

RESEARCH COLLEGE OF NURSING ***\$750, a PPO Product, on the Preferred-Care Blue Network***

Offered by Blue Cross and Blue Shield of Kansas City

STUDENT ENROLLMENT

Health Benefits Contract for:

RESEARCH COLLEGE OF NURSING

44284000

PBM9114A

Contract Effective Date: August 1, 2021

NOTICE

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

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

The 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. The Contract may be terminated by Us as described in the Contract.



Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

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

Discrimination is Against the Law

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

Blue KC:

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

If you need these services, contact Cynthia Aron, 816-395-6340 (local), 844-395-7126 (Toll free), languagehelp@bluekc.com

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

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

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

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

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

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

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

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

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

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

Arabic:

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

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

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

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

Laotian: ຖ້າ ທ່ານ, ຫຼື ຄົນ ທ່ານ ກໍ່ ຈ່ວຍ ຈຸດ ອຍເຫຼືອ, ມີ ຄຳ ຖາມ ກ່ຽວ ກັບ Blue KC, ທ່ານ ມີ ສິດ ທີ່ ຈະ ໄດ້ ຮັບ ການ ຈຸດ ອຍເຫຼືອ ແລະ ຂໍ້ ມູນ ຂ່າວ ສານ ທີ່ ບໍ່ ມາ ສາ ຂອງ ທ່ານ ບໍ່ ມີ ຄ່າ ຈ້າ ຈ່າຍ. ການ ໂອ້ ລົມ ກັບ ນາຍ ພາ ສາ, ໃຫ້ ໂທ ຫາ 1-844-395-7126.

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

Persian:

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

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

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

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

TABLE OF CONTENTS

Page

SECTION A. DEFINITIONS.....	15
SECTION B. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE.....	28
SECTION C. COVERED SERVICES	33
SECTION D. EXCLUSIONS AND LIMITATIONS	67
SECTION E. HOW TO FILE A CLAIM.....	73
SECTION F. COORDINATION OF BENEFITS (COB).....	76
SECTION G. PREMIUM PAYMENT, GRACE PERIOD AND CHANGES	82
SECTION H. TERMINATING THE CONTRACT	84
SECTION I. GENERAL INFORMATION	87
SECTION J. UTILIZATION REVIEW	93
SECTION K. COMPLAINT AND GRIEVANCE PROCEDURES	95

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

RESEARCH COLLEGE OF NURSING

"08/01/2021"

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

<p>Plan Type and Description (Visit our website at www.bluekc.com to receive a complete listing of network hospitals and physicians).</p>	<p>Your Plan Type is a Preferred Provider Organization (PPO). Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue Network. Please see the Covered Services section for further information.</p>
<p>Dependent Limiting Age</p>	<p>Dependent Limiting Age – 26 Coverage will be provided until the end of the Plan Year when they turn 26.</p>
<p>Domestic Partners</p>	<p>Not Covered</p>
<p>Newborn Eligibility</p>	<p>Individual only plan – employee must submit an application within 31 days following birth to employer group in order for newborn to be covered at date of birth. Any additional premium owed for the newborn addition will be collected according to normal billing practices.</p>

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
<p>Plan Year Deductible (Individual/Family)</p>	<p>Individual: \$750 Family: \$1,500</p>	<p>Individual: \$750 Family: \$1,500</p>
<p>Out-of-Pocket Maximum (Individual/Family) <i>Includes Deductible</i> (Total of Cost-Sharing members pay each year toward covered charges before BCBSKC pays 100% of benefits)</p>	<p>Individual: \$2,000 Family: \$4,000</p> <p>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.</p> <p>There are separate Out-of-Pocket Maximums for In-Network Providers and Out-of-Network Providers. The amount You pay for Covered Services received from In-Network Providers will apply to the In-Network Out-of-Pocket Maximum. The amount You pay for Covered Services received from Out-of-Network Providers will apply to the Out-of-Network Out-of-Pocket Maximum. The only exception is for Cost-Sharing for Emergency Services, which will apply to Your In-Network Preferred Provider Out-of-Pocket Maximum and Out-of-Network Non-Preferred Provider Out-of-Pocket Maximum, regardless of whether services are received from an In-Network Preferred or Out-of-Network Non-Preferred Provider.</p>	<p>Individual: \$4,000 Family: \$8,000</p>
<p>Standard Coinsurance The standard Coinsurance applies</p>	<p>20% Coinsurance</p>	<p>40% Coinsurance</p>

for Covered Services that are not specifically indicated in this Contract. Coinsurance is the portion of covered charges paid by You after You satisfy Your Deductible.		
--	--	--

COVERED MEDICAL SERVICES	COST-SHARING AND LIMITATIONS AT IN-NETWORK PROVIDERS	COST-SHARING AND LIMITATIONS AT OUT-OF-NETWORK PROVIDERS
Ambulance	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance <i>Ambulance services received from an Out-of-Network Provider will be subject to the In-Network Out-of-Pocket Maximum</i>
Autism	Deductible then 20% Coinsurance <i>Coverage for Applied Behavior Analysis for Covered Persons until age 19</i> These services must be Prior Authorized.	Deductible then 40% Coinsurance
Chiropractic Services	\$25 Copayment <i>Copayment applies to the Office Visit Charge Only. Other procedures performed in a Chiropractor's office are subject to deductible and coinsurance.</i>	Deductible then 40% Coinsurance
Diabetes Self-Management Education and Training	No Copayment	Deductible then 40% Coinsurance
Diabetic Shoes	Deductible then 20% Coinsurance <i>3 pair of inserts per Covered Person per Plan Year Maximum</i> These Services Must be Prior Authorized	Deductible then 40% Coinsurance
Diagnostic Testing (includes allergy testing and treatment)	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
Durable Medical Equipment	Deductible then 20% Coinsurance These Services Must be Prior Authorized	Deductible then 40% Coinsurance
Elective Sterilization	Covered under Routine Preventive Care	
Emergency Services	\$100 Copayment, then In-Network Deductible then 20% Coinsurance <i>This Copayment will not apply if You are admitted to a Hospital for the</i>	

COVERED MEDICAL SERVICES	COST-SHARING AND LIMITATIONS AT IN-NETWORK PROVIDERS	COST-SHARING AND LIMITATIONS AT OUT-OF-NETWORK PROVIDERS
	<p><i>same condition within 24 hours, but the applicable Inpatient Hospital Services Cost-Sharing will apply.</i></p> <p><i>If You visit an emergency room and are kept at the Hospital for observation (usually less than 24 hours), You must pay the Emergency Services Copayment, but will not be required to pay the applicable Inpatient Hospital Services Cost-Sharing amount for the time You are kept for observation.</i></p> <p><i>If You are admitted to the Hospital following the observation stay, the applicable Inpatient Hospital Services Cost-Sharing amount will apply.</i></p>	
Formula and Food Products for Phenylketonuria	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
<p><i>Your Coinsurance will never be greater than 50% of the cost of the formula or food product</i></p>		
Hearing Aids and Related Services	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
<p><i>Hearing Aids are limited to 1 set every 36 months</i></p>		
High-Tech Diagnostic Testing	MRI, MRA, CT, CTA, AND PET scans	Deductible then 20% Coinsurance
<p>These Services Must be Prior Authorized</p>		
	Nuclear Medicine, Cardiac Nuclear Medicine	Deductible then 40% Coinsurance
<p>These Services Must be Prior Authorized</p>		
Home Health Services	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
<p><i>100 visit Calendar Year Maximum</i></p>		
Hospice Services	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
<p><i>We provide Benefits for home 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</i></p> <p>These Services Must be Prior Authorized</p>		
Immunizations for Dependent Children under the age of 6	No Copayment	No Copayment
<p>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</p>		

COVERED MEDICAL SERVICES	COST-SHARING AND LIMITATIONS AT IN-NETWORK PROVIDERS	COST-SHARING AND LIMITATIONS AT OUT-OF-NETWORK PROVIDERS
	services.	
Inpatient Hospital Services	Deductible then 20% Coinsurance These Services Must be Prior Authorized	Deductible then 40% Coinsurance
Inpatient Hospice	Deductible then 20% Coinsurance These Services Must be Prior Authorized	Deductible then 40% Coinsurance
Inpatient Mental Illness	Deductible then 20% Coinsurance These Services Must be Prior Authorized	Deductible then 40% Coinsurance
Inpatient Substance Abuse (includes detoxification)	Deductible then 20% Coinsurance These Services Must be Prior Authorized	Deductible then 40% Coinsurance
Lab performed in the Physician's Office/Independent Lab(excluding allergy testing)	No Copayment 100% of Allowable Charges for Covered Services – See Your Routine Preventive Care for services covered	Deductible then 40% Coinsurance
Lab performed in the Hospital/Outpatient Facility (including an Ambulatory Surgery Center)	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
Maternity Services and Related Newborn Care Office Visit	\$25 Copayment <i>Only one Specialist Copayment shall apply for routine obstetrical services during Your pregnancy.</i> <i>You must pay Your office visit Copayment for each visit to a Physician for non-routine obstetrical services during Your pregnancy</i>	Deductible then 40% Coinsurance
Surgery and Services	Deductible then 20% Coinsurance <i>The Maternity Services Copayment will apply at the time of the vaginal delivery, caesarean section, or miscarriage in lieu of a Cost-Sharing for Inpatient Hospital or Outpatient Surgery and Services.</i> <i>This Copayment applies for up to 5 days per Calendar Year. Inpatient Hospital, Inpatient Mental Illness, Inpatient Substance Abuse, and Maternity Services are combined and count toward the 5 days covered at the applicable Copayment per Calendar Year. After the 5th day, Cost-</i>	Deductible then 40% Coinsurance

COVERED MEDICAL SERVICES	COST-SHARING AND LIMITATIONS AT IN-NETWORK PROVIDERS	COST-SHARING AND LIMITATIONS AT OUT-OF-NETWORK PROVIDERS
	<p><i>Sharing will not apply to any subsequent Inpatient Hospital, Inpatient Mental Illness, Inpatient Substance Abuse, and/or Maternity Services for the remainder of the Calendar Year.</i></p> <p><i>If both the mother and newborn child are covered under this Contract, routine nursery services are not subject to a separate Copayment during the covered portion of the mother's Hospital Confinement.</i></p>	
Office Visit - Primary Care	<p>\$25 Copayment</p> <p><i>Lab services that are drawn and processed in the Primary Care Physician's office, except for allergy testing, will not be subject to the applicable Cost-Sharing. Other procedures, including x-rays and other radiology procedures, performed in a Primary Care Physician's office are subject to the applicable Cost-Sharing.</i></p>	Deductible then 40% Coinsurance
Office Visit – Specialist	<p>\$25 Copayment</p> <p><i>This includes an office visit to a Chiropractor. Other procedures performed in a Chiropractor's office are subject to deductible and coinsurance.</i></p> <p><i>Lab services that are drawn and processed in the Specialist's office, except for allergy testing, will not be subject to the applicable Cost-Sharing. Other procedures, including x-rays and other radiology procedures, performed in a Specialist's office are subject to the applicable Cost-Sharing.</i></p>	Deductible then 40% Coinsurance
Organ Transplant	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
These Services Must be Prior Authorized		

COVERED MEDICAL SERVICES		COST-SHARING AND LIMITATIONS AT IN-NETWORK PROVIDERS	COST-SHARING AND LIMITATIONS AT OUT-OF-NETWORK PROVIDERS
Outpatient Colonoscopy		Outpatient colorectal cancer exams consisting of digital rectal exam (including colonoscopy, flexible sigmoidoscopy, and double contrast barium enema) <i>The office visit Cost-sharing will apply if applicable.</i>	Deductible then 40% Coinsurance
Outpatient Mental Illness	Office Visit	\$25 Copayment	Deductible then 40% Coinsurance
	Therapy	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
Outpatient Substance Abuse	Office Visit	\$25 Copayment	Deductible then 40% Coinsurance
	Treatment	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
Outpatient Surgery and Services in Hospital or other Outpatient Facility		Deductible then 20% Coinsurance Certain Outpatient Surgeries and Services must be Prior Authorized	Deductible then 40% Coinsurance
Outpatient X-ray or CT Scan Required to confirm a positive Tuberculosis test		Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
Pediatric Dental (Coverage will be provided until the end of the Calendar Year when the Covered Person reaches age 19)	Basic Services	No Copayment <i>Routine Oral Examination and Teeth Cleaning: 2 per Plan Year</i>	Not Covered
	Intermediate Service	Deductible then 20% Coinsurance	Not Covered
	Major Services	Deductible then 50% Coinsurance	Not Covered
Pediatric Vision (Coverage will be provided until the end of the Calendar Year when the Covered Person reaches age 19)	Routine Eye Exam	\$25 Copayment <i>1 per Plan Year</i>	Not Covered
	Eyewear (Eyeglasses or Contact Lenses)	Eyeglasses: Deductible then 20% Coinsurance <i>One pair of lenses per Plan Year. One set of frames per Plan Year.</i>	Not Covered
		Contact Lenses: Deductible then 20% Coinsurance <i>Annual supply of Contact Lenses provided in lieu of eyeglasses.</i>	

COVERED MEDICAL SERVICES		COST-SHARING AND LIMITATIONS AT IN-NETWORK PROVIDERS	COST-SHARING AND LIMITATIONS AT OUT-OF-NETWORK PROVIDERS
Prosthetic and Orthotic Appliances <i>(Not included in Durable Medical Equipment. See the Prosthetic and Orthotic Appliances Benefit under the Covered Services Section for specific Benefits)</i>		Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
These Services Must be Prior Authorized			
Rehabilitative and Habilitative Services (Physical, Occupational, Speech, Hearing, Pulmonary, and Cardiac)		Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
Physical Therapy: <i>20 visit Plan Year Maximum.</i> Occupational Therapy: <i>20 visit Plan Year Maximum</i> Speech and Hearing Therapy: <i>Unlimited visit Calendar Year Maximum</i> Pulmonary Therapy: <i>20 visit Plan Year Maximum</i> Cardiac Therapy: <i>36 visit Calendar Year Maximum</i> <i>Rehabilitative and Habilitative services for Autism Spectrum Disorder are not subject to any Plan Year Maximum.</i>			
Routine Preventive Care (includes Routine Preventive drugs)		No Cost-Sharing <i>Cost-Sharing 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 Cost-Sharing.</i>	Deductible then 40% Coinsurance <i>Childhood immunizations for children age 6 and younger will not be subject to any Cost-Sharing.</i>
Skilled Nursing Facility		Deductible then 20% Coinsurance <i>150 day Calendar Year Maximum</i>	Deductible then 40% Coinsurance These Services Must be Prior Authorized
Telehealth – Blue KC Virtual Care	Office Visits	\$25 Copayment	Not Covered
	Therapy	Deductible then 20% Coinsurance	Not Covered
Urgent Care and Retail Health Clinics		\$25 Copayment <i>Lab services that are drawn and processed in the clinic, except for allergy testing, will not be subject to the applicable Cost-Sharing.</i>	Deductible then 40% Coinsurance

COVERED MEDICAL SERVICES	COST-SHARING AND LIMITATIONS AT IN-NETWORK PROVIDERS	COST-SHARING AND LIMITATIONS AT OUT-OF-NETWORK PROVIDERS
	<i>Other procedures, including x-rays and other radiology procedures, performed in a clinic are subject to the applicable Cost-Sharing.</i>	
X-ray and other Radiology Procedures	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
All other Covered Services	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance

For questions regarding Benefits under this Contract, please call Customer Service. For Covered Persons who purchased their coverage through the Small Business Health Options Program, please call Customer Service at 816-395-2946 (toll free: 866-859-3814). For Covered Persons who did not purchase their coverage through the Small Business Health Options Program, please call Customer Service at 816-395-2947 (toll free: 866-859-3822)

Covered Services		In-Network Provider	Out-of-Network Provider
		Copayment, Deductible, Coinsurance and Limitations	Copayment, Deductible, Coinsurance and Limitations
Outpatient Prescription Contraceptives Short-Term Supplies at Retail Pharmacy <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>	Generic Drugs	No Copayment	\$15 Copayment then 50% Coinsurance
	Preferred Drugs	\$70 Copayment	\$70 Copayment then 50% Coinsurance
	Non-Preferred Drugs	\$110 Copayment	\$110 Copayment then 50% Coinsurance
Outpatient Prescription Contraceptives Long-Term Supplies Through Mail Order <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>	Generic Drugs	No Copayment	\$37.50 Copayment then 50% Coinsurance
	Preferred Drugs	\$175 Copayment	\$175 Copayment then 50% Coinsurance
	Non-Preferred Drugs	\$275 Copayment	\$275 Copayment then 50% Coinsurance
Short-Term Supplies At Retail Pharmacy	Generic Drugs	\$15 Copayment	\$15 Copayment then 50% Coinsurance
	Preferred Drugs	\$70 Copayment	\$70 Copayment then 50% Coinsurance
	Non-Preferred Drugs	\$110 Copayment	\$110 Copayment then 50% Coinsurance
Specialty Drugs		\$200 Copayment	\$200 Copayment then 50% Coinsurance

Covered Services		In-Network Provider	Out-of-Network Provider
		Copayment, Deductible, Coinsurance and Limitations	Copayment, Deductible, Coinsurance and Limitations
Long-Term Supplies through Mail Order	Generic Drugs	\$37.50 Copayment	\$37.50 Copayment then 50% Coinsurance
	Preferred Drugs	\$175 Copayment	\$175 Copayment then 50% Coinsurance
	Non-Preferred Drugs	\$275 Copayment	\$275 Copayment then 50% Coinsurance
Oral Chemotherapy Drugs		No Cost-Sharing	No Cost-Sharing

SECTION A. DEFINITIONS

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

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

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

Adverse Determination Means a determination by Us that 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 has a contract with Us and the terms of such contract. Providers are identified as In-Network, Out-of-Network, Participating, and Non-Participating.

You may be responsible for the difference between the amount that the Out-of-Network Provider that is Non-Participating bills and the payment We will make for the Covered Services as set forth in this paragraph.

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

- a. For Hospitals, other institutional health care facilities, Physicians, or suppliers of medical goods and services which are PPO 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 Out-of-Network 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 Out-of-Network 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 ground Ambulance services provided by Out-of-Network 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.

- e. For Participating pharmacies-

The Allowable Charge is the lesser of:

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

(2) The Usual and Customary Charge

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

f. For Non-Participating pharmacies –

The Allowable Charge is the provider's billed charges

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

The Allowable Charge is the lesser of:

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

(2) The provider's billed charges; or

(3) \$130 for one set of eyeglass frames and any additional lens services/features or \$300 for an annual supply of contact lenses provided in lieu of eyeglasses.

Ambulance	Means a vehicle designed and operated to provide medical services and that is licensed by state and local laws.
Ambulatory Review	Means Utilization Review of Health Care Services performed or provided in an outpatient setting.
Annual Enrollment Period	Means a period of time mutually agreed upon by the Employer and Us during which eligible persons who have not enrolled with Us may do so.
Authorized Representative	Means an individual (including a provider whom a Covered Person designates, in writing, to act on his or her behalf to file a claim for benefits or to appeal an Adverse Determination.
Benefits	Means the amount of Allowable Charges We pay for Covered Services after the Cost-Sharing requirements have been met.
Benefit Schedule	Means a listing of certain Covered Services specifying Copayments, Coinsurance, Deductibles and visit limitations under the Contract.

Blue Cross and Blue Shield of Kansas City	Means the company legally responsible for providing the Benefits under the Contract. Blue Cross and Blue Shield of Kansas City is referred to as "We," "Us" and "Our."
Calendar Year	Means January 1 through December 31 of the same year.
Case Management	Means a method of review whereby a Covered Person's health, or catastrophic or complex health problem or general health is evaluated and a plan of care is developed and implemented which meets that Covered Person's particular needs and is the most cost-effective.
Certification	Means a determination by Us that an Admission, availability of care, continued stay or other Health Care Service has been reviewed and, based on the information provided, satisfies Our requirements for Medical Necessity, appropriateness, health care setting, level of care and effectiveness.
Claim	Means a request for: (1) services that require Prior Authorization made in accordance with the procedures outlined in the Utilization Review Section; (2) payment for Covered Services rendered in accordance with the procedures outlined in the How to File a Claim Section; or (3) an appeal of a benefit determination ("Grievance") made in accordance with the procedures outlined in the Complaint and Grievance Procedures Section.
Coinsurance	Means the percentage of an Allowable Charge that You must pay for a Covered Service.
Complications of Pregnancy	Means non-routine care (medical or surgical) required due to medical complications occurring as a result of or during the pregnancy. This does not include the actual obstetrical procedure itself which is defined as a normal delivery miscarriage or elective pregnancy termination.
Concurrent Review	Means Utilization Review conducted during a patient's Hospital stay or course of treatment.
Confinement	Means an uninterrupted stay following formal Admission to a Hospital or Skilled Nursing Facility. It starts with the Admission and ends the day the Covered Person is discharged from the Hospital or Skilled Nursing Facility.
Contract	Means the agreement between the Contractholder and Us that contains all of the terms of coverage. The Contract includes this booklet, Your application for coverage, and any amendments/riders.
Contractholder	Means the person who originally applies for and is accepted for coverage by Us under the Contract.

Copayment	Means the dollar amount of a charge that a Covered Person must pay for certain Covered Services. For Chiropractic Services, Copayments shall not exceed 50% of the total cost of providing the service to the Covered Person.
Cost-Sharing	Means the applicable Copayment, Coinsurance, or Deductible that must be paid by the Covered Person for a Covered Service. Cost-Sharing does not include Premiums, amounts incurred for Non-Covered Services, or any amount above the Allowable Charge.
Covered Person	Means the Contractholder or any of the Contractholder's Dependents whose coverage is in effect under the Contract.
Covered Services	Means services, supplies, equipment and care specifically listed in the "Covered Services" section of the Contract.
Custodial Care	Means care furnished mainly to train or assist in personal hygiene or other activities of normal daily living such as dressing, feeding, and walking, rather than to provide medical treatment.
Deductible	Means the portion of Allowable Charges for Covered Services You must pay each Calendar Year before We will provide Benefits unless otherwise specified. The application of the Deductible during any Calendar Year will be based upon the date when Covered Services were actually received. Except as specifically provided, each Covered Person must satisfy a Deductible each Calendar Year before Benefits will be paid.
Dependent	Means a person in the Contractholder's family who meets the Dependent eligibility requirements of the "Eligibility, Enrollment and Effective Date" section of the Contract.
Delegate	Means an entity that We have contracted with to help Us administer Benefits, such as Our pharmacy benefit manager ("PBM"), behavioral health manager (currently New Directions Behavioral Health), or a company performing Utilization Review services for Us.
Discharge Planning	Means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.
Due Date	Means the first day of each month when Premiums are due and payable.
Effective Date	Means the date coverage begins for a Covered Person under the Contract.
Emergency Medical Condition	Means 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.

**Experimental/
Investigative Services**

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

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

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

- c. The national Blue Cross and Blue Shield Association’s uniform medical policy (as amended from time to time) has determined the device or medical treatment or procedure (“technology”) is investigational based on the following criteria:
 - (1) Final approval from the appropriate governmental regulatory bodies has not been received; or
 - (2) Scientific evidence does not permit conclusions concerning the effect of the technology on health outcomes; or
 - (3) The technology does not improve the net health outcome; or
 - (4) The technology is not as beneficial as established alternatives; or
 - (5) The improvement is not attainable outside the investigational settings; or
- d. To the extent paragraphs a., b., and c. above do not apply, the drug, device, medical treatment, or procedure and Related Services and Supplies will still be considered Experimental or Investigative if:
 - (1) We, utilizing additional authoritative sources of information and expertise, have determined that the technology does not meet the criteria listed in paragraph c. 1-5 above; or
 - (2) There is not sufficient evidence based peer reviewed studies published in medical literature to establish the safety and efficacy of the technology.

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

Health Care Service

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

Home Health Agency

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

Hospice

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

Hospital

Means a facility that:

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

Hospitals are classified as follows:

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

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

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

Immediate Family Member

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

In-Network Provider

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

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

Late Enrollee	Means a person who requests coverage under the Contract following the Semi-Annual Enrollment Period and who does not qualify to enroll under a Special Enrollment Period.
Medical Necessary (Medical Necessity)	<p>Means services and supplies which We, utilizing additional authoritative sources of information and expertise, determine are essential to the health of a Covered Person and are:</p> <ul style="list-style-type: none"> a. Appropriate and necessary for the symptoms, diagnosis and treatment of a medical or surgical condition; b. In accordance with Our local medical policies, which are consistent with acceptable medical practice according to the national Blue Cross and Blue Shield Association’s uniform medical policy (as amended from time to time); c. Not primarily for the convenience of the Covered Person, nor the Covered Person’s family, Physician or another provider; d. Consistent with the attainment of reasonably achievable outcomes; and e. Reasonably calculated to result in the improvement of the Covered Person’s physiological and psychological functioning. <p>Our determinations regarding Medical Necessity, just like any other determination, may be appealed pursuant to the grievance procedure.</p>
Medicare	Means Part A or Part B of the insurance program established by Title XVIII, of the United States Social Security Act, as amended.
Mental Illness	Means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders except for Substance Abuse.
Minimum Essential Coverage	Means one of the following: (1) medical coverage under a specified government sponsored program (e.g. Medicare, Medicaid, CHIP, etc.); (2) medical coverage under an eligible employer-sponsored plan; (3) medical coverage under a health plan offered in the individual market within a State (excluding short-term limited duration policies); (4) coverage under a grandfathered health plan; or (5) other medical coverage that the Secretary of Health and Human Services, in coordination with the Secretary of the Treasury Department, recognizes for purposes of section 5000A(f).
Non-Participating Provider	Means a provider who does not meet the definition of a Participating Provider.

Organ Transplant	Means surgically removing an organ or tissue from one person (donor) and placing it in another person (recipient) or returning the organ or tissue from the donor to the donor (same person), an autologous organ transplant.
Out-of-Network Provider	Means a Hospital, Physician or other provider of medical services and supplies that does not have a contract to provide services at negotiated rates for Your coverage under an In-Network Provider contract with Us.
Out-of-Pocket Maximum	<p>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:</p> <ul style="list-style-type: none"> 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 a Non-Participating Provider Hospital in Our Service Area, except for Emergency Services; d. Any amount for Covered Services incurred at a non-Designated Transplant Provider for an Organ Transplant. <p>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.</p>
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 amounts incurred for Non-Covered Services, amounts in excess of any Benefit limits of the Contract, and any applicable Cost-Sharing.
Physician	<p>Means anyone qualified and licensed to practice medicine and surgery by the state in which services are rendered who has the degree of Doctor of Medicine or Doctor of Osteopathy. Physician also means Doctors of Dentistry and Podiatry as well as Optometrists, Chiropractors and Psychologists when they are acting within the scope of their license.</p> <p>By use of this term and when We are required by law, We recognize and accept, to the extent of Our obligations under the Contract, other practitioners of medical care and treatment when the services performed are within the lawful scope of the practitioner's license and are provided pursuant to applicable laws.</p>
Physician Extender	Means a Nurse Practitioner, Physician Assistant, Certified Registered

Nurse Anesthetist, or Mid-wife.

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

Plan Year	Means August 1 through July 31 of the following year.
Plan Year Maximum	Means a maximum dollar amount or a maximum number of days, visits, or sessions for which Benefits for Covered Services are provided for a Covered Person in any one Plan Year. Once a Plan Year Maximum for a specific Covered Service is met, no more Benefits for such Covered Services will be provided during the same Plan 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 Plan Year.
Post-Service Claim	Means a request for payment for Health Care Services rendered.
Pre-Service Claim	Means a request for Health Care Services that require Prior Authorization.
Premiums	Means the amount paid on a periodic basis for Your coverage under the Contract.
Primary Care Physician (PCP)	Means an internist, family practitioner, general practitioner or pediatrician.
Prior Authorization or Prior Authorized	Means the procedure whereby We determine: (a) based on medically recognized criteria, whether or not an Admission to a Hospital as an inpatient is reasonable for the type of services to be received; or, (b) whether any service to be performed is reasonable and Medically Necessary for the condition being treated and the type of services to be provided.
Prospective Review	Means Utilization Review conducted prior to an Admission or a course of treatment.
Reinstatement	Means restoring a Contract that has been terminated (for example, because of nonpayment of Premiums).
Rescission	Means a retroactive cancellation or discontinuance of coverage under a health benefit plan, unless the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums. A Rescission qualifies as an Adverse Determination.

Retrospective Review	Means Utilization Review of Medical Necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.
Second Opinion	Means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed Health Care Services.
Semi-Annual Enrollment Period Service Area	Means a period of time each Calendar Year during which eligible persons who have not enrolled with Us may do so. (Sometimes referred to as “Our Service Area”) means the geographic area served by Us. Contact Us to determine the geographic area We serve. Our Service Area includes the following counties in Kansas: Johnson and Wyandotte. Our Service Area includes the following counties in Missouri: Clay, Jackson, Platte, Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Ray, Saint Clair, Saline, Vernon, and Worth.
Skilled Nursing Facility	Means a facility that: <ul style="list-style-type: none"> a. Operates pursuant to law; b. Provides 24-hour nursing services by Registered Nurses on duty or on call; and c. Provides convalescent and long-term illness care with continuous nursing and other Health Care Services by, or under the supervision of, a staff of one or more Physicians and registered nurses. <p>The Skilled Nursing Facility may be operated either independently or as part of an accredited general Hospital.</p> <p>Skilled Nursing Facility also means an extended care facility, convalescent care facility, intermediate care facility or long-term illness facility.</p>
Special Enrollment Period	Means a period of time during which a new Dependent may enroll in coverage. It also means a period of time during which an individual who did not enroll in 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.
Student	Means an individual enrolled in credit hours on a full-time [or part-time] basis.
Substance Abuse	Means the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.
Terminally Ill	Refers to a Covered Person that a Physician has certified has 6 months or less to live.
Totally Disabled	Means: <ul style="list-style-type: none"> 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.
We, Us, Our	Means Blue Cross and Blue Shield of Kansas City, the company legally responsible for providing the Benefits for Covered Services under the Contract, either acting on its own or through one of its Delegates, such as its pharmacy benefit manager ("PBM"), behavioral health manager (currently New Directions Behavioral Health), or a company performing Utilization Review services for Us.
You, Your	Refers to the Covered Person.

SECTION B. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

1. Eligibility

To be eligible to enroll the Contractholder must:

- a. Be an eligible student as defined by the University and agreed to in writing by Us
-

2. Dependent Eligibility

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

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

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

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

- c. The Contractholder's or Contractholder'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. Additional proof will not be required more than once per year.

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

3. Enrollment

a. Semi-Annual Enrollment Period

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

b. Special Enrollment Periods

(1) New Dependents

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

Notwithstanding the above paragraph, if the Contractholder has previously elected Dependent coverage and such coverage is in effect on the date of the newborn child's birth, then the Contractholder'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. The Contractholder must submit to Us a completed Contractholder application requesting coverage for such newborn to be added within 60 days of the child's birth in order to continue such child's coverage beyond the initial 31 days. Coverage for such newborn will be subject to all of the terms and conditions of the Contract.

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

- (a) Provide the Contractholder with forms and instructions; and

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

If the new Dependent for which additional Premium is due is not enrolled as a Dependent within 31 days of becoming eligible, then such Dependent will be considered a Late Enrollee.

(2) Loss of Minimum Essential Coverage

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

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

(3) Eligibility for Government Assistance

(a) If a Contractholder and/or his Dependent become eligible for premium assistance under Medicaid or CHIP and the coverage provided under the Contract is not a high deductible health plan as defined under IRS Code §223, the eligible Contractholder and/or his eligible Dependents may enroll during this Special Enrollment Period. To enroll during this Special Enrollment Period, a Contractholder must submit to Us a completed Contractholder application and any additional Premium due within 60 days after eligibility is determined and provide appropriate documentation verifying the eligibility, if requested.

(b) If the Contractholder and/or his Dependents gain or lose eligibility for government assistance for Premiums or Cost-Sharing, the eligible Contractholder and/or his eligible Dependents may be able to enroll during this Special Enrollment Period. To enroll during this Special Enrollment Period, a Contractholder must submit to Us a completed Contractholder application and any additional Premium due within 31 days after eligibility is determined and provide appropriate documentation verifying the eligibility, if requested.

c. Contractholder Application

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

4. Effective Date of Coverage

a. Semi-Annual Enrollment

Coverage is effective at 12:01 a.m. on the first day of the fall or spring/summer semester, whichever is earlier.

b. Special Enrollment

(1) New Dependents

Coverage for new Dependents will be effective as follows:

1. In the case of marriage, no later than the first day of the month following enrollment.
2. In the case of the birth of a child, the date of such birth.
3. 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 a child;
 - (ii) The date the petition for adoption was filed; or
 - (iii) The child's date of placement. Date of placement means the date the Contractholder assumed the legal obligation for total or partial support of the child to be adopted in connection with formal adoption proceedings.

(2) Loss of Minimum Essential Coverage

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

(3) Eligibility for Government Assistance

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

5. Other Changes in Coverage

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

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

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

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

SECTION C. COVERED SERVICES

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

Covered Services

Covered Services under the Contract are set forth in this section. All Covered Services are subject to Cost-Sharing 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 Cost Sharing. All Covered Services are subject to the maximums and other limits and conditions specified in the Contract.

Benefits are different depending on whether Covered Services are received from an In-Network Provider or an Out-of-Network Provider. Benefits for Covered Services will be greater if Covered Services are received from In-Network Providers. **It is Your responsibility to ensure that You use In-Network Providers to receive the maximum Benefits.** Failure to do so will increase Your financial responsibility.

Deductible

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

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

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

Copayments

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

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

Out-of-Pocket Maximum

After 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.

You will have an Out-of-Pocket Maximum for services received from In-Network Providers and a separate Out-of-Pocket Maximum for services received from Out-of-Network Providers. Cost-Sharing for services provided by In-Network Providers will apply to Your In-Network Provider Out-of-Pocket Maximum. Cost-Sharing for services provided by Out-of-Network Providers will apply to Your Out-of-Network Provider Out-of-Pocket Maximum. The only exception is for Cost-Sharing for Emergency Services, which will apply to Your In-Network Provider Out-of-Pocket Maximum regardless of whether services are received from an In-Network or Out-of-Network Provider.

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

Prior Authorization

Services that must be Prior Authorized by Us will state so in the applicable Covered Service subsection. The consequences of obtaining such services when they have not been Prior Authorized are as follows:

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

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

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

Benefits will be limited to the length of stay approved by Us. When the approved length of stay must be extended for Medically Necessary reasons, You or Your attending Physician, on Your behalf, must contact

Us in advance to obtain Our approval for the additional days. Failure to provide such notice or obtain Prior Authorization 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:

1. Accident-Related and Other Dental Services

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

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

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

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

- a. The repair of defects in the jaw due to tumor/cyst removal;
- b. Severe atrophy in a toothless arch;
- c. Exposure of nerves;
- d. Non-union of a jaw fracture;
- e. Loss of teeth due to an Accidental Injury; and
- f. Correction of a defect 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	<p>We provide Benefits for Orthognathic surgery for the following conditions:</p> <ol style="list-style-type: none"> 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, or c. For the treatment of medically diagnosed cleft lip, cleft palate, ectodermal dysplasia, non-dental lesions, and incision / drainage of infection of soft tissue (not including odontogenic cysts or abscesses)
Temporomandibular Joint Disorder	<p>We provide Benefits for the surgical treatment of temporomandibular joint disorder. We provide Benefits for the medical or dental management of temporomandibular joint disorder only in connection with acute dislocation of the mandible due to accidental bodily injury, fractures, or tumors.</p>
Complications of Dental Treatment	<p>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.</p>

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, whether via ground or water Ambulance, when it is Medically Necessary to transport You from the place where an Accidental Injury or other Emergency Medical Condition occurred to the nearest facility where appropriate treatment can be obtained.

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

4. Anesthesia

Medical	<p>We provide Benefits for anesthesia materials and their administration if the surgical, orthopedic, diagnostic, or obstetrical service requiring the</p>
---------	--

anesthesia is covered. Covered Services must be provided by a Physician (other than the operating Physician) or Certified Registered Nurse Anesthetist (CRNA).

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

Dental

We provide Benefits for general anesthesia materials, their administration, and medical care facility charges for dental care when such services are provided in a Hospital, surgical center or office to the following Covered Persons:

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

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

5. Autism Spectrum Disorder

The following definitions apply to this section:

Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior. Applied Behavior Analysis does 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 providing diagnostic or treatment services for Autism Spectrum Disorders that are 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 377 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.

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 in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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.

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

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

We provide Benefits for the diagnosis and treatment of Autism Spectrum Disorders 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.

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 through 18 years of age. 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 Contract 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.

6. Biofeedback We provide Benefits for biofeedback for the treatment of non-cluster headaches, fecal incontinence, and constipation.

7. 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.

8. Chemotherapy We provide Benefits for chemotherapy, including oral chemotherapy drugs.

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

10. 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; or
- 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; and
- (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.

11. 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.

12. Cranial (head) Remodeling Devices

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

13. 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 for the diabetic shoes per Covered Person per Calendar Year.

14. 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 include Echocardiogram and Stress Echocardiogram. 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.

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

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

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

Echocardiograms and Stress Echocardiograms must be Prior Authorized by Us.

15. Dialysis

We provide Benefits for hemodialysis and peritoneal dialysis services.

16. 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 and 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 also include 1 wig per Calendar Year following cancer treatment.

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

DME must be Prior Authorized by Us.

**17. Elective
Sterilization**

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

**18. Electrical
Stimulation**

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

- a. Spinal cord electrical stimulation and electrical stimulation for bone growth;
- b. electrical stimulation of the spine as an adjunct to spinal fusion and sacral nerve neuromodulation;
- c. spinal cord stimulation for chronic pain unresponsive to standard therapies;
- d. electrical bone growth stimulation for fracture nonunions or congenital pseudoarthroses;

- e. electrical bone growth stimulation of the spine as an adjunct to spinal fusion;
 - f. sacral nerve neuromodulation for urinary dysfunction;
 - g. vagus nerve stimulation for the treatment of refractory or intractable seizures;
 - h. Phrenic nerve stimulation; or
 - i. Deep brain stimulation for tremor associated with Parkinson's or essential tremor.
-

**19. Emergency Services
And Supplies**

We provide Benefits for the treatment of Emergency Medical Conditions.

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

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

**20. 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.

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.

21. Hearing Aids and Related Services

We provide Benefits for hearing aids and related services. Covered Services also include initial amplifications for newborns, implantable bone conduction, and bone anchored hearing aids.

Covered Services include the initial implant or hearing aid and related implant or hearing aid services. Covered Services also include necessary re-screening for newborns. Repairs or replacement are Covered Services only when necessary because of a change in the physiological condition of the patient. Covered Services do not include repair or replacement as the result of stolen, lost, destroyed, or damaged implants or hearing aids.

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

Coverage for implants or hearing aids will be provided subject to Cost-Sharing indicated in the Benefit Schedule and may be subject to a Calendar Year Maximum.

22. High-Tech Diagnostic Testing

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

These services must be Prior Authorized by Us.

23. Home Health Services

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

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

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

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

24. Hospice Services

Home Hospice

We provide Benefits for home 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.

a. Covered Services are limited to the following Home Hospice services:

- (1) Assessment and initial testing;
- (2) Family counseling of Immediate Family Members;
- (3) Non-prescription pharmaceuticals;
- (4) Medical supplies;
- (5) Respite care;
- (6) Professional, medical, social, and pastoral counseling services provided by salaried employees of the Hospice; and
- (7) Supportive services to the bereaved family members for up to 12 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; or

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

Inpatient Hospice

We provide Benefits for Inpatient Hospice.

- a. Covered Services are limited to services and supplies furnished by an Inpatient Hospice. Covered Services are limited to those You are eligible to receive as a Hospital bed patient and that would otherwise require confinement in a Hospital or Skilled Nursing Facility 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; and
 - (4) Supportive services to the bereaved family members for up to 12 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; or
 - (5) Respite care.

Inpatient Hospice services must be Prior Authorized by Us.

25. Infusion Therapy and Injectables

Infusion Therapy

We provide Benefits for infusion therapy services and supplies. Infusion therapy is the administration of drugs or nutrients using specialized delivery systems which otherwise would have required You to be hospitalized. The infusion drug itself will not be subject to any limits, but services received in conjunction with infusion drugs will be subject to any Home Health Service limit, if applicable. 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; and
- b. The services are ordered by a Physician and provided by an infusion therapy provider or Physician licensed to provide such services.

These services must be Prior Authorized by Us.

Injectables

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

The injectable drug itself will not be subject to any limits, but services received in conjunction with injectable drugs will be subject to any Home Health Service limit, if applicable..

These services may require Prior Authorization by Us. Please contact Us at the telephone number listed on Your ID card for the current list of injectables that must be Prior Authorized.

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

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

26. Inpatient Hospital Services

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

27. Maternity Services and Related Newborn Care

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

Covered Services include an inpatient stay of at least 48 hours for a covered mother and 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 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 newborn child and routine Hospital nursery services provided during the Hospital Confinement are eligible for Benefits. 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

Complications of Pregnancy

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

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

28. 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. Services for outpatient treatment will be covered to the same extent as any other illness as indicated in the Benefit Schedule. Covered Services for inpatient services are limited to Hospital and Physician services when You are confined in any Hospital or other residential facility licensed to provide such treatment. Services for inpatient treatment will be covered to the same extent as any other illness as indicated in the Benefit Schedule.

Covered Services include non-residential services, such as partial outpatient hospitalization and intensive outpatient services. These services will be subject to the Cost-Sharing indicated for Outpatient Mental Illness Therapy or Outpatient Substance Abuse Treatment.

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

29. Organ Transplants

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

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

If Organ Transplant Services are provided at a provider that is not a Designated Transplant Provider, Benefits will be provided at the Out-of-Network Provider level. . In addition, You will have no Benefit for transportation and lodging expenses when Organ Transplant Services are provided at a provider that is not a Designated Transplant Provider.

Covered Organ Transplant Services

Covered Services are limited to services and supplies for Organ Transplants when ordered by a Physician and provided at or arranged by a Designated Transplant Provider. Such services include, but are not limited to, Hospital charges, Physician charges, organ procurement, and ancillary services.

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

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

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

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

Immunosuppressant Drugs We provide Benefits for immunosuppressant drugs required as a result of a covered Organ Transplant under the Outpatient Prescription Drug Benefit.

Transportation and Lodging Expenses When a transplant is performed at a Designated Transplant Provider, We provide Benefits for transportation and lodging costs that are associated with the transplant if the transplant provider is more than 75 miles from the recipient's place of residence. Covered Services are limited to the Covered Person and one of the Covered Person's Immediate Family Members. If the Covered Person receiving treatment is a minor, then Covered Services will be provided for two Immediate Family Members. Covered Services are limited to:

- a. Transportation for the Covered Person and the Covered Person's Immediate Family Members to accompany the Covered Person to and from the Designated Transplant Provider, and
- b. Lodging at or near the Designated Transplant Provider for the Immediate Family Members who accompanied the Covered Person, while the Covered Person is confined at the Designated Transplant Provider.

Benefits for transportation and lodging associated with a transplant will be provided for up to 60 days per covered transplant. A Covered Person and the Covered Person's Immediate Family Members who accompanied the Covered Person will be provided a combined \$150 per diem.

Covered Services do not include alcohol, tobacco, non-food items, child care, telephone calls, laundry, postage, entertainment, services for a non-related condition, or travel expenses for a donor.

You will not be reimbursed for coupons, vouchers, travel tickets, or frequent flyer miles.

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 testing, typing, or screening when the person does not become a transplant or tissue donor.

**30. Outpatient Prescription
Drugs**

Introduction/Prior
Authorization

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

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

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

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

Drug Rebates and Credits

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

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

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

We are not acting as a fiduciary with respect to rebate administration, pharmacy network management, or the prescription drug plan. We receive

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

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

Covered Drugs

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

Covered Services are limited to:

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

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

“Peer-reviewed medical literature” means a published scientific study in a journal or other publication in which original manuscripts have been published only after having been critically reviewed for scientific

accuracy, validity and reliability by unbiased independent experts, and that has been determined by the international committee of medical journal editors to have met the uniform requirements for manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

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

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

- d. Insulin, syringes, needles, lancets, test strips, oral anti-diabetic agents and glucometers
- e. Oral and injectable contraceptive drugs
- f. Contraceptive devices and implants which require a Physician’s prescription; (medical services related to the administration of covered contraceptive devices and implants are Covered Services under the Contract).
- g. Smoking cessation agents by prescription only, except as otherwise provided.

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.

Short-Term Supplies

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

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

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. We will reimburse You as indicated in the Benefit Schedule.

Long-Term Supplies

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.

Specialty Pharmaceuticals

We provide Benefits for Specialty Pharmaceuticals. 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 mean 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 Cost-Sharing indicated in the Benefit Schedule.

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

Maintenance Drugs

We provide Benefits for prescription maintenance drugs. Maintenance drugs are those medications that must be used on a continuing basis to treat a chronic condition. Maintenance drugs may be obtained from a retail pharmacy on a short-term basis or a designated mail order prescription drug program under the long-term supply prescription drug benefit. If You obtain Your maintenance drug from a retail pharmacy, after obtaining Your second refill of that specific maintenance drug, You will be required to notify Us, and/or Our pharmacy benefit manager (PBM), whether You intend to continue to obtain the maintenance drug from the retail pharmacy, or if You would like to begin obtaining such drug from a designated mail order pharmacy. Subsequent refills of the prescription maintenance drug must be obtained using Your designated method.

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

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

You must pay the applicable Cost-Sharing for each prescription 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. 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, 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);
- g. Medications with no approved FDA indications;
- h. Immunization agents;
- i. Drugs related to treatment that is not a Covered Service under the Contract;
- j. Prescription drugs that are not Medically Necessary unless otherwise specified;
- k. Anabolic steroids, anti-wrinkle agents, dietary supplements, Fluoride supplements, blood or blood plasma, irrigational solutions and supplies;

- l. Lifestyle enhancing drugs, unless otherwise specified;
- m. Fertility drugs;
- n. Medications and devices used for the treatment of impotency;
- o. Drugs and devices that are intended to induce an abortion; or
- p. Drugs obtained outside the United States for consumption in the United States.

31. Outpatient Surgery and Services

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

Certain outpatient surgeries and services must be Prior Authorized by Us in order to be Covered Services: Please contact Us at the telephone number listed on Your ID card for the current list of outpatient surgeries and services that must be Prior Authorized.

32. Pediatric Dental

We provide Benefits for dental services for children age 18 and younger.

Basic Services

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

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

Intermediate Services

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

Major Services

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

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

Major Services include orthodontics only in the case of severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or Accidental Bodily Injury to the face resulting in serious health impairment to the Covered Person. Services for orthodontics must be Prior Authorized by Us and are subject to a 24 month Waiting Period. A Waiting Period is the length of time You must be continuously covered under the Contract in order to have Benefits.

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

33. Pediatric Vision

We provide Benefits for vision services when provided to a Covered Person age 18 and under.

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

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

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

34. 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.

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

35. Podiatry

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

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

Benefits are limited to the amount available for a basic (standard) item which meets the minimum specifications to allow for necessary activities of daily living. 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.

Diabetic shoes are Covered Services under the Diabetes Benefit.

Prosthetic and orthotic devices must be Prior Authorized by Us.

37. Radiation Therapy

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

These services must be Prior Authorized by Us.

38. Reconstructive Surgery and Cosmetic Repair

We provide Benefits for reconstructive surgery and cosmetic repair to correct birth defects or to correct a defect incurred through an Accidental Injury, to correct significant deformities caused by illness, or if needed as a result of an earlier treatment if the first treatment would have been a Covered Service.

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

39. 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.

40. Rehabilitative and Habilitative Services

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

Physical Therapy

Physical therapy services provided by a Physician, Registered Physical Therapist or Licensed Physical Therapist are covered when these services are expected to result in significant improvement in a Covered Person's condition.

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

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

Speech and Hearing Therapy This is treatment for the loss or impairment of speech or hearing disorders provided by a speech pathologist, speech/language pathologist or audiologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association, or both, 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.

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.

Pulmonary Therapy Pulmonary therapy services must be performed by a licensed therapy provider, under the direction of a Physician. Pulmonary therapy services are covered when these services are expected to result in significant improvement in a Covered Person's condition.

Cardiac Therapy Cardiac therapy services must be performed by a licensed therapy provider, under the direction of a Physician. Cardiac therapy services are covered when these services are expected to result in significant improvement in a Covered Person's condition.

41. Routine Preventive Care

We provide Benefits for routine preventive care as required by state or federal law. Covered Services include examinations, labs, and immunizations. In addition, Benefits are provided for 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 Services 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 coverage for contraceptives that require a prescription to obtain and elective sterilization for women. Such contraceptives are limited to Generic Drugs, unless a generic version is not available or Prior Authorization has been obtained for a Preferred or Non-Preferred Drug. If Prior Authorization is not obtained, Preferred or Non-Preferred Drugs are Covered Services under the Outpatient Prescription Drug Benefit.

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 federal law. A complete list of the preventive care services can be located at www.BlueKC.com or by contacting Us at the telephone number listed on Your ID card.

Examinations

We provide Benefits for routine preventive examinations and the related office visit. Covered Services include prostate exams, pelvic exams, colorectal cancer exams consisting of digital rectal exam (including colonoscopy, flexible sigmoidoscopy, and double contrast barium enema), and all associated labs, in accordance with the current American Cancer Society guidelines, at a minimum. Covered Services also include mammograms ordered by a Physician (including low-dose mammography screening for any non-symptomatic woman). Covered Services include hearing exams, electrocardiograms (EKGs), chest x-rays and bone density screenings for women. Benefits for pelvic exams and mammograms include those performed at the direction of a Physician in a mobile facility certified by The Centers for Medicare and Medicaid Services (CMS).

Covered Services also include evidence-informed preventive care and screenings for infants, children, and adolescents provided for in the HRSA comprehensive guidelines and for newborn hearing screening, audiological assessment and follow-up.

Covered Services do not include 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; and examinations and testing for or in connection with entering school, licensing, employment, insurance, adoption, immigration and naturalization, or premarital blood testing.

Immunizations

We provide Benefits for the following routine preventive immunizations and the related office visit. Covered immunizations are limited to the age ranges and gender recommended by the Advisory Committee on Immunization Practices and adopted by the Center for Disease Control.

Covered Services include: catch-up for Hepatitis B; catch-up for varicella; catch-up for MMR; Tetanus boosters as necessary, including tetanus, diphtheria and pertussis, diphtheria and tetanus, and tetanus only; Pneumococcal vaccine; Influenza virus vaccine; Meningococcal vaccine; catch-up for Hepatitis A; HPV vaccine; Zoster vaccine; Polio vaccine; and Haemophilus Influenza Type b (Hib) vaccine.

Covered Services also 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. This includes childhood immunizations as provided by the Missouri Department of Health and Senior Services.

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

Childhood immunizations for children age 6 and younger will not be subject to any Cost-Sharing, regardless of whether such immunizations are received from In-Network or Out-of-Network Providers.

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

Lab Services

We provide Benefits for the following routine preventive lab services and the related office visit.

Covered Services include the following screenings: metabolic screening; glucose screening; and thyroid stimulating hormone screening. With respect to sexually transmitted infections, the following lab services are covered: HIV screening; HPV testing; Chlamydia Trachomatis testing; and Gonorrhea testing.

Covered Services also include the following tests: lead testing; Hemoglobin/Complete Blood Count (CBC); urinalysis; lipid cholesterol panel; prostate specific antigen (PSA) tests; pap smears; and fecal colon cancer tests (including fecal occult blood test, fecal immunochemical test, and stool DNA test).

Non-routine lab services are Covered Services under the Diagnostic Services Benefit.

42. 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 services must be 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.

43. Urgent Care Center and Retail Health Clinics

We provide Benefits for urgent care services obtained at urgent care centers and retail health clinics. 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.

44. Vision Care We provide Benefits for non-routine vision care.

Eyewear following Surgery

We provide Benefits for either the first pair of eyeglasses or non-disposable contact lenses or refractive keratoplasty, only following cataract surgery. Benefits are limited to the amount available for a basic (standard) pair of eyeglasses 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.

Orthoptic Training

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

Eye Exam

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

SECTION D. EXCLUSIONS AND LIMITATIONS

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

1. For services or supplies received if there is no legal obligation for payment or for which no charge had been made; or for services or supplies received where a portion of the charge has been waived. This includes, but is not limited to full or partial waiver of any applicable Cost-Sharing amounts.
2. 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 or any comparable benefit that provides medical coverage 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.
3. Subject to Our Prior Authorization requirement and such approval was not obtained.
4. Not Medically Necessary.
5. Not specifically covered under the Contract.
6. Experimental or Investigative as determined by Us, except as specifically provided under the Clinical Trials Benefit.
7. For military service connected disabilities or conditions for which You are legally entitled to services and for which You have no obligation to pay.
8. For losses due in whole or in part to war or any action of war.
9. For Custodial, convalescent, or respite care, except as specifically provided under the Hospice Benefit, including but not limited to meals delivered to Your home, companionship, and homemaker services, that do not require services of licensed professional nurses in Our opinion even if provided by skilled nursing personnel.
10. For music therapy, remedial reading, recreational therapy, and other forms of education or special education except as specified under the Diabetes Benefit.
11. For marital counseling or counseling to assist in achieving more effective intra or interpersonal development except as specifically provided under the Autism Spectrum Disorder Benefit; dietary counseling, except as specifically provided; decisional; social; or educational development except as specifically provided under the Autism Spectrum Disorder Benefit; vocational development, or work hardening programs.

12. For removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes; or for cosmetic rhinoplasty, whether an independent procedure or done in conjunction with any other surgical procedure.
13. For cosmetic repair or reconstructive surgery, except as specifically provided for under the Reconstructive Surgery and Cosmetic Repair Benefit.
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, items for comfort and convenience, spas, whirlpools, Jacuzzis, and any other primarily nonmedical equipment, stethoscopes, blood pressure devices, and Durable Medical Equipment that would normally be provided by a Skilled Nursing Facility.
15. For repairs and replacement of prosthetic and orthotic devices, except when necessitated as indicated in the Prosthetic and Orthotic Devices Benefit.
16. For wigs and their care, except as specifically provided under the Durable Medical Equipment Benefit.
17. For hypnotism, hypnotic anesthesia, acupuncture, acupressure, rolfing, massage therapy and/or any services provided by a massage therapist, aromatherapy and other forms of alternative treatment.
18. For biofeedback (including neurofeedback), except as otherwise specifically provided under the Biofeedback Benefit.
19. For genetic testing, except as specifically provided under the Genetic Testing Benefit.
20. For court ordered services, including but not limited to examinations, treatment, and genetic testing.
21. 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.
22. Provided by You, Your Immediate Family Members or members of Your immediate household.
23. For vision services, except as otherwise specifically provided in the Contract, including but not limited to pleoptic training, orthoptic training that is not for convergence insufficiency, eyeglasses, contact lenses, and the examination for fitting of these items.
24. For hearing care services, except as otherwise specifically provided in the Contract, including but not limited to, hearing aids and the examination for fitting of these items.
25. 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.

26. Unless specifically covered under the Contract, 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.
27. 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.
28. For chemosurgery, laser, dermabrasion, chemical peel, salabrasion, collagen injections or other skin abrasion procedures associated with the removal of scars, tattoos and/or which are performed as a treatment of scarring secondary to acne or chicken pox.
29. For staff consultations required by Hospital rules and regulations.
30. 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, diet counseling (except as otherwise specified in the Contract) and Health Care 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, except for Emergency Medical Conditions.
31. 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.
32. For hairplasty or hair removal, regardless of reason or diagnosis.
33. For or related to the surgical insertion of a penile prosthesis including the cost of the prosthesis, regardless of diagnosis.
34. For orthotics and foot orthotics (including shoes) unless otherwise specified under the Contract.
35. For support/surgical stockings (for the lower extremities), including but not limited to custom made stockings.
36. For corrective shoes unless permanently attached to a brace.
37. For routine foot care, unless specifically covered under the Contract.
38. For or related to an Organ Transplant, except as specifically provided under the Organ Transplant Benefit.
39. For lodging or travel to and from a health professional or health facility, except as specifically provided under the Organ Transplant Benefit.
40. 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.

41. 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.
42. Obtained in an emergency room which are not Emergency Services.
43. Health Care Services which are related to complications arising from treatments or services otherwise excluded under the Contract, except when such services are received for an Emergency Medical Condition, or for complications related to maternity care as indicated in the Contract.
44. Health Care 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, except as otherwise specified under the Contract.
45. Mental Illness and/or Substance Abuse services received from a Non-Participating Provider provided in connection with or to comply with involuntary inpatient commitments after the Covered Person has been screened and stabilized, unless the Covered Person cannot be safely transferred or there is not an In-Network Provider who will accept the transfer.
46. 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.
47. 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.
48. 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.
49. 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.
50. For personal care and convenience items.
51. Occupational therapy provided on a routine basis as part of a standard program for all patients.
52. Speech therapy for vocal cord training/retraining due to vocational strain and/or weak cords.
53. Screening examinations or services available, arranged by, or received from any governmental body or entity, including school districts.
54. Received for (or in preparation for) any treatment for infertility (including drugs) by any name called and any related complications. 'Infertility' as used here means any medical condition causing the inability or diminished ability to reproduce. Treatment for infertility shall include, but not be limited

to, reversal of sterilization, all artificial means of conception including but not limited to sperm collection and/or preservation, artificial insemination, in vitro fertilization, in vivo fertilization, embryo transplants, gamete intra fallopian transplant (GIFT), zygote intra fallopian transplant (ZIFT), and related tests and procedures, surrogate parenting (which includes donating ovum or ova, or carrying the fetus to term for another woman), not Medically Necessary amniocentesis, and any other experimental fertilization procedure or fertility drugs.

55. For Health Care Services and associated expenses for elective pregnancy termination. Elective pregnancy termination does not include spontaneous abortion or services to prevent the death of the mother upon whom the procedure is performed.
56. Received for (or in preparation for) any diagnosis or treatment of impotency (including drugs) and any related complications, unless such complication is an Emergency Medical Condition.
57. For cranial (head) remodeling devices, including but not limited to Dynamic Orthotic Cranioplasty (“DOC Bands”) except as otherwise specifically provided in the Contract.
58. For growth hormone therapy for the diagnosis of idiopathic or genetic short stature, intrauterine growth retardation or small for gestational age.
59. Except as specifically provided in Physician Services, for 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.
60. 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.
61. For sales tax.
62. For services, supplies, equipment or care received in connection with a non-covered service, supply, equipment or care.
63. For extracorporeal shock wave therapy due to musculoskeletal pain or musculoskeletal conditions and for electrical stimulation, except as specifically provided in the Electrical Stimulation Benefit.
64. For nutritional assessment testing and saliva hormone testing.
65. For services and materials not meeting accepted standards of optometric practice.
66. For Applied Behavior Analysis services received as part of any Part C early intervention program or provided by any school district.
67. For the measurement of exhaled nitric oxide or exhaled breath condensate in the diagnosis and management of respiratory disorders.
68. For certain infusion therapy/injectables unless obtained from a designated specialty pharmacy or designated home infusion vendor

69. Tier 2 and Tier 3 drugs for the first 6 months following FDA approval for a new indication of an existing drug unless a shorter exclusion period is recommended by Our Pharmacy and Therapeutics Committee, which includes community physicians and pharmacists.
70. Amounts for services or supplies billed by Out-of-Network Providers that are Non-Participating that are not eligible for separate reimbursement according to Our payment policy.
71. Amounts for non-Emergency services billed by Out-of-Network Providers that are Non-Participating when proof of service is not established or supported by Your medical record.

SECTION E. HOW TO FILE A CLAIM

1. Hospital and Other Facility Services

a. For care received *inside* Our Service Area

- (1) In-Network or Participating Providers will file Your Claims for You. The facility will be paid directly by Us. You may be asked to make arrangements with such facility to pay for any non-Covered Services or Cost-Sharing amounts.

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

b. For care received *outside* Our Service Area

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

2. Physician Services

a. For care received *inside* Our Service Area

- (1) In-Network or Participating Providers will file Your Claim for You. The Physician will be paid directly by Us. After the Physician receives Our payment, the Physician may bill You for any non-Covered Services or Cost-Sharing amounts for which You are responsible.

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

b. For care received *outside* Our Service Area

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

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

It is necessary for You to file a completed Claim form with Us for these services. Contact Us at the telephone number listed on Your ID card for the proper Claim forms. The form will give You instructions for filing the Claim. If such forms are not furnished to You within 15 days after Your requesting the forms, You will have complied with the requirements of this Contract as to proof of loss upon submitting, within the required time period herein mentioned for filing Claims, such other written proof covering the occurrence, the character and the extent of the loss for which Claim is made.

4. Time Limits for Filing Claims

We must receive proof of a claim for payment for Covered Services no later than 365 days after the end of the Plan Year in which the service is received, unless it was not reasonably possible to give notice of proof within this time. We will deny any Claim not received within this time limit. Failure to furnish proof of a Claim for payment for Covered Services within such time limit will not invalidate or reduce such Claim if it was not reasonably possible to furnish such proof within the specified time.

**5. Processing of the
Filed Claim**

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

SECTION F. COORDINATION OF BENEFITS (COB)

1. The purpose of COB

Many people have group medical coverage through more than one Plan at the same time. Because these people usually have their claim for medical services sent to every Plan that covers them, most Plans include a Coordination of Benefits (COB) provision. A COB provision allows Plans to work together so that the total amount of all payments by all Plans will never be more than the Allowable Expense. This helps to keep down the increasing costs of health care coverage.

2. Definitions Applicable to this Section

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

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

If a Covered Person is covered under 2 or more Plans that provide benefits or services on the basis of negotiated fees or if one Plan calculates its benefits or services on the basis of usual, customary and reasonable fees and another Plan provides its benefit on the basis of negotiated fees then any amount in excess of the 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 benefits organization Plans;
- (4) Any “no fault” contracts and traditional automobiles “fault” contracts sold on a group basis, by whatever name called. This Contract is always secondary to benefits provided under any mandatory No-Fault Auto Insurance Act in the state in which the Covered Person resides; and
- (5) Group or group-type Plans designed to pay a fixed dollar benefits 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.

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 applicable rules:

a. Employee/Dependent:

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

b. Dependent Child/Parents 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. If a court decree states both parents have financial responsibility for the medical expenses, then the provisions of paragraph b. of this subsection apply.

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 other than a Dependent (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 available by Medicare, the Federal Medicare Secondary Payor Rules in effect at that time will apply and this Coordination of Benefits section shall not apply.

i. Plans without COB Provisions:

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

4. Effect on the Benefits of this Plan

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

- a. Determine its obligation to pay or provide benefits under its Contract;
- b. Determine whether a benefit reserve has been recorded for the Covered Person; and
- c. Determine whether there are any unpaid Allowable Expenses during that Claims 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 Claims Determination Period, the benefit reserve returns to zero. A new benefit reserve must be created for each new Claim Determination Period.

5. Right to Receive and Release Necessary Information

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

- a. Release to any person, insurance company or organization, the necessary claim information; and
- 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.

6. Facility of Payment

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

SECTION G. PREMIUM PAYMENT, GRACE PERIOD AND CHANGES

1. Premium Payment

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

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

2. Grace Period

You shall have a grace period of 31 calendar days for the payment of any Premium, during which time the Contract shall continue in force. In no event shall the grace period extend beyond the date the Contract terminates. The Contract will automatically terminate at 11:59 p.m. on the last day of the grace period if the grace period expires and any Premium remains unpaid.

3. Reinstatement

a. Reinstatement for Nonpayment of Premium

Except as provided below, if coverage under the Contract is terminated for nonpayment of Premiums, We have the right to decide whether or not to reinstate the Contract. Such decision will occur only after resubmission of a new application, if one is required, and payment of a Reinstatement fee.

b. Reinstatement for Individuals Deployed in Military Service

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

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

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

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

4. Changes in Premiums Your Premiums are age rated based on You and Your Dependents age classification as of Your enrollment date. We will automatically change the amount of Your Premiums on Your next enrollment date if You or Your Dependents have had a birthday which places You or Your Dependents into the next age classification upon which Premiums are based.

If You or Your Dependents change Your coverage and receive a new enrollment date, We will automatically change Your Premiums if You or Your Dependents have had a birthday which places You or Your Dependents into the next age classification upon which Premiums are based.

Premiums are age-rated and if the Covered Person's age has been misstated, We will adjust the Premium for the Covered Person's coverage under the Contract in a subsequent statement sent to You.

The amount of Your Premium may change if You or any of Your Dependents use or have used tobacco.

The amount of Your Premium may change if You or any of Your Dependents change place of residence.

If We find that You fall into a different risk classification due to a misrepresentation made by You in Your application, We may change the amount of Your Premium. If Your Premium would have been higher had We known the correct information, You will owe Us the difference between what Your Premium would have been and the Premium You were charged. This amount will be calculated from the effective date of Your Contract. You shall have 30 days from the date We notify You to remit this amount.

SECTION H. TERMINATING THE CONTRACT

- 1 Terminating a Covered Person's Coverage** We may terminate the Contract and/or a Covered Person's coverage on the the earliest of the dates specified below:
- a. On the last day of the fall or spring/summer semester in which You cease to meet the eligibility requirements set forth in the "Eligibility, Enrollment and Effective Date" section of the Contract, whichever is earlier;
 - b. On the last day of the month for which Premium has been paid if You fail to pay any required Premium. We may recover from You Benefits We paid subsequent to the date of termination;
 - c. On the last day of the Plan Year 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;
 - d. On the date indicated in writing to You by Us if a Covered Person performs an act of fraud or makes an intentional misrepresentation of a material fact in connection with the coverage, provided that such termination will not occur unless written notice was provided 31 days in advance;
 - e. On the original Effective Date of coverage if coverage is terminated by Us due to a Covered Person committing fraud or intentionally misrepresenting a material fact on the application;
 - f. On the last day of the month in which the Contract is terminated because the Contractholder no longer resides in Our Service Area;
 - g. On the last day of the year in which the Contract is terminated because the Contractholder changes his place of residence within Our Service Area to the state of Kansas. Contact Us for other coverage that may be available to You;
 - h. On the last day of the month in which the Contract is terminated because We cease offering the particular type of coverage in the individual market provided by this Contract in accordance with applicable laws and regulations. If We discontinue offering this particular type of coverage, We will provide You 90 days written notice prior to the date coverage is discontinued and will offer You, on a guaranteed issue basis, the option to purchase any other individual health insurance coverage that We are currently offering; or
 - i. On the last day of the month in which the Contract is terminated because We cease offering all individual health insurance coverage in

Kansas in accordance with applicable laws and regulations. If We discontinue all individual health insurance coverage in Kansas, We will provide You 180 days written notice prior to the date all such coverage will terminate.

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.
-

2. 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 a Student or Dependent under the Contract for 3 months, (except that a surviving Dependent of a deceased Student 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 Student's family coverage at the time of the Student's death):

- a. Students and Dependents whose coverage under the Contract is ending because the Contract is terminated and is not reinstated or replaced within 31 days.
- b. Students 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 periods 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 Period 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 I. GENERAL INFORMATION

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

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

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.

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

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

5. Reimbursement to Us a. Workers' Compensation

As a Covered Person, You agree to reimburse Us for any Benefits We paid to You or on Your behalf for Claims paid or payable for injuries or illnesses related to Your job to the extent You are covered or are required to be covered by a state or federal worker's 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 worker's 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

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.

We will not request a refund or offset against a Claim from Your provider more than twelve months after We have paid the provider's Claim except in cases of fraud or misrepresentation by the provider.

c. Misrepresentations

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

d. Recovery of Overpayment

If We determine that an erroneous payment for Benefits has been made, You (or any other person or entity receiving the erroneous payment on Your behalf) agree to return to Us the erroneous payment. In the event You (or any other person or entity receiving the erroneous payment on Your behalf) do not return to Us the erroneous payment, We shall have the equitable right to recoup such erroneous payment. Our right of recoupment provided in this section shall not be diminished, restricted, or limited in any manner whatsoever by any defenses, either in law or in equity, that the person or entity subject to Our claim of recoupment may otherwise have, and such defenses are hereby disclaimed.

6. Legal Actions

No action at law or equity shall be brought prior to the expiration of sixty days after proof of loss has been filed and no such action shall be brought after the expiration of 3 years after the time proof of loss is required to be furnished.

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

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) You.

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

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

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.

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

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

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

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

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

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.

14. 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.

15. Independent Licensee

The Contract constitutes a Contract solely between Employer and Blue Cross and Blue Shield of Kansas City. Blue Cross and Blue Shield of Kansas City is an independent corporation operating under an agreement with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the “Association”) permitting Blue Cross and Blue Shield of Kansas City to use the Blue Cross and Blue Shield Service Mark in a portion of the States of Missouri and Kansas. Blue Cross and Blue Shield of Kansas City is not contracting as the agent of the Association. No person, entity, or organization other than Blue Cross and Blue Shield of Kansas City shall be held accountable or liable to the Employer for any of Blue Cross and Blue Shield of Kansas

City's obligations to the Employer created under the Contract. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Kansas City other than those obligations created under other provisions of the Contract.

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

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

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

19. Entire Contract The applications are incorporated by reference in this document and made a part of the Contract. The definitions contained in the Contract will have the defined meaning when used in this document with the first letter capitalized. The Contract and any amendments or riders thereto constitute the entire agreement between the parties 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.

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

21. 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 coverage or reduces Benefits unless the statement is material to the risk assumed and contained in a 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 You.

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

23. 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 person to, or for, or with respect to, whom such payments were made;
- b. Any insurance companies or service plans; or
- c. Any other organizations.

We will not request a refund or offset against a Claim from Your provider more than twelve months after We have paid the provider's Claim except in cases of fraud or misrepresentation by the provider.

24. Identity Protection We provide identity protection services through Our designated vendor for Covered Persons. The identity protection services include credit monitoring, fraud detection, and credit/identity repair. Services are limited to only those specified by Us.

25. Incentives We are committed to ensuring Your health and wellness. We may offer incentives to encourage You to access certain medical services and/or to participate in various wellness or disease management programs. Incentives may include, but are not limited to: waiver or reduction of Cost-Sharing; contributions to a health savings or reimbursement account; gift cards; entries for a prize drawing; and/or merchandise. Eligibility for these incentive programs may be limited to Covered Persons with particular health factors. Participation in such programs has the potential to promote better health and to help prevent disease.

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

SECTION J. UTILIZATION REVIEW

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

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

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

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

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.

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.

- 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.
-

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

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

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

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

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

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

SECTION K. COMPLAINT AND GRIEVANCE PROCEDURES

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

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

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

Grievance means a written Complaint submitted by or on behalf of a Covered Person regarding (a) the availability, delivery or quality of Covered Services, including a Complaint regarding an Adverse Determination made pursuant to Utilization Review; (b) claims payment, handling or reimbursement for Health Care Services; or (c) matters pertaining to the contractual relationship between a Covered Person and Us. A Grievance may be submitted by a Covered Person, a Covered Person's representative, or a provider acting on behalf of a Covered Person.

Expedited Review means the procedure for the review of a Grievance (which may be submitted either orally or in writing) involving a situation where the time frame of the standard Grievance procedure would seriously jeopardize the life or health of a Covered Person or would jeopardize the Covered Person's ability to regain maximum function. However, for purposes of the Grievance register requirements, the request will not be considered a Grievance unless the request is submitted in writing.

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

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

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

3. Procedures for Filing a Grievance

If You prefer to file a formal Grievance, You may do so by requesting a Member Grievance form from Us by calling the telephone number listed on Your ID card, 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.

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

We will conduct a complete investigation of the Grievance within 20 working days or 30 calendar days, whichever is less, after receipt of the Grievance for Pre-Service Claims and within 20 working days after receipt of the Grievance for Post-Service Claims, unless the investigation of the Post-Service Claim cannot be completed within this period of time. If the investigation for Post-Service claims cannot be completed within the 20 working days, We will notify You in writing before the 20th working day. The notice will state the reasons for which additional time is needed for the investigation. The investigation will be completed within 30 working days thereafter, but no more than 60 calendar days after receipt of the Grievance for Post-Service Claim. We will notify You and/or 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 Your additional appeal rights.

4. Procedures to Request an Expedited Review

If the time frame of the standard Grievance procedure would jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, a request for an Expedited Review may be submitted orally or in writing. We will notify You orally within 72 hours after receiving a request for an Expedited Review of Our decision. We will send written confirmation of Our decision within 3 working days of providing oral notification of Our decision.

5. External Review

You or Your representative has the right to file a Grievance concerning an Adverse Determination with the 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.

6. Expedited External Review

a. Request for an Expedited External Review

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

- (1) An Adverse Determination that involves an Admission, availability of care, continued stay, or Covered Service for which You received Emergency Services, but have not been discharged from the facility; or
- (2) An Adverse Determination that involves a medical condition for which the delay of the standard external review would jeopardize

Your life or health or would jeopardize Your prognosis or ability to regain maximum function.

b. Preliminary Review

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

7. 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 that:
 - a 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 Service or treatment.

8. Department of Insurance

You may also contact the Missouri Department of Insurance, Financial Institutions and Professional Registration (“Department”), 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.

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

- 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.
-
- 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.

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

AMENDMENT: BCBSKC-225-16-K

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

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

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

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

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

- a. Spinal cord electrical stimulation and electrical stimulation for bone growth;
- b. electrical stimulation of the spine as an adjunct to spinal fusion and sacral nerve neuromodulation;
- c. spinal cord stimulation for chronic pain unresponsive to standard therapies;
- d. electrical bone growth stimulation for fracture nonunions or congenital pseudoarthroses;
- e. electrical bone growth stimulation of the spine as an adjunct to spinal fusion;
- f. sacral nerve neuromodulation for urinary dysfunction;
- g. vagus nerve stimulation for the treatment of refractory or intractable seizures;
- h. Phrenic nerve stimulation; or
- i. Deep brain stimulation for tremor associated with Parkinson's or essential tremor.

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

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

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

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

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

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

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

A handwritten signature in black ink that reads "Erin Stucky". The signature is written in a cursive, flowing style.

Erin Stucky
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-206-19-MK

In Section A., Definitions, the following is added:

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

In Section A., Definitions, the following is added:

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

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

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

- a. Appropriate and necessary for the symptoms, diagnosis or treatment of a medical or surgical condition;
- b. In accordance with Our local medical policies and the medical policies of Our Delegates;
- c. Not primarily for the convenience of the Covered Person, nor the Covered Person’s family, Physician or another provider;
- d. Consistent with the attainment of reasonably achievable outcomes;
- e. Reasonably calculated to result in the improvement of the Covered Person’s physiological and psychological functioning; and
- f. If more than one service or supply would meet the requirements a through e above, furnished in the most cost-effective manner which may be provided safely and effectively to the Covered Person.

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

In Section A., Definitions, *We, Us, Our* is deleted in its entirety and replaced as follows:

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

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

(j) hypoglossal nerve stimulation;

(k) tumor treating fields therapy, as a form of electrical stimulation, for the treatment of glioblastoma multiforme.

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

1. For speech therapy for 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.

And replaced as follows:

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

In Section J., General Information, the following is added as subsection c. under *Reimbursement to Us*:

- c. Recovery of Overpayment

If We determine that an erroneous payment for Benefits has been made, You (or any other person or entity receiving the erroneous payment on Your behalf) agree to return to Us the erroneous payment. In the event You (or any other person or entity receiving the erroneous payment on Your behalf) do not return to Us the erroneous payment, We shall have the equitable right to recoup such erroneous payment. Our right of recoupment provided in this section shall not be diminished, restricted, or limited in any manner whatsoever by any defenses, either in law or in equity, that the person or entity subject to Our claim of recoupment may otherwise have, and such defenses are hereby disclaimed.

In Section J., General Information, the following provision is added:

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

of an Adverse Determination in accordance with the provisions of this plan governing authorized representatives.

In Section J., General Information, the following is deleted:

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

And replaced as follows:

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

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



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

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

AMENDMENT: BCBSKC-201-21-M

In the Benefit Schedule, the following is added under Outpatient Therapy, *Occupational Therapy*:

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

In the Benefit Schedule, the following is added under Outpatient Therapy, *Physical Therapy*:

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

In the Benefit Schedule, the following is added under Outpatient Therapy, *Speech Therapy*:

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

In Section A., Definitions, the following is added:

Developmental or Physical Disability means a severe chronic disability that:

- a. Is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness or autism spectrum disorder which results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services;
- b. Manifests before the individual reaches age nineteen;
- c. Is likely to continue indefinitely; and
- d. Results in substantial functional limitations in three or more of the following areas of major life activities: (1) Self-care; (2) Understanding and use of language; (3) Learning; (4) Mobility; (5) Self-direction; or (6) Capacity for independent living.

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 that reads "Erin Stucky". The signature is written in a cursive, flowing style.

Erin Stucky
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-200-20-MK

In Section A., Definitions, *Allowable Charge* is deleted in its entirety and replaced as follows:

Allowable Charge

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

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

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

- a. For Hospitals, other institutional health care facilities, Physicians or suppliers of medical goods and services which are In-Network providers-
 - (1) The amount the provider has agreed to accept as payment in full as of the date of service; or
 - (2) The provider's billed charges.
- b. For non-Emergency Services provided by Hospitals, other institutional health care facilities, Physicians or suppliers of medical goods and services which are Out-of-Network Providers inside Our Service Area-

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

- (3) The provider's billed charges.
- c. For Emergency Services provided by Hospitals, other institutional health care facilities, Physicians or suppliers of medical goods and services which are Out-of-Network Providers inside Our Service Area-

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

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

- d. For In-Network pharmacies-

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

- (1) The negotiated rate the pharmacy has agreed to accept for Our members; or
- (2) The Usual and Customary Charge

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

- e. For Out-of-Network pharmacies-

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

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



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

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

AMENDMENT: PPO-201-21-MK

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

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

Orthognathic Surgery We provide Benefits for 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.

And is replaced with:

Orthognathic Surgery We provide Benefits for orthognathic surgery for the following conditions:

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

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

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

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



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

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

AMENDMENT: BCBSKC-223-19-MK

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

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

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

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

Covered Services include diabetic continuous glucose monitors and the associated supplies. These services do not require Prior Authorization.

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

Obtained in an emergency room which are not Emergency Services.

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

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

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



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

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

AMENDMENT: BCBSKC-217-18-MK

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

Inter-Plan Arrangements

I. Out-of-Area Services

Overview

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

When you receive care outside of Our service area, you will receive it from one of two kinds of providers. Most providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield Plan in that geographic area (“Host Blue”). Some providers (“nonparticipating providers”) don’t contract with the Host Blue. We explain below how We pay both kinds of providers.

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

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

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

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a

discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

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

B. Negotiated (non–BlueCard Program) Arrangements

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

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

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

C. Special Cases: Value-Based Programs

BlueCard® Program

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

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

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

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

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

E. Nonparticipating Providers Outside Our Service Area

1. Member Liability Calculation

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

2. Exceptions

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

F. BlueCard Worldwide® Program

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

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

- **Inpatient Services**

In most cases, if you contact the BlueCard Worldwide Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claims to the BlueCard Worldwide Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact Us to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

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

- **Submitting a BlueCard Worldwide Claim**

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

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



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

BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

PRIVACY PRACTICES NOTICE

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

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

Summary of Our Privacy Practices

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

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

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

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

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

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

Contact Information

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

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

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

Organizations Covered by this Notice

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

Blue Cross and Blue Shield of Kansas City

Good Health HMO, Inc.

Blue-Advantage Plus of Kansas City, Inc.

Missouri Valley Life and Health Insurance Company

Our Legal Duty

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

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

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

Uses and Disclosures of Your Medical Information

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

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

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

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations (although we are prohibited from using or disclosing any genetic information for these underwriting purposes); 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. To the extent (if any) that we maintain or receive psychotherapy notes about you, most disclosures of these notes require your authorization. Also, to the extent (if any) that we use or disclose your information for our fundraising practices, we will provide you with the ability to opt out of future fundraising communications. In addition, most (but not all) uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of protected health information, require your authorization. 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: Where permitted by law, we may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

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

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

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;

- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Your Rights

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

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. This may include an electronic copy in certain circumstances if you make this request in writing.

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 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. 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.

Breach Notification: In the event of breach of your unsecured health information, we will provide you notification of such a breach as required by law or where we otherwise deem appropriate

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.