician that does not have a Participating Provider Physician contract with the Service Organization.

Plan Means the self-funded health and welfare benefit Plan approved and adopted by the Plan Sponsor. The Plan may be amended by the Plan Sponsor from time to time.

Plan Administrator Means the Plan Sponsor, or the person or entity appointed by the Plan Sponsor, who has the authority and responsibility to manage and direct the operation and administration of the Plan. The Service Organization is not the Plan Administrator.

Plan Document(s) Means the written agreement adopted and executed by the Plan Sponsor to provide an Employee health and welfare benefit Plan. The Plan Documents may be amended by the Plan Sponsor from time to time.

Plan Sponsor Means the entity designated on the cover of the Benefit Booklet.

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

Pre-Service Claim Means a request for services that require Prior Authorization.

Primary Care Physician (PCP) Means an internist, family practitioner, general practitioner or pediatrician.

Prior Authorization or Prior Authorized Means the procedure whereby the Service Organization determines: (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.

Prior Authorization means that a service is Medically Necessary for treatment of a Covered Person's condition. Prior Authorization is not a guarantee or verification of Benefits. Payment of Benefits is subject to a Covered Person's eligibility, Waiting Periods and all other Plan limitations and exclusions. Final Benefit determination will be made when claims are filed.

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

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 Means the geographic area served by the Service Organization. The Service Area includes the Missouri counties of: Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, Saline, St. Clair, Vernon, and Worth; and the Kansas counties of: Johnson and Wyandotte.

Service Organization Means Blue Cross and Blue Shield of Kansas City. The Plan Administrator has contracted with the Service Organization to provide limited services pursuant to a written agreement. The Service Organization is not a plan fiduciary by virtue of performing administrative functions pursuant to the terms of its contract with the Plan Administrator or the terms of this Plan.

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 the Service Organization or any Blue Cross and/or Blue Shield Plan to provide the Skilled Nursing Facility Covered Services, if any, described in the Plan 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 the Service Organization 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.

Spira Clinic — Means a designated healthcare facility that has contracted with the Service Organization to provide primary care and care coordination services exclusively to Covered Persons in the Plan's Service Area as indicated in the Benefit Schedule.

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

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

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

Utilization Review	Means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, Health Care Services, procedures, or settings. Techniques may include Ambulatory Review, 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 Plan Sponsor before he is eligible to enroll for coverage under the Plan.
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 as determined by the Plan Sponsor and satisfy any Waiting Periods required by the Plan Sponsor; and

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

The Plan Sponsor has final discretionary authority to determine eligibility under the Plan. Discretionary authority for determining eligibility not expressly delegated to another party remains entirely with the Plan Sponsor.

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;

(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. The Employee's or Employee's legal spouse's, unmarried Dependent child (defined above) who has reached the limiting age but who cannot support himself because of a physical or mental handicap. The Dependent's handicap must have started before the end of the Calendar Year in which the Dependent reached the limiting age and

the Dependent must have been continuously covered by the Plan or a prior health plan at the time of reaching the limiting age.

The Plan Sponsor must receive satisfactory proof, as determined by the Plan Sponsor, of the child's handicap within 31 days before the Dependent reaches the limiting age, or within 31 days after the Dependent is enrolled for coverage under the Plan to continue coverage beyond the Dependent Limiting Age. In addition, The Plan Sponsor must receive satisfactory proof, as determined by the Plan Sponsor, annually of the handicap, 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 the Plan Sponsor's files, claims will be rejected for such individuals.

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

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

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

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3. Enrollment

a. Annual Enrollment Period

If an Employee has elected coverage under another health plan offered by the Plan Sponsor, such Employee and his Dependents will not be eligible for coverage under this Plan unless they enroll during the Annual Enrollment Period. During the Plan Sponsor designated Annual Enrollment Period, an individual who is eligible for coverage as an Employee or Dependent may apply for coverage by submitting to the Plan Sponsor 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 the Plan Sponsor a completed Employee application and any Contribution 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, other eligible Dependent children 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 Plan Sponsor a completed Employee application and any additional Contribution 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 Contribution will be assessed for coverage for these 31 days. If additional Contribution is due, the Employee must submit to Plan Sponsor 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 Plan.

If the Plan Sponsor is advised of the birth either verbally or in writing within 31 days of the date of birth, the Plan Sponsor 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 the earlier of the date on which the Employee's legal support obligation for the child ends or 280 days after such child's date of placement.

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:

(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 Contributions 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 the Plan Sponsor a completed Employee application and any additional Contributions 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 the Plan Sponsor a completed Employee application and any additional Contributions 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 Plan 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 the Plan Sponsor a completed Employee application and any additional Contribution 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 Plan Sponsor 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 Plan Sponsor a completed Employee application, a copy of the court order awarding guardianship, and any additional Employee Contribution 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, Plan Sponsor must receive a completed Employee application and any additional Employee Contribution 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 Plan and the payment of applicable Contributions, as follows:

a. Annual Enrollment Period

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

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

e. Guardianship

In the case of a child placed for legal 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 Plan 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 Plan Sponsor 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 Plan.

g. Extension of Benefits from Prior Plan

If You are covered under an extension of benefits under a prior plan, coverage under the Plan 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 Plan subject to the Plan's Coordination of Benefits section.

h. Actively at Work

If You are not actively at work on the date Your coverage would otherwise become effective, for a reason unrelated to a health condition, coverage will not become effective until you return to active work as an eligible Employee. However, if You have been hired and have not yet reported for work, Your coverage will not become effective prior to the date You report for work regardless of the reason You are not actively at work.

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5. Section 125 Eligibility The eligibility provisions of the Plan Sponsor'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 Plan Sponsor will determine who is eligible under this provision and will advise the Service Organization 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 Plan. All Covered Services are subject to the conditions, limitations and exclusions of the Plan.

Covered Services

Covered Services under the Plan are set forth in this section. All Covered Services are subject to Deductible, Copayment, and Coinsurance requirements and the limitations and exclusions of the Plan.

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

a. Incurred for a Covered Person while coverage is effective;

b. Performed, prescribed or ordered by a Physician;

c. Medically Necessary for the treatment of Your injury or illness, except for specifically listed routine preventive or diagnostic services;

d. Not excluded under the Plan; and

e. Received in accordance with the requirements of the Plan.

f. Received from In-Network Providers, except as described in the Emergency Services provision, Mental Health provision, or if You receive a referral due to being diagnosed with a life threatening condition or disabling degenerative disease

Benefits

The Plan provides 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 Plan.

Services from Out-of-Network Providers Prior Authorized by the Service Organization

If You have a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, You may receive services from an Out-of-Network specialty care center with expertise in treating such condition when such services are approved in advance by the Service Organization. If the Service Organization or Your In-Network Provider, in consultation with one of the Service Organization's Medical Directors, determines that Your care would be most appropriately provided by a specialty care center, the Service Organization shall approve these services in advance from such center. Such services shall be pursuant to a treatment plan developed by the specialty care center and approved by the Service Organization, in consultation with the In-Network Provider, if any, or a Specialist as designated previously, and You or Your designee. If the Service Organization approves in advance services from a specialty care center which is not an In-Network Provider, services provided pursuant to the approved treatment plan shall be provided at no greater

cost to You than if such services were obtained from an In-Network Provider. A specialty care center shall mean only such centers accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating such condition or disease for which it is accredited or designated.

Deductible

The Deductible is applied each Calendar Year. Except as specifically provided, the Calendar Year Deductible must be satisfied before the Plan 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.

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 family members.

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

Individual Lifetime Maximum

The amount of Benefits provided under the Plan shall not exceed the individual Lifetime Maximum shown in the Benefit Schedule. This maximum shall not be affected by any break in coverage; nor shall it be affected by a change in status from Dependent to Employee, or vice versa.

Prior Authorization

Services that must be Prior Authorized by the Service Organization will state so in the applicable Covered Service provision. Please visit http://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 the Service Organization's 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.

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

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

The Plan provides 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.

The Plan provides 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 the Service Organization.

Orthognathic Surgery

The Plan provides 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. 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

The Plan provides Benefits for the surgical treatment of temporomandibular joint disorder. The Plan provides Benefits for the medical or dental management of temporomandibular joint disorder only in connection with acute dislocation of the mandible due to trauma, fractures or tumors.

Complications of Dental Treatment

The Plan provides Benefits for inpatient Hospital 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

The Plan provides 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

The Plan provides 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 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

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

Dental

The Plan provides 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.

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5. Autism Spectrum Disorder

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 <u>not</u> 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. 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;

c. Any person who is licensed by the Kansas Behavioral Sciences Regulatory Board as a licensed behavior analyst or a licensed assistant behavior analyst, or who is obtaining supervised field experience under a licensed behavior analyst.

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.

The Plan provides 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 Copayment and/or Coinsurance provisions as other Covered Services for Covered Persons until their 19th birthday. Such maximum benefit limit may be exceeded, upon prior approval by New Directions, if the provision of ABA therapy beyond the maximum limit is Medically Necessary for a Covered Person.

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 the Plan to pay the claim. Except for inpatient services, the Service Organization has 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 Plan 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 the Service Organization.

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6. Bone Marrow Testing

The Plan provides 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

The Plan provides Benefits for chemotherapy, including oral chemotherapy drugs.

If Your Plan does not provide coverage for outpatient prescriptions, You have no Benefit for oral chemotherapy drugs.

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8. Clinical Trials

The Plan provides 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

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 the Service Organization.

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9. Cochlear Implants

The Plan provides 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 the Service Organization. Implant repairs and replacement parts (including batteries) do not require Prior Authorization

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10. Cranial (head) Remodeling Devices

The Plan provides 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.

11. Diabetes

The Plan provides 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 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.

The Plan provides 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.

12. Diagnostic Services

The Plan provides 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.

Any Diagnostic Services provided in a Spira Clinic will be covered at 100% as indicated in the Benefit Schedule.

The Plan provides Benefits for breathing capacity tests and blood oxygen tests, for any condition, when performed in a Physician's office. Services for breathing Services for breathing capacity tests and blood oxygen tests are covered at 100% when received from a Spira Clinic, when received from an In-Network Provider these services are subject to Your Deductible as indicated in Your Benefit Schedule.

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.

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

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 the Service Organization.

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13. Dialysis

The Plan provides Benefits for hemodialysis and peritoneal dialysis services.

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14. Durable Medical Equipment

The Plan provides 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. The Service Organization retains the right to possess the equipment and You agree to cooperate with the Service Organization in arrangements to return the equipment following Your authorized use; and

c. The Service Organization has 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; and

d. Mechanical equipment for the treatment of chronic or acute respiratory failure (ventilators and respirators); and

e. Oral appliances for sleep apnea.

f. continuous glucose monitors and the associated sensory strips for the treatment of diabetes. These services do not require Prior Authorization.

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.

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, the Service Organization retains 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. See the Exclusions section of the Plan for additional exclusions which may apply.

DME must be Prior Authorized by the Service Organization.

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15. Elective Sterilization

The Plan provides 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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16. Electrical Stimulation

The Plan provides Benefits for the following: spinal cord electrical stimulation and electrical stimulation for bone growth. Electrical stimulation of the spine as an adjunct to spinal fusion growth. Electrical stimulation of the spine as an adjunct to spinal fusion and sacral nerve neuromodulation. Spinal cord stimulation for chronic pain unresponsive to standard therapies; electrical bone growth stimulation for fracture nonunions or congenital pseudoarthroses; electrical bone growth stimulation of the spine as an adjunct to spinal fusion; and sacral nerve neuromodulation for urinary dysfunction. The Plan also provides Benefits for vagus nerve stimulation for the treatment of refractory seizures.

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17. Emergency Services And Supplies

The Plan provides 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 the Service Organization 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 Plan in addition to Your emergency room Copayment, if any.

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.

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

Services will be covered under this Benefit to evaluate or treat an Emergency Medical Condition. A subsequent admission to the hospital will be covered under the Inpatient Hospital Services benefit if You are admitted to an In-Network Provider Hospital. If You are admitted to an Out-of-Network Provider Hospital, the admission will not be covered.

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18. Formula and Food Products for Phenylketonuria (PKU)

The Plan provides 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.

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.

19. Genetic Testing

The Plan provides 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 the Service Organization.

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20. Home Health Services

The Plan provides 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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21. Hospice Services

The Plan provides Benefits for Hospice services if a Physician certifies that You are Terminally Ill. Covered Services are limited to palliative care. If the Service Organization determines 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 the Service Organization.

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22. Immunizations for Children

The Plan provides 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 Copayment requirements.

Any office visit charges incurred in conjunction with these immunizations will be subject to the office visit Copayment, Coinsurance, and Deductible requirements of the Plan, 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.

23. Infusion Therapy and Self-Injectables

Infusion Therapy

The Plan provides 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.

c. **Services are Prior Authorized by the Service Organization.**

Injectables

The Plan provides Benefits for self-injectables administered in the Physician's office or in the home setting. **These services may require Prior Authorization by the Service Organization.** 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 the Service Organization's 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.

Allergy injections and insulin are not Covered Services under this Benefit. Please see the Allergy and Diabetes Benefits in the Plan 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 the Service Organization.

24. Inpatient Hospital Services

The Plan provides 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 the Service Organization. The Service Organization requires notification of emergency and maternity Admissions within 48 hours of the Admission or as soon as reasonably possible.

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25. Maternity Services and Related Newborn Care

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

Covered Services include an inpatient stay of at least 48 hours for a covered mother and 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, the Plan 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 Plan, 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.

Complications of Pregnancy

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

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.

Covered Services do not include elective pregnancy termination, except when the life of the mother would be endangered if the fetus was carried to term.

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26. Mental Illness and Substance Abuse

The Plan provides Benefits for the treatment of Mental Illness and Substance Abuse as indicated in the Benefit Schedule. New Directions Behavioral Health ("New Directions") performs intake services designed to provide crisis intervention, assessment, benefits management and referral services. Covered Services for outpatient evaluation and treatment are limited to crisis intervention, stabilization and therapy for conditions which New Directions and the Service Organization 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 New Directions.

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.

b. Inpatient Treatment (including Residential Treatment)

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

For coverage for psychotherapeutic drugs, please see the Outpatient Prescription Drug Benefit.

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27. Organ Transplants

The Plan provides Benefits for Organ Transplants. **These services must be Prior Authorized by the Service Organization.** If it appears that You may need an Organ Transplant, the Plan encourages You to review these Covered Services with Your Physician. Covered Services may be

limited to an Organ Transplant Lifetime Maximum if indicated in the Benefit Schedule.

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.
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.
Designated Transplant Provider	A Designated Transplant Provider is a provider who has entered into an agreement with the Service Organization, or through a national organ transplant network with which the Service Organization contracts to render Organ Transplant Services or another provider in the BlueCard Program if designated by the Service Organization. Designated Transplant Providers will be determined by the Service Organization and may or may not be located within the Service Organization's Service Area.
Donor Covered Services	The following apply when a human Organ Transplant is provided from a living donor to a transplant recipient: a. When both the recipient and the donor are covered under the Plan, Covered Services received by the donor and recipient will be provided. b. When only the recipient is covered under the Plan, both the donor and the recipient are entitled to the Covered Services of the Plan. The donor's Covered Services are limited to only those Benefits which are not provided by or available to the donor from any other source. This includes, but is not limited to, other health care plan coverage or any government program. c. When only the donor is covered under the Plan, 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 Plan. d. If any organ or tissue is sold rather than donated to a recipient covered under the Plan, 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	The Plan provides 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 the Service Organization. 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 the Service Organization.**
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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28. Osteoporosis

The Plan provides 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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29. Outpatient Prescription Drugs

Introduction/Prior Authorization:	The Plan provides Benefits for drugs and medicines for use outside a Hospital that require a Physician's prescription, including psychotherapeutic drugs. Certain medications or classes of medication may require Prior Authorization. To receive Prior Authorization, Your Physician will need to submit to the Service Organization 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 the Service Organization 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. For 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.

Deductible and Out-of-Pocket Maximum:	The Covered Person is responsible for any Cost Sharing amounts specified in the Schedule of Benefits. And Cost Sharing amounts that are paid for or reimbursed by pharmaceutical manufacturers, for Specialty Prescription Drugs processed under Your Outpatient Prescription Drug Benefit do not accumulate towards Your Deductible or Out-of-Pocket Maximum. This includes payments made through any discount programs, coupon programs, or similar arrangements.
Drug Rebates and Credits:	The Service Organization contracts with a pharmacy benefit manager ("PBM") for certain prescription drug administrative services, including prescription drug rebate administration and pharmacy network contracting services. Under the agreement, PBM obtains rebates from drug manufacturers based on the utilization of certain prescription products by 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, the Service Organization and the PBM also contract with pharmacies to provide prescription products at discounted rates for Covered Persons. The discounted rates paid by PBM and the Service Organization to these pharmacies differ among pharmacies within a network, as well as between networks. For pharmacies that contract with the PBM, the Service Organization pays a uniform discount rate under the Service Organization's contract with the PBM regardless of the various discount rates PMB pays to the pharmacies. Thus, where the Service Organization's 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 the Service Organization before payment to a pharmacy is due, the PBM retains the benefit of the use of these funds between these payments. The Service Organization is guaranteed a minimum level of discount whether through the PBM or where the Service Organization directly contracts with network pharmacies, which could result in the amount paid by You to be more or less than the amount PBM and/or the Service Organization pays to pharmacies. The Service Organization is not acting as a fiduciary with respect to rebate administration, pharmacy network management, or the prescription drug

plan. The Service Organization receives rebates from the PBM and may receive positive margin in connection with the pharmacy network, as well as other financial credits, administrative fees and/or other amounts from network pharmacies, drug manufacturers or the PBM (collectively "Financial Credits"). The Service Organization retains sole and exclusive right to all Financial Credits, which constitute the Service Organization's property (and are not plan assets), and the Service Organization may use such Financial Credits in the Service Organization's sole and absolute discretion, including, for example, to help stabilize the Service Organization's overall rates and to offset expenses, and the Service Organization does not share Financial Credits with You.

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

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 the Service Organization.

   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 the Service Organization deems 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

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. The Service Organization 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.

Out-of-Pocket Maximum: The Copayments and/or any applicable Coinsurance You pay for outpatient prescription drugs will apply to and will be limited by Your Out-of-Pocket Maximum.

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:

Participating Pharmacies: When a prescription is purchased at a participating pharmacy, You must pay the applicable Copayment and/or any applicable Coinsurance for each 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 a 34 day

supply. The pharmacy will then file the claim for the prescription. See Your provider directory for a listing of participating 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 a participating 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 the Plan for reimbursement.

Long-Term Supplies:

Mail Order Prescription Drugs: The Plan provides Benefits for long-term prescriptions when obtained from a designated mail order prescription drug program. Call the Service Organization 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.

Specialty Pharmaceuticals: The Plan provides 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 Plan. In addition, Covered Services do not include any of the following:

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

b. Appetite suppressants, anorexiants and anti-obesity drugs

c. Drugs or medications obtained from an Out-of-Network Provider pharmacy, except for Emergency Services

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

e. Experimental, Investigative or unproven services and medications; medications used for Experimental indications and/or dosage regimens determined by the Service Organization 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)

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

g. Except as specifically provided in the Plan, 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)

h. 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).

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

j. Medications with no approved FDA indications

k. Immunization agents

l. Drugs related to treatment that is not a Covered Service under the Plan

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

n. Emergency contraceptives (e.g. Plan B) and IUD's (includes insertion and removal of IUD's)

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

p. Lifestyle enhancing drugs, unless otherwise specified

q. Fertility drugs

r. Impotency medications and devices

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

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

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30. Outpatient Surgery And Services

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

Non-Participating Provider Hospital/Outpatient Facility Benefits Inside the Service Organization's Service Area

Your Benefit for an outpatient service at a Non-Participating Provider Hospital and outpatient facility inside the Service Organization's Service Area will be limited to a maximum of $200 per Calendar Year. Benefits for services received from a Non-Participating Provider Hospital/outpatient facility inside the Service Organization's Service Area will not be subject to any Deductible or Coinsurance requirements.

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

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31. Outpatient Therapy

The Plan provides 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.

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 Benefit Booklet for other exclusions which may apply.

Physical Therapy

Physical Therapy Services, including skeletal manipulations, 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.

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.

Covered Services for therapy services combined (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 the Service Organization.** Such services will be subject to the limit, if any for Home Health Services.

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32. Physician Services

The Plan provides Benefits for Physician services unless otherwise noted. Covered Services are limited to the following:

a. Office visits.

b. Surgical and orthopedic services. Covered Services are limited to cutting and other operative procedures for treating illness or injury.

c. Surgical assistant services provided by a Physician. Covered Services are limited to the assistance at the operating table which is given to the operating Physician by another Physician. This assistance must be Medically Necessary, as determined by the Service Organization 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 is 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. Emergency Services by a Physician

If Your receive treatment of an Emergency Medical Condition from an Out-of-Network Provider physician in the Emergency Room, the physician charges will be covered as if you received services from an In-Network Provider.

h. 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.

33. Podiatry

Routine Care	The Plan provides 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	The Plan provides Benefits for bone surgery on the foot.

34. Pre-Surgery Testing

The Plan provides 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 Plan.

35. Prosthetic and Orthotic Appliances

The Plan provides Benefits for prosthetics and orthotics other than foot orthotics (including shoes). Please see the Diabetes Benefit in the Plan 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 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 the Plan or someone else) and may include one or more temporary prostheses when Medically Necessary.

Repairs and replacement are not Covered Services if the need for repair or replacement is due to misuse or abuse of the device, or to the extent the device is covered under any warranty. Covered Services also do not include 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 Plan/Benefit Booklet for a description of how prosthetic bras are covered.

Prosthetic and orthotic devices must be Prior Authorized by the Service Organization.

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36. Radiation Therapy

The Plan provides 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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37. Reconstructive Surgery/Prosthetic Devices Following a Mastectomy

The Plan provides 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 and physical complications in all stages of mastectomy, including lymphedemas. No time limit will be imposed on a Covered Person for the receipt of a prosthetic device or reconstructive surgery following a mastectomy.

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38. Routine Preventive Care

The Plan provides 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:

a. Prostate exams and prostate specific antigen (PSA) tests,

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),

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

d. Colorectal cancer exams and laboratory tests 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,

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

g. Lead testing, and

h. The related office visit.

The Plan also Provides the following Benefits for routine preventive care received from **In-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 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. Polio vaccine

xii 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 Plan, 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, the Service Organization 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 the Service Organization 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.

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39. Skilled Nursing Facility

The Plan provides 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 the Service Organization. No Benefits are available under this provision for custodial care or for the care of a nervous or mental condition, drug addiction, alcoholism or chemical dependency.

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40. 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.

41. Vision Care

The Plan provides 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.

The Plan provides 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.

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 from an Out-of-Network Provider unless specifically covered under the Plan.

2. 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.

3. Subject to the Service Organization's Prior Authorization requirement and such approval was not obtained.

4. 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, the Plan 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, the Plan will not pay for services You receive from providers, authorized or unauthorized, by Your workers' compensation program.

5. Not Medically Necessary.

6. Not specifically covered under the Plan.

7. Experimental or Investigative as determined by the Service Organization except as specifically provided under Clinical Trials.

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

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

10. 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 the Service Organization's opinion even if provided by skilled nursing personnel.

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

12. For marital counseling or counseling to assist in achieving more effective intra or interpersonal development; dietary counseling, except as specifically provided; decisional; social; or educational development; vocational development; or work hardening programs.

13. For cosmetic purposes, other than to correct birth defects or to correct a defect incurred through an Accidental Injury. 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.

14. 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, items for comfort and convenience, spas, whirlpools, Jacuzzis, and any other primarily non-medical equipment, 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.

15. For hypnotism, hypnotic anesthesia, acupuncture, acupressure, biofeedback (including neurofeedback), rolfing, massage therapy, and/or any services provided by a massage therapist, aromatherapy and other forms of alternative treatment.

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

17. 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.

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

19. For vision services and hearing care services and cochlear implants, except as otherwise specifically provided in the Plan, including but not limited to pleoptic training, and orthoptic training that is not for convergence insufficiency, eyeglasses, contact lenses, and the examination for fitting of these items.

20. Unless specifically covered under the Plan, 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, including but not limited to Mason Shunt, banding, gastroplasty, intestinal bypass, gastric balloons, stomach stapling, jejunal bypass, wiring of the jaw, as well as related office visits, laboratory services, prescription drugs, medical weight reduction programs, nutrients, and diet counseling (except as otherwise specified in the Plan) and health services of a similar nature whether or not it is part of a treatment plan for another illness. This exclusion also applies to any complications arising from any of the above.

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.

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 Diabetes benefit.

30. For support/surgical stockings (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 Plan.

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

34. For health and dental services resulting from Accidental Injuries arising out of a motor vehicle accident to the extent such services are payable under any expense payment provisions (by whatever terminology used, including such benefits mandated by law) of any automobile insurance policy.

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

36. 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.

37. Provided for an Emergency Medical Condition Admission in excess of the first 48 hours if the Service Organization is not notified within 48 hours of the Admission, or as soon as reasonably possible.

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

39. Health services and associated expenses for megavitamin therapy; 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.

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

41. 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.

42. For non-prescription enteral feedings and other nutritional and electrolyte supplements. This does not apply to the treatment of phenylketonuria, any inherited disease of amino or organic acids.

43. For personal care and convenience items.

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

45. 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, 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.

46. 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.

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

48. For growth therapy for the diagnosis of idiopathic or genetic short stature, intrauterine growth retardation or small for gestational age.

49. For cranial (head) remodeling devices, including but not limited to Dynamic Orthotic Cranioplasty ("DOC Bands") except for post-operative care of congenital birth defects and birth abnormalities caused by synostotic plagiocephaly and craniosynostosis.

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

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

52. Except as specifically provided under 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.

53. 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 the Plan for such services.

54. For sales tax.

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

56. For extracorporeal shock wave therapy due to musculoskeletal pain or musculoskeletal conditions and for electrical stimulation, except as specifically provided in the Plan.

57. For nutritional assessment testing and saliva hormone testing.

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

59. 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.

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

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 Plan Sponsor, by law, is not permitted to allow the Plan to be secondary to Medicare.

SECTION E. HOW TO FILE A CLAIM

1. Claim Procedures

The Service Organization is responsible for processing all Claims and first and second level Appeals under the Plan. The Service Organization may secure independent medical or other advice, and require such other evidence as the Service Organization deems necessary to decide Your Claim.

If the Service Organization denies, 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 Plan 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 submit an Appeal of the Service Organization's decision

When reviewing first level Appeals, the Service Organization will conduct a complete investigation of the facts and information necessary to make a determination as to whether Your Claim was processed according to Your Plan. If You disagree with the Service Organization's decision regarding a first level Appeal, You must write the Service Organization to request a second level Appeal. For additional information about first level Appeals, see the "How to Appeal a Claim" section.

The second level Appeal is a required appeal process. When reviewing second level Appeals, the Service Organization may secure independent medical or other advice, and require such other evidence as the Service Organization deems necessary to decide Your Claim. If the Appeal involves a decision regarding Medical Necessity, or a service or supply that has been determined to be Experimental or Investigational, the Service Organization will consult with appropriate clinical peers who were not involved in the circumstances giving rise to the appeal or in any subsequent investigation or determination. For additional information about second level Appeals, see the "How to Appeal a Claim" section.

If the Service Organization upholds the denial of Your Claim, in whole or in part, after a first or second level Appeal, You will be furnished with a written notice of the decision setting forth:

a. The reason or reasons for the denial;

b. Reference to the specific Plan provision on which the denial is based; and

c. Any clinical rationale; and

d. Appropriate information as to 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.

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2. Post-Service Claims

a. Hospital and other Facility Services

(1) For care received *inside* the Service Organization's Service Area.

(a) In-Network or Participating Providers will file Your Post-Service Claims for You. The facility will be paid directly by the Plan or the Host Blue plan. 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 the Service Organization's Customer Service Department. The form will give You instructions for filing the Post-Service Claim.

(2) For care received *outside* the Service Organization's Service Area.

Post-Service Claims should be filed directly with the Service Organization. If a Hospital or other facility will not file Your Post-Service Claim for You, You can obtain a Post-Service Claim form from the Service Organization's Customer Service Department. The form will give You instructions for filing the Post-Service Claim.

b. Physician Services

(1) For care received *inside* the Service Organization's Service Area .

(a) In-Network or Participating Providers will file Your Post-Service Claim for You. The Physician will be paid directly by the Plan or the Host Blue plan. After the Physician receives the Plan's 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 the Service Organization's Customer Service Department. The form will give You instructions for filing the Post-Service Claim.

(2) For care received *outside* the Service Organization's Service Area.

If You ask, a Physician outside the Service Organization's Service Area and the BlueCard PPO Program Service Area will frequently file Your Post-Service Claim for You. Post-Service Claims must be filed with the Service Organization. If the Physician declines to file Your Post-Service Claim for You, You can obtain a Post-Service Claim form from the Service Organization's Customer Service Department. The form will give You instructions for filing the Post-Service Claim.

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 the Service Organization for these services. Contact the Service Organization's Customer Service Department for the proper Post Service Claim forms. The form will give You instructions for filing the Post-Service Claim. The presentation of a prescription at a Participating Pharmacy is not a Claim. If You disagree with the amount of Copayment, Coinsurance or whether the prescription would be covered under the Plan, You must file a completed Post-Service Claim form with the Service Organization.

d. Time Limits for Filing Post-Service Claims

The Service Organization 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. The Service Organization will deny any Post-Service Claim not received within this time limit.

e. Processing of the Filed Post-Service Claim

The Service Organization will process Your Post-Service Claim as soon as reasonably possible but in no more than thirty (30) calendar days after receipt. The Service Organization 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 the Service Organization's request to provide the Service Organization with the additional information. Upon receipt of the additional information, The Service Organization will process Your Post-Service Claim within fifteen (15) calendar days. If You fail to provide the Service Organization with the additional information within forty-five (45) calendar days of receipt of the Service Organization's request, the Service Organization 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 Section K. The presentation of a prescription at a Participating Pharmacy that requires Prior Authorization is not a Claim. If You disagree with whether the prescription would be covered under the Plan, You must request Prior Authorization in accordance with Section K.

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 including Deductibles, Coinsurance or Copayments that is covered in full or in part by one or more of the Plans covering the person for whom the claim is made. An Allowable Expense does not include dental coverage, outpatient prescription drug coverage, or group-type accident only coverage. A medical expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense unless the private room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

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

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

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

b. *Closed Panel Plan* means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), or other plan that provides health benefits to covered persons primarily in the form of services through a panel or provider that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

c. *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, Closed Panel Plans, 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) 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 $200.00 per day; and

(5) The medical care components of group long-term care contracts, such as skilled nursing care.

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

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 overinsurance 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.

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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 , other than a Dependent, 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;

(3) Then, the Plan of the parent not having custody of the child;

(4) Finally, the Plan of the spouse of the noncustodial parent.

Notwithstanding (1), (2), (3) and (4) 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.

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.

h. Medicare:

When benefits under the Plan are being coordinated with any benefits available by Medicare, the Federal Medicare Secondary Payor Rules in effect at that time will apply and this section F 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.

j. Plans Share Equally:

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

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4. Effect on the Benefits of this Plan

a. 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 Plan;

(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.

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

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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, the Plan (without the consent of or notice to any person) has 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 Plan must give the Service Organization any information needed by the Service Organization 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 the Plan, then the Plan has the right to pay that other Plan any amount necessary to satisfy its obligation.

SECTION G. SUBROGATION

1. Right of Recovery

The Plan has the right to recover any benefits paid to You or for a Covered Person under the Plan on any loss for which a third party is liable. Such recovery will be available from any liable third party, including but not limited to:

1. The persons and entities, either individually or collectively, causing an accidental injury, illness or other loss for which the Plan had or may provide benefits;
2. Third Party Insurance;
3. No-fault or personal injury protection ("PIP") insurance;
4. Financial responsibility or catastrophe funds mandated by motor vehicle or other state law;
5. Uninsured or underinsured motorist insurance;
6. Motor vehicle medical reimbursement insurance; regardless of whether or not it is purchased by You or the Dependents;
7. Homeowner's insurance and other premises insurance, including medical reimbursement coverage; or
8. Worker's compensation insurance or fund.

2. Covered Person's Responsibilities

The Covered Person, or the legal representative of a minor or incapacitated Covered Person, will:

1. Notify the Plan promptly of how, when, and where an accident or incident resulting in personal injury or illness to the Covered Person occurred and all information regarding the parties involved;
2. Execute and deliver instruments and papers and do whatever is necessary to secure such rights of recovery as may exist;
3. Refrain from acts detrimental to the Plan's rights of subrogation;
4. Cooperate with the Plan in any investigation, settlement, and protection of the Plan's rights;
5. Provide the Plan with copies of any documents in connection with the accident or injury resulting in personal injury or illness to the Covered Person;

6. Promptly notify the Plan if an attorney is retained, or if a lawsuit is filed, on the Covered Person's behalf;

7. Disclose the amount of any settlement or recovery to the Plan;

8. Hold in trust for the Plan the proceeds of the gross recovery to be paid to the Plan immediately upon receipt of the recovered amounts without any set-off or reduction for attorney's fees, other expenses or costs; and

9. Do nothing after or before payment to prejudice such rights of recovery.

If the Covered Person, or the legal representative, fails to cooperate in fulfilling the responsibilities set forth in the preceding paragraph, no further benefits will be payable under the Plan for charges incurred in connection with or resulting from the condition for which such loss is undergoing recovery proceedings. If the amount the Plan has paid on the Covered Person's behalf is not repaid or otherwise recovered by the Plan, or if the Covered Person or the legal representative fails to cooperate, the Plan shall be entitled to deduct any unsatisfied portion of the amount the Plan has paid or the amount of the Covered Person's recovery, whichever is less, from any future benefit under the Plan. The Plan's rights will not be reduced due to negligence on behalf of the Covered Person or the Covered Person's legal representative.

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3. Authority to Assert Subrogation

The Plan Administrator, or the Service Organization, will have the authority to assert a subrogation lien as soon as it is placed on notice that the Plan will be requested to provide benefits for an injury to a Covered Person for which a third party is liable. However, the Plan Administrator, or the Service Organization, will not be required to initiate or intervene in court actions in order to establish the lien. The Plan Administrator, or the Service Organization on its behalf, may compromise the amount of the lien where such action is in the best interests of all Plan beneficiaries. In the event the Covered Person fails to disclose the amount of any settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

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4. Priority and Satisfaction of Recovery

Notwithstanding any allocation or designation of any recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a first priority right of full recovery against amounts recovered. The Plan shall also have a first priority right of full recovery against amounts recovered regardless of whether the Covered Person is fully compensated and regardless of whether the payments the Covered Person receives make him or her whole for losses, illnesses and/or injuries.

The amount of the Plan's subrogation interest will be deducted first and in full from a Covered Person's recovery arising out of the injury. Any amounts so recovered will be applied to reimburse the Service Organization on behalf of the Plan Sponsor to the extent of its payment under the Plan. If any recovery is insufficient to satisfy the Plan's subrogation claim and any claim held by a Covered Person, the Plan's subrogation claim shall be first satisfied before any part of amounts recovered are applied to a Covered Person's claim, attorney fees, and other expenses or costs. If any balance remains from such recovery, it will be applied to reimburse the Covered Person or any other insurance company providing benefits to the Covered Person for such loss, as their interest may appear.

The Plan is entitled to reimbursement from any recovery, in first priority, even if the recovery does not fully satisfy the judgment, settlement, or underlying claim for damages or fully compensate the Covered Person or make the Covered Person whole. The Plan shall also be entitled to recover any of the unsatisfied portions of the amount the Plan has paid or the amount recovered by a Covered Person, whichever is less, directly from the providers to whom the Plan has made payments on behalf of the Covered Person. In such circumstances, it may then be the obligation of the Covered Person to pay the provider the full billed amount, and the Plan will have no obligation to pay the provider or reimburse the Covered Person.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by the Covered Person to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

If the Covered Person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to these provisions. Likewise, if the Covered Person's relatives, heirs, and/or assignees make any recovery because of injuries sustained by the Covered Person, such recovery shall be subject to these provisions.

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5. Expenses and Legal Action

The expenses of all such recovery proceedings will be apportioned and borne by all parties in interest, in ratio of respective recoveries. However, when there is no recovery from any proceeding instituted and conducted solely by the Plan Administrator or by the Service Organization on behalf of the Plan Sponsor, the institutor will bear the expense exclusively. The Plan or the Plan Administrator, or the Service Organization, will not be required to pay attorney fees or other costs incurred in connection with its recovery unless it consents in writing to make such payment. The "common fund" doctrine does not apply to any funds recovered by any attorney hired by a Covered Person regardless of whether funds are

recovered are used to repay benefits by the Plan.

The Plan has the right to take whatever legal action it sees fit against any person, party, or entity to recover the benefits paid under the Plan. The Plan is entitled to recover attorney's fees and costs incurred in enforcing these provisions. The Plan Sponsor has the sole discretion to interpret the terms of these provisions in their entirety and reserves the right to make changes as it deems necessary.

SECTION H. TERMINATION AND EXTENSION OF COVERAGE

1. Terminating a Covered Person's Coverage

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

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

b. On the last day of the month for which Contributions has been paid if You fail to pay any required contribution toward such Contributions. The Plan may recover from You Benefits The Plan paid for Covered Services made subsequent to the date of termination;

c. On the last day of the month 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 Plan;

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

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

f. On the original Effective Date of coverage if coverage is terminated by the Plan 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 Plan Sponsor, by law, is not permitted to allow the Plan to be secondary to Medicare; or

If the Plan Sponsor's Plan is terminated for any reason, the Plan Sponsor is solely responsible for notifying all Covered Persons of such termination and that coverage will not continue beyond the termination date.

When a Covered Person's coverage terminates, he may have continuation of coverage rights. See the "Continuation of Coverage" section of the Benefit Booklet.

2. Extension of Coverage If a Covered Person is confined in a Hospital on the date the Plan is terminated, the Covered Person's coverage will be extended without payment of Contributions. Coverage under this extension will only be for Covered Services directly related to the Hospital Confinement; provided, however, the benefits of the new plan will be determined before the Benefits under this Plan. The total amount payable under the new plan and under this Plan shall never be more than the Allowable Expense as that term is defined under the Coordination of Benefits section of the Plan.

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

a. The date the Hospital Confinement ends; or

b. The end of a 31 day period following the date the Plan is terminated.

SECTION I. CONTINUATION OF COVERAGE

1. Continuation of Coverage

Certain persons whose group health coverage is terminated may be allowed to continue that coverage for a limited time, in accordance with 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.) **Contact the Plan Sponsor to determine whether federal continuation is available.**

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

The following COBRA continuation provisions apply to most employers who employed twenty (20) or more employees on at least half of its business days during the preceding Calendar Year. The COBRA provisions of the Plan will conform with the minimum requirements of the COBRA law, provided that the Plan Sponsor and Covered Persons comply with COBRA requirements. Coverage under the Plan will not be continued if the Plan Sponsor or the Covered Person(s) do not comply with the COBRA requirements.

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 Plan Sponsor files for Chapter 11 bankruptcy, but only for a retired Employee and his covered Dependents.

The Employee, or the covered Dependents must notify the Plan Sponsor (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 Plan or within 60 days of the date coverage under the Plan 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 Plan Sponsor 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 Plan or any child who is born to or placed for adoption with a covered Employee during a period of COBRA 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 Plan Sponsor 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.

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 Plan, qualified beneficiaries may continue coverage for up to 36 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.

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 not 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 Plan Sponsor(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 Plan Sponsor 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 Plan Sponsor 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 Plan 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 Plan Sponsor 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 COBRA election form that is postmarked within 60 days after the person's coverage would terminate due to the Qualifying Event; or, 60 days after the Plan Sponsor or plan administrator sends notice of the continuation right; whichever is later. An individual must then pay the initial Contribution within 45 days after electing continuation.

If an Employee or Covered Dependent contacts the Service Organization regarding a qualifying event, such contact does not constitute notice to the Plan Sponsor or its designated Plan Administrator, and the Plan 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.

g. Effective Date of Continuation Coverage

Upon receipt of both the first month's Contribution 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 Plan or Covered Services are changed, the COBRA coverage is also subject to the amended terms of the Plan 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 Plan Sponsor's 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.

i. Termination of COBRA Continuation Coverage

COBRA continuation of 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 Plan for failure to make timely payment of the required Contribution; if the individual fails to make the required Contribution payment within the grace period (payment of Contribution 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 COBRA coverage for the length of a preexisting condition or to the COBRA maximum coverage period, if less. COBRA 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 COBRA election;

(7) For retirees, in the case of a qualifying event that is the Chapter 11 bankruptcy of an Plan Sponsor, 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 Plan terminates.

Trade Act of 2002

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. American Recovery and Reinvestment Act of 2009 made several amendments to these provisions, including an increase in the

amount of the credit to 80% of premiums for coverage before January 1, 2011 and temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (covered employees who have a non-forfeitable right to a benefit any portion of which is to be paid by the PBGC) and TAA-eligible individuals.

If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

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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 Plan conform with the minimum requirements of the USERRA law, provided that the Plan Sponsor and Covered Person(s) comply with the USERRA requirements. Coverage under this Plan will not be continued if the Plan Sponsor or the Covered Person(s) do not comply with the USERRA requirements.

Apart from other rights to continued coverage provided under the Plan, 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 Plan Sponsor 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 Plan. 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 Plan. 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 Plan Sponsor or plan administrator sends notice of the USERRA continuation rights; whichever is later. An individual must then pay the initial Contribution within 45 days after electing USERRA continuation coverage.

In no event shall the Plan be obligated to provide USERRA continuation of coverage to a Covered Person if the Plan Sponsor 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 the Service Organization in a timely manner, of the Covered Person's election of USERRA continuation coverage.

c. Coverage Changes

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

d. Contribution Payment

The Contribution 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 Plan Sponsor is required to pay its normal share of the Contribution 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 Plan Sponsor's portion, determined in the same manner as COBRA continuation coverage under the Plan.

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 Plan for failure to make timely payment of the required Contribution; if the individual fails to make the required Contribution payment within the grace period (payment of Contribution must be postmarked no later than the last day of the grace period); or

(4) The date the Plan 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 Plan Sponsor(including absences under the Family and Medical Leave Act (FMLA), if eligible), coverage may be continued if the Plan Sponsor:

1. forwards the Contribution 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.

SECTION J. GENERAL INFORMATION

1. Terms and Conditions of the Plan

The Plan is subject to amendment, modification or termination in accordance with any provision hereof by mutual agreement with the Service Organization and the Plan Sponsor without Your consent or concurrence. The Plan is governed by and subject to the laws of the State of Missouri and any applicable federal law. To the extent that applicable state and federal laws conflict, federal law shall govern. If any provision of the Plan conflicts with such law, the Plan shall automatically be amended solely as required to comply with such state or federal law. By electing coverage under the Plan, You agree to all terms, conditions and provisions hereof.

2. Complaint Procedures

The Service Organization's 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.

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

3. Exhaustion or 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.

4. Medical Examination

To fulfill the obligations under the Plan, the Plan Sponsor may require a Covered Person to have a medical examination by a Physician of the Plan Sponsor's choice and at the Plan Sponsor's expense. The Covered Person

must pay for any medical examination required to restore his Lifetime Maximum.

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5. Release of Records

During the processing of Your claim, the Service Organization may need to review Your health records.

As a Covered Person, You hereby authorize the release to the Service Organization 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.

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6. Reimbursement to the Plan

a. Workers' Compensation

As a Covered Person, You agree to reimburse the Plan for any Benefits the Plan 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 the Plan 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.

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 the Plan. The Plan has the right of setoff in all case.

b. Errors

If the Plan determines that an erroneous payment for Benefits has been made, The Plan has the right to correct Benefits paid in error, including any Benefits the Plan paid that exceed the amount needed to satisfy the Plan's obligation. The Plan has the right to recover the excess amount from You or any other person or entity receiving the erroneous payment on Your behalf. Such individual or organization has the responsibility to return any overpayments to the Plan. In the event You, or any other person or entity receiving the erroneous payment on Your behalf do not return to the Plan the erroneous payment, The Plan shall have the equitable right to recoup such erroneous payment. The Plan has the responsibility to make additional payment if an underpayment is made.

c. Misrepresentations

The Plan has the right to recover payments from You for Claims submitted on behalf of You or any Covered Person under the Plan in the event that the Plan rescinds Your Coverage due to fraud or intentional misrepresentation of material fact by You or any Covered Person in Your application.

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7. Commission or Omission

No Hospital, Physician or other provider of service will be liable for any act of commission or omission by the Plan or the Service Organization. The Plan 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.

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8. Clerical Errors

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

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9. Negligence or Malpractice

The Plan and the Service Organization do not practice medicine. Any medical treatment, service or medical supplies rendered to or supplied to any Covered Person by a Provider is rendered or supplied by such Provider and not by the Plan or the Service Organization. The Plan and the Service Organization are not liable for any improper or negligent act, inaction, or act of malfeasance of any Provider in rendering such medical treatment, service, medical supply or medication.

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10. Assignment

The Plan and all rights, responsibilities, and Covered Services under it are personal to You, including any legal cause of action, or remedy, derived therefrom. Except for assignment of claim payment to Preferred 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.

However, any Covered Services provided under the Plan 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 Plan 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 the Plan has made its 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 the Service Organization's receipt of a claim from the public Hospital or clinic. Any payment made to the public Hospital or clinic will satisfy the Plan's liability to the extent of that payment.

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11. Medicaid

The Covered Services provided under the Plan 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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12. Authority to Construe Terms of the Plan

The Plan Sponsor has the discretionary authority to determine eligibility. The Service Organization has the discretionary authority to construe Plan Benefits to the extent authorized by the Plan Sponsor. The Service Organization reserves full discretion and authority to interpret and apply the provisions of Your Plan to the extent permitted by law and authorized by the Plan Sponsor. Should You disagree with any of the decisions the Service Organization has made relating to the above provisions, You may file an Appeal as provided in the How to Appeal a Claim section.

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13. Plan Sponsor and Plan Administrator

For Employee Welfare Benefit Plans subject to the Employee Retirement Income Security Act (ERISA), the Plan Sponsor is the Plan Sponsor and the named Plan Administrator (unless You receive written notice from the Plan Sponsor that someone else is fulfilling those roles). The Service Organization is not the Plan Sponsor or Plan Administrator.

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14. Special Programs

As an individual covered under the Plan, 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 the Plan Sponsor's discretion.

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15. Independent Licensee

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 Plan Sponsor for any of Blue Cross and Blue Shield of Kansas City's obligations to the Plan Sponsor created under the Plan. 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 Plan.

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16. Gender Any use of the male pronoun in the Plan shall also apply equally to the female gender.

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

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

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19. Provider Directory At no additional cost, Provider Directories are provided by the Service Organization and upon request when You call the Service Organization's Customer Service Department. In addition, You may access the Service Organization's Provider Directory on the Service Organization's website at www.BlueKC.com.

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20. Recoveries Recovery of Plan assets can arise in several ways, including but not limited to subrogation, anti-fraud and abuse audits, provider/hospital audits, credit balance audits and unsolicited refunds. In some cases, the Service Organization will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be returned to the Plan.

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21. Newborns' and Mothers' Health Protection Act Notice Under the terms of the Newborn and Mother's Health Act of 1996, the Plan generally may not restrict Covered Services for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following vaginal delivery (not including the day of delivery), or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, the Plan may not require that a Provider obtain authorization from the Plan for prescribing a length of stay not in

excess of forty-eight (48) or ninety-six (96) hours, as applicable. However, preauthorization is required to use certain Providers or facilities, or to reduce out-of-pocket costs.

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22. Women's Health and Cancer Rights Act Notice

Along with benefits detailed in your Plan and Schedule of Benefits, your benefits include coverage for (1) breast reconstruction in connection with a mastectomy, including reconstruction of the other breast to produce a symmetrical appearance; (2) prosthesis; and (3) treatment of physical complications from all stages of mastectomy, including lymphedemas. This coverage is subject to copayments, coinsurance and deductibles consistent with other benefits under your plan. This notice is being provided in accordance with the Women's Health and Cancer Rights Act of 1998, a federal law.

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23. Genetic Information Nondiscrimination Act

Effective January 1, 2010, and notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act. In general, the Plan cannot set Contributions on the basis of genetic information, request or require a participant to undergo a genetic test, or request, require, or purchase genetic information for underwriting purposes or collect genetic information about a participant before the participant is enrolled or covered under the Plan.

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24. 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.

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

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. The Service Organization's 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 The Service Organization's Medical Management Department.

1. Initial Determination

For initial determinations, the Service Organization 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, the Service Organization 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, the Service Organization 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.

The Service Organization 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 the Service Organization's 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 the Service Organization with the requested information for Urgent Care Services, and 45 calendar days from the date You are notified to provide the Service Organization 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, the Service Organization 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, the Service Organization 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, the Service Organization 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, the Service Organization 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, the Service Organization 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, the Service Organization will make the determination within 30 working days of receiving all necessary information. the Service Organization will provide notice in writing of the Service Organization's 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 Plan. In addition to the Covered Services specified in the Plan, 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. The Plan may elect to provide Benefits furnished by any provider pursuant to the Service Organization's approved alternate treatment plan for case management.

The Service Organization shall provide any extension of Covered Services' Benefits or other Medically Necessary services when The Service Organization determines 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 and/or Lifetime Maximum, if applicable.

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 the Plan elects to extend Benefits for Covered Services or provide other Medically Necessary services for a Covered Person in one instance, it shall not obligate the Plan to provide the same or similar services for any Covered Person in any other instance, nor shall it be construed as a waiver of the Plan's right to thereafter administer the Covered Service in strict accordance with the terms of the Plan.

SECTION L. HOW TO APPEAL A CLAIM

The Service Organization has a formal process that gives You the right to submit an Appeal, in writing, regarding Claim payment decisions or other aspects of service, and to receive a response from the Service Organization explaining its actions. The following procedures will be used to address any Appeals that You or any other Covered Person may have.

1. Procedures for Filing a First Level Appeal

If You wish to file an Appeal, You may do so by requesting an Appeal form from the Service Organization and submitting the form to the Service Organization. In order to request a first level Appeal, Your request must be filed within one-hundred eighty (180) 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. .

The Appeal form must be sent to the attention of the Service Organization's Appeals Department. The Service Organization will acknowledge receipt of the Appeal in writing within 10 working days unless it is resolved within that period of time. Upon request, the Service Organization will provide You, free of charge, with copies of all documents, records, and other information relevant to Your Claim for Benefits as part of providing an opportunity for a full and fair review. This information will be provided as soon as reasonably possible in order to give You a reasonable opportunity to respond. You have the opportunity to submit written comments, documents, records, and other information relating to the Claim for Benefits. The Service Organization must receive such documents prior to its review of Your Claim. The Service Organization 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.

The Service Organization will conduct a complete investigation of the appeal within 20 working days or 30 calendar days, whichever is less, after receipt of the appeal for Pre-Service Claims and within 20 working days after receipt of the appeal for Post-Service Claims unless the investigation of the Post-Service Claim cannot be completed within this period of time. If the investigation of the Post-Service claims cannot be completed within the 20 working days, the Service Organization 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 Appeal for Post-Service Claim. The Service Organization will notify You, Your representative, and the person who submitted the appeal, provided such disclosure does not violate Title II of HIPAA in writing of its decision within 5 working days from the day the Service Organization makes 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 Your right to request a second level review.

You must file a first level Appeal before You can bring a civil action under ERISA Section 502(a).

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2. Procedures for filing a Second Level Appeal

If You are dissatisfied with the Service Organization's first level Appeal decision, You may request a second level review by an Appeal Advisory Panel (the "Panel"). In order to request a second level Appeal, Your request must be filed within one-hundred eighty (180) days from the later of the date: (a) You are allowed to file a first level Appeal; or (b) You or Your representative, were sent notification of the Service Organization's first level Appeal decision. Please note the second level review is required in order to exhaust any administrative remedies available. If You do not elect to pursue a second level review, the Plan retains its right to assert that You have failed to exhaust administrative remedies. In addition, the Plan agrees 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 Plan. The Plan 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 Appeal must be sent to the attention of the Service Organization's Appeals Department. The Service Organization will acknowledge receipt of the Appeal in writing within 10 working days unless it is resolved within that period of time. Upon request, the Service Organization will provide You with copies of all documents, records, and other information relevant to Your Claim for Benefits, if not previously provided during the first level Appeal. You have the opportunity to submit written comments, documents, records, and other information relating to the Claim for Benefits. The Service Organization must receive such documents prior to the Service Organization's review of Your Claim. The Service Organization 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 Appeal. The Panel will consist of one or more enrollees and representatives of the Service Organization who have not been involved in the circumstances giving rise to the Appeal. In addition, if the Appeal involves a decision regarding Medical Necessity, or a service or supply that has been determined to be Experimental or Investigational, the Panel will consist of a majority of persons that are appropriate 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 Appeal or in any subsequent

investigation or determination. If the Service Organization obtains advice from a medical or vocational expert in connection with a benefit determination, the Service Organization will provide You with the identification of the expert upon written request. The Second Level Appeal process will adhere to the same time frames associated with the First Level Appeal process. The Service Organization will notify You in writing of the Panel's decision within 5 working days from the day the Panel makes a determination.

You must file a second level Appeal before You can bring a civil action under ERISA Section 502(a).

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3. Procedures to Request an Expedited Review

If the time frame of the standard Appeal 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, a request for an Expedited Review may be submitted orally or in writing. The Service Organization will notify You orally within 72 hours after receiving a request for an Expedited Review of its decision. The Service Organization will send written confirmation of its decision within 3 calendar days of providing oral notification of its decision.

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4. Procedures to Request an Independent External Review

A. <u>Request for an Independent External Review</u>

You or Your representative may have the right to request an independent external review by the external review organization. Such external review organization may be available only for:

1) Adverse Determinations (including a final internal Adverse Determination) that involve medical judgment including, but not limited to:

   a. Determinations based on requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service; or

   b. Determination that a treatment is experimental/investigational) as determined by the external review organization; and

2) Rescissions of coverage (whether or not the rescission has any effect on any particular Benefit at that time).

You may request an external review provided such request is made within four (4) months after the date of Your receipt of the notice of

adverse Determination. For detailed information regarding requesting an external review, please contact the Service Organization.

B. Preliminary Review

Within five (5) business days following receipt of Your request for an external review, the Service Organization will complete a preliminary review of the request to determine whether:

1) You are or were a Covered Person at the time the service was requested or provided;

2) The Adverse Determination or the final internal Adverse Determination does not relate to a denial, reduction, termination, or a failure to provide payment for a Benefit based on a determination that You fail to meet eligibility requirements;

3) You have exhausted the internal appeals process unless You are not required to do so; and

4) You have provided all the information and forms required to process the request for an external review.

Within one (1) day after completion of the preliminary review, the Service Organization will provide a written notice to You. If Your request for an independent external review was complete but You are not eligible for an external review, the notice will include the reasons for its ineligibility. If Your request for an independent external review is not complete, the notice will describe the information that is needed to complete the request. You will be allowed to provide such information the later of: (1) within the four (4) month period described above, or (2) within the 48 hour period following receipt of the notice.

C. Assignment to an Independent Review Organization ("IRO")

The Service Organization will provide the IRO with documents and any information used in making the Adverse Determination or final internal Adverse Determination. The IRO will review all the documents and provide You and the Service Organization a written notice of the final external review decision within 45 days after the IRO receives the request for the external review.

After the external review decision, the IRO will maintain records of all claims and notices associated with the external review process for six (6) years. Such records are available for examination by You, the Service Organization, or State or Federal oversight agencies, except where such disclosure would violate State or Federal privacy laws.

D. Reversal of Service Organization's Decision

Upon receipt of the decision by the IRO that reverses the Adverse Determination or final internal Adverse Determination, the Service Organization will provide coverage for the claim as stipulated in the external review decision.

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5. Procedures to Request an Expedited External Review

A. Request for an Expedited External Review

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

1) An Adverse Determination that involves a medical condition for which the timeframe for completion of an internal Expedited Review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, and You filed a request for an Expedited Review; or

2) A final internal Adverse Determination, if You have a medical condition where the timeframe for completing an External Review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, or if the final Adverse Determination concerns an admission, availability of care, continued stay, or health care item or service for which You received Emergency Services, but You have not been discharged from the facility.

B. Preliminary Review

Immediately upon receipt of a request for an expedited external review, the Service Organization will complete a preliminary review of the request to determine whether the request satisfies the requirements in Section 5.A. above for a standard external review. Immediately upon completion of the preliminary review, the Service Organization will provide a written notice to You.

C. Assignment to an Independent Review Organization ("IRO")

Upon determination of that a request is eligible for an expedited external review, the Service Organization will provide the IRO with documents and any information used in making the Adverse Determination or final internal Adverse Determination. The IRO will review all the documents and provide You and the Service Organization a notice of the expedited external review decision not later than 72 hours after the IRO receives the request and all necessary records/information for the expedited external review.

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6. Denial of Coverage

If a request for external review of an Adverse Determination involves a

for Experimental of Investigational

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 Plan except for the fact that the Service Organization 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 Plan.

B. The request for external review of an Adverse Determination involving a denial of coverage based on the Service Organization's 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 Plan 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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7. ERISA Exhaustion of Internal Procedures

If Your plan is subject to ERISA and Your request for coverage or Benefits is denied or any other ERISA statutory claim is denied, You have the right to bring a civil action under ERISA Section 502(a) provided You have exhausted Your first and second level Appeal rights.

AMENDMENT NUMBER ONE
TO THE UNIFIED SCHOOL DISTRICT NO 500 BENEFIT BOOKLET

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

Inter-Plan Arrangements

I. Out-of-Area Services

Overview

Service Organization has 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 Service Organization serves, 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 Service Organization's 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 Service Organization pays both kinds of providers.

The Plan covers healthcare services received outside of Service Organization's service area when received from a participating provider. The Plan covers only limited healthcare services received outside of Service Organization's service area from a nonparticipating provider. Such healthcare services are limited to emergency services received from a nonparticipating provider. Any other healthcare services received from a nonparticipating provider will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Service Organization.

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 the Plan 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, Service Organization will remain responsible for doing what Service Organization 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 Service Organization's 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 Service Organization.

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 Service Organization has used for your claim because they will not be applied after a claim has already been paid.

B. 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 Service Organization through average pricing or fee schedule adjustments.

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

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

C. 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, Service Organization will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

D. Nonparticipating Providers Outside Service Organization's Service Area

1. Member Liability Calculation

When Covered Services are provided outside of Service Organization's 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 the Plan 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, Service Organization may use other payment methods, such as billed charges for Covered Services, the payment the Plan would make if the healthcare services had been obtained within Service Organization's service area, or a special negotiated payment to determine the amount the Plan 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 the Plan will make for the Covered Services as set forth in this paragraph.

E. 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 Service Organization 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 Service Organization, 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.

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

AMENDMENT ISSUED BY
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

AMENDMENT: EPO-207-21-MK

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

Effective upon the later of Your Effective Date or January 1, 2020 and ending upon the earlier of termination of Your enrollment or December 31, 2021 the following applies.

> Covered Individuals shall not be subject to Cost-Sharing for Inpatient Hospital Services, Inpatient Physician Services, and other Inpatient related services for the treatment of Covid-19 to the extent such services are covered under the Contract for dates of service from January 1, 2020 through December 31, 2021.

Effective January 1, 2022, the following applies.

> Covered Individuals shall be subject to the Cost-Sharing in the Benefit Schedule for Inpatient Hospital Services, Inpatient Physician Services, and other Inpatient related services for the treatment of Covid-19 to the extent such services are covered under the Contract for all dates of service beginning January 1, 2022 and after.

For Inpatient Hospital Services, the date of service is the date of admission.

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

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

AMENDMENT ISSUED BY
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

AMENDMENT: EPO-214-21-K

Notwithstanding any provision to the contrary, the contract is amended in accordance with the Consolidated Appropriations Act of 2021 (CAA). This is a federal law that includes the No Surprises Billing Act.

"Surprise billing" (sometimes called "balance billing"):

Non-Participating 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.

Surprise billing is an unexpected balance bill. This can happen when You cannot control who is involved in Your emergency care or when You schedule a service at an In-Network Hospital or ambulatory surgical center (ASC) but are unexpectedly treated by a Non-Participating Provider.

To the extent Covered Services are provided by Out-of-Network Providers under the CAA, you will not be subject to balance billing.

The No Surprises Billing Act requirements:

1. Emergency Services

   If You have an Emergency Medical Condition and Emergency Services are provided by a Non-Participating Provider at a hospital or free- standing emergency room, the most You can be billed is Your plan's In-Network Cost-Sharing amount (i.e., copayments, and applicable coinsurance). Any Cost-Sharing payments made with respect to Your Emergency Service will be counted towards Your In-Network deductible and/or Out of Pocket Maximum. Additionally, Emergency Services will be covered without Prior Authorization. You cannot be balanced billed for these emergency services.

2. Air Ambulance Services

   Air Ambulance Services received from an Out-of-Network Provider will be subject to any In-Network Provider Deductible, if applicable, and the In-Network Provider Out-of-Pocket-Maximum. Any applicable Coinsurance or Copayment listed in the Benefit Schedule will still apply.

Notwithstanding any contrary provision in Section A. Definitions, under Allowable Charge", the following is added:

The Allowable Charge for the above services, Emergency Services, Air Ambulance services, or for Covered Services received by a Non-Participating Provider at a Network Facility, will be calculated using the median rate that We pay In-Network Providers.

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