Preferred-Care Dental

Offered by Blue Cross and Blue Shield of Kansas City

Dental Benefits Certificate for:

MISSOURI WESTERN STATE UNIVERSITY
34607000
DP01026A
January 1, 2015

- Diagnostic and Preventive Services
- Basic Restorative Services; Endodontics; Periodontics; and Extractions
- Major Restorative Services; and Maintenance of Prosthodontics
- Orthodontic Services

This Certificate describes the Benefits for dental care services covered by Blue Cross and Blue Shield of Kansas City and the extent to which Benefits may be limited

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

2301 Main • P.O. Box 419169 • Kansas City, MO 64141-6169 • 1-800-822-2583
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Amendments, if any, are located in the back of this Certificate.
**BENEFIT SCHEDULE**

<table>
<thead>
<tr>
<th>Effective Date: 01/01/2015</th>
<th>Dependent Limiting Age: 26</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group Name:</strong> MISSOURI WESTERN STATE UNIVERSITY</td>
<td><strong>Student Dependent Limiting Age:</strong> 26</td>
</tr>
<tr>
<td><strong>Benefit Waiting Period for Late Enrollees:</strong> None</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Covered Services</th>
<th><strong>PREFERRED PROVIDER</strong></th>
<th><strong>NON-PREFERRED PROVIDER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible (Individual/Family)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type I</td>
<td>None/None</td>
<td>None/None</td>
</tr>
<tr>
<td>Type II and III</td>
<td>$50/$150</td>
<td>$50/$150</td>
</tr>
<tr>
<td>Type IV</td>
<td>None/None</td>
<td>None/None</td>
</tr>
<tr>
<td>Calendar Year Maximum Each Covered Person</td>
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<td></td>
</tr>
<tr>
<td>Type I, II and III</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Type I Services</td>
<td>No Coinsurance</td>
<td>No Coinsurance</td>
</tr>
<tr>
<td>Type II Services</td>
<td>Deductible then 10% Coinsurance</td>
<td>Deductible then 10% Coinsurance</td>
</tr>
</tbody>
</table>
## BENEFIT SCHEDULE

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<thead>
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<th>Covered Services</th>
<th>PREFERRED PROVIDER</th>
<th>NON-PREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deductible, Coinsurance and Limitations</td>
<td>Deductible, Coinsurance and Limitations</td>
</tr>
<tr>
<td>Type III Services</td>
<td>Deductible then 40% Coinsurance</td>
<td>Deductible then 40% Coinsurance</td>
</tr>
<tr>
<td>Type IV Services</td>
<td>50% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>$1,500 Lifetime Maximum</td>
<td>$1,500 Lifetime Maximum</td>
</tr>
<tr>
<td></td>
<td>Benefits for Type IV Services are limited to Covered Persons under age 19</td>
<td>Benefits for Type IV Services are limited to Covered Persons under age 19</td>
</tr>
</tbody>
</table>
SECTION A. DEFINITIONS

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

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

The following explains what the Allowable Charge is for different providers:

1. For Dentists or other covered professionals practicing within the scope of their license, who are Participating Providers;

   The Allowable Charge is the lesser of:

   a. Our basic fee schedule amount for the same services or supplies; or

   b. The provider’s billed charges.

2. For Dentists or other covered professionals practicing within the scope of their license, who are Non-Participating Providers inside Our Service Area;

   The Allowable Charge is the lesser of:

   a. The amount the provider has agreed to accept as payment in full as of the date of service; or

   b. Our basic fee schedule amount for the same services or supplies provided by Participating Providers;

   c. The provider’s billed charges.

3. For Dentists or other covered professionals practicing within the scope of their license, who are Non-Participating Providers outside Our Service Area:

   a. An amount that is based on 90% of the nationally recognized commercial fee schedule to which Blue KC currently subscribes. 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

b. An amount that is within the reasonable range of charges in the locality where the services were received for a dental service, good or supply item.

**Anniversary Date**
Means the day each year that this Contract is renewed as agreed to by Your Employer and Us.

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

**Benefits**
Means the amount of Allowable Charges We pay for Covered Services after the Deductible requirement has been met.

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

**Benefit Waiting Period**
Means the length of time after the Effective Date of coverage a Late Enrollee must wait before he will be eligible to receive Benefits for a specific type of dental service. Benefit Waiting Periods, if any, are listed in the Benefit Schedule.

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

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

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

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

**Certificate**
Means this booklet and any amendments.

**Claim**
Means a request for (1) payment for Covered Services made in accordance with the procedures outlined in the How to File a Claim Section; or (2) 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.

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

Covered Person
Means the Employee or any of the Employee’s Dependents whose coverage is in effect under the Contract.

Covered Services
Means services, supplies, equipment and care specifically listed in the “Covered Services” section of the Contract, except those services, supplies, equipment and care excluded or subject to conditions and limitations identified in the Contract.

Benefits are payable for Covered Services that are provided on the date:

1. A fixed bridge, crown, inlay or onlay is inserted (seated); or
2. A denture or a partial is inserted; or
3. Root canal therapy is completed; or
4. Surgery is performed for periodontal surgery; or
5. An orthodontic service is received; or
6. On the date the Covered Service is provided for all services not listed under 1., 2., 3., or 4., above.

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

Dental Care Service
Means a service for the diagnosis, prevention, treatment, cure or relief of a dental condition, dental illness, dental injury or dental disease.

Dentist
Means anyone qualified and licensed to practice dentistry by the state in which services are rendered, and who has a degree of Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.).

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

**Dependent**

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

**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.

**Employee**

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

**Employer**

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

**Immediate Family Member**

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

**Late Enrollee**

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

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

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

**Lifetime Maximum**

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

If the Contract replaces any dental plan issued by Blue Cross and Blue Shield of Kansas City under which a Covered Person was covered, then this maximum will be reduced by the amount of Benefits a Covered Person received through the previous plan(s). However, the maximum may be restored in whole or in part at Our discretion with evidence of insurability acceptable to Us.

**Medically Necessary (Medical Necessity)**

Means any dental services or supplies You receive for Your dental disease, defect, injury or other condition:

1. Must agree with Your Dentist's diagnosis and treatment of the dental disease, defect, injury or other condition; and

2. Must be consistent with accepted standards of dental practice as determined by Our established dental review processes.
NOTE: We will determine whether services or supplies are Medically Necessary. This means that services or supplies will not automatically be considered Medically Necessary because they are prescribed by Your Dentist. We may consult with a professional dental consultant or other appropriate source for recommendations regarding the Medical Necessity of services or supplies.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Participating Provider</td>
<td>Means a Dentist who is not a Preferred Provider and does not have a contract with Us to provide dental care to Covered Persons.</td>
</tr>
<tr>
<td>Non-Preferred Provider (Non-PPO)</td>
<td>Means a Dentist who does not have a contract to provide services at negotiated rates for Your coverage under a Preferred Provider contract with Us.</td>
</tr>
<tr>
<td>Participating Provider</td>
<td>Means a Dentist who has entered into a contract that defines the method We will use to determine the Allowable Charges for Covered Services. Participating Providers have agreed to accept Our Allowable Charge as payment in full for Covered Services. However, You are responsible for the payment of any Coinsurance and Deductible amounts, non-Covered Services and amounts in excess of any Benefit maximums of the Contract.</td>
</tr>
<tr>
<td>Post-Service Claim</td>
<td>Means a request for payment for Dental Care Services rendered.</td>
</tr>
<tr>
<td>Predetermination</td>
<td>Means a written report prepared by a Dentist describing the recommended treatment for any dental disease, defect, injury or other condition that is prepared as a result of a Dentist’s examination of a Covered Person that is submitted for Our review of the recommended treatment and a determination of coverage based upon eligibility, Contract Benefits, and Medical Necessity. Predetermination is strongly recommended for certain Covered Services provided by any Dentist including Preferred, Non-Preferred, Participating and Non-Participating Dentists.</td>
</tr>
<tr>
<td>Preferred Provider</td>
<td>Means a Dentist participating in the Preferred Provider Organization (PPO) as named in the provider directory.</td>
</tr>
<tr>
<td></td>
<td>Such Preferred Provider will bill Us directly for Covered Services You receive and will not bill You for any charges above the amount agreed upon by Us and the Dentist except for any Coinsurance and/or Deductible amounts for which You are responsible.</td>
</tr>
<tr>
<td>Premium(s)</td>
<td>Means the amount paid on a periodic basis for Your coverage under the Contract.</td>
</tr>
<tr>
<td>Reinstatement</td>
<td>Means restoring a Contract that has been terminated (for example, because of non-payment of Premiums).</td>
</tr>
<tr>
<td>Service Area</td>
<td>(Sometimes referred to as “Our Service Area”) means the geographic area served by Us. Contact Us to determine the geographic area We serve.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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</tr>
<tr>
<td>Waiting Period</td>
<td>Means the length of time the Employee must continuously work for the Employer before he is eligible to enroll for coverage under the Contract.</td>
</tr>
<tr>
<td>We, Us, Our</td>
<td>Means Blue Cross and Blue Shield of Kansas City, the company legally responsible for providing the Benefits for Covered Services under the Contract.</td>
</tr>
<tr>
<td>You, Your</td>
<td>Refers to the Covered Person.</td>
</tr>
</tbody>
</table>
SECTION B. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

1. Employee Eligibility

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

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

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

2. Dependent Eligibility

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

a. The Employee’s legal spouse of the opposite sex;

b. The Employee’s or Employee’s legal spouse’s child. Such child includes:

   • a child by birth;
   • an adopted child;
   • a child under the age of 18 who has been placed with the Employee for the purpose of adoption for whom the Employee has a legal obligation to support; or
   • a child under the age of 18 who has been placed under the Employee’s legal guardianship.

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

c. The Employee’s or Employee’s legal spouse’s unmarried Dependent child (defined above) who has reached the limiting age but who cannot support himself because of a physical or mental handicap. The Dependent’s handicap must have started before the end of the Calendar Year in which the Dependent reached the limiting age and the Dependent must have been continuously covered by 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 before the Dependent reaches the limiting age, or within 31 days after the Dependent is enrolled for coverage under the Contract to continue coverage beyond the Dependent Limiting Age. In addition, We must receive satisfactory proof annually of the handicap, following the Dependent’s attainment of the limiting age.

It is the Employee’s responsibility to see that Dependent information is kept current. If necessary Dependent information is not in Our files, claims will be rejected for such individuals.
Dependents will not be eligible for coverage unless the Employee is covered under the Contract.

3. Enrollment

a. Annual Enrollment Period

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

b. Initial Enrollment Period for a Newly Eligible Employee

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

c. Special Enrollment Periods

(4) New Dependents: If a new Dependent is acquired by an Employee due to marriage, birth of a child, adoption of a child, or placement for adoption of a child, the new Dependent, the spouse of an Employee. Other eligible Dependent children and/or an Employee who previously declined coverage may enroll during this Special Enrollment Period, even if coverage was previously declined. To enroll during this Special Enrollment Period, an Employee must submit to Us a completed Employee application and any additional Premium due within 31 days after the date of marriage, birth, adoption, or placement for adoption. Documentation verifying the event must be provided, if requested.

Notwithstanding the above paragraph, if the Employee previously has elected Dependent coverage and such coverage is in effect on the date of the newborn child’s birth, then the Employee’s newborn child will be covered automatically for 31 days from the moment of birth. No additional Premium will be assessed for coverage for these 31 days. If additional Premium is due, the Employee must submit to Us a completed Employee application requesting coverage for such newborn to be added within 31 days of the child’s birth in order to continue such child’s coverage beyond the initial 31 days. Coverage for such a newborn will be subject to all of the terms and conditions of the Contract.
If You notify Our Customer Service Department of the birth either verbally or in writing within 31 days of the date of birth, We must:

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

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

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

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

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

(a)

(i) The employer’s contributions toward such coverage were terminated;

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

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

1. Legal separation, divorce, no longer qualifying as a dependent under the other coverage, death of an Employee, termination of employment or reduction in the number of hours of employment.
2. Reaching a Lifetime Maximum on all Benefits under coverage offered by an employer.
3. An employer no longer offers any health coverage to a class of similarly situation individuals.
(b) Except as provided below, the Employee must submit to Us a completed Employee application and any additional Premium due within 31 days after the loss of such other coverage and provide appropriate documentation verifying the loss of such other coverage, if requested.

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

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

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

d. Guardianship

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

e. Qualified Medical Child Support Order

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

Employees must fully and accurately complete and sign the Employee application, either via paper or electronic format. False or misrepresented material information provided may cause coverage of an Employee and/or Dependents to be null and void from inception if validated within two years from the date of issue.

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4. **Effective Date of Coverage**

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

a. **Annual Enrollment Period**

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

If You enroll during any subsequent Annual Enrollment Period, the Effective Date of coverage is the Contract anniversary date. Benefits for Late Enrollees may be subject to a Benefit Waiting Period if indicated in the Benefit Schedule.

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

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

c. **Special Enrollment Period**

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

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

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

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

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

d. Late Enrollees

The Effective Date of coverage for an individual who is a Late Enrollee is the next Contract anniversary date. Benefits for Late Enrollees may be subject to a Benefit Waiting Period if indicated in the Benefit Schedule.

e. Guardianship

In the case of a child placed for guardianship, the Effective Date of coverage is the date the court order awarding guardianship is legally effective.
f. Qualified Medical Child Support Order

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

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

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

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

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

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

g. Extension of Benefits from Prior Plan

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

5. Section 125 Eligibility

The eligibility provisions of Your Employer’s Section 125 plan are incorporated into this Section provided such provisions are consistent with the final permitted mid-year election changes outlined under Treas. Reg. §1.125-4 and §1.125-3. Your Employer will determine who is eligible under this provision and will advise Us of such person’s eligibility and Effective Dates of coverage.
SECTION C. COVERED SERVICES

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

Covered Services

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

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

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

b. Performed, prescribed or ordered by a Dentist;

c. Except for Type I Services, Medically Necessary for the treatment of Your dental disease, defect or other condition;

d. Not excluded under the Contract; and

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

If You, during the course of treatment, transfer to the care of another Dentist, or if more than one Dentist provides services for one dental procedure, Benefits will not exceed the amount that would be payable if services were provided by only one Dentist.

Benefits

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

Benefits are different depending on whether Covered Services are received from a Preferred Provider or a Non-Preferred Provider. Benefits for Covered Services will be greater if Covered Services are received from Preferred Providers. See Your provider directory or call Us for a listing of Preferred Providers.

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. Separate Deductibles may apply to each type of Covered Service as indicated in the Benefit Schedule.

Predetermination

Services for which Predetermination is recommended will state so in the applicable Covered Services provision. The following explanation outlines
Your responsibilities for obtaining a Predetermination and the consequences of receiving services when a recommended Predetermination was not obtained.

It is strongly recommended that Your Dentist submit a Predetermination claim form to Us for Type III and Type IV services before the services are performed. We will review the claim form and determine if Benefits are available. If You receive the service from a Preferred Provider and a Predetermination was not obtained, the Dentist will be responsible for the cost associated with such services if We later determine that the services were not Medically Necessary. If you receive the service from a Non-Preferred Provider and a Predetermination was not obtained, You will be responsible for the cost associated with such services if We later determine that the services were not Medically Necessary. If there is any change in the treatment plan after services begin, an additional Predetermination claim form should be submitted to Us for approval.

When Your coverage terminates, Benefits for Covered Services that have been Predetermined will not be available for those services received more than 31 days from the date of the Predetermination approval subject to the limitations of this Contract.

**It is to Your advantage to encourage Your Dentist to submit Type III and Type IV services for Predetermination as You will be responsible for the costs associated with any non-Covered Services and for services provided by a Non-Preferred Provider that are not Medically Necessary.**

The following information provides a detailed description of Covered Services:

1. **Type I Services**
   - **Diagnostic; Preventive**

   We provide Benefits for Type I (Diagnostic and Preventive) Dental Services. Covered Services are limited to the following:

   a. Oral evaluations. Oral evaluations are limited to 2 per Calendar Year.

   b. X-rays are limited as follows:

      (1) Periapical (single tooth) x-rays are limited to 12 per Calendar Year.

      (2) Complete mouth survey x-rays or panoramic x-rays are limited to 1 every 3 Calendar Years.

      (3) Bitewing x-rays are limited to 2 occurrences per Calendar Year.

   c. Adult or child prophylaxes (teeth cleanings) are limited to 2 per Calendar Year.
d. Fluoride treatments are limited to 2 per Calendar Year and are available only for Covered Persons age 19 and under.

e. Topical application of a sealant on a posterior tooth is limited to Covered Persons age 14 and under and is limited to no more than 1 treatment per tooth in any 3 Calendar Year period.

Limitation: The services listed below are included in the fee paid to Your Dentist for topical sealants; therefore no separate payment will be made for: occlusal and contact adjustments when associated with topical sealants.

f. Fixed and removable space maintainers, to maintain arch length for missing primary molars, are limited to the initial appliance only. No Benefits are available for adjustments made within 6 months of installation.

g. Emergency treatment to temporarily relieve acute dental pain is paid as a separate Benefit only if no other service was provided during the visit (except for x-rays).

2. Type II Services—We provide Benefits for Type II (Basic Restorative; Endodontics; Extractions; and Periodontics) Dental Services. Covered Services are limited to the following:

a. Fillings:

(1) Amalgam restorations

(2) Resin-based composites

(3) Pin retentions

(4) Stainless steel crowns (for primary teeth only)

Limitation: Multiple restorations on one surface will be covered as a single filling. The services listed below are included in the fee paid to Your Dentist for fillings; therefore no separate payment will be made for these services when received in connection with a filling: bonding agents for amalgams, bases, liners, indirect pulp caps, protective or medicated coatings, occlusal and contact adjustments associated with the related restoration, and opposing or adjacent structures and polishing or finishing the final restoration.
b. Other restorative services:

(1) Recementation of inlays and crowns if more than 6 months have elapsed since the date of insertion.

(2) Recementation of a bridge if more than 6 months have elapsed since the date of insertion.

(3) Sedative fillings if no other service is provided during the visit (except for x-rays).

c. Endodontics:

(1) Direct pulp cap (covering of exposed pulp with a dressing or cement). Benefits are not available for more than one direct pulp cap per tooth or for direct pulp caps on primary teeth.

(2) Therapeutic pulpotomy (removal of a portion of the pulp and placement of a dressing over the remaining pulp).

(3) Root canal therapy and related necessary treatments.

Limitation: The services listed below are included in the fee paid to Your Dentist for root canal therapy; therefore no separate payment will be made for these services when received in connection with root canal therapy: analgesics and topical and local anesthetics, opening and draining of pulp chambers and canals, removal of pulp tissue and instrumentation of canals, application of medications, x-rays required during the procedure, temporary bands or crowns used to isolate the tooth during treatment, culture and sensitivity, post-therapeutic x-rays, six (6) months of follow-up care and any emergency care for the involved tooth during the course of treatment by the Dentist providing the root canal therapy.

(4) Apicoectomy and periradicular surgery (amputation of the apex or root tip of a tooth).

(5) Retrograde fillings (a method of sealing the root canal by preparing and filling it from the root apex (tip)).

d. Tooth extractions, simple and surgical, including wisdom teeth.

e. Alveoloplasty (the surgical preparation of the ridge for a denture).
f. General Anesthesia/IV Sedation will be payable only if provided in connection with a Covered Service. No separate Benefits are available for analgesics, topical and local anesthetics including, but not limited to, the application of a numbing agent in preparation for an anesthetic injection, anesthetics, and their administration. Analgesics and topical and local anesthetics are included in the fee paid to Your Dentist for services that require them. Nitrous oxide is not covered.

g. Periodontics. Payment will only be made for the following services in the presence of periodontal disease:

1. Periodontal maintenance procedures following active periodontal therapy (including, but not limited to scaling, root planing and osseous surgery) limited to two (2) per Calendar Year.

2. Gingival curettage.

3. Occlusal adjustment when performed in conjunction with periodontal therapy.

4. Periodontal scaling and root planing.

5. Occlusal guard appliances (biteguards) limited to one (1) every three (3) Calendar Years.

6. Osseous surgery.

7. Bone replacement grafts, excluding grafts placed in extraction or apicoectomy sites.

8. Gingivectomy or gingivoplasty.

9. Gingival grafts, connective tissue grafts and gingival flap procedures.

Limitation: The services listed below are included in the fee paid to Your Dentist for periodontics; therefore no separate payment will be made for the following dental care received in connection with the periodontal care described above: routine preoperative and postoperative care; sutures; suture removal and periodontal pack placement and removal.
3. **Type III Services—Major Restorative Services, and Maintenance of Prosthodontics**

We provide Benefits for Type III (Major Restorative and Maintenance of Prosthodontics) Dental Services. Covered Services are limited to the following:

a. Single crowns, inlays and onlays. Gold restorations and single crowns, except over implants, are covered only when needed due to decay or traumatic injury and the tooth cannot be restored with a routine filling material.

   (1) Single crowns, except over implants

   (2) Inlays and onlays

   (3) Crown buildups

   (4) Crown lengthening (hard tissue).

Limitation: The services listed below are included in the fee paid to Your Dentist for single crowns, inlays and onlays; therefore no separate payment will be made for these services when received in connection with single crowns, inlays and onlays: preparation of the tooth or soft tissue; drugs and supplies necessary to perform the procedure; bases; liners; protective or medicated coatings; retraction, cauterization or excision of gingival tissue necessary for impression; impressions; permanent cementation of a crown; occlusal and contact adjustments; polishing or finishing of the final restoration; recementation of a crown within the 6 months following placement; removable denture abutments; a crown to fill a space between teeth; and replacement of a crown made within the last 5 years if the original placement or replacement of the crown was covered under a dental contract issued by Us.

b. Bridges, fixed and removable, except over implants.

Limitation: The services listed below are included in the fee paid to Your Dentist for fixed and removable bridges; therefore no separate payment will be made for these services when received in connection with fixed and removable bridges: preparation of the tooth or soft tissue; drugs and supplies necessary to perform the procedure; bases; liners; protective or medicated coatings; retraction, cauterization or excision of gingival tissue necessary for impression; impressions; permanent cementation of a bridge; occlusal and contact adjustments; polishing or finishing of the final restoration; recementation of a bridge within the 6 months following placement; bridge abutment crowns used for precision attachments; removable denture abutments; a crown to fill a space between teeth; and
replacement of a bridge made within the last 5 years if the original placement or replacement of the bridge was covered under a dental contract issued by Us.

c. Dentures and partial dentures, except over implants.

Limitation: The services listed below are included in the fee paid to Your Dentist for dentures and partial dentures; therefore no separate payment will be made for these services when received in connection with dentures and partial dentures: preparation of the mouth for dentures; any study models and impression tray fabrication or denture adjustments; post-delivery care; replacement of existing dentures inserted while the Covered Person was covered under a dental contract issued by Us, unless five (5) years have elapsed from the date of insertion and then only if the appliance cannot be made serviceable; over-dentures or customized dentures; and precision or semi-precision attachments.

d. Maintenance of prosthodontics. Payment will be made for the following services only:

(1) Adjustments to dentures if more than 6 months after installation.

(2) Repair of a broken complete or partial denture or replacement of one or more broken teeth.

(3) Reattachment of a damaged clasp or replacement of a broken clasp on a denture.

(4) Relining of dentures and partial dentures.

Limitation: Payment will not be provided for the relining of a denture if less than 6 months has elapsed since the date of insertion or more than one relining of a denture during any 2 Calendar Year period.

(5) Addition of teeth to a partial denture to replace extracted teeth.

Your Dentist should submit a Predetermination claim form to Us for Type III services before the services are performed. We will review the claim form and determine if Benefits are available. If there is any change in the treatment plan after services begin, an additional Predetermination claim form should be submitted to Us for approval.

It is to Your advantage to encourage Your Dentist to submit Type III services for Predetermination as You will be responsible for the costs associated with any non-Covered
4. **Type IV Services—Orthodontic Services**

We provide Benefits for Type IV (Orthodontic) Dental Services. Covered Services are limited to the following:

Payment will be provided for only the following orthodontic services for the treatment of a handicapping malocclusion.

- a. Preliminary study including cephalometric x-rays and diagnostic impressions of the upper and lower arches.
- b. Active treatment per month, including orthodontic appliances, monthly treatment for appliance adjustments, and retention appliances. No lump sum payment will be made for the initial appliance (banding) fee, or for the total orthodontic case fee.
- c. Surgical access of an unerupted tooth when an orthodontic attachment is placed to facilitate eruption.

**Limitation:** See Your Benefit Schedule to determine the Lifetime Maximum for orthodontic services and the limiting age up to which We will provide Benefits.

**Your Dentist should submit a Predetermination claim form to Us for Type IV services before the services are performed.** We will review the claim form and determine if Benefits are available. If there is any change in the treatment plan after services begin, an additional Predetermination claim form should be submitted to Us for approval.

**It is to Your advantage to encourage Your Dentist to submit Type IV services for Predetermination as You will be responsible for the costs associated with any non-Covered Services and for services provided by a Non-Preferred Provider that are not Medically Necessary.**
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, services, supplies, equipment or care that are:

1. For any services, appliances or restorations to change vertical dimension or restore occlusion.
2. For patient education services.
3. Not specifically covered under the Contract.
4. For interest charges, document processing or copying fees, mailing costs, collection fees, telephone consultations, charges for missed appointments, charges for completion of forms or other non-dental charges.
5. For analgesics, topical and local anesthetics billed as a separate charge; nitrous oxide; and routine post-operative care.
6. Charges for take-home supplies, personal care or convenience items.
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 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 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 future dental benefits under a worker’s 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.

9. For free services or supplies received where there is no legal obligation for payment or for care or treatment for which no charge has been made.
11. Experimental or investigative as determined by Us.
12. For losses due in whole or in part to war or any action of war.
13. Charges for care provided by any medical or non-medical facility.
14. For Cosmetic purposes, other than to correct birth defects or to correct a defect incurred through an Accidental Injury. For example, teeth-whitening is not covered.
15. For hypnotism, hypnotic anesthesia, acupuncture, acupressure or any other form of alternative treatment.

16. Provided by You, Your Immediate Family Members or member of Your immediate household.

17. For prescription or non-prescription drugs and medicines.

18. Services or supplies for diagnosis, evaluation, medical and dental management, and/or surgical treatment related to conditions of the temporomandibular joint, unless specifically covered under the Contract.

19. For orthognathic surgery, which means any service or supply received for corrections of deformities of the jaw. This consists of surgical repositioning of portions of the upper or lower jaws or the bodily repositioning of entire jaws.

20. For dental implants, bone replacement grafts prior to implant placement, or prostheses over the implants.

21. For any implant procedures performed which are not listed as Covered implant procedures in Covered Services.

22. For dental appliances for the control of harmful habits including, but not limited to orthodontic appliances for thumb sucking and occlusal guards for bruxism (teeth grinding).

23. For infection control procedures and supplies.

24. For any dental services or supplies, including dental prostheses required for damage to sound and natural teeth or dental prostheses, required when damage occurs during the act of chewing.

25. For temporary, treatment or interim crowns, bridges or dentures.

26. For localized delivery of chemotherapeutic agents.

27. For guided tissue regeneration (resorbable or nonresorbable barriers) for the treatment of periodontal conditions.

28. For the replacement of lost, stolen, damaged or misplaced dental or orthodontic appliance; or denture duplication.

29. For precision or semi-precision attachments.

30. For the initial placement of dentures, partials, or bridges if it includes the replacement of teeth missing prior to Your Effective Date. This exclusion will not apply if the prosthesis replaces a functioning tooth which was extracted while covered under this Contract or this is a replacement prosthesis. This exclusion will not apply when this Contract replaces coverage under a prior plan that covered dental services because continuous coverage under the prior plan may be applicable to the replacement of missing teeth that were previously extracted under the prior plan’s coverage.
31. For the replacement of any bridges, partials, dentures, orthodontic appliances, inlays, or crowns which were inserted within five (5) years of the date of last placement that was covered under a dental contract issued by Us except for a replacement, excluding third molars, which is essential due to the extraction of functioning teeth.

32. For crowns or bridges for the purpose of splinting.

33. For bone replacement grafts placed in extraction or apicoectomy sites.

34. Services or supplies that are considered obsolete and no longer meeting accepted standards of dental practice as determined by a dental consultant.

35. 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 BCBSKC for such services.

36. For sales tax.

37. For services, supplies, equipment or care received in connection with a non-covered service, supply, equipment or care.
SECTION E.  HOW TO FILE A CLAIM

1. Claim Procedures

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

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

a.  The reason or reasons for the denial,

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

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

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

2. Claims for Dental Services

a.  For care received inside Our Service Area

(1) Preferred Providers and Participating Providers will file Your Claim for You, and We will pay them directly. You may be asked to pay any non-Covered Services, Deductible and/or Coinsurance amounts for which You are responsible at the time of service.

(2) Non-Participating Providers will generally file Your Claim for You. If a Non-Participating Provider declines to file Your Claim for You, You may obtain a Claim form from Our Customer Service Center. A Non-Participating Provider may require You to pay the total charge at the time of service.

b.  For care received outside Our Service Area

If You ask, a Dentist outside Our Service Area will frequently file Your Claim for You. Claims must be filed with Us. If the Dentist declines to file Your Claim for You, You may obtain a Claim form from Our Customer Service Center. A Dentist outside Our Service Area may require You to pay the total charge at the time of service.

3. Time Limits for

We must receive proof of a Post-Service Claim for reimbursement for
Filing Post-Service Claims

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

4. Processing of the Filed Claim

We will process the Claim as soon as reasonably possible but in no more than 30 calendar days after receipt. We will also notify You within 30 calendar days after receipt if additional information is necessary to process the Claim. You have 45 calendar days from the date You receive Our request to provide Us with the additional information. Upon receipt of the additional information, We will process Your Claim within 15 calendar days. If You fail to provide Us with the additional information within 45 calendar days of receipt of Our request, We will deny Your Claim.
SECTION F.  PREMIUM PAYMENT, GRACE PERIOD AND CHANGES

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<thead>
<tr>
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<th>Premium Payment</th>
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<tbody>
<tr>
<td>1</td>
<td>Initial Premiums are due and payable by Your Employer on or before the Contract effective date. Subsequent Premiums are due and payable by Your Employer on or before the monthly Due Date.</td>
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<th>Grace Period</th>
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<tr>
<td>2</td>
<td>The Employer shall have a grace period of 31 days for the payment of any Premium, during which time the Contract shall continue in force. In no event shall the grace period extend beyond the date the Contract terminates. The Contract will automatically terminate on the last day of the period for which Premiums have been paid if the grace period expires and any Premium remains unpaid.</td>
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<th>Reinstatement</th>
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<td>3</td>
<td>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 in writing within 45 days of receiving Your resubmission of a new application and payment of a reinstatement fee.</td>
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<th>Changes in Premiums</th>
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<tr>
<td>4</td>
<td>We reserve the right to change Premiums upon 31 days prior written notice to the Employer. Notwithstanding the foregoing, We may change the Premiums at any time upon 31 days prior written notice whenever the terms of the Contract are changed.</td>
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</table>

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

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

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

Terminating a Covered Person's Coverage

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

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

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

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

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

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

f. On the original Effective Date of coverage if coverage is terminated by Us due to a material misrepresentation or misstatement of fact on the Employee application;

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

When a Covered Person’s coverage terminates, he may have continuation of coverage rights. See the Continuation section of the Contract.
SECTION H. CONTINUATION

1. Continuation of Coverage

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

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

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

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

a. Qualifying Events

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

(1) Termination of employment (other than for gross misconduct);

(2) Reduction in work hours;

(3) Death of the Employee;

(4) The Employee becomes entitled (eligible and enrolled) to Medicare Benefits;

(5) Divorce or legal separation;
(6) A Dependent child ceases to qualify as a Dependent under the terms of the Plan; or

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

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

b. Qualified Beneficiary

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

c. Maximum Coverage Period

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

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

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

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

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

e. Social Security Disability

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

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

f. Electing Continuation Coverage

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

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

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

g. Effective Date of Continuation Coverage

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

h. Coverage Changes

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

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

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

i. **Termination of Continuation Coverage**

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

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

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

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

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

5. The date the individual first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise). However, an individual who becomes covered under a group health plan which has a preexisting condition limit must be allowed to continue coverage for the length of a preexisting condition or to the continuation maximum coverage period, if less. Continuation coverage may be terminated if the individual becomes covered under a group health plan with a preexisting condition limit, if the preexisting condition limit does not apply to (or is satisfied by) the individual by reason of HIPAA, ERISA or the Public Health Services Act;

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

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

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

j. Extension of COBRA Continuation for Spouses

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

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

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

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

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

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

(4) The spouse’s 65th birthday.

3. **Continuation of Coverage for Dependents Reaching the Dependent Limiting Age**

   If a Dependent’s coverage would otherwise terminate due to reaching the Dependent Limiting Age indicated in the Benefit Schedule, coverage for such Dependent may be continued provided the Dependent is:

   1. unmarried and no more than 25 years of age; and

   2. a resident of Missouri; and

   3. not provided coverage as a named subscriber, insured, enrollee, or covered person under any group or individual health benefit plan, or entitled to benefits under Medicare.

   The request for continuation of coverage for Dependents reaching the Dependent Limiting Age must be provided to Us within 31 days following the date coverage terminates due to reaching the Dependent Limiting Age.

   Continuation coverage for such Dependent is subject to all other terms and conditions of Your Contract/Certificate including the termination provisions. In addition, Continuation coverage for such Dependent shall also terminate upon the earlier of the following:

   1. The end of the calendar year the Dependent reaches age 25; or

   2. The end of the calendar year the Dependent no longer meets the requirements of 1. or 2. above.

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

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

   a. Pays the Premium for such continued coverage; and

   b. Provides continued coverage to all Employees in the same class as the Employee whose coverage would otherwise terminate because of an approved leave of absence.
SECTION I. GENERAL INFORMATION

1. Terms and Conditions of the Contract

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

2. Statements

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

3. Dental Examination

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

4. Release of Records

During the processing of Your claim, We may need to review Your dental records, including:

a. A complete current dental charting. The charting should show extractions, missing teeth, fillings, crowns and pocket depths. The dates of any work previously done should be shown.

b. An itemized bill for all dental care listed on the claim.

c. Preoperative x-rays, study models and reports.

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

5. Reimbursement to Us

a. Workers’ Compensation

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

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

b. Errors

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

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6. Legal Actions

No action at law or equity shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

7. Conformity with State Laws

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

8. Commission or Omission

No Dentist will be liable for any act of commission or omission by Us. We will not be liable for any act of commission or omission by: (a) any Dentist or Dentist's agent or employee; or (b) the Employer or the Employer’s agent or employee.

9. Clerical Errors

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

10. Notice

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

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

12. Assignment

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

However, any Covered Services provided under the 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.

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. ERISA Statement of Rights

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

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

ERISA provides that all plan participants shall be entitled to:

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

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

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

e. Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If You have a claim for Covered Services which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the plan’s decision or lack thereof concerning the qualified status of a medical child support order, You may file suit in Federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the United States Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.
If You have any questions about the plan, You should contact the plan administrator. If You have any questions about this statement or Your rights under ERISA, or if You need assistance in obtaining documents from the plan administrator, You should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

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

15. Authority to Construe Terms of the Contract

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

16. Plan Sponsor and Plan Administrator

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

17. Independent Licensee

The Contract constitutes a Contract solely between the 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 an agent of the Association. No person, entity, or organization other than Blue Cross and Blue Shield of Kansas City shall be held accountable or liable to Employer for any of Blue Cross and Blue Shield of Kansas City's obligations to 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.
18. Gender

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

19. Titles

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

20. Entire Contract

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

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 the coverage or reduces Benefits unless the statement was 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 the Employee. No claim for loss incurred or disability (as defined in the policy) commencing after twelve months from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss has existed prior to the effective date of coverage of this policy.

22. Dental Provider Directory

At no additional cost, Dental Provider Directories are provided by Us and upon request when You call Our Customer Service Department. In addition, You may access Our Dental 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 under this section, 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 organization.

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.
SECTION J.  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. Complaint Procedures

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

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

2. Procedures for Filing a Grievance

   If You prefer to file a formal Grievance, You may do so by requesting a Member Grievance form from Our Customer Service Department, and submitting the form to Us. In order to request a Grievance, Your request must be filed within one hundred and eighty (180) days from the date: (a) You received notice of an Adverse Determination made pursuant to Utilization Review, or (b) for Post-Service Claims, You received the Explanation of Benefits. For Employee Welfare Benefit Plans subject to the Employee Retirement Income Security Act (ERISA) You must file a Grievance before You can bring a civil action under ERISA Section 502(a). Call Your Employer to find out if You are subject to ERISA.

   The grievance form must be sent to the attention of the Appeals Department. Upon request, We will provide You with copies of all documents, records, and other information relevant to Your 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 denied Claim within 60 calendar days after receipt of the appeal. We will notify You in writing of Our decision. The notification will also explain the member’s additional appeal rights, if any.
<table>
<thead>
<tr>
<th>3. <strong>Department of Insurance</strong></th>
<th>You may also contact the Missouri Department of Insurance, Financial Institutions &amp; Professional Registration, 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.</th>
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<tbody>
<tr>
<td>4. <strong>ERISA Exhaustion of Internal Procedures</strong></td>
<td>If Your plan is subject to ERISA and Your request for coverage of Benefits is denied, You have the right to bring a civil action under ERISA Section 502(a) provided You have exhausted Your appeal rights.</td>
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NOTICE OF
PROTECTION PROVIDED BY
MISSOURI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
RSMo 376.715, et. seq.

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

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Missouri law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

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

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is as follows:

- $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance
- $5,000,000 to one policy owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons

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

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

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

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

Insurance companies and agents are not allowed by Missouri law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Missouri law, then Missouri law will control.
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.
Organizations Covered by this Notice

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

Blue Cross and Blue Shield of Kansas City

Good Health HMO, Inc.

Blue-Advantage Plus of Kansas City, Inc.

Missouri Valley Life and Health Insurance Company

Our Legal Duty

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

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

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

Uses and Disclosures of Your Medical Information

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

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

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

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

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

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

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

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

We will provide you with an opportunity to object to these disclosures, unless you are not present or are
incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our
professional judgment to determine whether disclosing your medical information is in your best interest
under the circumstances.
**Your Employer:** We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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**Complaints**

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

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

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