

# *Preferred-Care Blue*

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*Offered by Blue Cross and Blue Shield of Kansas City*

**Health Benefits Certificate for:  
SYNERGY SERVICES INC**

**Group No: 25677000  
PBM4254V**

**Contract Effective Date: January 1, 2015**



The Certificate describes the Benefits for Health Care Services covered by Blue Cross and Blue Shield of Kansas City and the extent to which Benefits may be limited.

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

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



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



**MISSOURI  
BENEFIT SCHEDULE**

	<b>Effective Date:</b> January 1, 2015
<b>Group Name:</b> SYNERGY SERVICES INC	<b>Dependent Limiting Age:</b> 26
<b>Preexisting Condition Exclusion Period:</b> None	<b>Student Dependent Limiting Age:</b> 26

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

<b>Covered Services</b>	<b>PREFERRED PROVIDER</b>	<b>NON-PREFERRED PROVIDER</b>
	<b>Copayment, Deductible, Coinsurance and Limitations</b>	<b>Copayment, Deductible, Coinsurance and Limitations</b>
<b>Calendar Year Deductible (Individual/Family)</b>	\$2,500/\$5,000	\$2,500/\$5,000
<b>Out-of-Pocket Maximum (Individual/Family)</b> <i>Includes Deductible</i>	\$2,500/\$5,000	\$5,000/\$10,000
<b>Physician Services</b>	Deductible	Deductible then 20% Coinsurance
<b>X-ray and other Radiology Procedures</b>	Deductible	Deductible then 20% Coinsurance <i>Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to a \$200 Calendar Year Maximum</i>
<b>Routine Preventive Care – (See the Routine Preventive Care Benefit under the Covered Services Section for a description of Routine Preventive Services for which you have Benefits)</b>	No Copayment	Deductible then 20% Coinsurance
<b>Urgent Care</b>	Deductible	Deductible then 20% Coinsurance

**MISSOURI  
BENEFIT SCHEDULE**

	<b>PREFERRED PROVIDER</b>	<b>NON-PREFERRED PROVIDER</b>
<b>Covered Services</b>	<b>Copayment, Deductible, Coinsurance and Limitations</b>	<b>Copayment, Deductible, Coinsurance and Limitations</b>
<b>Diagnostic and Routine Preventive Mammograms, Pap Smears and PSA Tests</b>	No Copayment	Deductible then 20% Coinsurance
<b>Emergency Services</b>	Deductible	Deductible
<b>Ambulance</b>	Deductible	Preferred Provider Deductible
<b>Inpatient Hospital Services</b>	Deductible	Deductible then 20% Coinsurance  <i>Inpatient hospital services in a Non-Participating Provider Hospital inside Our Service Area are limited to a \$200 maximum per day and are limited to a 30 day Calendar Year Maximum.</i>
<b>Outpatient Services in Hospital or other Outpatient Facility</b>	Deductible	Deductible then 20% Coinsurance  <i>Outpatient Services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility inside Our Service Area are limited to a \$200 Calendar Year Maximum.</i>
<b>Durable Medical Equipment</b>	Deductible	Deductible then 20% Coinsurance
<b>Formula and Food Products for Phenylketonuria</b>	Deductible	Deductible then 20% Coinsurance but never greater than 50% of the cost of the formula or food product.

**MISSOURI  
BENEFIT SCHEDULE**

	<b>PREFERRED PROVIDER</b>	<b>NON-PREFERRED PROVIDER</b>
<b>Covered Services</b>	<b>Copayment, Deductible, Coinsurance and Limitations</b>	<b>Copayment, Deductible, Coinsurance and Limitations</b>
<b>Inpatient Hospice Facility</b>	Deductible  <i>14 day Lifetime Maximum</i>	Deductible then 20% Coinsurance
<b>Home Health Services</b>	Deductible  <i>60 visit Calendar Year Maximum</i>	Deductible then 20% Coinsurance
<b>Skilled Nursing Facility</b>	Deductible  <i>30 day Calendar Year Maximum</i>	Deductible then 20% Coinsurance
<b>Outpatient Therapy (Speech, Hearing, Physical, Occupational and Skeletal Manipulations not performed by a Chiropractor)</b>	Deductible  <b>Physical Therapy (including skeletal manipulations) and Occupational Therapy:</b> Combined 40 visit Calendar Year Maximum  <b>Speech and Hearing Therapy:</b> Combined 20 visit Calendar Year Maximum	Deductible then 20% Coinsurance
<b>Chiropractic Services</b>	Deductible	Deductible then 20% Coinsurance
<b>Outpatient Chemical Dependency</b>	Deductible  <i>26 day Calendar Year Maximum</i>	Deductible then 20% Coinsurance

**MISSOURI  
BENEFIT SCHEDULE**

	<b>PREFERRED PROVIDER</b>	<b>NON-PREFERRED PROVIDER</b>
<b>Covered Services</b>	<b>Copayment, Deductible, Coinsurance and Limitations</b>	<b>Copayment, Deductible, Coinsurance and Limitations</b>
<b>Residential Treatment Chemical Dependency</b>	Deductible  <i>21 day Calendar Year Maximum</i>	Deductible then 20% Coinsurance
<b>Detoxification Chemical Dependency</b>	Deductible  <i>6 day Calendar Year Maximum</i>	Deductible then 20% Coinsurance
<b>Outpatient Mental Illness</b>	Deductible	Deductible then 20% Coinsurance  <i>60 visit Calendar Year Maximum. Outpatient Mental Illness Preferred Provider services apply to this limit.</i>
<b>Residential Mental Illness</b>	Deductible	Deductible then 20% Coinsurance  <i>30 day Calendar Year Maximum. Residential Mental Illness Preferred Provider services apply to this limit.</i>
<b>Inpatient Mental Illness</b>	Deductible	Deductible then 20% Coinsurance
<b>Organ Transplant</b>	Deductible <i>Unlimited Organ Transplant Lifetime Maximum</i>	Deductible then 20% Coinsurance <i>Unlimited Organ Transplant Lifetime Maximum</i>

**MISSOURI  
BENEFIT SCHEDULE**

		<b>PREFERRED PROVIDER</b>	<b>NON-PREFERRED PROVIDER</b>
<b>Covered Services</b>		<b>Copayment, Deductible, Coinsurance and Limitations</b>	<b>Copayment, Deductible, Coinsurance and Limitations</b>
<b>Outpatient Prescription Drugs includes oral and injectable contraceptives, and contraceptive devices and implants</b>		Covered	
<b>Short-Term Supplies</b>	<b>Tier 1</b>	\$12 Copayment	\$12 Copayment then 50% Coinsurance
	<b>Tier 2</b>	\$35 Copayment	\$35 Copayment then 50% Coinsurance
	<b>Tier 3</b>	\$60 Copayment	\$60 Copayment then 50% Coinsurance
<b>Long-Term Supplies (Mail Order)</b>	<b>Tier 1</b>	\$30 Copayment	\$30 Copayment then 50% Coinsurance
	<b>Tier 2</b>	\$87.50 Copayment	\$87.50 Copayment then 50% Coinsurance
	<b>Tier 3</b>	\$150 Copayment	\$150 Copayment then 50% Coinsurance
<b>All other Covered Services</b>		Deductible	Deductible then 20% Coinsurance
<b>Lifetime Maximum</b>		Unlimited	

## SECTION A. DEFINITIONS

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

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

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

**Adverse Determination** Means a determination by Us that an Admission, availability of care, continued stay or other Health Care Service has been reviewed and, based upon the information provided, does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is therefore denied, reduced, or terminated.

**Allowable Charge** Means the dollar amount upon which Benefits will be determined. Any amounts for Covered Services (other than Copayments) a Covered Person is required to pay will be based on this Allowable Charge. Benefit limits, if any, will also be based on this Allowable Charge. The Allowable Charge may vary depending upon whether or not the provider is a Participating Provider and the terms of that provider's contract with Us.

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 Preferred Providers-

The Allowable Charge is the lesser of:

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

- (2) The provider's billed charges.

- b. For Hospitals, other institutional health care facilities, Physicians or suppliers of medical goods and services which are Non-Preferred Providers, but are Participating Providers-

The Allowable Charge is the lesser of:

- (1) The amount the provider has agreed to accept as payment in full as of the date of service; or
  - (2) The provider's billed charges.
- c. For Hospitals, other institutional health care facilities, Physicians or suppliers of medical goods and services which are Non-Preferred Providers and Non-Participating Providers inside Our Service Area-

The Allowable Charge is the lesser of:

- (1) The amount the provider has agreed to accept as payment in full as of the date of service; or
  - (2) Our participating fee schedule amount for the same services or supplies for such provider-type, if any; or
  - (3) The provider's billed charges.
- d. For Hospitals, other institutional health care facilities, Physicians or suppliers of medical goods and services, which are Non-PPO Providers and Non-Participating Providers outside Our Service Area-

The Allowable Charge is the lesser of:

- (1) The amount that the local Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to Us if the claim was submitted to Us through the BlueCard PPO Program for Physicians or suppliers of medical goods and services; or
  - (2) An amount that is based on the nationally recognized fee schedule to which BCBSKC currently subscribes if the claim is not submitted to Us through the BlueCard PPO Program. If no allowable is available because the service provided does not have a specific code, BCBSKC will apply the same methodology used to establish an allowable for a Participating Provider; or
  - (3) The amount the provider has agreed to accept as payment in full at the time of claim payment; or
  - (4) The provider's billed charges.
- e. For BlueCard PPO Program Providers outside Our Service Area-

When You obtain Covered Services outside of Our 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 Us.

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, We 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.

f. For participating pharmacies-

The Allowable Charge is the lesser of:

- (1) The negotiated rate the pharmacy benefit manager has agreed to accept for Our members, if applicable; or
- (2) The Usual and Customary Charge as described in the Outpatient Prescription Drug Benefit in the Covered Services Section.

**Ambulance**

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

**Ambulatory Review**

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

**Annual Enrollment Period**

Means a period of time mutually agreed upon by the Employer and Us during which eligible persons who have not enrolled with Us may do so.

**Benefits**

Means the amount of Allowable Charges We pay for Covered Services after the Copayment and/or Deductible requirement has been met.

<b>Benefit Schedule</b>	Means a listing of certain Covered Services specifying Copayments, Coinsurance, Deductibles and limitations under the Contract.
<b>BlueCard PPO Program</b>	Means a national Preferred Provider program offered by Blue Cross and Blue Shield of Kansas City 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.
<b>BlueCard PPO Program Service Area</b>	Means Our Service Area as well as any other 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.
<b>Blue Cross and Blue Shield of Kansas City</b>	Means the company legally responsible for providing the Benefits under the Contract. Blue Cross and Blue Shield of Kansas City is referred to as "We," "Us" and "Our."
<b>Calendar Year</b>	Means January 1 through December 31 of the same year.
<b>Calendar Year Maximum</b>	Means a maximum dollar amount, or a maximum number of days, visits or sessions for which Benefits for Covered Services are provided for a Covered Person in any one Calendar Year. Once a Calendar Year Maximum for a specific Covered Service is met, no more Benefits for such Covered Services will be provided during the same Calendar Year.  If the Contract replaces any health plan issued by Blue Cross and Blue Shield of Kansas City or any of its affiliates under which a Covered Person was covered, then this maximum will be reduced by the amount of Benefits a Covered Person received through the previous plan(s) during that Calendar Year.
<b>Certificate</b>	Means this booklet and any amendments.
<b>Certificate of Creditable Coverage</b>	Means a certificate issued from a former health plan or insurance company that documents the number of days of Creditable Coverage a person has had which may be used to reduce the number of days of a person's Preexisting Condition Exclusion Period.
<b>Certification</b>	Means a determination by Us that an Admission, availability of care, continued stay or other Health Care Service has been reviewed and, based on the information provided, satisfies Our requirements for Medical Necessity, appropriateness, health care setting, level of care and effectiveness.
<b>Claim</b>	Means a request for: (1) services that require Approval in Advance made in accordance with the procedures outlined in the Utilization Review

Section; (2) payment for Covered Services rendered in accordance with the procedures outlined in the How to File a Claim Section; or (3) an appeal of a benefit determination ("Grievance") made in accordance with the procedures outlined in the Complaint and Grievance Procedures Section.

<b>Coinsurance</b>	Means the percentage of an Allowable Charge that You must pay for a Covered Service.
<b>Complications of Pregnancy</b>	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, cesarean section, or elective abortion.
<b>Concurrent Review</b>	Means Utilization Review conducted during a patient's Hospital stay or course of treatment.
<b>Confinement</b>	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.
<b>Contract</b>	Means the agreement between the Employer and Us that contains all of the terms of coverage. The Contract includes the Certificate, the Employer application, the Employee application, and any amendments.
<b>Copayment</b>	Means the dollar amount of a charge that a Covered Person must pay for certain Covered Services.
<b>Covered Person</b>	Means the Employee or any of the Employee's Dependents whose coverage is in effect under the Contract.
<b>Covered Services</b>	Means services, supplies, equipment and care specifically listed in the "Covered Services" section of the Contract.
<b>Creditable Coverage</b>	Means coverage of an individual under any of the following: individual or group health insurance, a self-funded ERISA group health plan, Part A or B of Medicare, Medicaid, CHAMPUS, an Indian Health Service program or of a tribal organization, a state health benefits risk pool, the Federal Employees Health Benefits Program, a public health plan established or maintained by a State, the United States government, a foreign country, or the Peace Corps Act, or a State Children's Health Insurance Program (SCHIP).
<b>Custodial Care</b>	Means care furnished mainly to train or assist in personal hygiene or other activities of normal daily living such as dressing, feeding, and walking, rather than to provide medical treatment.

**Deductible** Means the portion of Allowable Charges for Covered Services other than prescription drugs a Covered Person must pay each Calendar Year before We will provide Benefits unless otherwise specified. The application of the Deductible during any Calendar Year will be based upon the date when Covered Services were actually received. Each Covered Person must satisfy a Deductible each Calendar Year before Benefits will be paid.

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

- a. Deductible credit will be available only to those Covered Persons who were covered by the former plan on the day immediately prior to the Effective Date of the Contract when the Effective Date of the Contract is other than January 1; and
- b. Credit will be limited to the charges for Covered Services that applied to the Deductible and were received within the 90 day period prior to the Effective Date of the Contract.

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

**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 Your Premiums are due and payable.

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

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

- a. Placing the person's health in significant jeopardy;
- b. Serious impairment to a bodily function;
- c. Serious dysfunction of any bodily organ or part;
- d. Inadequately controlled pain; or
- e. With respect to a pregnant woman who is having contractions:

- (1) That there is inadequate time to effect a safe transfer to another Hospital before delivery; or
- (2) That transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

**Emergency Services**

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

**Employee**

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

**Employer**

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

**Experimental/  
Investigative Services**

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

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

- a. The drug or device cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- b. Reliable evidence shows that the drug, device or medical treatment or procedure:
  - (1) Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the maximum tolerated dose, safety, toxicity, or efficacy as its objective;
  - (2) Is provided pursuant to a written protocol or other document that lists an evaluation of its safety, toxicity, or efficacy as its objective; or
  - (3) Is Experimental/Investigative per the informed consent document utilized with the drug, device or medical treatment; 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, Our local Medical Policy Committee, 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 there is not sufficient evidence based peer reviewed studies published in medical literature to establish the safety and efficacy of the technology.

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

**Health Care Service**

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

**Home Health Agency**

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

**Hospice**

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

**Hospital**

Means a facility that:

- a. Operates pursuant to law;
- b. Provides 24-hour nursing services by Registered Nurses (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 staff of Physicians.

Hospitals are classified as follows:

- a. Preferred Provider Hospital. See definition of Preferred Provider.

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

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

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

**Immediate Family Member**

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

**Initial Enrollment Period**

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

**Institution of Higher Learning**

Means any of the following accredited institutions:

- a. State universities or colleges or community colleges;
- b. Licensed private colleges or universities; or
- c. Post-high school vocational or technical schools, nursing training schools, beautician schools, automotive schools or any similar licensed training schools.

This definition does not include high schools, vocational high schools, correspondence schools or schools not providing an entire course progression. If a Covered Person takes certain specialized courses, for example adult education courses, such Covered Person will not be considered enrolled in an Institution of Higher Learning.

**Late Enrollee**

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

- a. The Employer offers multiple health benefit plans and the person elects a different health benefit plan during an Annual Enrollment Period without a lapse in coverage; or
- b. A court ordered coverage to be provided for a minor child.

**Lifetime Maximum**

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

**Medically Necessary  
(Medical Necessity)**

Means services and supplies which are essential to the health of a Covered Person and are:

- a. Appropriate and necessary for the symptoms, diagnosis and treatment of a medical or surgical condition;
- b. Consistent with acceptable medical practice according to the national Blue Cross and Blue Shield Association's uniform medical policy (as amended from time to time);
- c. Not primarily for the convenience of the Covered Person, nor the Covered Person's family, Physician or another provider;
- d. Consistent with the attainment of reasonably achievable outcomes; and
- e. Reasonably calculated to result in the improvement of the Covered Person's physiological and psychological functioning.

Determinations regarding Medical Necessity, just like any other determination, may be appealed pursuant to the grievance procedure.

**Medicare**

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

**Mental Illness**

Means those conditions classified as "mental disorders" in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders but not including mental retardation.

**Non-Participating  
Provider**

Means a provider who does not have a contract with Us to provide health care to Covered Persons.

**Non-Preferred Provider  
(Non-PPO)**

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 a Preferred Provider contract with Us or another designated Blue Cross and/or Blue Shield Plan through the BlueCard PPO Program.

**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-Pocket Maximum** Means the total amount of the Calendar Year Deductible, plus the amount of any Coinsurance and/or Copayments a Covered Person must pay each Calendar Year for Covered Services before Benefits will be paid at 100%. 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. Prescription drug Copayment and/or Coinsurance, if applicable.
- d. Office visit Copayments;
- e. Emergency room Copayments;
- f. Any amount for Covered Services incurred in a Non-Participating Provider Hospital or in a Non-Participating outpatient facility in the Service Area; or
- g. Any amount for Covered Services incurred at a non-Designated Transplant Provider for an Organ Transplant.

Copayments and Coinsurance shall apply for paragraphs c, d, e, f and g regardless of whether the Covered Person has met the Out-of-Pocket Maximum.

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

**Participating Provider** Means a Hospital, health care facility, Physician, or other provider of medical care or supplies, which has entered into a contract that defines the method We will use to determine the Allowable Charges for Covered Services. Participating Providers have agreed to accept Our Allowable Charge as payment in full for Covered Services. However, You are responsible for the payment of any Copayment, Coinsurance and Deductible amounts, non-Covered Services and amounts in excess of any Benefit maximums of the Contract.

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

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

Physicians are classified as follows:

- a. Preferred Provider Physician. See the definition of Preferred Provider.
- b. Non-Preferred Provider Physician. A Non-Preferred Provider Physician may or may not be a Participating Provider Physician. See the definition of Non-Preferred Provider.
- c. Participating Provider Physician means a Physician who, by a contract with a Blue Cross and/or Blue Shield Plan, agrees to accept the Allowable Charge as full payment for Covered Services. Any applicable Copayments, Coinsurance and/or Deductible for Covered Services are Your responsibility. A Participating Provider Physician may or may not be a Preferred Provider Physician.
- d. Non-Participating Provider Physician means a Physician that does not have a Participating Provider Physician contract with Us.

**Post-Service Claim**

Means a request for payment for Covered Services rendered.

**Pre-Service Claim**

Means a request for services that require Approval in Advance.

**Preexisting Condition**

Means any illness, injury or other condition for which medical advice, diagnosis, care or treatment was received or recommended during the 6 months prior to the first day of Your Waiting Period (or the date coverage is effective if there is no Waiting Period).

**Preferred Provider**

Means a Hospital, Physician or other provider of medical services and supplies participating under a contract with Us through a Preferred Provider Organization (PPO) as named in the provider directory. Preferred Provider also includes providers outside Our Service Area who participate in other designated Blue Cross and/or Blue Shield Plan networks in the BlueCard PPO program. Call the toll free number on Your identification card or consult Our website at [www.bluekc.com](http://www.bluekc.com) for a list of Preferred Providers participating in the BlueCard PPO Program.

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

<b>Premiums</b>	Means the amount paid on a periodic basis for Your coverage under the Contract.
<b>Primary Care Physician (PCP)</b>	Means an internist, family practitioner, general practitioner or pediatrician.
<b>Prior Authorization or Prior Authorized</b>	Means the procedure whereby We determine: (a) based on medically recognized criteria, whether or not an Admission to a Hospital as an inpatient is reasonable for the type of services to be received; or, (b) whether any service to be performed is reasonable and Medically Necessary for the condition being treated and the type of services to be provided.
<b>Prospective Review</b>	Means Utilization Review conducted prior to an Admission or a course of treatment.
<b>Reinstatement</b>	Means restoring a Contract that has been terminated (for example, because of nonpayment of Premiums).
<b>Retrospective Review</b>	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.
<b>Second Opinion</b>	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.
<b>Service Area</b>	(Sometimes referred to as "Our Service Area") means the geographic area served by Us. Contact Us to determine the geographic area We serve. (Note: Our Service Area is different than the BlueCard PPO Program Service Area. See the definition of BlueCard PPO Program Service Area.)
<b>Skilled Nursing Facility</b>	Means a facility that: <ul style="list-style-type: none"> <li>a. Operates pursuant to law;</li> <li>b. Provides 24-hour nursing services by registered nurses (R.N.'s) on duty or on call; and</li> <li>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.</li> </ul> <p>The Skilled Nursing Facility may be operated either independently or as part of an accredited general Hospital.</p>

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

Skilled Nursing Facilities are classified as follows:

- a. Participating Provider Skilled Nursing Facility means a Skilled Nursing Facility that contracts with Us or any Blue Cross and/or Blue Shield Plan to provide the Skilled Nursing Facility Covered Services, if any, described in the Contract and accepts the Allowable Charge as full payment for Covered Services except for Copayments, Coinsurance and/or Deductibles if any.
- b. Non-Participating Provider Skilled Nursing Facility means a Skilled Nursing Facility which does not have a contract with Us or any Blue Cross and/or Blue Shield Plan.

**Special Enrollment Period**

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

**Specialist**

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

**Stabilize**

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

**Terminally Ill**

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

**Totally Disabled**

Means:

- a. A Covered Person has a condition which prevents him from performing the material and substantial duties of his occupation; or
- b. A nonworking Dependent has a condition which prevents him from performing activities normally associated with a person of the same sex and age.

**Utilization Review**

Means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, Health Care Services, procedures, or settings. Techniques may include Ambulatory Review, Prospective Review, Second Opinion, Certification, Concurrent Review, case management, Discharge Planning or

Retrospective Review. Utilization Review shall not include elective requests for clarification of coverage.

**Waiting Period**

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

**We, Us, Our**

Means Blue Cross and Blue Shield of Kansas City, the company legally responsible for providing the Benefits for Covered Services under the Contract.

**You, Your**

Refers to the Covered Person.

## SECTION B. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

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- 1. Employee Eligibility** To be eligible to enroll as an Employee, a person must be:
- a. In an eligible class of Employees listed in the Contract and satisfy any Waiting Periods required by the Employer; and
  - b. A resident citizen or legal alien residing in the United States.
- 

- 2. Dependent Eligibility** To be eligible to enroll as a Dependent, a person must be:
- a. The Employee's spouse as defined by the Employer;
  - b. The Employee's or Employee's legal spouse's unmarried child who is dependent upon the Employee or the Employee's legal spouse. Such child includes a child by birth, an adopted child, a child under the age of 18 who has been placed with the Employee for the purpose of adoption for whom the Employee has a legal obligation to support, or a child placed under the Employee's legal guardianship. Coverage will be provided until the end of the Calendar Year in which such child reaches the Dependent limiting age or if a full-time student in an Institution of Higher Learning, the earlier of: (i) the end of the month in which the child ceases to meet the eligibility requirements; or (ii) the end of the Calendar Year in which the child reaches the Dependent student limiting age; or
  - c. The Employee's or Employee's legal spouse's unmarried child (defined above) who has reached the limiting age but who cannot support himself because of a physical or mental handicap. The child's handicap must have started before the end of the Calendar Year in which the child reached the limiting age and the child must have been continuously covered by Us or a prior health plan at the time of reaching the limiting age.

We must receive satisfactory proof of the child's handicap within 31 days after the child reaches the Dependent limiting age, or within 31 days after the child is enrolled for coverage under the Contract. In addition, We must receive satisfactory proof annually, following the child's attainment of the limiting age.

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

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

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### **3. Effects of Rescission on Eligibility**

If a person's coverage under a medical insurance policy underwritten by Blue Cross and Blue Shield of Kansas City or one of its subsidiaries was rescinded or terminated due to fraud or material misrepresentation, such individual shall not be eligible to enroll under this Contract regardless of whether such individual otherwise meets the Eligibility and Dependent Eligibility requirements of the Contract.

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### **4. Enrollment**

#### **a. Annual Enrollment Period**

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

#### **b. Initial Enrollment Period for a Newly Eligible Employee**

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

#### **c. Special Enrollment Periods**

(1) New Dependents: If a new Dependent is acquired by an Employee due to marriage, birth of a child, adoption of a child, or placement for adoption of a child, the new Dependent, the spouse of an Employee, 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 Us a completed Employee application and any additional Premium due within 31 days after the date of marriage, birth, adoption, or placement for adoption. Documentation verifying the event must be provided, if requested.

Notwithstanding the above paragraph, if the Employee previously has elected Dependent coverage and such coverage is in effect on the date of the newborn child's birth, then the Employee's newborn child will be covered automatically for 31 days from the moment of birth. No additional Premium will be assessed for coverage for these 31 days. If additional Premium is due, the Employee must submit to Us

a completed Employee application requesting coverage for such newborn to be added within 31 days of the child's birth in order to continue such child's coverage beyond the initial 31 days. Coverage for such a newborn will be subject to all of the terms and conditions of the Contract.

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

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

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

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

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

- a. (i) The employer's contributions toward such coverage were terminated;
- (ii) The Employee's and/or his Dependent's COBRA or state continuation coverage has been exhausted; or
- (iii) The Employee's and/or his Dependent's coverage terminated as a result of loss of eligibility for coverage. Loss of eligibility for coverage does not include termination due to untimely payment of premiums or termination for cause. Events that could result in a loss of eligibility for coverage include:
  - 1. Legal separation, divorce, no longer qualifying as a dependent under the other coverage, death of an Employee, termination of employment or reduction in the number of hours of employment.
  - 2. Reaching a Lifetime Maximum on all Benefits under coverage offered by an employer.

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

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

(3) Coverage Options: The Employee and/or his Dependents may enroll in any health benefit plan offered by his Employer.

**d. Full-time Student Enrollment Period**

The Employee's or Employee's legal spouse's unmarried child who becomes eligible as a Dependent due to full-time student status at an Institution of Higher Learning may enroll by submitting to Us a completed Employee application and satisfactory proof of student status within 31 days of becoming eligible. If the Dependent does not enroll within 31 days of becoming eligible, then that Dependent will be considered a Late Enrollee.

**e. Guardianship**

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

**f. Qualified Medical Child Support Order**

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

**g. Employee Application**

Employees must fully and accurately complete and sign the Employee application. False or misrepresented material information provided may cause coverage of an Employee and/or Your Dependents to be null and void from inception.

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**5. Effective Date of Coverage**

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

**a. Annual Enrollment Period**

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

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

**b. Initial Enrollment Period for a Newly Eligible Employee**

The Effective Date of coverage of a person who first becomes eligible as an Employee will be the first day of the month following satisfaction of the Waiting Period, if any. If an Employee has Dependents on the date the Employee's coverage becomes effective, coverage for those Dependents will begin on the Employee's coverage Effective Date, provided the Employee requested coverage for the Dependents on the Employee application when the Employee enrolled.

**c. Special Enrollment Period**

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

(a) In the case of marriage, the date of the marriage.

(b) In the case of the birth of a child, the date of such birth.

(c) In the case of adoption of a child, the earlier of: (i) the moment of birth for a newborn child if a petition for adoption was filed within 31 days of the birth of the child; (ii) the date the petition for adoption was filed; or (iii) on the child's date of placement. Date of placement means the date You assume the legal obligation for total or partial support of the child to be adopted in connection with formal adoption proceedings.

(2) Loss of Other Coverage: If an individual enrolls under the Special Enrollment Period due to a loss of coverage, coverage is effective on the first day following the date the other coverage terminates if a completed Employee application and any additional Premium required is submitted to Us within 31 days of the loss of other coverage.

**d. Late Enrollees**

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

**e. Guardianship**

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

**f. Qualified Medical Child Support Order**

Notwithstanding any provision in the Contract to the contrary, children who are the subject of a "Qualified Medical Child Support Order" will be eligible for coverage in accordance with such order, provided the order is "qualified" in accordance with Section 609 of ERISA.

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

- (1) Promptly notify the participant and each alternate recipient of such order and the procedures for determining whether an order is a Qualified Medical Child Support Order;
- (2) Within a reasonable period after receipt of such order, determine whether such order is a Qualified Medical Child Support Order and notify the participant and each alternate recipient of such determination; and
- (3) Permit an alternate recipient to designate a representative for receipt of copies of notices that are sent to the alternate recipient with respect to a medical child support order.

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

**g. Extension of Benefits from Prior Plan**

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

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**6. Dual Coverage**

For the same Employer-sponsored coverage, an individual cannot be covered

under this Contract simultaneously as an Employee and a Dependent, nor can an individual be covered under this Contract simultaneously as a Dependent of more than one Employee.

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

## SECTION C. COVERED SERVICES

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

### Covered Services

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

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

- a. Incurred for a Covered Person while coverage is effective;
- b. Performed, prescribed or ordered by a Physician;
- c. Medically Necessary for the treatment of Your injury or illness, except for specifically listed routine preventive or diagnostic services;
- d. Not excluded under the Contract; and
- e. Received in accordance with the requirements of the Contract.

### Benefits

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

Benefits are different depending on whether Covered Services are received from a Preferred Provider or a Non-Preferred Provider. Benefits for Covered Services will be greater if Covered Services are received from Preferred Providers. **It is Your responsibility to ensure that You use Preferred Providers to receive the maximum Benefits.** Failure to do so will increase Your financial responsibility. See Your provider directory or call Us for a listing of Preferred Providers.

BlueCard PPO: If You receive Covered Services outside of Our Service Area, You may still receive Benefits for Covered Services as if You received the Covered Services in Our Service Area. Providers outside of Our Service Area will be considered Preferred Providers in the following situations:

- a. Covered Services are received from a BlueCard PPO Provider;
- b. Covered Services are received from a provider in the BlueCard PPO Program Service Area, that is not in a classification of providers currently offered an opportunity to become Preferred Providers; or

- c. Covered Services are received from a provider in an area which is not served by the BlueCard PPO Program.

**Deductible**

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

**Copayments**

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

Copayments are shown in the Benefit Schedule.

**Out-of-Pocket Maximum**

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

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

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

**Individual Lifetime Maximum**

The amount of Benefits provided under the Contract 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 Us will state so in the applicable Covered Service provision.** 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 Preferred Providers Inside Our Service Area – If these services are not Prior Authorized, the admitting Physician, provider and/or Hospital will be responsible for the cost associated with such services, regardless of Medical Necessity.

Services Received from Non-Preferred Providers or Preferred Providers Outside Our Service Area – If these services are not Prior Authorized,

You will be responsible for the cost associated with such services, regardless of Medical Necessity.

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

Benefits will be limited to the length of stay approved by Us. When the approved length of stay must be extended for Medically Necessary reasons, You or Your attending Physician, on Your behalf, must contact Us in advance to obtain Our approval for the additional days. Failure to provide such notice or obtain Approval in Advance 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. Dental Services/  
Surgery**

Accidental Injury

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

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

We provide Benefits for:

Tooth Extractions

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

Dental Implants

Dental implants and bone grafts for the following conditions:

- a. The repair of defects in the jaw due to tumor/cyst removal;
- b. Severe atrophy in a toothless arch;
- c. Exposure of nerves;

- d. Non-union of a jaw fracture;
- e. Loss of tooth (teeth) due to an Accidental Injury; and
- f. Correction of a defect diagnosed within 31 days of birth.

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

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

Orthognathic Surgery      Orthognathic surgery for the following conditions:

- a. Correction of a defect 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.

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

Complications of Dental Treatment      We provide 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.

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

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

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

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

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#### **4. Anesthesia**

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

**Dental** We provide Benefits for general anesthesia materials, their administration, and medical care facility charges for dental care if provided to the following Covered Persons:

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

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

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#### **5. Bone Marrow Testing**

We provide Benefits for bone marrow testing. Covered Services are limited to Human Leukocyte Antigen testing for A, B and DR antigens used in bone marrow transplantation. Covered Services may be limited to a bone marrow testing Lifetime Maximum if indicated in the Benefit Schedule.

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#### **6. Chemotherapy**

We provide Benefits for chemical treatment (chemotherapy) of a disease, including the cost of the chemotherapy drug.

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#### **7. Chiropractic Services**

We provide Benefits for Chiropractic Services. Coverage includes initial diagnosis and clinically appropriate and Medically Necessary services to treat the diagnosed disorder. Covered Services may be limited to a Calendar Year Maximum if indicated in the Benefit Schedule.

Chiropractic services received from a Non-Preferred Provider must be **Prior Authorized by Us.**

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## 8. Clinical Trials

### *Phase II*

We provide Benefits for Routine Patient Care Costs as the result of a Phase II clinical trial for the purposes of prevention, early detection or treatment of cancer, 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. The National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center;
- b. The person is enrolled in the Phase II clinical trial, not merely following protocol of Phase II.

**Covered Services for Phase II clinical trials are limited to services rendered by Preferred Providers.**

### *Phase III and IV*

We provide Benefits for Routine Patient Care Costs as the result of a Phase III or IV clinical trial for the purposes of prevention, early detection or treatment of cancer, 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. One of the National Institutes of Health (NIH).
- b. An NIH cooperative group or center.
- c. The FDA in the form of an investigational new drug application.
- d. The federal Departments of VA or Defense.
- e. An institutional review board in MO that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with an implementation of regulations for the protection of human subjects.
- f. A qualified research entity that meets the criteria for NIH Center support grant eligibility.

### *Phase II, III and IV*

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

Routine Patient Care Costs are defined as follows:

- a. Drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's particular condition.
- b. Reasonable and Medically Necessary services needed to administer a drug or device under evaluation in a clinical trial; and
- c. All other items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial, except:
  - (i) The Investigational item 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; and
  - (iii) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

**These services must be Prior Authorized by Us.**

## **9. Cochlear Implants**

We provide Benefits for cochlear implants. Covered Services are limited to the initial cochlear implant and related implant services. Covered Services do not include repairs, replacements or duplicates.

**Cochlear implants must be Prior Authorized by Us.**

## **10. Diabetes**

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

We provide Benefits for one pair of Diabetic Shoes and up to a maximum of 3 pair of inserts per Covered Person per Calendar Year.

## **11. Diagnostic Services**

We provide Benefits for diagnostic services including x-ray examinations, laboratory services, other diagnostic procedures and tests required to diagnose an illness, injury, or other Covered Service. Covered Services do not include screening examinations or routine physical examinations unless these services are specifically listed as Covered Services under the Routine Preventive Care Benefit in this section. Benefits for diagnostic

services may vary based on where the services are rendered as indicated in the Benefit Schedule.

Non-Participating  
Provider/Outpatient  
Facility Benefits Inside  
Our Service Area

The following provisions apply to Covered Services received from Non-Participating Provider outpatient facilities including an imaging center.

- a. Your Benefit for an outpatient service at a Non-Participating Provider outpatient facility including an imaging center inside Our Service Area will be limited to a maximum of \$200 per Calendar Year.
- b. Benefits for services received from a Non-Participating Provider Outpatient facility including an imaging center inside Our Service Area will not be subject to any Deductible or Coinsurance requirements.

Except for Non-Participating Providers in Our Service Area, Benefits for Diagnostic Services are paid the same as any other services unless otherwise indicated in the 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 a Preferred 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 Contract, 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 a Preferred Provider. The office visit Copayment will apply if applicable.

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**12. Dialysis**

We provide Benefits for hemodialysis and peritoneal dialysis services.

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**13. Durable Medical  
Equipment**

We provide Benefits for the rental or purchase of durable medical equipment (DME) for use outside a Hospital subject to the following conditions:

- a. Use of DME will be authorized for a limited period of time;

- b. We retain the right to possess the equipment and You agree to cooperate with Us in arrangements to return the equipment following Your authorized use; and
- c. We have the right to stop covering the rental when the item is no longer Medically Necessary.

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

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

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

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

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

Covered Services do not include repair or replacement required as a result of abuse or misuse of DME. If repair or replacement of DME is authorized, We retain the option to determine whether to repair or replace the equipment. Covered Services do not include muscle stimulators; portable paraffin bath units; sitz bath units; stethoscopes, or blood pressure devices; nor items for comfort or convenience, such as but not limited to spas, whirlpools, Jacuzzis, hot tubs, humidifiers, dehumidifiers and air conditioners. Covered Services also do not include DME that would normally be provided by a Skilled Nursing Facility. See the Exclusions section of the Contract for additional exclusions which may apply.

Covered Services may be limited to a Calendar Year Maximum if indicated in the Benefit Schedule.

**DME must be Prior Authorized by Us.**

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**14. Early Intervention Services**

We provide Benefits for Early Intervention Services. Early Intervention Services are Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology devices for children from birth to age three who are Missouri residents and are identified as eligible for services under Part C of the Individuals with Disabilities Education Act. Early intervention services must be provided and billed by the Department of Elementary and Secondary Education (DESE).

These Benefits are subject to the same Deductible, Copayment and/or Coinsurance provisions as other Covered Services and are limited to a \$3,000 Calendar Year Maximum and a \$9,000 Lifetime Maximum per child. The allowable charge for these services is the Medicaid allowable in effect on the date the service is provided.

Aggregate payments made during a calendar year for services provided under this provision may be limited to 0.5% of the direct written premium or \$500,000, whichever is less on or before January 31 of the current year.

The Deductible, Copayment and/or Coinsurance for Early Intervention Services will not apply to and will not be limited by the Lifetime Maximum for all Covered Services that are indicated in the Benefit Schedule.

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**15. Elective Sterilization**

We provide Benefits for elective sterilization.

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**16. Electrical Stimulation**

Spinal cord electrical stimulation and electrical stimulation for bone 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.

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**17. Emergency Services And Supplies**

We provide Benefits for the treatment of Emergency Medical Conditions. You must pay the Emergency Services and Supplies Copayment if indicated in the Benefit Schedule for each visit to an emergency room. This Copayment will not apply if You are admitted to a Preferred Provider Hospital for the same condition within 24 hours.

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

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

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

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**18. Formula and Food Products for Phenylketonuria (PKU)**

We provide Benefits for formula and low protein modified food products recommended by a Physician for the treatment of Phenylketonuria (PKU) or any inherited disease of amino and organic acids. Covered Services for formula and low protein modified food products are limited to Covered Persons under the age of 6. Covered Services may be limited to a Calendar Year Maximum if indicated in the Benefit Schedule.

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

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

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**19. Genetic Testing**

We only provide Benefits for the genetic testing for breast and colorectal cancer. Covered Services are limited to selected genetic tests and the associated pre-test and post-test genetic counseling.

**Genetic Testing for breast and colorectal cancer must be Prior Authorized by Us.**

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**20. Home Health Services**

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

- a. Covered Services are limited to part-time skilled nursing care, part-time services from home health aides, private duty nursing, physical therapy, occupational therapy or speech therapy;

- b. The services are received as an alternative to inpatient Confinement in a Hospital or Skilled Nursing Facility; and
- c. Your Physician determines that You need home health care and designs a home health care plan for You.

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

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

## 21. Hospice Services

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

### Home Hospice

- a. Covered Services are limited to the following home Hospice services:
  - (1) Assessment and initial testing.
  - (2) Family counseling of Immediate Family Members.
  - (3) Non-prescription pharmaceuticals.
  - (4) Medical supplies.
  - (5) Respite care.
  - (6) Professional, medical, social, and pastoral counseling services provided by salaried employees of the Hospice.
  - (7) Supportive services to the bereaved family members for up to 3 months following the death of the Covered Person.
- b. Covered Services do not include:
  - (1) Services for which there is no charge.
  - (2) Services related to organization or dispensation of nonmedical, personal, legal, and financial affairs such as, but not limited to, the execution of a will.
  - (3) Services received in a free standing Hospice facility, a Hospital-based Hospice, or provided to a Hospital bed patient except that Covered Services will be provided for an assessment visit, family

counseling and supportive services to the bereaved Immediate Family Members.

- (4) Services received by persons other than the Covered Person or his Immediate Family Members.
- (5) Services received from Hospice organizations that do not have a contract with a Blue Cross and/or Blue Shield Plan to provide such services to Covered Persons.

#### Inpatient Hospice

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

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

- b. Covered Services do not include:

- (1) Services for which there is no charge.
- (2) Services related to organization or dispensation of nonmedical, personal, legal, and financial affairs such as, but not limited to, the execution of a will.
- (3) Services received by persons other than the Covered Person or his Immediate Family Members.
- (4) Services received from Hospice organizations that do not have a contract with a Blue Cross and/or Blue Shield Plan to provide such services to Covered Persons.
- (5) Respite care.

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

**Inpatient Hospice services must be Prior Authorized by Us.**

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## 22. Immunizations for Children

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

Covered Services for routine and necessary immunizations will be provided at 100% of the Allowable Charge and will not be subject to any 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 Contract, the same as any other services.

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

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## 23. Infusion Therapy and Self-Injectables

### Infusion Therapy

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

- a. If You did not receive infusion therapy at home or in Your Physician's office, You would have to receive such services in a Hospital or Skilled Nursing Facility;
- b. The services are ordered by a Physician and provided by an infusion therapy provider or Physician licensed to provide such services.
- c. **Services are Prior Authorized by Us.**

### Injectables

We provide Benefits for self-injectables administered in the Physician's office or in the home setting. **These services must be Prior Authorized by Us.** Covered Services for growth hormones are limited to treatment for pediatric growth deficiency for Covered Persons under age 19. Most self injectables are processed under Your Outpatient Prescription Drug

Benefit; however, selected self injectables may be processed under Your medical benefit. Please refer to the Prescription Drug List for a listing of self-injectables that are processed under Your medical benefit or visit Our website at [www.bluekc.com](http://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. See the Allergy and Diabetes Benefits in the Contract for a description of how allergy injections and insulin are covered.

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

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## 24. Inpatient Hospital Services

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

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

Covered Services for inpatient Hospital services for the treatment of Mental Illness, Chemical Dependency and alcoholism are limited as indicated in the Mental Illness and Chemical Dependency Benefit.

Non-Participating  
Provider Hospital/  
Benefits Inside Our  
Service Area

The following provisions apply to Covered Services received from Non-Participating Provider Hospitals and residential facilities:

- a. Your Benefit for Covered Services for inpatient hospital services in a Non-Participating Provider Hospital inside Our Service Area is limited to a maximum of \$200 per day. However, this Benefit will be provided only for up to 30 days per Calendar Year, per Covered Person, for all Admissions combined in such Non-Participating Provider Hospitals.
- b. Your Benefit for an outpatient service at a Non-Participating Provider Hospital inside Our Service Area will be limited to a maximum of \$200 per Calendar Year.

- c. Your Benefit for Covered Residential Chemical Dependency and Mental Illness Treatment Programs in a Non-Participating Provider facility inside Our Service Area is limited to a maximum of \$200 per day. However, this benefit will be provided only for up to 30 days per Calendar Year for Mental Illness and 21 days per Calendar Year for Chemical Dependency, per Covered Person, for all admissions combined in Non-Participating Provider facilities.

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

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

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**25. Maternity Services  
and Related Newborn  
Care**

We provide Benefits for maternity services. Covered Services are limited to pre-natal, obstetrical and postpartum services.

Covered Services include an inpatient stay of at least 48 hours for a covered mother and a covered newborn child following any vaginal delivery or 96 hours following a cesarean section delivery. If the attending Physician, after consulting with the mother, authorizes a shorter inpatient Confinement, We will provide Benefits for post-discharge care. If the mother and newborn child are discharged early, Covered Services include post-discharge care for a covered mother and a covered newborn child for 2 visits (at least 1 visit in home) by a Physician or registered professional nurse with experience in maternal and child health nursing. Such services include, but are not limited to, physical assessment of the mother and newborn child; parent education; assistance and training in breast or bottle feeding; education and services for immunizations; and, appropriate chemical tests and submission of a metabolic specimen to the state laboratory.

Services provided for a covered newborn child and routine Hospital nursery services provided during the Hospital Confinement, are eligible for Benefits under the newborn child's Dependent coverage. Benefits shall also include coverage during the confinement for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If both the mother and newborn child are covered under this Contract, the routine Hospital nursery services are not subject to the child's Deductible. If Your plan provides coverage for routine Physician examinations, the Physician services associated with the routine Hospital nursery stay will be subject to the child's Deductible. The list of Covered Services under the Routine Preventive Care benefit will include Physician examinations if You have coverage for such Physician Services.

Dependent daughters are not covered for maternity services.

Complications of  
Pregnancy

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

Covered Services do not include elective pregnancy termination, 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  
Chemical Dependency**

We provide Benefits for the treatment of Mental Illness and Chemical Dependency.

Covered Providers: In addition to Physicians and Hospitals, Covered Services provided by the following providers will be eligible for coverage, if such services are within the lawful scope of the provider and the provider is licensed by the state in which the services are rendered (if applicable): (1) psychologists; (2) licensed clinical social workers; (3) psychiatric residential and nonresidential treatment facilities; (4) alcoholism treatment facilities; (5) drug abuse treatment facilities; (6) community mental health centers or clinics; and (7) licensed professional counselors.

Chemical Dependency  
Services

Covered Services provided by Preferred or Non-Preferred Providers are limited as follows:

- a. Services for outpatient treatment through Nonresidential Treatment Programs or through partial or full-Day Program Services are subject to a Calendar Year Maximum if indicated in the Benefit Schedule;
- b. Services for Residential Treatment Programs are subject to a Calendar Year Maximum if indicated in the Benefit Schedule;
- c. Services for Medical or Social Setting Detoxification are subject to a Calendar Year Maximum if indicated in the Benefit Schedule;

These Benefits are also limited to 10 Episodes of treatment. This limit will not apply to Medical Detoxification in a life-threatening situation.

For purposes of this Benefit, the following terms mean:

"Chemical Dependency" means the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

"Day Program Services" means a structured, intensive day or evening treatment or partial hospitalization program, certified by the department of mental health or accredited by a nationally recognized organization.

"Episode" means a distinct course of Chemical Dependency treatment separated by at least 30 days without treatment.

"Medical Detoxification" means Hospital inpatient or residential medical care to ameliorate acute medical conditions associated with Chemical Dependency.

"Nonresidential Treatment Program" means a program certified by the department of mental health involving structured, intensive treatment in a nonresidential setting.

"Residential Treatment Program" means a program certified by the department of mental health involving residential care and structured, intensive treatment.

"Social Setting Detoxification" means a program in a supportive non-Hospital setting designed to achieve detoxification, without the use of drugs or other medical intervention, to establish a plan of treatment and provide for medical referral when necessary.

**Services for Residential Treatment Programs, Medical or Social Setting Detoxification, and Outpatient partial or full-Day Program Services must be Prior Authorized by New Directions.**

Mental Illness  
Services:

Covered Services rendered by Preferred Providers are limited as follows:

a. Outpatient Treatment

Services for outpatient treatment, including partial or full-Day Program Services will be covered to the same extent as any other illness.

b. Residential Treatment Programs

Services for Residential Treatment Programs rendered in a psychiatric residential treatment center will be covered to the same extent as any other illness.

c. Inpatient Treatment

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

Mental Illness Services received from Non-Preferred Providers are limited as follows:

a. Outpatient Treatment

Services for outpatient treatment, including partial or full-Day Program Services will be covered to the same extent as any other illness and are subject to a Calendar Year Maximum if indicated in the Benefit Schedule.

Outpatient Mental Illness Services received from Preferred Providers will apply to any Calendar Year Maximum for Non-Preferred Providers that is indicated in the Benefit Schedule.

b. Residential Treatment Programs

Services for Residential Treatment Programs rendered in a psychiatric residential treatment center will be covered to the same extent as any other illness and are subject to a Calendar Year Maximum if indicated in the Benefit Schedule.

Residential Mental Illness Services received from Preferred Providers will apply to any Calendar Year Maximum for Non-Preferred Providers that is indicated in the Benefit Schedule.

c. Inpatient Treatment

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

**Services for Residential Treatment Programs, Inpatient Treatment, and Outpatient partial or full-Day Program Services must be Prior Authorized by New Directions.**

Outpatient Mental Illness - 2 Sessions per Calendar Year

Notwithstanding any provision in the Contract to the contrary, Covered Services include 2 visits per Calendar Year, for the treatment of Mental Illness, to a licensed psychiatrist, licensed psychologist, licensed professional counselor, licensed clinical social worker, or a licensed marital and family therapist. Benefits will be provided for the purpose of diagnosis or assessment, but will not be dependent upon the findings of such practitioner. Coverage and Benefits for these 2 visits are not subject to Our Approval in Advance requirement and will be covered the same as any other illness.

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**27. Organ Transplants**

We provide Benefits for Organ Transplants. **These services must be Prior Authorized by Us.** If it appears that You may need an Organ Transplant, We encourage You to review these Covered Services with

Your Physician. Covered 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. Coverage is limited to the following transplants only when such transplants are Medically Necessary in accordance with Our Policies for transplantation services:

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

Preferred Providers

Benefits will be paid at the Preferred 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 Us, or through a national organ transplant network with which We contract to render Organ Transplant Services or another provider in the BlueCard Program if designated by Us. Designated Transplant Providers will be determined by Us and may or may not be located within Our Service Area.

Non-Preferred Providers

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

- a. Benefits will be provided at the Non-Preferred Provider level.

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

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

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

- a. When both the recipient and the donor are covered under the Contract, Covered Services received by the donor and recipient will be provided up to the recipient's Organ Transplant Benefit Maximum, if any. This means that both the donor and recipient's transplant related services will be combined and will apply to the recipient's Lifetime Organ Transplant Maximum, if any.
- b. When only the recipient is covered under the Contract, both the donor and the recipient are entitled to the Covered Services of the Contract. The donor's Covered Services are limited to only those Benefits which are not provided by or available to the donor from any other source. This includes, but is not limited to, other health care plan coverage or any government program. Covered Services provided to a donor will be applied towards the recipient's Benefit limits under the Contract and will reduce the recipient's Lifetime Organ Transplant Maximum, if any, to the extent Covered Services are provided to the donor.
- c. When only the donor is covered under the Contract, Covered Services are limited to only those services which are not provided by or available to the donor from any other source. This includes, but is not limited to, other health care plan coverage or any government program. No Covered Services will be provided to a transplant recipient who is not covered under the Contract.
- d. If any organ or tissue is sold rather than donated to a recipient covered under the Contract, no Covered Services will be provided for the purchase price of such organ or tissue. However, other costs related to evaluation and organ "Procurement Services" are covered and subject to the Lifetime Organ Transplant Maximum, if any.

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

Immunosuppressant Drugs We provide Benefits for immunosuppressant drugs required as a result of a covered Organ Transplant under the Outpatient Prescription Drug Benefit. Such Benefits do not apply toward and are not limited by Your prescription drug Calendar Year Maximum, if any.

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

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

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

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

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

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**29. Outpatient Prescription Drugs**

Introduction/Prior Authorization: We provide Benefits for drugs and medicines for use outside a Hospital that require a Physician's prescription. Certain medications or classes of medication may require Prior Authorization. To receive Prior Authorization, Your Physician will need to submit to Us a statement of Medical Necessity. Certain medications are subject to utilization programs that require You to try to use a therapeutic alternative before another medication will be considered a Covered Service. Your Physician may submit to Us a statement of Medical Necessity if the utilization program is not appropriate for Your medical condition.

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 participating pharmacy's Usual and Customary Charge if the Usual and Customary Charge is less than Your Copayment. 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.

Drug Rebates and Credits:

We contract with a pharmacy benefit manager (“PBM”) for certain prescription drug rebate administration services and pharmacy network contracting services. Under the agreement, PBM obtains rebates from drug manufacturers based on the utilization of certain branded prescription products by Covered Persons. As partial consideration for these services, pharmaceutical manufacturers pay administrative fees to PBM and PBM retains the benefit of the funds prior to disbursement. Administrative fees retained by PBM in connection with its rebate program do not exceed the greater of (i) 4.58% of the Average Wholesale Price, or (ii) 5.5% of the wholesale acquisition cost of the products. PBM may also receive other service fees from manufacturers as compensation for various services unrelated to rebates or rebate-associated administrative fees.

We receive rebates from the PBM and may receive financial credits, administrative fees and/or other amounts (collectively “Financial Credits”) from network pharmacies, drug manufacturers, or the PBM. We retain sole and exclusive right to all Financial Credits and may use such Financial Credits in Our sole and absolute discretion (including, for example, to help stabilize overall rates and to offset expenses) and we do not share Financial Credits with You. Without limitation to the foregoing, the following rules (“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; (3) Any Coinsurance that You must pay for prescription drugs is based upon the Allowable Charge, and does not change as a result of any Financial Credits; 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.

We and the PBM also contract with pharmacies to provide prescription products at discounted rates for our Members. The discounted rates paid by PBM and Us to these pharmacies differ among pharmacies within a network. For pharmacies that contract with the PBM, We pay a uniform discount rate under Our contract with the PBM regardless of the various discount rates it pays to the pharmacies. Thus, where our rate exceeds the rate the PBM negotiated with a particular pharmacy, the PBM will realize a positive margin on the applicable prescription. The reverse may also be true, resulting in negative margin for the PBM. The PBM and directly contracted network pharmacies have guaranteed Us a minimum level of discount which could result in a Financial Credit. In addition, when the PBM receives payment from Us before payment to a pharmacy is due, the PBM retains the benefit of the use of the funds between these payments.

Covered Drugs:

Covered Services are limited to:

- a. Legend drugs that by federal or state law can only be dispensed upon written prescription from an authorized prescriber
- b. Compound medications that contain at least one legend drug in a therapeutic amount
- c. Off-label use of prescription drugs when treatment of the indication is recognized in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature. Your Physician must submit documentation supporting the proposed off-label use or uses if requested by Us

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

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

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

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

- d. Insulin, syringes, needles, lancets, test strips, oral anti-diabetic agents and glucometers
- e. Oral and injectable contraceptive drugs
- f. Contraceptive devices and implants which require a Physician's prescription;
- g. Smoking cessation agents by prescription only

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

Administration (FDA) regardless of where the drugs are obtained. Drugs or medicines approved by the FDA for Experimental or Investigative Services are not covered. We may impose administrative limits on the quantity or frequency by which a drug may be dispensed. These limits will be based on recommendations of the drug manufacturer or by community Physicians and pharmacists.

Though the Contract includes coverage for contraceptives, You have the right under Missouri State law to exclude coverage for contraceptives.

If You desire to exclude contraceptives, call Our Customer Service Department for information on how to make this election.

Out-of-Pocket  
Maximum:

Copayments and/or any Coinsurance You pay for outpatient prescription drugs will not apply to and will not 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 prescription up to a 34 day supply. If Your Physician prescribes a prescription for more than a 34 day supply, You must obtain a refill for any quantity above the 34 day supply. The pharmacy will then file the claim for the prescription. See Your provider directory for a listing of 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.

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

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

**Non-Participating Pharmacies:**

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

- a. The amount You paid the pharmacy for the drug will be reduced by the applicable Copayment and/or any applicable Coinsurance amount.
- b. Your Benefits will be 50% of the remaining balance (after the Copayment amount is subtracted).

**Long-Term Supplies:**

**Mail Order Prescription Drugs:**

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

You must pay a Copayment and/or any applicable Coinsurance for each long-term prescription if indicated in the Benefit Schedule.

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

**Specialty Pharmaceuticals:**

We provide Benefits for Specialty Pharmaceuticals when obtained from a designated specialty pharmacy. Refer to the Prescription Drug List for a listing of Specialty Pharmaceuticals and specialty pharmacies. In some cases, these drugs will be delivered to Your home.

Specialty Pharmaceuticals means biotechnology drugs or other drug products that may require special ordering, handling, clinical monitoring and/or customer service. Specialty Pharmaceuticals are limited to a 34 day supply and are subject to the applicable Prescription Drug Copayment, or any applicable Coinsurance if indicated in the Benefit Schedule.

**Exclusions:**

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

- a. Appetite suppressants, anorexiant and anti-obesity drugs
- b. Compounded medications with ingredients that do not require a prescription

- c. Experimental, Investigative or unproven services and medications; medications used for Experimental indications and/or dosage regimens determined by Us to be Experimental (including, but not limited to those labeled "caution - limited by federal law to investigational use" and drugs found by the Food and Drug Administration to be ineffective)
- d. Medications for cosmetic purposes, such as but not limited to isotretinoin, tretinoin (Retin-A), topical minoxidil, and finasteride
- e. Except as specifically provided in the Contract, 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)
- f. Medications and other items available over-the-counter that do not require a prescription order or refill by federal or state law (whether provided with or without a prescription)
- g. Any medication that is equivalent to an over-the-counter medication
- h. Medications with no approved FDA indications
- i. Immunization agents
- j. Drugs related to treatment that is not a Covered Service under the Contract
- k. Prescription drugs that are not Medically Necessary unless otherwise specified
- l. Anabolic steroids, anti-wrinkle agents, dietary supplements, Fluoride supplements, growth hormones prescribed for anyone over age 18, blood or blood plasma, irrigational solutions and supplies
- m. Lifestyle enhancing drugs, unless otherwise specified
- n. Fertility drugs
- o. Impotency medications and devices
- p. Drugs and devices that are intended to induce an abortion
- q. Drugs obtained outside the United States for consumption in the United States

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### 30. Outpatient Surgery And Services

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

Non-Participating  
Provider  
Hospital/Outpatient  
Facility Benefits  
Inside Our Service  
Area

Your Benefit for an outpatient service at a Non-Participating Provider Hospital and outpatient facility inside Our 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 Our Service Area will not be subject to any Deductible or Coinsurance requirements.

**The following outpatient surgeries and services must be Prior Authorized by Us in order to be Covered Services:** blepharoplasty, elective pre-operative observation status, reduction mammoplasty, rhinoplasty, sclerotherapy, PET scans, septoplasty, some radiological procedures and uvulopharyngoplasty (UPP). This list of services is subject to change. **Please contact customer service for the current list of outpatient surgeries and services that must be Prior Authorized.**

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### 31. Outpatient Therapy

We provide Benefits for Speech Therapy, Hearing Therapy, Physical Therapy and Occupational Therapy provided on an outpatient basis.

Speech Therapy and  
Hearing Therapy

This is treatment for the loss or impairment of speech or hearing disorders provided by a speech pathologist, speech/language pathologist or audiologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both, and which fall within the scope of such license or certification. Covered Services include examination, evaluation, counseling and any testing required to diagnose any loss or impairment of speech or hearing. Benefits for Speech Therapy are covered only when the Speech Therapy is being requested as the result of illness; injury; permanent, moderate to severe, bilateral sensorineural hearing loss; and /or birth defects such as cleft lip and cleft palate.

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

Physical Therapy

Physical Therapy Services provided by a Physician, Registered Physical Therapist (R.P.T.) or Licensed Physical Therapist (L.P.T.) are covered when these services are expected to result in significant improvement in a Covered Person's condition. Except for treatment of neuromuscular disorders in Covered Persons under age 19, Covered Services are limited to treatment of acute illnesses and injuries.

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

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. Except for treatment of neuromuscular disorders in Covered Persons under age 19, Covered Services are limited to treatment of acute illnesses and injuries. 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 may be limited to a Calendar Year Maximum if indicated in the Benefit Schedule. **This limit will not apply to speech, physical or occupational therapy services provided by a Home Health Care Agency pursuant to a home health plan of treatment Prior Authorized by Us.** Such services will be subject to the limit, if any for Home Health Services.

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## 32. Physician Services

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

- a. Office visits.
- b. Surgical and orthopedic services. Covered Services are limited to cutting and other operative procedures for treating illness or injury.
- c. Surgical assistant services provided by a Physician. Covered Services are limited to the assistance at the operating table which is given to the operating Physician by another Physician. This assistance must be Medically Necessary, as determined by Us and in connection with procedures that normally require assistance. Covered Services do not include any activities of internship or residency, or any type of training.
- d. Inpatient Specialist services. Covered Services are limited to those that are provided when a Covered Person has a medical condition that is not in the attending Physician's specialty and the attending Physician asks the opinion of a Physician with that specialty. Covered Services do not include staff consultations required by Hospital rules and regulations.
- e. Hospital bed patient care by a Physician.
  - (1) General care. Covered Services are limited to a Physician's visits to a Covered Person if the reason for the Hospital stay is strictly to treat a medical condition 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.

### 33. Podiatry

Routine Care	We provide Benefits for routine foot care <u>only</u> if the Covered Person has a disease such as diabetes that can potentially affect circulation and/or the loss of feeling in lower limbs. Routine foot care means the paring and removal of corns and calluses or trimming of nails.
Bone Surgery	We provide Benefits for bone surgery on the foot.

### 34. Pre-Surgery Testing

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

### 35. Prosthetic and Orthotic Appliances

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

Covered Services are limited to the purchase and fitting of prosthetic and orthotic devices that are Medically Necessary as a result of congenital defects, injury or sickness. Repairs or replacement of prosthetics are Covered Services only when necessary because of any of the following:

- a. A change in the physiological condition of the patient;

- b. An irreparable change in the condition of the device; or
- c. The condition of the device requires repairs and the cost of such repairs would be more than 60% of the cost of a replacement device.

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

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

Benefits are limited to the amount available for a basic (standard) item which meets the minimum specifications to allow for necessary activities of daily living. Activities of daily living include bathing, dressing, eating, continence, toileting, transferring and/or ambulating. Charges for deluxe prosthetic or orthotic devices are not covered, except for those prosthetic or orthotic devices that are Medically Necessary for the Covered Person.

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

See the Diabetes Benefit in the Contract/Certificate for a description of how diabetic shoes are covered.

**Prosthetic and orthotic devices must be Prior Authorized by Us.**

**36. Radiation Therapy**

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

**37. Reconstructive Surgery/Prosthetic Devices Following a Mastectomy**

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

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### 38. Routine Preventive Care

We provide Benefits for routine preventive care as required by state or federal law. These services are not limited and do not apply to the Calendar Year Maximum indicated in the Benefit Schedule. Covered Services are limited to the following and may be received from Preferred or Non-Preferred Providers:

- 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) Flexible sigmoidoscopy;
  - (3) Colonoscopy;
  - (4) Double contrast barium enema,
- e. Newborn hearing screening, audiological assessment and follow-up, and initial amplifications,
- f. Childhood immunizations as referenced in the Immunizations for Children Benefit of this Contract,
- g. Lead testing, and
- h. The related office visit.

We also provide the following Benefits for routine preventive care received from **Preferred or Non-Preferred 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 age ranges and gender recommended by the Advisory Committee on Immunization Practices and/or adopted by the Center for Disease Control.**

- i. Catch-up for Hepatitis B
  - ii. Catch-up for varicella
  - iii. Catch-up for MMR
  - iv. Tetanus boosters as necessary, including tetanus, diphtheria and pertussis; diphtheria and tetanus; and tetanus only
  - v. Pneumococcal vaccine
  - vi. Influenza virus vaccine
  - vii. Meningococcal vaccine
  - viii. Catch-up for Hepatitis A
  - ix. HPV vaccine
  - x. Zoster vaccine
  - xi. 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 Contract, including but not limited to, immunizations required only for travel, work-related immunizations, Anthrax vaccine and Lyme Disease vaccine.

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### **39. Skilled Nursing Facility**

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

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

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**41. Vision Care**

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

Benefits are limited to the amount available for a basic (standard) pair of eyeglasses which meet the minimum specifications to allow for necessary vision correction. Charges for eyeglasses which exceed a basic pair of eyeglasses are not covered, beyond the extent allowed for basic eyeglasses.

## SECTION D. EXCLUSIONS AND LIMITATIONS

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**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 Preexisting Conditions during the Exclusion Period. The Exclusion Period for Preexisting Conditions is 12 consecutive months. The Exclusion Period begins on the first day of the Waiting Period (or the date coverage is effective if there is no Waiting Period).

The Exclusion Period will only apply to Preexisting Conditions. Benefits for Preexisting Conditions will only be provided for Covered Services that are received after this Exclusion Period has expired.

- a. Exception for children: A covered child will not be subject to an Exclusion Period if the child had Creditable Coverage within 30 days after birth, adoption, or placement for adoption and provided the child did not have a 63 or more day break in Creditable Coverage.
- b. Exception for pregnancy: The Preexisting Condition Exclusion Period will not apply to pregnancy.

The length of the Exclusion Period for Preexisting Conditions will be reduced by the number of days the Covered Person had Creditable Coverage. If You have had a 63-day break in Creditable Coverage, any days of coverage prior to the gap will not be used to reduce the Exclusion Period. (The length of Your Waiting Period is not considered to be part of a gap in coverage).

In order to have the Exclusion Period for Preexisting Conditions reduced, You must provide Us with a Certificate of Creditable Coverage from the prior plan(s) or insurance company, or provide other evidence of such Creditable Coverage. The Exclusion Period will be reduced based upon the information We receive. If an Exclusion Period will apply, We will notify You of the length of Your Preexisting Condition Exclusion Period. We have the right to change the length of the Preexisting Condition Exclusion Period if it is later determined You did not have the claimed Creditable Coverage.

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 Our 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 worker's compensation benefit whether or not You file a claim. If You enter into a settlement giving up Your right to recover future medical benefits under a worker's compensation benefit, medical benefits that would have been compensable except for the settlement will not be Covered Services.
5. Not Medically Necessary.

6. Not specifically covered under the Contract.
7. Experimental or Investigative as determined by Us at Our sole discretion, 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 Our 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, aromatherapy and other forms of alternative treatment.
16. For genetic testing unless specifically covered under the Contract; or examinations or treatment ordered by a court.
17. Related to sex transformations.
18. 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.

19. Provided by You, Your Immediate Family Members or members of Your immediate household.
20. For vision services and hearing care services and cochlear implants, except as otherwise specifically provided in the Contract, including but not limited to hearing aids, pleoptic and orthoptic training, eyeglasses, contact lenses, and the examination for fitting of these items.
21. Unless specifically covered under the Contract, for all dental services, complications of dental treatment; temporomandibular joint disorder; and orthognathic surgery. Injections for treatment of pain that are in close proximity to the teeth or jaw and due to a dental cause. For orthodontic treatment and surgical correction of a malocclusion. For dental splints, dental prostheses, extractions or any treatment on or to the teeth, gums or jaws and other services customarily provided by a dentist. Services related to injuries caused by or arising out of the act of biting or chewing are also excluded.
22. For drugs and medicines that do not require a prescription for their use; or prescription drugs purchased from a Physician for self-administration outside a Hospital.
23. 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.
24. For staff consultations required by Hospital rules and regulations.
25. 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 Contract) 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.
26. 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.
27. For hairplasty or hair removal, regardless of reason or diagnosis.
28. For, or related to the surgical insertion of a penile prosthesis including the cost of the prosthesis, regardless of diagnosis.
29. For orthotics unless otherwise specified.
30. For foot orthotics, including shoes except as specifically covered under the Diabetes benefit.
31. For support/surgical stockings (for the lower extremities), including but not limited to custom made stockings.
32. For corrective shoes unless permanently attached to a brace.

33. For routine foot care, unless specifically covered under the Contract.
34. For, or related to an Organ Transplant not specifically covered in the Contract.
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 We are 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; psychosurgery; nutritional-based therapy for alcoholism, chemical dependency, or other medical conditions; services and supplies for smoking cessation programs and treatment of nicotine addiction unless otherwise stated under the Outpatient Drug benefit.
40. For learning disabilities, developmental delays, and mental retardation.
41. Health services which are related to complications arising from treatments or services otherwise excluded under the Contract except for complications related to maternity care as indicated in the Contract.
42. Methadone, L.A.A.M. (1-Alpha-Acetyl-Methadol) Cyclazocine, or their equivalents when prescribed as maintenance for substance abuse; provided however, Methadone will be covered if prescribed as detoxification treatment in a federally approved detoxification program but shall only be covered for a maximum of up to six consecutive months.

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 a Preferred Provider who will accept the transfer.

Mental Illness and/or substance abuse services provided in connection with or to comply with the sentencing of a criminal activity for outpatient, partial hospitalization, residential or inpatient treatment.

43. For non-prescription enteral feedings and other nutritional and electrolyte supplements. This does not apply to the treatment of phenylketonuria or any inherited disease of amino or organic acids.
44. For personal care and convenience items.
45. Occupational therapy provided on a routine basis as part of a standard program for all patients.

46. 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, not Medically Necessary amniocentesis, and any other experimental fertilization procedure or fertility drugs.
47. 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.
48. Received for or in preparation for any diagnosis or treatment (including drugs) of impotency and any related complications.
49. For growth hormone therapy for the diagnosis of idiopathic or genetic short stature, intrauterine growth retardation or small for gestational age. Testing for growth hormone deficiencies in Covered Persons age 19 or older.
50. 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.
51. For speech therapy for behavioral problems, attention disorders, stammering and/or stuttering, vocal cord training/retraining due to vocational strain and/or weak cords, conceptual handicap, psychosocial speech and conductive hearing loss due to otitis media and ear infections.
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 Us 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 Contract.
57. For nutritional assessment testing and saliva hormone testing.

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**Limitations:** If an individual is enrolled in Medicare, Benefits for Covered Services will be coordinated with any benefits paid by Medicare. This limitation will not apply

if the Employer, by law, is not permitted to allow the Contract to be secondary to Medicare.

## SECTION E. HOW TO FILE A CLAIM

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### 1. Claim Procedures

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

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

- a. The reason or reasons for the denial,
- b. Reference to the Contract provision on which the denial is based,
- c. A description of any additional material or information necessary for You to complete Your Claim and an explanation of why such material or information is necessary, and
- d. Appropriate information as to the steps to be taken if You wish to appeal Our decision, including Your right to file suit under the Employee Retirement Income Security Act "ERISA" (if Your plan is subject to ERISA) with respect to any Claim denial after appeal of Your Claim.

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### 2. Post-Service Claims

#### a. Hospital and other Facility Services

##### (1) For care received *inside* the BlueCard PPO Program Service Area.

- (a) Participating Providers will file Your Post-Service Claims for You. We will pay the facility directly. You may be asked to make arrangements with such facility to pay for any non-Covered Services, Deductible, Copayment or Coinsurance amounts.
- (b) If You receive care from a Non-Participating Provider, it will be Your responsibility to make payment arrangements with the facility. Some Non-Participating Providers will submit Your Post-Service Claim for You. If not, You can obtain a Post-Service Claim form from Our Customer Service Department. The form will give You instructions for filing the Post-Service Claim.

**(2) For care received *outside* the BlueCard PPO Program Service Area.**

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

**b. Physician Services**

**(1) For care received *inside* the BlueCard PPO Program Service Area.**

(a) Participating Providers will file Your Post-Service Claim for You. We will pay the Physician directly. After the Physician receives Our payment, the Physician may bill You for any non-Covered Services, Deductible, Copayment or Coinsurance amounts for which You are responsible.

(b) Non-Participating Physicians will sometimes file Your Post-Service Claim for You. If a Non-Preferred Provider or Non-Participating Physician declines to file Your Post-Service Claim for You, You can obtain a Post-Service Claim form from Our Customer Service Department. The form will give You instructions for filing the Post-Service Claim.

**(2) For care received *outside* the BlueCard PPO Program Service Area.**

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

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

It is necessary for You to file a completed Post-Service Claim form with Us for these services. Contact Our Customer Service Department for the proper Post-Service Claim forms. The form will give You instructions for filing the Post-Service Claim. 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 Contract, You must file a completed Post-Service Claim form with Us.

**d. Time Limits for Filing Post-Service Claims**

We must receive proof of a Post-Service Claim for reimbursement for Covered Services no later than 365 days after the end of the Calendar Year in which the service was received, except if it was not reasonably possible to give notice of proof within this time. We will deny any Post-Service Claim not received within this time limit.

**e. Processing of the Filed Post-Service Claim**

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

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**3. Pre-Service Claims**

Requests for Pre-Service Claims must be made in accordance with 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 Contract, You must request Prior Authorization in accordance with Section K.

## SECTION F. COORDINATION OF BENEFITS (COB)

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- 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.
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- 2. Definitions Applicable to this Section**
- a. *Allowable Expense* means a medical expense or service that is covered at least in part by one or more of the Plans covering the person for whom the claim is made. An Allowable Expense does not include dental coverage. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense unless the private room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

When benefits are reduced under a primary Plan because a Covered Person did not comply with the Plan provisions, the amount of that reduction will not be considered an Allowable Expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. When the HMO Plan is primary, this provision will not be used by a secondary Plan to refuse to pay benefits because an HMO member has elected to have medical services provided by a Non-HMO provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services.

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

- b. *Plan* means any arrangement that provides coverage for medical services. COB applies to the following Plans:
- (1) Group or blanket coverage, except for student accident coverage;
  - (2) Group practice, individual practice, HMOs and other prepayment coverage on a group basis;

- (3) Prepayment coverage under labor-management trustee plans, employer organization Plans, union welfare Plans, self-funded Plans, or employee benefit organization Plans;
- (4) Coverage under any governmental program(s) to include any coverage required or provided by statute(s). Benefits available from Part A and Part B of Medicare are included. However, benefits under a state Medicaid program are not included;
- (5) Any "no fault" contracts and traditional automobile "fault" contracts sold on a group basis, by whatever name called. This Contract is always secondary to benefits provided under any mandatory No-Fault Auto Insurance Act in the state in which the Covered Person resides; and
- (6) 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 \$100.00 per day.

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

- c. *Claim Determination Period* means a period of not less than 12 consecutive months, over which Allowable Expenses shall be compared with total benefits payable in the absence of COB, to determine whether 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 an Employee, will be determined before the benefits of a Plan which covers such person as a Dependent.

**b. Dependent Child/Parents not Separated or Divorced:**

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

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

**c. Dependent Child/Parents Separated or Divorced:**

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

- (1) First, the Plan of the parent with custody of the child;
- (2) Then, the Plan of the spouse of the parent with custody of the child; and
- (3) Finally, the Plan of the parent not having custody of the child.

Notwithstanding (1), (2) and (3) above, if there is a court decree which would otherwise establish financial responsibility for the medical expenses with respect to the child, the benefits of a Plan which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a Dependent child.

**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 Contract are being coordinated with any benefits made by Medicare, the order of benefit determination will follow the Federal Medicare Secondary Payor Rules in effect at that time.

**i. Plans without COB Provisions:**

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

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**4. Effect on the Benefits of this Plan**

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 Contract;
- (2) Determine whether a benefit reserve has been recorded for the Covered Person; and
- (3) Determine whether there are any unpaid Allowable Expenses during that Claim Determination Period.

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

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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, We (without the consent of or notice to any person) have the right to:

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

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

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**6. Facility of payment**

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

## SECTION G. PREMIUM PAYMENT, GRACE PERIOD AND CHANGES

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

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**2. Grace Period** The Employer shall have a grace period of 31 days for the payment of any Premium, during which time the Contract shall continue in force. In no event shall the grace period extend beyond the date the Contract terminates. The Contract will automatically terminate on the last day of the period for which Premiums have been paid if the grace period expires and any Premium remains unpaid.

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

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

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

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

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

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

## SECTION H. TERMINATION AND EXTENSION OF COVERAGE

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- 1. Terminating a Covered Person's Coverage** We may terminate a Covered Person's coverage on the earliest of the dates specified below.
- a. On the date the Contract is terminated. The Employer is responsible for notifying You of the termination of the Contract. Failure of the Employer to notify the Employee of termination will not continue coverage beyond the effective date of termination of this Contract;
  - b. On the last day of the month for which Premium has been paid if You fail to pay any required contribution toward such Premium. We may recover from You Benefits We paid 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 Contract;
  - 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 Contract;
  - e. On the date a Covered Person becomes covered under another health plan sponsored by the Employer;
  - f. On the original Effective Date of coverage if coverage is terminated by Us due to a material misrepresentation or misstatement of fact on the Employee application;
  - g. On the date a Covered Person allows an unauthorized person to use the Covered Person's identification card, or files a fraudulent claim; or
  - h. On the date a Covered Person chooses Medicare as primary coverage, and the Employer, by law, is not permitted to allow the Contract to be secondary to Medicare.

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

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

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

- a. The end of a 12 month period following the date the Contract is terminated; or
- b. The date the Covered Person is no longer considered Totally Disabled.

## SECTION I. CONTINUATION AND CONVERSION

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### 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 state or federal COBRA laws.

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

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### 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 Contract will conform with the minimum requirements of the COBRA law, provided that the Employer and Covered Persons comply with COBRA requirements. Coverage under the Contract will not be continued if the Employer 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 Employer files for Chapter 11 bankruptcy, but only for a retired Employee and his covered Dependents.

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

**b. Qualified Beneficiary**

A qualified beneficiary is any individual who, on the day before a qualifying event, is covered under the Contract or any child who is born to or placed for adoption with a covered Employee during a period of 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 Employer or plan administrator within 30 days of the birth or placement for adoption. A qualified beneficiary does not include an individual who marries any qualified beneficiary on or after the date of the qualifying event and a newborn or adopted child (other than one born to or placed for adoption with a covered Employee).

**c. Maximum Coverage Period**

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

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

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

**e. Social Security Disability**

A special rule applies if a qualified beneficiary is found to have been disabled during the first 60 days of continuation coverage. All qualified beneficiaries may be eligible to continue coverage for up to 29 months. The determination of disability must be made by the Social Security Administration, and must be issued within the disabled individual's initial 18 months of continuation coverage. That individual must then notify the Employer of the Social Security Administration's disability determination as follows: (1) within 60 days of the later of the date after the determination is issued, the date of the qualifying event, or the date coverage under the Contract is terminated as a result of termination of employment or a reduction in hours; and (2) within the individual's first 18 months of continuation coverage. This extension applies for all qualified beneficiaries, including a qualified beneficiary born or adopted during the continuation period, if notice is given within 60 days of such birth or adoption.

If the Social Security Administration later determines that an individual is no longer disabled, that individual must notify the Employer within 30 days after the date of that second determination. The individual and other qualified beneficiaries' right to the 11 month extension of continuation coverage will terminate as of the first day of the month that begins more than 30 days after the second determination is issued. However, if another qualifying event occurs giving rise to 36 months of continuation coverage during the 11 month

disability extension, the qualified beneficiaries receive the full 36 months of coverage beginning from the initial date of continuation coverage. This extension cannot be shortened if disability ceases.

**f. Electing Continuation Coverage**

An individual who wishes to continue coverage must complete a 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 Employer or plan administrator sends notice of the continuation right; whichever is later. An individual must then pay the initial Premium within 45 days after electing continuation.

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

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

**g. Effective Date of Continuation Coverage**

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

**h. Coverage Changes**

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

The qualified beneficiary has the same right to change benefit programs as the active Employees. If the active Employee is allowed to change to another benefit program during the Employer'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.

If the Employer changes insurance carriers during the period of COBRA continuation, the COBRA covered individual for that Employer will be terminated as to the coverage under this Contract

and become the responsibility of the new insurance carrier or health plan.

**i. Termination of 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 Contract for failure to make timely payment of the required Premium; if the individual fails to make the required Premium payment within the grace period (payment of Premium must be postmarked no later than last day of the grace period);
- (5) The date the individual first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise). However, an individual who becomes covered under a group health plan which has a preexisting condition limit must be allowed to continue 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 Employer, the earlier of the date of the qualified beneficiary's death or the date that is 36 months after the death of the retired covered Employee;

- (8) The date any Covered Person allows someone other than an eligible Dependent to use his or her identification card, or submits a fraudulent claim; or
- (9) The date the Contract terminates.

**j. Extension of COBRA Continuation for Spouses**

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

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

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

- (1) The date coverage terminates under the Contract for failure to make timely payment of the required Premium; if the individual fails to make payment on any Due Date;
- (2) The date the Contract terminates except if a different group policy is made available to all other Covered Persons. In this instance,

the legally separated, divorced or surviving spouse will be eligible for continuation of coverage under such different group policy as if coverage under the Contract had not been terminated.

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

(4) The spouse's 65th birthday.

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

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

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

**a. Eligibility**

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

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

**b. Electing USERRA Continuation Coverage**

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

electing USERRA continuation coverage.

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

**c. Coverage Changes**

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

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

**d. Premium Payment**

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

**e. Termination of USERRA Coverage**

Coverage will end on the earliest of the following dates:

- (1) 24 months from the date USERRA continuation coverage began;
- (2) The date the Employee fails to apply for or return to a position of employment;
- (3) The date coverage terminates under the Contract for failure to make timely payment of the required Premium; if the individual fails to make the required Premium payment within the grace period (payment of Premium must be postmarked no later than the last day of the grace period); or
- (4) The date the Contract terminates.

#### **f. COBRA and USERRA Continuation Rights**

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

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#### **4. Continuation Coverage under State Law**

Continuation coverage may be available under state law if an individual is not eligible for continuation coverage under federal law. The following applies only to persons who do not have a right to continue coverage under COBRA.

State continuation of coverage is available to Employees and their Dependents when coverage terminates due to termination of employment; or, for Dependents, when their coverage terminates due to the death of the Employee, or divorce. In order to continue coverage, such individuals must have been continuously covered under the Contract (or any similar group contract it replaced) for at least 3 months immediately prior to termination. The maximum period of continuation coverage under Missouri law is 9 months.

A Dependent may continue coverage only if the Employee continues coverage, except in the case of divorce, or death. In the case of divorce or death, Dependent children may continue coverage only if the spouse continues coverage.

**To continue group coverage, obtain a state continuation of coverage request form from Your Employer.** This form must be completed and returned to Us along with the first month's Premium payment within 31 days of the date coverage would otherwise terminate.

- a. An Employee or Dependent shall not be entitled to continuation of coverage if:
  - (1) Coverage terminated for failure to pay timely Premium;
  - (2) The individual is or could be covered by Medicare;
  - (3) The individual is, or could be covered to the same extent by any other group plan; or
  - (4) The Contract terminates.
- b. Continuation of coverage under state law shall terminate upon the earlier of the following:
  - (1) Nine (9) months after coverage would have otherwise terminated;
  - (2) The end of the period for which Premiums were paid if Premiums are not paid timely;

- (3) The date the person becomes eligible to be covered under Medicare or any other group plan, whether or not covered; or,
  - (4) The date on which the Contract is terminated. However, if coverage under the Contract is replaced by similar coverage under another group policy, then:
    - i. The Employee shall have the right to become covered under that other group policy for the balance of the period that he would have remained covered under this Contract if the Contract had not been terminated;
    - ii. The minimum level of benefits to be provided by the other group policy shall be the applicable level of Benefits provided under this Contract reduced by any Benefits payable under this Contract; and
    - iii. This Contract will continue to provide Benefits to the extent of its accrued liabilities and extensions of Benefits as if the replacement of coverage had not occurred.
- 

**5. Continuation of Coverage Pursuant to a Leave of Absence**

If an Employee's coverage would terminate because of a leave of absence approved by the Employer, coverage may be continued for up to 90 days if the Employer:

- (1) Forwards the Premium for such continued coverage; and
  - (2) Provides continued coverage to all Employees in the same class as the Employee whose coverage would otherwise terminate because of an approved leave of absence.
- 

**6. Conversion Coverage**

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

- a. Employees and Dependents whose coverage under the Contract is ending because the Contract is terminated and is not reinstated or replaced within 31 days.
- b. Employees or Dependents who have continued coverage for the maximum time allowed under state law or federal law (COBRA), whichever is applicable.

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

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

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

## SECTION J. GENERAL INFORMATION

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**1. Terms and Conditions of the Contract** The Contract is subject to amendment, modification or termination in accordance with any provision hereof by mutual agreement with Us and the Employer without Your consent or concurrence. The Contract may be modified at any time by Us as necessary to comply with state or federal laws or regulations. By electing coverage under the Contract, You agree to all terms, conditions and provisions hereof.

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

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**3. Medical Examination** To fulfill the obligations under the Contract, We may require a Covered Person to have a medical examination by a Physician of Our choice and at Our expense. The Covered Person must pay for any medical examination required to restore his Lifetime Maximum.

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**4. Release of Records** During the processing of Your claim, We may need to review Your health records.

As a Covered Person, You hereby authorize the release to Us of all physical or mental health records related to Your claim. This authorization constitutes a waiver of any provision of law forbidding such disclosure. Your records will be maintained with strict confidentiality.

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**5. Reimbursement to Us a. Workers' Compensation**

As a Covered Person, You agree to refund to Us any Benefits We paid to You or on Your behalf for a claim paid or payable under any workers' compensation or employers' liability law.

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

**b. Errors**

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

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**6. Legal Actions** No action at law or equity shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

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

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**8. Commission or Omission** No Hospital, Physician or other provider of service will be liable for any act of commission or omission by Us. We will not be liable for any act of commission or omission by: (1) any Hospital or Hospital's agent or employee; (2) any Physician or Physician's agent or employee; (3) any other providers of services or their agent or employee; or (4) the Employer or the Employer's agent or employee.

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

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

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

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**12. Assignment** You are required to assign all of Your right to payment under the Contract to Preferred and Participating Providers to the extent services are received from those providers. Except for assignment of claim payment to Preferred and Participating Providers, the Contract and all the rights, responsibilities and Benefits for Covered Services under it are personal to You. 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. All Benefits for Covered Services rendered by a Non-participating Provider will always be paid directly to the Employee.

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

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

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

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### **13. Medicaid**

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

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### **14. ERISA Statement of Rights**

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

As a participant in this plan You are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

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

Description. The plan administrator may charge a reasonable fee for the copies.

- c. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of You and other plan participants and beneficiaries. No one, including Your Employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit, or exercising Your rights under ERISA. If Your claim for a welfare benefit is denied or ignored in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denials, all within certain time schedules.
- d. Continue health care coverage for Yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or Your Dependents may have to pay for such coverage. Review Your Summary Plan Description and the documents governing the plan on the rules governing Your COBRA continuation coverage rights.
- e. Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay You up to \$110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If You have a claim for Covered Services which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, You may file suit in Federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the United States Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

If You have any questions about the plan, You should contact the plan administrator. If You have any questions about this statement or Your rights under ERISA, or if You need assistance in obtaining documents

from the plan administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

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

- f. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under Your group health plan, if You have Creditable Coverage from another plan, You should be provided a Certificate of Creditable Coverage, free of charge, from Your group health plan or insurance issuer: (1) when You lose coverage under the plan; (2) when You become entitled to elect COBRA continuation coverage; (3) when Your COBRA continuation coverage ceases, if You request it before losing coverage; or (4) if You request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, You may be subject to a Preexisting Condition exclusion for 12 months after Your enrollment date in Your coverage.

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**15. Authority to Construe Terms of the Contract**

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

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**16. Plan Sponsor and Plan Administrator**

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

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**17. Special Programs**

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

These programs are made possible through arrangements with various providers and cooperating businesses. Changes in these arrangements

and/or their discontinuance may occur at any time in the future at Our discretion.

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

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

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

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**21. Second Opinion Policy** You have the right to seek a second medical opinion from a Preferred or non-Preferred provider. Benefits will be provided at the same level as for any other Covered Service rendered by that provider.

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**22. Entire Contract** The Employer application, Employee applications, and Certificate(s) issued to the Employee are incorporated by reference in this document and made a part of the Contract. Any conflict between the Contract and the Certificate(s) will be resolved according to the terms which are most favorable to the Covered Person. The definitions contained in the Certificate(s) will have the defined meaning when used in this document with the first letter capitalized. The Contract and any amendments or riders thereto constitute the entire agreement between the parties and any change in the Contract must be signed by an officer of the Company to be valid. No agent or representative has the authority to change the Contract or waive any of the provisions.

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

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**24. PPO Provider Directory** At no additional cost, PPO Provider Directories are provided by Us and upon request when You call Our Customer Service Department. In addition, You may access Our PPO Provider Directory on Our website at <http://blueaccess/ProvDir/ASP/provsrch.asp>.

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

- a. Any persons to, or for, or with respect to whom such payments were made;
- b. Any insurance companies or service Plans; or
- c. Any other organization.

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

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**26. Right to Request a Certificate of Creditable Coverage ("COCC")** You have the right to request a Certificate of Creditable Coverage ("COCC"). To obtain a COCC for Your coverage with Us, please contact the Customer Service Department of Blue Cross and Blue Shield of Kansas City at 816-395-2222.

## SECTION K. UTILIZATION REVIEW

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

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

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

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

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

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

For purposes of the Utilization Review Section, Urgent Care Services are defined as:

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

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

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**2. Concurrent Review Determination**

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

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

In the case of an Adverse Determination, We will notify by telephone the provider rendering the service within 24 hours of making the Adverse Determination, and provide written or electronic notification to the Covered Person and the provider within one working day of the telephone notification. The service will be continued without liability to the Covered Person until the Covered Person has been notified of the determination.

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

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**3. Reconsideration**

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

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**4. Retrospective Review Determinations**

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

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**5. Case Management**

Case management 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. 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. However, case management may also

provide for reimbursement for alternative methods of care even if the Covered Person does not have Covered Services for the alternate care or setting. It may also include any plan of care set forth to promote health and prevent illness and injury of the Covered Person. This plan is not designed to extend extra-contractual Covered Services for alternative methods of care to persons who do not meet the plan standards and criteria.

We may elect to provide Benefits furnished by any provider pursuant to Our approved alternate treatment plan for case management.

We shall provide Benefits for alternative methods of care at Our sole discretion and only when and for so long as it is determined that the alternative services are appropriate, Medically Necessary and cost effective. Such Benefits shall count toward a Covered Person's Calendar Year Maximum (if applicable) and the Lifetime Maximum.

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

If We elect to provide alternative services for a Covered Person in one instance, it shall not obligate Us to provide the same or similar services for any Covered Person in any other instance, nor shall it be construed as a waiver of Our right to thereafter administer the health care Covered Service in strict accordance with the terms of the Contract.

## SECTION L. COMPLAINT AND GRIEVANCE PROCEDURES

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

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**1. Definitions Applicable to this Section** Inquiry - A question or request for information or action. Usually an Inquiry can be resolved on initial contact with no follow-up action required.

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

Grievance - A written Complaint submitted by or on behalf of a Covered Person to Our Appeals Department regarding: (a) the availability, delivery or quality of Covered Services, including a Complaint regarding an Adverse Determination made pursuant to Utilization Review; (b) Post-Service Claims payment, handling or reimbursement for health care services; or (c) matters pertaining to the contractual relationship between a Covered Person and Us. A Grievance may be submitted by a Covered Person, a Covered Person's representative, or a provider acting on behalf of a Covered Person.

Expedited Review - The procedure for the review of a Grievance (which may be submitted either orally or in writing) involving a situation where the time frame of the standard Grievance procedure: (a) would seriously jeopardize the life or health of a Covered Person; (b) would jeopardize the Covered Person's ability to regain maximum function; or (c) in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the requested care or treatment. However, for purposes of the Grievance register requirements, the request will not be considered a Grievance unless the request is submitted in writing.

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

A Covered Person should refer to his identification (I.D.) card for a toll-free number to call for instruction or any questions.

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**3. Procedures for Filing a First Level Grievance**

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

**The Grievance form must be sent to the attention of the Appeals Department.** We will acknowledge receipt of the Grievance within 10 working days unless it is resolved within that period of time. Upon request, We will provide You with copies of all documents, records, and other information relating to the Claim for Benefits. You have the opportunity to submit written comments, documents, records and other information relating to the Claim for Benefits. We must receive such documents prior to Our review of Your Claim. We will take into account all comments, documents, records and other information from You or Your authorized representative, regardless of whether the information was considered in the initial benefit determination.

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

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**4. Procedures for Filing a Second Level Grievance**

If You are dissatisfied with Our first level Grievance decision, You may request a second level review by a Grievance Advisory Panel (the "Panel"). In order to request a second level Grievance, Your request must be filed within three hundred sixty-five (365) days from the later of the

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

**Your written Grievance must be sent to the attention of the Appeals Department.** We will acknowledge receipt of the second level Grievance within 10 working days unless it is resolved within that period of time. Upon request, We will provide You with copies of all documents, records and other information relevant to Your Claim for Benefits, not previously provided during the first level Grievance. You have the opportunity to submit written comments, documents, records and other information relating to the Claim for Benefits. We must receive such documents prior to the Panel's review of Your Claim. We will take into account all comments, documents, records and other information from You or Your authorized representative, regardless of whether the information was considered in the initial benefit determination or first level Grievance. The Panel will consist of one or more enrollees and representatives of Ours who have not been involved in the circumstances giving rise to the Grievance. In addition, if the Grievance involves an Adverse Determination, 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 Grievance or in any subsequent investigation or determination. If We obtain advice from a medical or vocational expert in connection with a benefit determination, We will provide You with the identification of the expert upon written request. The Second Level Grievance process will adhere to the same time frames associated with the First Level Grievance process. We will notify You in writing of the Panel's decision within 5 working days from the day the Panel makes a determination and of the right to file an appeal with the Insurance Director's Office.

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**5. Procedures to Request an Expedited Review**

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

an Expedited Review may be submitted orally or in writing. We will notify You orally within 72 hours after receiving a request for an Expedited Review of Our decision. We will send written confirmation of Our decision within 3 calendar days of providing oral notification of Our decision.

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**6. Department of Insurance**

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

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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 level Grievance rights.

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

AMENDMENT: BCBSKC-201-14-M

It is mutually understood and agreed that the provisions noted below are amended as follows:

**In Section A. DEFINITIONS, the following definition is added:**

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

**In Section A. DEFINITIONS, the definition(s) for *Out-of-Pocket Maximum* is deleted in its entirety and replaced as follows:**

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

- a. Any amount that is above the Allowable Charge;
- b. Any amount that exceeds a specific maximum for Benefits;
- c. Any amount for Covered Services incurred in a Non-Participating outpatient facility or in a Non-Participating Provider Hospital in the Service Area, except for Emergency Services;
- d. Any amount for Covered Services incurred at a non-Designated Transplant Provider for an Organ Transplant;

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

**In Section C. COVERED SERVICES, *Out-of-Pocket Maximum* is deleted and replaced as follows:**

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

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

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

**In Section C. COVERED SERVICES, *Autism Spectrum Disorder* is added as follows:**

Notwithstanding any provision to the contrary, Applied Behavior Analysis (ABA) is not subject to a dollar Calendar Year Maximum.

**ABA services must be Prior Authorized by Us.**

**In Section C. COVERED SERVICES, *Clinical Trials* is deleted and replaced as follows:**

**Clinical Trials**

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

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

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

Routine Patient Care Costs are defined as follows:

- a. Drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's particular condition;
- b. Reasonable and Medically Necessary services needed to administer a drug or device under evaluation in a clinical trial; and
- c. All other items and services that are otherwise generally available in the clinical trial, except:
  - i. The Investigational item, device, or service itself;
  - ii. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
  - iii. Costs for services clearly inconsistent with widely accepted and established standards of care for a particular diagnosis, or
  - iv. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

**These services must be Prior Authorized by Us.**

**In Section C. COVERED SERVICES, the following sentence is added to *Diagnostic Services*:**

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

**In Section C. COVERED SERVICES, the following paragraph under *Outpatient Therapy* is deleted:**

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

**And is replaced as follows:**

Covered Services for all 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 Us.** Such services will be subject to the limit, if any, for Home Health Services.

**In Section C. COVERED SERVICES, the following paragraph is added to *Physician Services*:**

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.

**In Section D. EXCLUSIONS AND LIMITATIONS, the following Exclusion is deleted in its entirety:**

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.

**And replaced with the following Exclusion:**

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

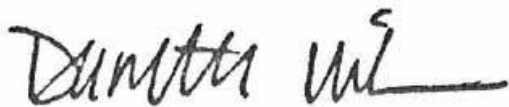
**In Section D. EXCLUSIONS AND LIMITATIONS, the following Exclusions are added:**

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

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

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.

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



Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

AMENDMENT: BCBSKC-225-10-MK

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

**Notwithstanding any provision in the Contract/Certificate to the contrary, all references to *Student Dependent Limiting Age* are deleted in their entirety.**

**In Section A., Definitions, the definition of *Institutions of Higher Learning* is deleted in its entirety.**

**Under Section B., Eligibility, Enrollment, and Effective Date, Subsection 2.b. is deleted in its entirety and replaced with the following:**

- b. The Employee's or Employee's legal spouse's, child. Such child includes:
- a child by birth;
  - an adopted child;
  - a child under the age of 18 who has been placed with the Employee for the purpose of adoption for whom the Employee has a legal obligation to support; or
  - 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

**Under Section B., Eligibility, Enrollment, and Effective Date, Subsection 2.c. is deleted in its entirety and replaced with the following:**

- 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 Us or a prior health plan at the time of reaching the limiting age.

We must receive satisfactory proof of the Dependent's handicap within 31 days after the child reaches the Dependent limiting age, or within 31 days after the Dependent is enrolled for coverage under the Contract to continue coverage beyond the Dependent Limiting Age. In addition, We must receive satisfactory proof 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 Our files, claims will be rejected for such individuals.

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

**Under Section B., Eligibility, Enrollment, and Effective Date, Subsection 4.d. (*Full-time Student Enrollment Period*) is deleted in its entirety.**

**Under Section H., Termination and Extension of Coverage, Subsection 1.d. is deleted in its entirety and replaced with the following:**

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

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

A handwritten signature in black ink, appearing to read "Danette Wilson", with a horizontal line extending to the right.

Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

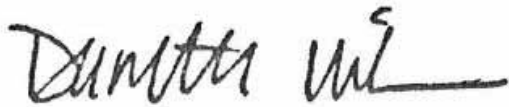
**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

AMENDMENT: BCBSKC-233-10-MK

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

Notwithstanding any provision in the Contract/Certificate to the contrary, Inpatient hospital services provided in a Non-Participating Provider Hospital inside Our Service Area are limited to a \$200 maximum per day. Outpatient services provided in a Non-Participating Provider Hospital or in a Non-Participating outpatient facility (including an imaging center) inside Our Service Area are limited to \$200 per day.

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

A handwritten signature in black ink, appearing to read "Danette Wilson", with a long horizontal flourish extending to the right.

Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

AMENDMENT: BCBSKC-228-14-MK

It is mutually understood and agreed that the provisions noted below are amended as follows:

**Under Section B., Eligibility, Enrollment, and Effective Date, Subsection 3, *Effects of Rescission on Eligibility*, is deleted in its entirety.**

**Under Section B., Eligibility, Enrollment, and Effective Date, Subsection 4.f. (*Employee Application*) is deleted in its entirety and replaced with the following:**

**g, 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.

**Under Section H., Termination and Extension of Coverage, Subsection 1.f. is deleted in its entirety and replaced with the following:**

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

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.



Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

AMENDMENT: BCBSKC-226-13-MK

It is mutually understood and agreed that the provisions noted below are amended as follows:

**In the Benefit Schedule, the following is added:**

		<b>PREFERRED PROVIDER</b>	<b>NON-PREFERRED PROVIDER</b>
<b>Covered Services</b>		<b>Copayment, Deductible, Coinsurance and Limitations</b>	<b>Copayment, Deductible, Coinsurance and Limitations</b>
<b>Outpatient Prescription Contraceptives</b>	<b>Generic</b>	No Copayment	\$12 Copayment then 50% Coinsurance
	<b>Preferred</b>	\$35 Copayment	\$35 Copayment then 50% Coinsurance
	<b>Non-Preferred</b>	\$60 Copayment	\$60 Copayment then 50% Coinsurance
<i>If a generic version is not available or Prior Authorization is obtained, Preferred Drugs and Non-Preferred Drugs will be subject to the Cost-Sharing indicated for Generic Drugs.</i>			

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

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

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

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

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

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

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

**In Section C., Covered Services, Outpatient Prescription Drugs, the following is deleted:**

Medications and other items available over-the-counter that do not require a prescription order or refill by federal or state law (whether provided with or without a prescription)

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

**And replaced as follows:**

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)

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

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.

**In Section D., Exclusions and Limitations, the following is deleted:**

For drugs and medicines that do not require a prescription for their use; or prescription drugs purchased from a Physician for self-administration outside a Hospital.

**And replaced as follows:**

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.

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

A handwritten signature in black ink, appearing to read "Danette Wilson". The signature is written in a cursive style with a long horizontal stroke at the end.

Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

AMENDMENT: BCBSKC-204-14-MK

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

**In Section A., Definitions, the following is added under *Allowable Charge*:**

- e. For ground Ambulance services provided by Non-Preferred and Non-Participating Providers inside Our Service Area –

The Allowable Charge is the lesser of:

- (1) The amount the provider has agreed to accept as payment in full as of the date of service; 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 a Participating Provider; or
- (3) The provider's billed charges.

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.



Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

AMENDMENT: BCBSKC-204-12-MK

It is mutually understood and agreed that, any provisions of Your Contract/Certificate notwithstanding, the provisions noted below are amended as follows:

Section I. Continuation and Conversion, *Continuation of Coverage Pursuant to a Leave of Absence* is deleted in its entirety and replaced with the following language

5. Continuation of Coverage Pursuant to a Leave of Absence

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

- (1) forwards the Premium for such continued coverage; and
- (2) provides continued coverage to all Employees in the same class as the Employee whose coverage would otherwise terminate because of an approved leave of absence.

Such continuation of coverage shall terminate no later than:

- (1) 90 days after the Employee's coverage would have otherwise terminated were it not for this continuation coverage; or
- (2) If an Employee is eligible for FMLA leave to care for an injured or ill service member, 180 days after the Employee's coverage would have otherwise terminated were it not for this continuation coverage; or
- (3) If an Employee is eligible for FMLA leave for service member-related qualified exigencies, 90 days after the Employee's coverage would have otherwise terminated were it not for this continuation coverage.

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



Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

AMENDMENT: BCBSKC-234-11-MK

It is mutually understood and agreed that, any provisions of Your Contract/Certificate notwithstanding, the provisions noted below are amended as follows:

In **Section C., Covered Services**, the following is added to the Vision Care Benefit:

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

In **Section D., Exclusions and Limitations**, the following exclusion is deleted in its entirety:

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

In **Section D., Exclusions and Limitations**, the following exclusion is added:

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

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



Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

AMENDMENT: BCBSKC-233-11-MK

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

**In Section C., Covered Services, Cochlear Implants is deleted:**

**Cochlear Implants**

We provide Benefits for cochlear implants. Covered Services are limited to the initial cochlear implant and related implant services. Covered Services do not include repairs, replacements or duplicates.

**Cochlear implants must be Prior Authorized by Us.**


**and replaced as follows:**

**Cochlear Implants**

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

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

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



Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

AMENDMENT: BCBSKC-240-11-M

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

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

**External Review**

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

A. Assignment to an IRO

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

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

B. IRO Decision

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

**Expedited External**

A. Request for an Expedited External Review

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

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

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

B. Preliminary Review

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

**Denial of Coverage  
for Experimental or  
Investigational**

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

- A. The IRO shall make a preliminary determination as to whether the requested health care service or treatment is a Covered Service under this Contract except for the fact that We determined that the service or treatment is Experimental or Investigational for a particular medical condition; and is not explicitly listed as an exclusion under this Contract.
- B. The request for external review of an Adverse Determination involving a denial of coverage based on Our determination that the health care service or treatment is Experimental or Investigational must include a certification from Your Physician that:
  1. Standard health care services or treatments have not been effective in improving Your condition; or
  2. Standard health care services or treatments are not medically appropriate for You; or
  3. There is no available standard health care service or treatment covered under the Contract that is more beneficial than the recommended or requested health care service or treatment; and

4. 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.

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

A handwritten signature in black ink, appearing to read "Danette Wilson", with a horizontal line extending to the right.

Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

It is mutually understood and agreed that the provisions noted below are amended as follows:

AMENDMENT: BCBSKC-244-10-M

**In Section A. Definitions, the following Definitions are added:**

**Autism Spectrum Disorders (ASD)**

Means a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

**Applied Behavior Analysis (ABA)**

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

**Autism Service Provider** means

- a) any person, entity, or group that provides diagnostic or treatment services for Autism Spectrum Disorders who is licensed or certified by the state in which services were rendered to provide health care services; or
- b) Any person who is licensed under Missouri Chapter 337 or by the state in which services were rendered, as a board certified behavior analyst by the behavior analyst certification board or as an assistant board certified behavior analyst.

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

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

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

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

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

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

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

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

- (a) Psychiatric care;
- (b) Psychological care;
- (c) Habilitative or rehabilitative care, including Applied Behavior Analysis therapy;
- (d) Therapeutic care;
- (e) Pharmacy care.

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

**Autism Spectrum Disorder**

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

The Benefits for Applied Behavior Analysis are subject to the same Copayment and/or Coinsurance provisions as other Covered Services and are limited to a \$41,263 Calendar Year Maximum for Covered Persons until their 19<sup>th</sup> 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. An ABA therapy treatment plan must include all elements necessary for Us to pay the claim. Except for inpatient services, We

have the right to review the treatment plan once every six months, unless the treating physician agrees a more frequent review is necessary.

Benefits will be paid at the Preferred Provider level only if Autism Spectrum Disorders are provided by an Autism Service Provider in the network.

Notwithstanding any provision in the Certificate to the contrary, services provided by an Autism Service Provider (ASP) for Speech Therapy, Occupational Therapy or Physical Therapy will not be subject to any visit limits.

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

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

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

A handwritten signature in black ink, appearing to read "Danette Wilson". The signature is written in a cursive style with a long horizontal stroke at the end.

Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

**THE FOLLOWING AMENDMENT DOES NOT APPLY TO KANSAS RESIDENTS**

It is mutually understood and agreed that, any provisions of Your Contract/Certificate notwithstanding, the provisions noted below are amended as follows:

AMENDMENT: BCBSKC-209-09-M

**In the Benefit Schedule, the benefits for *Outpatient, Residential, and Inpatient Mental Illness, and Outpatient, Residential Treatment, and Detoxification for Chemical Dependency* are deleted in their entirety.**

**In the Benefit Schedule, the following sections are added:**

	<b>PREFERRED PROVIDER</b>	<b>NON-PREFERRED PROVIDER</b>
<b>Covered Services</b>	<b>Copayment, Deductible, Coinsurance and Limitations</b>	<b>Copayment, Deductible, Coinsurance and Limitations</b>
<b>Outpatient Mental Illness and Substance Abuse</b>	Deductible	Deductible then 20% Coinsurance  <i>Outpatient Services at a Non-Participating Provider Hospital or a Non-Participating Provider outpatient facility inside Our Service Area are limited to a \$200 Calendar Year Maximum.</i>
<b>Inpatient Mental Illness and Substance Abuse</b>	Deductible	Deductible then 20% Coinsurance  <i>Inpatient hospital services in a Non-Participating Provider Hospital inside Our Service Area are limited to a \$200 maximum per day and are limited to a 30 days per Calendar Year.</i>

**In Section A. Definitions, the definition of *Mental Illness* is deleted in its entirety and replaced with the following:**

**Mental Illness** Means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders except for Substance Abuse.

**In Section A. Definitions, the following definition of *Substance Abuse* is added:**

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

**Section C. Covered Services, the *Inpatient Hospital Services* benefit provision is deleted in its entirety and replaced with the following:**

**Inpatient Hospital Services**

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

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

Non-Participating  
Provider Hospital  
Benefits Inside Our  
Service Area

The following provisions apply to Covered Services received from Non-Participating Provider Hospitals and residential treatment facilities:

- a. Your Benefit for Covered Services for inpatient hospital services in a Non-Participating Provider Hospital inside Our Service Area is limited to a maximum of \$200 per day. However, this Benefit will be provided only for up to 30 days per Calendar Year, per Covered Person, for all Admissions combined in such Non-Participating Provider Hospitals.
- b. Your Benefit for an outpatient service at a Non-Participating Provider Hospital inside Our Service Area will be limited to a maximum of \$200 per Calendar Year.

Benefits for services received from a Non-Participating Provider Hospital inside Our Service Area will not be subject to any Deductible or Coinsurance requirements.

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

**Section C. Covered Services, the *Mental Illness and Chemical Dependency* benefit provision is deleted in its entirety and replaced with the following:**

**Mental Illness and Substance Abuse**

We provide Benefits for the treatment of Mental Illness and Substance Abuse as indicated in the Benefit Schedule. New Directions Behavioral Health (“New Directions”) performs intake services designed to provide crisis intervention, assessment, benefits management and referral services. Covered Services for outpatient evaluation and treatment are limited to crisis intervention, stabilization and therapy for conditions which New Directions and We determine will substantially benefit You. Covered Services for inpatient services are limited to Hospital and Physician services when You are confined in any Hospital or other residential facility licensed to provide such treatment.

**Inpatient and Residential Mental Illness and Substance Abuse Services must be Prior Authorized by New Directions.**

Covered Providers In addition to Physicians and Hospitals, Covered Services provided by the following providers will be eligible for coverage, if such services are within the lawful scope of the provider and the provider is licensed by the state in which the services are rendered (if applicable):

- Licensed clinical social workers;
- Psychiatric residential and nonresidential treatment facilities;
- Alcoholism treatment facilities;
- Drug abuse treatment facilities;
- Community mental health centers or clinics; and
- Licensed professional counselors.

Mental Illness and Substance Abuse Services:

Mental Illness and Substance Abuse Services rendered by Preferred Provider 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.

Mental Illness and Substance Abuse Services rendered by Non-Preferred Providers are limited as follows:

a. Outpatient Treatment

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

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.

**Section D. Exclusions and Limitations, the following exclusions are deleted in their entirety.**

- Health services and associated expenses for megavitamin therapy; psychosurgery; nutritional-based therapy for alcoholism, chemical dependency, or other medical conditions; services and supplies for smoking cessation programs and treatment of nicotine addiction, unless otherwise stated in the Outpatient Prescription Drug benefit.
- For learning disabilities, developmental delays, and mental retardation.
- Methadone, L.A.A.M. (1-Alpha-Acetyl-Methadol) Cyclazocine, or their equivalents when prescribed as maintenance for substance abuse; provided however, Methadone will be covered if prescribed as detoxification treatment in a federally approved detoxification program but shall only be covered for a maximum of up to six consecutive months.

Mental Illness and/or chemical dependency 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 a Preferred Provider who will accept the transfer.

Mental Illness and/or substance abuse services provided in connection with or to comply with the sentencing of a criminal activity for outpatient, partial hospitalization, residential or inpatient treatment.

- For speech therapy for behavioral problems, attention disorders, stammering and/or stuttering, vocal cord training/retraining due to vocational strain and/or weak cords, conceptual handicap, psychosocial speech and conductive hearing loss due to otitis media and ear infections.

**Section D. Exclusions and Limitations, the following exclusions are added.**

- 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.
- 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 a Preferred 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.

- Vocal cord training/retraining due to vocational strain and/or weak cords, speech therapy for psychosocial speech and conductive hearing loss due to otitis media and ear infections.
- Screening examinations or services available, arranged by, or received from any governmental body or entity, including school districts.

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



Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

It is mutually understood and agreed that the provisions noted below are amended as follows:

AMENDMENT: BCBSKC-219-11-MK

**In the Benefit Schedule, the following is added:**

		<b>PREFERRED PROVIDER</b>	<b>NON-PREFERRED PROVIDER</b>
<b>Covered Services</b>		<b>Copayment, Deductible, Coinsurance and Limitations</b>	<b>Copayment, Deductible, Coinsurance and Limitations</b>
<b>Prescription Oral Chemotherapy Drugs</b>		Covered	
<b>Short-Term Supplies</b>	<b>Tier 1</b>	No Copayment	No Copayment
	<b>Tier 2</b>	No Copayment	No Copayment
	<b>Tier 3</b>	No Copayment	No Copayment

**In Section C. Covered Services, Chemotherapy, is deleted and replaced as follows:**

We provide Benefits for intravenous chemical treatment (chemotherapy) of a disease, including the cost of the chemotherapy drug.

We provide Benefits for oral chemotherapy drugs under the Outpatient Prescription Drug Benefit as indicated in the Benefit Schedule.

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



Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

Effective Date: June 26, 2009

It is mutually understood and agreed that, any provisions of Your Contract/Certificate notwithstanding, the provisions noted below are amended as follows:

Amendment: BCBSKC-236-09-M

**In Section I. Continuation and Conversion, Subsection 2. *Continuation of Coverage under Federal Law (“COBRA”)* is deleted in its entirety and replaced with the following:**

**2. Continuation of Coverage under Federal Law (“COBRA”) or under State Law**

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

**a. Qualifying Events**

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

- (1) Termination of employment (other than for gross misconduct);
- (2) Reduction in work hours;
- (3) Death of the Employee;
- (4) The Employee becomes entitled (eligible and enrolled) to Medicare Benefits;
- (5) Divorce or legal separation;
- (6) A Dependent child ceases to qualify as a Dependent under the terms of the Plan; or

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

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

#### **b. Qualified Beneficiary**

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

#### **c. Maximum Coverage Period**

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

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

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

#### **e. Social Security Disability**

A special rule applies if a qualified beneficiary is found to have been disabled during the first 60 days of continuation coverage. All qualified beneficiaries may be eligible to continue coverage for up to 29 months. The determination of disability must be made by the Social Security Administration, and must be issued within the disabled individual's initial 18 months of continuation coverage. That individual must then notify the Employer of the Social Security Administration's disability determination as follows: (1) within 60 days of the later of the date after the determination is issued, the date of the qualifying event, or the date coverage under the Contract is terminated as a result of termination of employment or a reduction in hours; and (2) within the individual's first 18 months of continuation coverage. This extension applies for all qualified beneficiaries, including a qualified beneficiary born or adopted during the continuation period, if notice is given within 60 days of such birth or adoption.

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

**f. Electing Continuation Coverage**

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

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

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

**g. Effective Date of Continuation Coverage**

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

## **h. Coverage Changes**

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

The qualified beneficiary has the same right to change benefit programs as the active Employees. If the active Employee is allowed to change to another benefit program during the Employer'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.

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

## **i. Termination of Continuation Coverage**

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

- (1) 18 months from the date continuation began if coverage ended because of the Employee's termination of employment or reduction in hours worked or 36 months for qualified beneficiaries (other than the Employee) after the date of Medicare entitlement if the Employee became entitled to Medicare within 18 months before the termination or reduction of hours;
- (2) 29 months from the date continuation began for a qualified beneficiary who is totally disabled in accordance with the Social Security Disability provisions above;
- (3) 36 months from the date continuation began if coverage ended because of the Employee's death, divorce, legal separation or a child's loss of Dependent status;
- (4) The date coverage terminates under the Contract for failure to make timely payment of the required Premium; if the individual fails to make the required Premium payment within the grace period (payment of Premium must be postmarked no later than last day of the grace period);

- (5) The date the individual first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise). However, an individual who becomes covered under a group health plan which has a preexisting condition limit must be allowed to continue coverage for the length of a preexisting condition or to the continuation maximum coverage period, if less. Continuation coverage may be terminated if the individual becomes covered under a group health plan with a preexisting condition limit, if the preexisting condition limit does not apply to (or is satisfied by) the individual by reason of HIPAA, ERISA or the Public Health Services Act;
- (6) The date the Covered Person becomes entitled to Medicare Benefits, if after the date of continuation coverage election;
- (7) For retirees, in the case of a qualifying event that is the Chapter 11 bankruptcy of an Employer, the earlier of the date of the qualified beneficiary's death or the date that is 36-months after the death of the retired covered Employee.
- (8) The date any Covered Person allows someone other than an eligible Dependent to use his or her identification card, or submits a fraudulent claim; or
- (9) The date the Contract terminates.

**j. Extension of COBRA Continuation for Spouses**

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

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

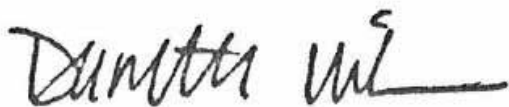
- (2) A divorced or legally separated spouse (and Dependent children) whose coverage would otherwise terminate due to the divorce or legal separation, if the spouse is 55 or older at the time their federal COBRA continuation coverage expires. Within sixty days of legal separation or the entry of a decree of dissolution of marriage, or prior to the expiration of a thirty-six month federal COBRA continuation period covering a legally separated or divorced spouse (and Dependent children), if such spouse has elected and maintained such COBRA coverage, a legally separated or divorced spouse eligible for such continuation of coverage shall provide Us written notice of the legal separation or dissolution. The notice shall include the mailing address of the legally separated or divorced spouse. This extension of continuation coverage will terminate.

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

- (1) The date coverage terminates under the Contract for failure to make timely payment of the required Premium; if the individual fails to make payment on any Due Date;
- (2) The date the Contract terminates except if a different group policy is made available to all other Covered Persons. In this instance, the legally separated, divorced or surviving spouse will be eligible for continuation of coverage under such different group policy as if coverage under the Contract had not been terminated.
- (3) The date the person becomes covered under any other group health plan; or
- (4) The spouse's 65th birthday.

**In Section I. Continuation and Conversion, Subsection 4. *Continuation of Coverage under State Law* is deleted in its entirety.**

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

A handwritten signature in black ink, appearing to read "Dimitri M.", with a long horizontal line extending to the right.

Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

Effective Date: April 1, 2009

It is mutually understood and agreed that, any provisions of Your Contract/Certificate notwithstanding, the provisions noted below are amended as follows:

AMENDMENT: BCBSKC-204-09-MK

**Section B. Eligibility, Enrollment and Effective Date, Subsection 4.c.(2) and (3) are deleted in their entirety and replaced with the following:**

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

- a. (i) The employer's contributions toward such coverage were terminated;
- (ii) The Employee's and/or his Dependent's COBRA or state continuation coverage has been exhausted; or
- (iii) The Employee's and/or his Dependent's coverage terminated as a result of loss of eligibility for coverage. Loss of eligibility for coverage does not include termination due to untimely payment of Premiums or termination for cause. Events that could result in a loss of eligibility for coverage include:
  1. Legal separation, divorce, no longer qualifying as a dependent under the other coverage, death of an Employee, termination of employment or reduction in the number of hours of employment.
  2. Reaching a Lifetime Maximum on all Benefits under coverage offered by an Employer.
  3. An Employer no longer offers any health coverage to a class of similarly situated individuals.
- b. Except as provided in subparagraph c. below, the Employee must submit to Us a completed Employee application and any additional Premium due within 31 days after the loss of such other coverage and provide appropriate documentation verifying the loss of such other coverage, if requested.
- c. If the Employee and/or Dependent lost Medicaid or CHIP coverage, the Employee must submit to Us a completed Employee application and any additional Premium due within 60 days after the loss of such coverage and provide appropriate documentation verifying the loss of such coverage, if requested.

- (3) Eligibility for Premium Assistance under Medicaid or CHIP. If an Employee and/or his Dependent become eligible for premium assistance under Medicaid or CHIP the eligible Employee and/or his eligible Dependents may enroll during this Special Enrollment Period, even if coverage was previously declined. To enroll during this Special Enrollment Period, an Employee must submit to Us a completed Employee application and any additional Premium due within 60 days after eligibility is determined and provide appropriate documentation verifying the eligibility, if requested.
- (4) Coverage Options: The Employee and/or his Dependents may enroll in any health benefit plan offered by his Employer.

**Section B. Eligibility, Enrollment and Effective Date, Subsection 5.c.(2) is deleted in its entirety and replaced with the following:**

- (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.

**Section B. Eligibility, Enrollment and Effective Date, Subsection 5.c.(3) is hereby added as follows:**

- (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.

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



Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

AMENDMENT: BCBSKC-222-11-M

It is mutually understood and agreed that the provisions noted below are amended as follows:

**In Section F. Coordination of Benefits (COB), subsection 2.c.(4), the following is deleted in its entirety:**

(4) Coverage under any governmental program(s) to include any coverage required or provided by statute(s). Benefits available from Part A and Part B of Medicare are included. However, benefits under a state Medicaid program are not included;

**Section F. Coordination of Benefits (COB), subsection 3.h. is deleted in its entirety and replaced with the following:**

h. Medicare:  
When benefits under the Contract are being coordinated with any benefits available by Medicare, the Federal Medicare Secondary Payor Rules in effect at that time will apply and this section F shall not apply.

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



Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD  
OF KANSAS CITY**

It is mutually understood and agreed that the provisions noted below are amended as follows:

AMENDMENT: BCBSKC-218-11-MK

**In Section E., Exclusions and Limitations, the exclusion is deleted and replaced as follows:**

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 or illness whether or not You file a claim. If You enter into a settlement giving up Your right to recover past or future medical benefits under a workers' compensation law, We will not pay past or future medical benefits that are the subject of or related to that settlement.

In addition if You are covered by a workers' compensation program that limits benefits to certain authorized providers, We will not pay for services You receive from providers, authorized or unauthorized, by Your workers' compensation program.

**In Section J., General Information, the *Reimbursement to Us* provision is deleted and replaced as follows:**

**Reimbursement to Us**

**a. Workers' Compensation**

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

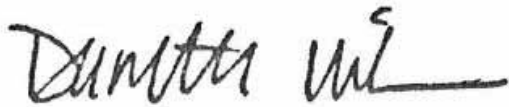
If You are covered by a workers' compensation program that limits certain authorized providers, You agree to reimburse Us for any Benefits We paid to You or on Your behalf for claims paid or payable for services You receive from providers, authorized or unauthorized, by Your workers' compensation program.

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

**b. Errors**

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

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

A handwritten signature in black ink, appearing to read "Danette Wilson". The signature is written in a cursive style with a long horizontal line extending to the right.

Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

It is mutually understood and agreed that the provisions noted below are amended as follows:

AMENDMENT: BCBSKC-217-11-MK

**In Section D., Exclusions and Limitations, .the following exclusion is deleted:**

For hypnotism, hypnotic anesthesia, acupuncture, acupressure, biofeedback (including neurofeedback), rolfing, massage therapy, aroma therapy and other forms of alternative treatment.

**And replaced as follows:**

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.

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

A handwritten signature in black ink, appearing to read "Danette Wilson", with a horizontal line extending to the right.

Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

AMENDMENT: BCBSKC-204-11-MK

It is mutually understood and agreed that the provisions noted below are amended as follows:

**In Section C. Covered Services, Outpatient Prescription Drugs, Covered Drugs, subsection a., the following is deleted:**

- a. Legend drugs that, by federal or state law, can only be dispensed upon written prescription from an authorized prescriber

**and replaced with:**

- a. Legend drugs that, by federal law, can only be dispensed upon written prescription from an authorized prescriber

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



Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

It is mutually understood and agreed that the provisions noted below are amended as follows:

AMENDMENT: BCBSKC-241-10-MK

**In Section A. Definitions, the Definition of Allowable Charge, section f. For Participating Pharmacies is deleted and replaced as follows:**

For participating 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.

**In Section C. Covered Services, Outpatient Prescription Drugs, the Introduction/Prior Authorization language is deleted and replaced as follows:**

Introduction/Prior Authorization:

We provide Benefits for drugs and medicines for use outside a Hospital that require a Physician's prescription. Certain medications or classes of medication may require Prior Authorization. To receive Prior Authorization, Your Physician will need to submit to Us a statement of Medical Necessity. Certain medications are subject to utilization programs that require You to try to use a therapeutic alternative before another medication will be considered a Covered Service. Your Physician may submit to Us a statement of Medical Necessity if the utilization program is not appropriate for Your medical condition.

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.

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



Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

It is mutually understood and agreed that the provisions noted below are amended as follows:

AMENDMENT: BCBSKC-200-10-MK

In Section A. Definitions, the definition of Preferred Provider is amended to include only providers in the VSP network.

The following Benefit is added to your Certificate/Contract:

**VISION CARE**

We provide Benefits for certain Vision Care. Covered Services are limited to the following and may be received from any Physician, however, Benefits will be greater when Preferred Providers as defined above are used. When Covered Services are received from a Non-Preferred Provider, You are responsible for paying the provider’s billed charge at the time of service and for submitting an itemized bill to VSP for reimbursement. VSP will reimburse You for the amount shown in the Schedule of Benefits, minus any Copayment.

	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
VISION CARE SERVICES	<b>Copayment, Deductible, Coinsurance and Limitations</b>	<b>Copayment, Deductible, Coinsurance and Limitations</b>
Eye Examination  <i>One Eye Exam per Calendar Year</i>	\$20 Copayment	\$20 Copayment  <i>\$45 benefit maximum.</i>

**ADDITIONAL DISCOUNT**

Each Covered Person shall be entitled to receive a discount of 20% toward the purchase of non-covered materials from any Preferred Provider when a complete pair of glasses is dispensed. Also, Covered Persons shall be entitled to receive a discount of 15% off of contact lens examination services from any Preferred Provider.

Discounts are applied to the Preferred Provider’s usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient’s last eye exam.

**LIMITATIONS:**

- Discounts do not apply to vision care benefits obtained from Non-Preferred Providers.
- 20% discount applies to complete pairs of glasses only.
- Discounts do not apply if prohibited by the manufacturer.
- Discounts do not apply to sundry items: e.g., contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

## EXCLUSIONS AND LIMITATIONS OF BENEFITS

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Corneal Refractive Therapy (CRT).
- Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
- Refitting of contact lenses after the initial (90-day) fitting period.
- Plano contact lenses (lenses with refractive correction of less than  $\pm .50$  diopter).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Low vision services and materials.
- Plano contact lenses to change eye color cosmetically.
- Costs for services and/or materials exceeding Plan Benefit allowances.
- Artistically-painted contact lenses.
- Contact lens modification, polishing or cleaning.
- Additional office visits associated with contact lens pathology.
- Contact lens insurance policies or service agreements.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

In Section F. Coordination of Benefits (COB), notwithstanding any provision to the contrary, an Allowable Expense for purposes of COB does not include dental coverage or routine vision coverage.

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



Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

AMENDMENT: BCBSKC-216-14-M

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

**In Section K., Utilization Review, the following is deleted:**

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

**And replaced as follows:**

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

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.

A handwritten signature in black ink, appearing to read "Danette Wilson", with a horizontal line extending to the right.

Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY  
FOR KANSAS RESIDENTS ONLY**

AMENDMENT: BCBSKC-219-14-M

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

**In Section C., Covered Services, *Autism Spectrum Disorder* is deleted in its entirety and replaced as follows:**

**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 not include cognitive therapies or psychological testing, personality assessment, intellectual assessment, neuropsychological assessment, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, family therapy and long-term counseling as treatment modalities.

**Autism Service Provider** means:

- a. Any person, entity, or group that provides diagnostic or treatment services for Autism Spectrum Disorders who is licensed or certified by the state in which services were rendered to provide health care services;
- b. In states that do not have licensure and/or certification requirements, any person who is a Behavioral Analyst with national certification from the Behavior Analyst Certification Board; or
- c. Any person who is licensed, trained and qualified to provide such services or an autism specialist or an intensive individual service provider as such terms are defined by the Kansas Department of Aging and Disability Services Autism Waiver

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

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

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

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

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

- a. The Benefits for Applied Behavior Analysis are subject to the same Cost-Sharing as All Other Covered Services and are limited to a \$41,263 Calendar Year Maximum 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.; or
- b. The Benefits for Applied Behavior Analysis are subject to the same Cost-Sharing as All Other Covered Services. For Covered Persons diagnosed with an Autism Spectrum Disorder between birth and five years of age, ABA coverage is limited to 1,300 hours per Calendar Year for the first four years of such coverage. After the first four years of coverage, and for Covered Persons diagnosed with an Autism Spectrum Disorder after five years of age, ABA coverage is limited to 520 hours per Calendar Year until reaching age 12.

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

Notwithstanding any provision in the Certificate to the contrary, services provided by an Autism Service Provider for Speech Therapy, Occupational Therapy or Physical Therapy will not be subject to any visit limits and shall

not be subject to the age limitations described in this subsection, except for Applied Behavior Analysis.

**ABA services must be Prior Authorized by Us.**


**In Section D., Exclusions and Limitations, the following is deleted in its entirety:**

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.

**And replaced as follows:**

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

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.

A handwritten signature in black ink, appearing to read "Danette Wilson". The signature is written in a cursive, flowing style.

Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross Blue Shield of Kansas City

**AMENDMENT ISSUED BY  
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

**FOR KANSAS RESIDENTS ONLY**

It is mutually understood and agreed that, any provisions of your Contract/Certificate notwithstanding, the various provisions noted below are amended as follows:

Amendment: BCBSKC-229-11-K

**BIRTH MOTHER COVERAGE**

In Your Certificate, the following provision is added to the Maternity Services and Related Newborn Care Benefit in Section C., Covered Services:

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

**MENTAL ILLNESS AND SUBSTANCE ABUSE COVERAGE**

In the Benefit Schedule, the benefits for *Outpatient, Residential, and Inpatient Mental Illness, and Outpatient, Residential Treatment, and Detoxification for Chemical Dependency* are deleted in their entirety.

In the Benefit Schedule, the following sections are added:

Covered Services	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
	Copayment, Deductible, Coinsurance and Limitations	Deductible, Coinsurance and Limitations
<b>Outpatient Mental Illness and Substance Abuse</b>	Deductible	Deductible then 20% Coinsurance  <i>Services at a Non-Participating Provider Hospital or a Non-Participating Provider outpatient facility inside Our Service Area are limited to a \$200 Calendar Year Maximum.</i>
<b>Inpatient Mental Illness and Substance Abuse</b>	Deductible	Deductible then 20% Coinsurance  <i>Inpatient hospital services for <u>Mental Illness</u> in a Non-Participating Provider Hospital inside Our Service Area are limited to a \$200 maximum per day and are limited to 45 days per Calendar Year.</i>

		<p><i>Inpatient hospital services for <u>Substance Abuse</u> in a Non-Participating Provider Hospital inside Our Service Area are limited to a \$200 maximum per day and are limited to 30 days per Calendar Year.</i></p>
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**In Section A. Definitions, the definition of *Mental Illness* is deleted in its entirety and replaced with the following:**

**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).

**Section C. Covered Services, the *Inpatient Hospital Services* benefit provision is deleted in its entirety and replaced with the following:**

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

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

Non-Participating  
Provider Hospital  
Benefits Inside  
Our Service Area

The following provisions apply to Covered Services received from Non-Participating Provider Hospitals and residential treatment facilities:

- a. Your Benefit for Covered Services for inpatient hospital services in a Non-Participating Hospital inside Our Service Area is limited to a maximum of \$200 per day. However, this Benefit will be provided only for up to 30 days per Calendar Year, per Covered Person, for all Admissions combined in such Non-Participating Provider Hospitals.
- b. Your Benefit for an outpatient service at a Non-Participating Provider Hospital inside Our Service Area will be limited to a maximum of \$200 per Calendar Year.

Benefits for services received from a Non-Participating Provider Hospital inside Our Service Area will not be subject to any Deductible or Coinsurance requirements.

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

**Section C. Covered Services, the *Mental Illness and Substance Abuse* benefit provision is deleted in its entirety and replaced with the following:**

**Mental Illness and Substance Abuse**

We provide Benefits for the treatment of Mental Illness and Substance Abuse as indicated in the Benefit Schedule. New Directions Behavioral Health (“New Directions”) performs intake services designed to provide crisis intervention, assessment, benefits management and referral services. Covered Services are provided for Medically Necessary outpatient evaluation and treatment of Mental Illness and Substance Abuse. 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.**

**Covered Providers**

In addition to Physicians and Hospitals, Covered Services provided by the following providers will be eligible for coverage, if such services are within the lawful scope of the provider and the provider is licensed by the state in which the services are rendered (if applicable):

- Licensed clinical social workers;
- Psychiatric residential and nonresidential treatment facilities;
- Alcoholism treatment facilities;
- Drug abuse treatment facilities;
- Community mental health centers or clinics; and
- Licensed professional counselors

**Mental Illness and Substance Abuse Services:**

Mental Illness and Substance Abuse Services rendered by Preferred 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. Benefits for Outpatient Therapy Services for Substance Abuse and Mental Illness will be paid at 100% of the Allowable Charge, after You pay Your office visit Copayment, when services are rendered by a Preferred Provider.

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.

Mental Illness and Substance Abuse Services rendered by Non-Preferred Providers are limited as follows:

a. Outpatient Treatment

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

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.

**Section D. Exclusions and Limitations, the following exclusions are deleted in their entirety.**

- Health services and associated expenses for megavitamin therapy; psychosurgery; nutritional-based therapy for alcoholism, chemical dependency, or other medical conditions; services and supplies for smoking cessation programs and treatment of nicotine addiction, unless otherwise stated under the Outpatient Prescription Drug benefit.
- For learning disabilities, developmental delays, and mental retardation.
- Methadone, L.A.A.M. (1-Alpha-Acetyl-Methadol) Cyclazocine, or their equivalents when prescribed as maintenance for substance abuse; provided however, Methadone will be covered if prescribed as detoxification treatment in a federally approved detoxification program but shall only be covered for a maximum of up to six consecutive months.

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 a Preferred Provider who will accept the transfer.

Mental Illness and/or substance abuse services provided in connection with or to comply with the sentencing of a criminal activity for outpatient, partial hospitalization, residential or inpatient treatment.

- For speech therapy for behavioral problems, attention disorders, stammering and/or stuttering, vocal cord training/retraining due to vocational strain and/or weak cords, conceptual handicap, psychosocial speech and conductive hearing loss due to otitis media and ear infections.

**Section D. Exclusions and Limitations, the following exclusions are added.**

- 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.

- 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 a Preferred 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.

- Vocal cord training/retraining due to vocational strain and/or weak cords, speech therapy for psychosocial speech and conductive hearing loss due to otitis media and ear infections.
- Screening examinations or services available, arranged by, or received from any governmental body or entity, including school districts.

## **CONTINUATION OF COVERAGE**

Section I. Continuation and Conversion, Subsection 2a. Continuation of Coverage under Federal Law (“COBRA”) or under State Law is amended by adding the following additional “qualifying event”.

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

Section I. Continuation and Conversion, Subsection 2c. *Maximum Coverage Period* is amended by adding the following the following paragraph:

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

## **PREEXISTING CONDITIONS**

Unless the Preexisting Exclusion Period is waived in the Benefit Schedule, the following conditions apply:

In Section A., Definitions, the reference to 6 months in the Preexisting Condition definition is deleted and replaced with 90 days.

In Section D., Exclusions and Limitations, the reference to 12 consecutive months in the exclusion for Preexisting Conditions during the Exclusion Period is deleted and replaced with 90 consecutive days.

## **COORDINATION OF BENEFITS (COB)**

The Coordination of Benefits Section F. is amended by deleting 2. Definitions Applicable to this Section, b.(5) and (6) in their entirety and replacing with the following:

- (5) Group or group-type Plans designed to pay a fixed dollar benefit per day while the individual is confined in a Hospital, provided however, COB will be applied only to the portion of the daily benefit which exceeds \$200.00 per day.

## GENERAL INFORMATION

The Legal Actions provision in Section J. General Information of Your Certificate is deleted in its entirety and replaced with the following:

- 6. Legal Actions** No action at law or equity shall be brought after the expiration of 5 years after the time written proof of loss is required to be furnished.

## COMPLAINT AND GRIEVANCE PROCEDURES

In Section L. Complaint and Grievance Procedures of Your Certificate, the following provision is added:

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

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

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

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

In no event shall the Insured be held responsible for any portion of the external review organization's fee for performance.

Only 1 external review is available for any request arising out of the same set of facts during a period of 12 consecutive months beginning on the date of the initial request for external review.

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

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

A handwritten signature in black ink, appearing to read "Danette Wilson". The signature is written in a cursive style with a long horizontal stroke at the end.

Danette Wilson  
Interim President and Chief Executive Officer  
Blue Cross and Blue Shield of Kansas City

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

## **COVERED PERSON'S RIGHTS AND RESPONSIBILITIES**

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- 1. You have the right to:**
- a. Receive considerate and courteous care with respect and recognition of personal privacy, dignity and confidentiality.
  - b. Have a candid discussion of medically necessary and appropriate treatment options or services for your condition from any participating physician, regardless of cost or benefit.
  - c. Receive medically necessary and appropriate care or services from any participating physician or other participating healthcare provider from those available as listed in your managed care plan directory or from any non-participating physician or other healthcare provider.
  - d. Receive information in clear and understandable terms, and ask questions to ensure you understand what you are told by your physician and other medical personnel.
  - e. Participate with practitioner in making decisions about your health care, including accepting and refusing medical or surgical treatments.
  - f. Give informed consent to treatment and make advance treatment directives, including the right to name a surrogate decision maker in the event you cannot participate in decision making.
  - g. Discuss your medical records with your physician and have health records kept confidential, except when disclosure is required by law or to further your treatment.
  - h. Be provided with information about your PPO managed healthcare plan, its services, and the practitioners and providers providing care, as well as have the opportunity to make recommendations about your rights and responsibilities.
  - i. Communicate any concerns with your PPO managed healthcare plan regarding care or services you received, receive an answer to those concerns within a reasonable time, and initiate the complaint and grievance procedure if you are not satisfied.

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- 2. You have the responsibility to:**
- a. Respect the dignity of other members and those who provide care and services through your PPO managed health care plan.

- b. Ask questions of your treatment physician or treatment provider until you fully understand the care you are receiving and participate in developing mutually agreed upon treatment goals to the degree possible.
- c. Follow the mutually agreed upon plans and instructions for care that you have discussed with your healthcare practitioner, including those regarding medications. Comply with all treatment follow-up plans, and be aware of the medical consequences of not following instructions.
- d. Communicate openly and honestly with your treatment provider regarding your medical history, health conditions and the care you receive.
- e. Keep all scheduled healthcare appointments and provide advance notification to the appropriate provider if it is necessary to cancel an appointment.
- f. Know how to use the services of your PPO managed healthcare plan properly.
- g. Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

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

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

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Missouri law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

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

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is as follows:

- \$300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- \$500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance
- \$5,000,000 to one policy owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons

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

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association’s website at [www.mo-iga.org](http://www.mo-iga.org), or contact:

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

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

Insurance companies and agents are not allowed by Missouri law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Missouri law, then Missouri law will control.

# **BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

## **PRIVACY PRACTICES NOTICE**

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

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

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### **Summary of Our Privacy Practices**

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

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

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

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

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

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

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### **Contact Information**

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

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

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

### **Organizations Covered by this Notice**

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

Blue Cross and Blue Shield of Kansas City

Good Health HMO, Inc.

Blue-Advantage Plus of Kansas City, Inc.

Missouri Valley Life and Health Insurance Company

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### **Our Legal Duty**

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

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

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

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### **Uses and Disclosures of Your Medical Information**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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## Your Rights

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

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

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

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

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

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

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

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

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

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

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

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### Complaints

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

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

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

