

ELIGIBILITY REQUIREMENTS

Active Employees

Active Employees and their Dependents are eligible for coverage on the first monthly effective date following thirty (30) days of employment. An active Employee is an Employee who is Actively at Work as defined in the section entitled "DEFINITIONS AND COVERAGE REQUIREMENTS". If application is not made within the first thirty-one (31) days of eligibility, the application cannot be made until the next open enrollment period, family status change or Special Enrollment period.

A Dependent's eligibility for or receipt of Medicaid assistance will not be considered in enrolling that Dependent for coverage under this Plan of Benefits.

For a Dependent to be eligible for coverage under this Plan of Benefits, the required Premium and administrative charge must be paid, prior to the termination of the enrollment period.

If an Employee is not enrolled such Dependents are not eligible to enroll for coverage under this Plan of Benefits.

Membership Application

The Corporation will only accept a Membership Application submitted by the Employer on behalf of each Employee. The Corporation will not accept a Membership Application directly from an Employee or Dependent.

Member Contributions

The Covered Member is solely responsible for making all payments for any Premiums.

Disclosure of Medical Information

By accepting Benefits or payment of Covered Expenses, the Covered Member agrees that the Employer's Group Health Plan (including BlueCross BlueShield on behalf of the Employer's Group Health Plan) may obtain claims information, medical records, and other information necessary for the Employer's Group Health Plan to consider a request for Preauthorization, a Continued Stay Review, an Emergency Admission Review, a Preadmission Review or to process a claim for Benefits.

Election of Coverage

Any Employee may enroll for coverage under the Employer's Group Health Plan for such Employee and such Employee's Dependents by completing and filing a Membership Application with the Employer. Dependents must be enrolled within thirty-one (31) days of the date on which they first become Dependents. Employees and Dependents may also enroll if eligible under the terms of any Special Enrollment procedure.

The Employee is required to submit a marriage license and file it with the Employer. The Corporation reserves the right to request documentation of such marriage.

Commencement of Coverage

Coverage under the Employer's Group Health Plan will commence as follows, provided that coverage will not be effective more than sixty (60) days before the Corporation received such Employee's Membership Application:

- Employees and Dependents Eligible on the Employer's Effective Date

For Employees (and such Employee's Dependents for whom such Employee has elected coverage) who are Actively at Work prior to and on the Employer effective date will generally commence on the Plan of Benefits Effective Date.

If the Corporation receives an Employee's Membership Application dated after the Employer effective date, coverage will commence on the date chosen by the Employer.

- Employees and Dependents Eligible After the Plan of Benefits Effective Date

Employees and Dependents who become eligible for coverage after the Plan of Benefits Effective Date and have elected coverage will have coverage after they have completed the Probationary Period.

- Dependents Resulting from Marriage

Dependent(s) resulting from the marriage of an Employee will have coverage upon enrollment provided they have enrolled for coverage and the coverage must be paid for under this Plan of Benefits within thirty-one (31) days after marriage. If a Dependent resulting from a marriage is not enrolled within thirty-one (31) days after the marriage, coverage will begin on the date chosen by the Employer and after the payment of the applicable Premium and Administrative Charge.

- Newborn Children

A newborn Child will have coverage upon the date of the Child's birth provided he or she has been enrolled for coverage and the coverage has been paid for under this Plan of Benefits within thirty-one (31) days after the Child's birth for the Child to have coverage from the date of birth. If a newborn Child is not enrolled within the time frame set forth in the prior sentence, coverage will begin on the date chosen by the Employer and upon the payment of the applicable Premium and Administrative Charge.

- Adopted Children

For an adopted Child of an Employee, coverage shall commence as follows:

- Coverage shall be retroactive to the Child's date of birth when a decree of adoption is entered within thirty-one (31) days after the date of the Child's birth.
- Coverage shall be retroactive to the Child's date of birth when adoption proceedings have been instituted by the Employee within thirty-one (31) days after the date of the Child's birth, and if the Employee has obtained temporary custody of the Child.

- For an adopted Child other than a newborn, coverage shall begin when temporary custody of the Child begins. However, such coverage shall only continue for one (1) year unless a decree of adoption is entered in which case coverage shall be extended so long as such Child is otherwise eligible for coverage under the terms of this Plan of Benefits.
 - If an adopted Child is not enrolled within the time frame set forth in bullets above, coverage will begin on the date chosen by the Employer and upon the payment of the applicable Premium and Administrative Charge.
- Special Enrollment

In addition to enrollment under the “ELIGIBILITY REQUIREMENTS” section, the Corporation shall permit an Employee or Dependent who is not enrolled to enroll if each of the following is met:

- The Employee or Dependent was covered under a Group Health Plan or had creditable coverage at the time coverage was previously offered to the Employee or Dependent;
- The Employee stated in writing at the time of enrollment, that the reason for declining enrollment was because the Employee or Dependent was covered under a Group Health Plan or had creditable coverage at that time. This requirement shall only apply if the Employer required such a statement at the time the Employee declined coverage and provided the Employee with notice of the requirement and the consequences of the requirement at the time; and,
- The Employee or Dependent's coverage described above:
 - Was under a COBRA continuation provision and the coverage under the provision was exhausted;
 - Was not under a COBRA continuation provision described in the previous paragraph above, and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment), or reduction in the number of hours of employment, or if the Employer's contributions toward the coverage were terminated;
 - Was one of multiple Plans offered by an employer and the Employee elected a different plan during an open enrollment period or when an employer terminated all similarly situated individuals;
 - Was under an Health Maintenance Organization (HMO) that no longer serves the area in which the Employee lives, works or resides; or,
 - Under the terms of the Plan, the Employee requests the enrollment not later than thirty-one (31) days after date of exhaustion described above, or termination of coverage or Employer contribution described above.
- Medicaid or State Children's Health Insurance Program (SCHIP) Coverage:
 - The Employee or Dependent was covered under a Medicaid or SCHIP plan and coverage was terminated due to loss of eligibility; or,
 - The Employee or Dependent becomes eligible for Premium assistance under a Medicaid or SCHIP plan; and
 - The Employee or Dependent requests such enrollment not more than sixty (60) days after either:

- i. Date of termination of Medicaid or SCHIP coverage; or,
- ii. Determination that the Employee or Dependent is eligible for such assistance.

A Covered Member who's Child becomes eligible to enroll in and revived child health assistance under a SCHIP plan also may disenroll the Child from the Plan of Benefits, pursuant to applicable procedures and deadlines established by the state.

The above list is not an all-inclusive list of situations when an Employee or Dependent loses eligibility. For situations other than those listed above see the Employer.

Eligibility Related Definitions:

Actively at Work

A term describing all permanent, full-time Employees scheduled to work at least thirty-five (35) hours a week or who qualify under the definition of a full-time Employee as established by PPACA. To qualify, you can't be absent from work during the initial enrollment period, because of a leave of absence or temporary lay-off, unless the absence is due to a Health Status-Related Factor.

Child

An Employee's Child, whether a natural Child, adopted Child, foster Child, stepchild, or Child for whom an Employee has legal guardianship. The term "Child" also includes an Incapacitated Dependent and a Child of a divorced or divorcing Employee who, under a Qualified Medical Child Support Order, has a right to enroll under the Employer's Group Health Plan. The term "Child" does not include the Spouse of an eligible Child.

Dependent(s)

An individual who is:

- An Employee's Spouse;
- A Child under the age set forth on the Schedule of Benefits;
- An Incapacitated Dependent.

Enrollment Date

The date of enrollment in the Group Health Plan or the first day of the Probationary Period for enrollment, whichever is earlier.

Grace Period

A period of time as determined by the Employer after the initial due date that the Employer allows for the Covered Member to pay any Premium due.

Member Effective Date

The date on which an Employee or Dependent is covered for Benefits under the terms of the section entitled "Eligibility Requirements" of this Plan of Benefits.

Membership Application

Any mechanism agreed upon by the Corporation and the Employer for transmitting necessary Covered Member enrollment information from the Employer to the Corporation.

Probationary Period

The period of continuous employment with the Employer that an Employee must complete before becoming eligible to enroll in the Plan of Benefits. The Employer may require an additional orientation period.

Probationary Periods and/or contribution levels will not be based on any factor which discriminates in favor of higher wage Employees as required under PPACA.

Special Enrollment

The time period during which an Employee or eligible Dependent who is not enrolled for coverage under this Plan of Benefits may enroll for coverage due to the involuntary loss of other coverage or under permitted circumstances described in this section of the Plan of Benefits.

Spouse

Any individual who is legally married under any state law.

Totally Disabled/Total Disability

Means that the Covered Member is able to perform none of the usual and customary duties of such Covered Member's occupation. With respect to a Covered Member who is a Dependent, the terms refer to disability to the extent that such Covered Member can perform none of the usual and customary duties or activities of a person in good health of the same age. The Covered Member must provide a licensed medical doctor's statement of disability upon periodic request by the Employer's Group Health Plan.

TERMINATION OF THIS PLAN OF BENEFITS

GENERALLY

TERMINATION OF AN EMPLOYEE'S COVERAGE AND ALL OF SUCH EMPLOYEE'S DEPENDENTS' COVERAGE WILL OCCUR ON THE EARLIEST OF THE FOLLOWING CONDITIONS OR ON THE DATE DETERMINED BY THE EMPLOYER:

- The date the Employer's Group Health Plan is terminated pursuant to the remaining terms under this section;
- The date an Employee retires unless the Employer's Group Health Plan covers such individual as a retiree;
- The date an Employee ceases to be eligible for coverage as set forth in the section entitled "Eligibility Requirements";
- The date an Employee is no longer Actively at Work, except that an Employee may be considered Actively at Work during a disability leave of absence for a period not to exceed twelve (12) weeks to run concurrently with medical paid leave or, for a qualified Employee (as qualified under the Family and Medical Leave Act of 1993), during any leave taken pursuant to the Family and Medical Leave Act of 1993;
- In addition to terminating when an Employee's coverage terminates, a Dependent Spouse's coverage terminates on the date of entry of a court order ending the marriage between the Dependent Spouse and the Employee regardless of whether such order is subject to appeal;
- In addition to terminating when an Employee's coverage terminates, a Child's coverage terminates when that individual no longer meets the definition of a Child under this Plan of Benefits;
- In addition to terminating when an Employee's coverage terminates, an Incapacitated Dependent's coverage terminates when that individual no longer meets the definition of an Incapacitated Dependent; or,
- Death of the Employee.

TERMINATION FOR FAILURE TO PAY PREMIUMS

If a Covered Member fails to pay the Premium during the Grace Period, such Covered Member shall automatically be terminated from participation in the Employer's Group Health Plan, without prior notice to such Covered Member.

In the event of termination for failure to pay Premiums, Premiums received after termination will not automatically reinstate the Employee in participation under the Employer's Group Health Plan. If the Employee's participation in the Employer's Group Health Plan is not reinstated, the late Premium will be refunded to the Employee.

TERMINATION WHILE ON LEAVE

During an Employee's leave of absence that is taken pursuant to the Family and Medical Leave Act, the Employer must maintain the same health Benefits as provided to Employees not on leave. The Employee must continue to pay his or her portion of the Premium. If Premiums are not paid by an Employee, coverage ends as of the due date of that Premium contribution.

NOTICE OF TERMINATION TO COVERED MEMBERS

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

REINSTATEMENT

The Employer's Group Health Plan in its discretion (and upon such terms and conditions as any stop-loss carrier or the Employer may determine) may reinstate coverage under the Employer's Group Health Plan that has been terminated for any reason. If a Covered Member's coverage (and including coverage for the Covered Member's Dependents) for Covered Expenses under the Employer's Group Health Plan terminates while the Covered Member is on leave pursuant to the Family and Medical Leave Act because the Covered Member fails to pay such Covered Member's Premium, the Covered Member's coverage will be reinstated without new Probationary Periods if the Covered Member returns to work immediately after the leave period, re-enrolls, and within thirty-one (31) days following such return pays all such Employee's portion of the past due amount and then current Premium.

EMPLOYER IS AGENT OF COVERED MEMBERS

By accepting Benefits, a Covered Member agrees that the Employer is the Covered Member's agent for all purposes of any notice under the Employer's Group Health Plan. The Covered Member further agrees that notifications received from, or given to, the Employer by the Corporation are notification to the Employees except for any notice required by law to be given to the Covered Members by the Corporation.

INTRODUCTION



Kansas City

Dear Member:

Blue Cross and Blue Shield of Kansas City (BCBSKC) is pleased to provide administrative services for your Employer's Group Health Plan as outlined in this Preferred Provider Plan of Benefits BCBSKC provides you and your covered family members with cost-effective healthcare coverage administration both locally and on a nationwide basis.

Please refer to the Benefits outlined in this Plan of Benefits for all your healthcare coverage.

See your Member ID Card for specific phone numbers, including but not limited to:

- Customer Service
- Preauthorization
- Mental Health and Substance Use Disorder

TTY users please call:

- 1-800-735-8583

The Blue Cross and Blue Shield networks offer the best geographic access to Providers and Hospitals of any Participating Provider in the nation. This national coverage is available through the BlueCard Program in which all Blue Cross and Blue Shield Plans participate. For more Provider information visit our website at www.MyHealthToolkitKC.com.

We welcome you to our family of healthcare coverage through BCBSKC and look forward to meeting your healthcare administration needs.

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE

Under your Employer's health Plan, the Benefits you receive will depend on whether the Provider of medical services is a Participating or Non-Participating Provider. You will receive the maximum Benefits that can be paid if you use Participating Providers and you get Preauthorization, when required, before getting medical care. The amount you have to pay will increase when you do not use Participating Providers and if you do not get Preauthorization.

Members of the Blue Cross and Blue Shield Association (BCBSA) attempt to contract with Providers that practice at participating Hospitals. For various reasons, some Providers may elect not to contract as Participating Providers. If you use a Non-Participating Provider, you have no protection from balance billing from the Provider.

BCBSKC (hereafter referred to as Corporation) is the Claims Administrator for this Preferred Provider Plan. BCBSKC has retained BlueCross BlueShield of South Carolina as a primary provider of claims processing, customer service, medical management, and other services.

IMPORTANT INFORMATION

How to get help on Preauthorization:

- 1-888-376-6544

Please do not call these numbers for claims inquiries.

Please note that Preauthorization is required for the procedures on the Schedule of Benefits that have a Preauthorization note.

HOW TO FILE CLAIMS

Participating Providers have agreed to file claims for healthcare services they rendered to you. However, in the event a Provider does not file a claim for such services, it is your responsibility to file the claim. If you choose to use a Non-Participating Provider, you are responsible for filing your claim.

Once the claim has been processed, you will have quick access to an Explanation of Benefits (EOB) through our website or by contacting customer service. An EOB will also be mailed to you. The EOB explains who provided the care, the kind of service or supply received, the amount billed, the Allowable Charge, the Coinsurance rate and the amount paid. It also shows Benefit Year Deductible information and the reasons for denying or reducing a claim.

The only time you must pay a Participating Provider is when you have a Benefit Year Deductible, Coinsurance, Copayment or when you have services or supplies that are not Covered Expenses under your Plan of Benefits.

If you need a claim form, you may obtain one from us at the address below or print a copy from the website. Or, call us at the number listed or website on your Identification Card and we will send you a form. After filling out the claim form, send it to the address below:

BlueCross BlueShield
P.O. Box 100121
Columbia, South Carolina 29202

Please refer to Article VIII of the Plan of Benefits for more information on filing a claim.

SCHEDULE OF BENEFITS

Employer Contract Number: 71-60352-50 and appropriate subgroups

Employer: Commerce Bancshares, Inc.

HDHP

Plan of Benefits Effective Date: January 1, 2017

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of the Plan of Benefits. In the event of a conflict between the Plan of Benefits and this Schedule of Benefits, the Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in the Plan of Benefits.

To maximize your Benefits, seek medical services from a Participating Provider who participates in the Preferred Provider Organization (PPO). Please call 1-800-340-0109 if you are residing or traveling in the Kansas City area or 1-800-810-2583 if you are residing or traveling outside the Kansas City area or access our website at www.MyHealthToolkitKC.com to find out if your Provider is a Participating Provider.

GENERAL PROVISIONS

When a Benefit is listed below and has a dollar or percentage amount associated with it then the Benefit will be provided to Members subject to the terms of the Plan of Benefits. When a Benefit has a "Covered" notation associated with it, the Benefit will pay based on the location of the service (e.g. inpatient, outpatient, office). When a Benefit has a "Non-Covered" notation associated with it, the Benefit is not available to the Member. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.

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| | \$2,000 per Member for Participating Providers. |
| | \$2,000 per Member for Non-Participating Providers. |
| | \$4,000 per family and may be met by any combination of one or more Members for Participating Providers. |
| | \$4,000 per family and may be met by any combination of one or more Members for Non-Participating Providers. |
| Benefit Year Deductible: | Covered Expenses for services rendered by Participating or Non-Participating Providers will be applied only to the Participating Provider Benefit Year Deductible or the Non-Participating Provider Benefit Year Deductible, respectively. |
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| Out-of-Pocket Maximums for Participating Providers: | <p>\$4,000 per Member.</p> <p>\$6,850 per family and may be met by any combination of one or more Members.</p> <p>All Benefit Year Deductibles, Coinsurance and Copayments incurred will contribute to the Out-of-Pocket Maximum.</p> <p>All Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. If Coinsurance does not contribute to the Out-of-Pocket Maximum, the percentage of reimbursement does not change from the amount indicated on the Schedule of Benefits.</p> <p>Coinsurance, Benefit Year Deductibles and Copayments for services rendered by Participating or Non-Participating Providers will be applied only to the Participating Provider Out-of-Pocket Maximum or the Non-Participating Provider Out-of-Pocket Maximum, respectively.</p> |
| Out-of-Pocket Maximums for Non-Participating Providers: | <p>\$7,000 per Member</p> <p>\$14,000+ per family and may be met by any combination of one or more Members.</p> <p>Copayments do not contribute to the Out-of-Pocket Maximum determination.</p> <p>Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. If Coinsurance does not contribute to the Out-of-Pocket Maximum, the percentage of reimbursement does not change from the amount indicated on the Schedule of Benefits.</p> <p>Coinsurance and Benefit Year Deductibles for services rendered by Participating or Non-Participating Providers will be applied only to the Participating Provider Out-of-Pocket Maximum or the Non-Participating Provider Out-of-Pocket Maximum, respectively.</p> |
| This Schedule of Benefits applies during the 01/01 through 12/31 Benefit Year. The Anniversary Date is 01/01. | |
| All Admissions require Preauthorization. If Preauthorization is not obtained, and you or your dependents are still admitted, financial penalties may be assessed for failure to obtain Preauthorization, for Participating Provider Admissions. | |
| Preauthorization is required for the following outpatient Benefits: | |
| Cochlear implants | |
| Prosthetics | |
| Applied Behavioral Analysis (ABA) related to Autism Spectrum Disorder | |
| Please see the Mental Health Services and Substance Use Disorder Services section of the Schedule of Benefits for specific Preauthorization penalties related to those services. | |
| All charges will be denied for human organ and tissue transplant services not performed at a Blue Distinction Center of Excellence or a transplant center approved by the Corporation in writing. | |

| ADMISSIONS/INPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES | | |
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| | Participating Provider | Non-Participating Provider |
| Hospital charges for room and board related to Admissions | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible (Preauthorization is required)</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge (Preauthorization is required)</p> |
| All other Benefits in a Hospital during an Admission (including for example, facility charges related to the administration of anesthesia, obstetrical services including labor and delivery rooms, drugs, medicine, lab and X-ray services) | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible (Preauthorization is required)</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge (Preauthorization is required)</p> |
| Inpatient physical rehabilitation services | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible (Preauthorization is required)</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge (Preauthorization is required)</p> |
| Skilled Nursing Facility Admissions, limited to sixty (60) days per Member per Benefit Year | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible (Preauthorization is required)</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge (Preauthorization is required)</p> |
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| OUTPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES | | |
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| | Participating Provider | Non-Participating Provider |
| Hospital and Ambulatory Surgical Center charges for Benefits provided on an outpatient basis, including: lab, X-ray and other diagnostic services | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Emergency room | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Surgery | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Maternity | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |

| PROVIDER SERVICES OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES | | |
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| | Participating Provider | Non-Participating Provider |
| Provider Services in a Hospital | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Surgical Services, when rendered in a Hospital, Provider's office or Ambulatory Surgical Center | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Outpatient Provider Services for lab, X-ray and other diagnostic services | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Provider Services for treatment in a Hospital outpatient department or Ambulatory Surgical Center | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Provider's Services in the office, including contraceptives and birth control devices* (excluding physical therapy, speech therapy and occupational therapy) | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |

*Contraceptives and birth control devices covered under the Patient Protection and Affordable Care Act (PPACA) will pay at 100% of the Allowable Charge at Participating Providers. No Benefits are payable at Non-Participating Providers.

| MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES | | |
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| Preauthorization is required for Mental Health Services and Substance Use Disorder Services. | | |
| | Participating Provider | Non-Participating Provider |
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| Inpatient Hospital charges for Mental Health Services and Substance Use Disorder Services | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible (Preauthorization is required)</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge (Preauthorization is required)</p> |
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| Residential Treatment Center | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible (Preauthorization is required)</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge (Preauthorization is required)</p> |
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| Outpatient Hospital or clinic charges for Mental Health Services and Substance Use Disorder Services | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
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| Inpatient Provider charges for Mental Health Services and Substance Use Disorder Services | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
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| Outpatient or office Provider charges for Mental Health Services and Substance Use Disorder Services | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
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| Outpatient Hospital Emergency room charges for Mental Health Services and Substance Use Disorder Services | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
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| OTHER SERVICES | | |
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| | Participating Provider | Non-Participating Provider |
| Ambulance service (including air ambulance) | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Durable Medical Equipment and Orthopedic Devices | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Prosthetic devices, limited to a single purchase of each type of Prosthetic Device per Member every three (3) years (if purchase or rental of Durable Medical Equipment is \$500 or more, Preauthorization is required) | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Ostomy supplies, limited to a Maximum Payment of \$2,500 per Member per Benefit Year | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Medical Supplies | Covered | Covered |
| Home Health Care, limited to forty (40) visits per Member per Benefit Year | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |

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| Hospice Care | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| ABA related to Autism Spectrum Disorder | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible (Preauthorization is required)</p> | Non-Covered |
| Habilitation related to physical therapy (limited to twenty four (24) visits per Member per Benefit Year. Please see the "Outpatient Rehabilitation" section in Article II of the Plan of Benefits for limitations) | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Rehabilitation related to physical therapy (limited to twenty four (24) visits per Member per Benefit Year. Please see the "Outpatient Rehabilitation" section in Article II of the Plan of Benefits for limitations) | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Habilitation related to occupational therapy (limited to twenty four (24) visits per Member per Benefit Year. Please see the "Outpatient Rehabilitation" section in Article II of the Plan of Benefits for limitations) | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Rehabilitation related to occupational therapy (limited to twenty four (24) visits per Member per Benefit Year. Please see the "Outpatient Rehabilitation" section in Article II of the Plan of Benefits for limitations) | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |

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| Habilitation related to speech therapy (limited to twenty four (24) visits per Member per Benefit Year. | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Rehabilitation related to speech therapy (limited to twenty four (24) visits per Member per Benefit Year. | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Pulmonary rehabilitation therapy, limited to twenty four (24) visits per Member per Benefit Year | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| <p>Human organ and tissue transplant services</p> <p>Human organ and tissue transplant services are only covered if provided at a Blue Distinction® Center of Excellence or a transplant center approved by the Corporation in writing</p> <p>Provider charges are subject to the Benefit Year Deductible.</p> | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible (Preauthorization is required)</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge (Preauthorization is required)</p> |
| Travel and lodging for human organ and tissue transplant services for recipients and their family members, limited to \$10,000 per Member per lifetime | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |

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| Allergy injections | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Rehabilitation related to chiropractic services, including spinal manipulation/subluxation, related X-rays, modalities and office visits, limited to twenty four (24) visits per Member per Benefit Year | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Obesity services | Covered | Covered |
| Morbid obesity services | Covered | Covered |
| Surgical services for the treatment of morbid obesity | Non-Covered | Non-Covered |
| Infertility, limited to diagnosis, testing and treatment of the underlying medical condition | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Accidental dental, limited to a Maximum Payment of \$900 per tooth per Member per Benefit Year and \$3,000 per Member per Benefit Year | Covered | Covered |
| Cardiac rehabilitation, limited to twenty four (24) visits per Member per Benefit Year | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |

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| <p>Cochlear implants, limited to one (1) initial implant per ear per Member and a second (2nd) cochlear implant after ten (10) years from the initial placement</p> <ul style="list-style-type: none"> • Replacements for external cochlear implant components, after three (3) years of use if damaged or broken, limited to a Maximum Payment of \$15,000 per Member per three (3) years • Remapping, monitoring, reprogramming and rehabilitation services <p>(Please see the “Cochlear Implants” section in Article II of the Plan of Benefits for further limitations)</p> | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible (Preauthorization is required)</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge (Preauthorization is required)</p> |
| Gender dysphoria | Covered (Preauthorization is required) | Covered (Preauthorization is required) |
| Gender reassignment services, limited to a Maximum Payment of \$75,000 per Member per lifetime | Covered (Preauthorization is required) | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge (Preauthorization is required)</p> |
| Hearing aids & hearing aid exams, limited to a Maximum Payment of \$5,000 per Member per lifetime | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| Urgent care | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |

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| Wigs after cancer treatment | <p>The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p> | <p>The Employer pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p> |
| | | |

| PREVENTIVE BENEFITS The Benefit Year Deductible does not apply to these Benefits | | |
|--|--|-----------------------------------|
| | Participating Provider | Non-Participating Provider |
| Preventive Benefits under the Patient Protection and Affordable Care Act (PPACA) (Refer to www.healthcare.gov for guidelines) | Covered | Non-Covered |
| SUSTAINED HEALTH SERVICES This Benefit does not include preventive Benefits offered under the Patient Protection and Affordable Care Act (PPACA). Payment will be made for the PPACA preventive Benefits prior to Sustained Health services. See the preventive Benefits section in this Schedule of Benefits for payment of preventive Benefits under the PPACA. | | |
| | Participating Provider | Non-Participating Provider |
| Pap smear screenings (the report and interpretation only), limited to one (1) per Member per Benefit Year* | The Employer pays 100% of the Allowable Charge | Non-Covered |
| Physical exam, including well women exams, limited to one (1) per Member per Benefit Year | The Employer pays 100% of the Allowable Charge | Non-Covered |
| Prostate screenings, limited to one (1) per Member per Benefit Year* | The Employer pays 100% of the Allowable Charge | Non-Covered |
| Well Child Care performed in the Provider's office and immunizations for dependents | The Employer pays 100% of the Allowable Charge | Non-Covered |
| Immunizations | The Employer pays 100% of the Allowable Charge | Non-Covered |
| Flu shots, including Flu Mist | The Employer pays 100% of the Allowable Charge | Non-Covered |
| Routine bone density screenings* | The Employer pays 100% of the Allowable Charge | Non-Covered |
| Routine colonoscopies* | The Employer pays 100% of the Allowable Charge | Non-Covered |

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| Mammography screenings, for any female Member age forty (40) or older* | The Employer pays 100% of the Allowable Charge | Non-Covered |
| | | |
| Preventive labwork | The Employer pays 100% of the Allowable Charge | Non-Covered |
| | | |

*Family history diagnosis is considered preventive, and eligible for mammograms, pap smears, prostate screening, colonoscopies, and bone density screenings.

| PRESCRIPTION DRUG BENEFIT | | | |
|---|---|---|--|
| Prescription Drugs | Mail Service Pharmacy | Participating Pharmacy | All Other Pharmacies |
| Generic Drugs | The Member pays 10% of the Allowable Charge for each prescription or refill after the Benefit Year Deductible*, up to a 90 day supply | The Member pays 10% of the Allowable Charge for each prescription or refill after the Benefit Year Deductible*, up to a 31 day supply | Non-Covered |
| Preferred Brand Drug | The Member pays 10% of the Allowable Charge for each prescription or refill after the Benefit Year Deductible*, up to a 90 day supply | The Member pays 10% of the Allowable Charge for each prescription or refill after the Benefit Year Deductible*, up to a 31 day supply** | Non-Covered |
| Non-Preferred Brand Drug | The Member pays 10% of the Allowable Charge for each prescription or refill after the Benefit Year Deductible*, up to a 90 day supply | The Member pays 10% of the Allowable Charge for each prescription or refill after the Benefit Year Deductible*, up to a 31 day supply** | Non-Covered |
| <p>***Contraceptives: oral contraceptives, cervical cap, diaphragms, emergency contraception, female condom, implantable rod, intrauterine device (IUD), patch, shot/injection, spermicide, sponge, vaginal contraceptive ring and approved sterilization procedures for women</p> <p>A complete list of specific Prescription Drugs or supplies covered at 100% is available at www.MyHealthToolkitKC.com</p> | Prescription Drugs will be covered at 100%, up to a 90 day supply | Prescription Drugs will be covered at 100%, up to a 31 day supply | The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 100%, up to a 31 day supply |
| ****All other contraceptives (Prescription Drugs) | Covered | Covered | Non-Covered |
| Sexual dysfunction Prescription Drugs, limited to six (6) pills per Member per thirty (30) days | Covered | Covered | Non-Covered |

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|---|---|---|-------------|
| Tobacco cessation Prescription Drugs as identified by the Affordable Care Act (ACA), including Over-the-Counter Drugs | Covered | Covered | Non-Covered |
| Obesity/weight control Prescription Drugs | Non-Covered | Non-Covered | Non-Covered |
| Infertility Prescription Drugs | Non-Covered | Non-Covered | Non-Covered |
| Cosmetic Prescription Drugs | Non-Covered | Non-Covered | Non-Covered |
| Prescription Drug deductible | \$0 (No Prescription Drug deductible) | \$0 (No Prescription Drug deductible) | Non-Covered |
| Prescription Drug out-of-pocket | \$0 (No Prescription Drug out-of-pocket) | \$0 (No Prescription Drug out-of-pocket) | Non-Covered |
| Maximum Prescription Drug Benefit | \$0 (No maximum Prescription Drug Benefit) | \$0 (No maximum Prescription Drug Benefit) | Non-Covered |
| Diabetic syringes and supplies | Covered | Covered | Non-Covered |
| Syringes and related supplies for conditions such as cancer or burns, test tape, surgical trays and renal dialysis supplies | Non-Covered | Non-Covered | Non-Covered |
| Lilly and novo insulin products | The Member pays 10% of the Allowable Charge for each prescription or refill after the Benefit Year Deductible*, up to a 90 day supply | The Member pays 10% of the Allowable Charge for each prescription or refill after the Benefit Year Deductible*, up to a 31 day supply | Non-Covered |
| <p>*Covered Expenses for Prescription Drugs are integrated with the Benefit Year Deductible.</p> <p>**Including Specialty Drugs.</p> <p>***Contraceptives listed above are covered under the participating medical Benefits at the same payment levels. Refill quantities for the contraceptives listed above may vary.</p> <p>****All other contraceptives are paid at the Generic, Preferred Brand and Non-Preferred Brand Drug payment levels.</p> | | | |

PREFERRED PROVIDER PLAN OF BENEFITS

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ARTICLE I - DEFINITIONS

Capitalized terms that are used in this Plan of Benefits shall have the following defined meanings:

Accountable Care Organization (ACO): a group of healthcare Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their Member populations.

Administrative Expense Allowance (AEA) Fee: the AEA Fee is a fixed per-claim dollar amount charged by the Host Blue to Corporation for administrative services the Host Blue provides in processing claims for Employer's Members. The dollar amount is normally based on the type of claim (e.g. institutional, professional, international, etc.) and can also be based on the size of your group enrollment. The amount of the AEA Fee is listed on the Schedule A.

Admission: the period of time between a Member's Admission as a patient into a Hospital or Skilled Nursing Facility and the time the Member leaves or is discharged.

Adverse Benefit Determination: any denial, reduction or termination of, or failure to provide or make (in whole or in part) payment for a claim for Benefits, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a Plan, and including a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for a Benefit which results from the application of any utilization review as well as a failure to cover an item or services for which Benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate. An Adverse Benefit Determination includes any cancellation or discontinuance of coverage that has retroactive effect (whether or not there is an adverse effect on any particular Benefit), except to the extent attributable to a failure to pay any required premiums or Employee contributions.

Allowable Charge: the amount the Corporation or a licensee of the Blue Cross and Blue Shield Association (BCBSA) agrees to pay a Participating Provider or Non-Participating Provider as payment in full for a service, procedure, supply or equipment. For a Non-Participating Provider, (i) the Allowable Charge shall not exceed the Maximum Payment and (ii) in addition to the Member's liability for Benefit Year Deductibles, Copayments and/or Coinsurance, the Member may be balance billed by the Non-Participating Provider for any difference between the Allowable Charge and the Billed Charge.

Alternate Recipient: any child who is recognized under a Medical Child Support Order as having a right to enroll in this Plan of Benefits.

Ambulatory Surgical Center: a licensed facility that:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
2. Provides treatment by or under the supervision of licensed medical doctors or oral surgeons and provides nursing services when the Member is in the facility;
3. Does not provide inpatient accommodations; and,
4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a licensed medical doctor or oral surgeon.

Ambulatory Surgical Center includes an endoscopy center.

Applied Behavioral Analysis (ABA): behavioral modification to target cognition, language and social skills.

Autism Spectrum Disorder: the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

1. Autistic Disorder;
2. Asperger's Syndrome;
3. Pervasive Developmental Disorder-not otherwise specified.

Behavioral Health Provider: a Provider who renders Mental Health Services and/or Substance Use Disorder Services.

Benefit Year: the period of time set forth on the Schedule of Benefits. The initial Benefit Year may be more or less than twelve (12) months.

Benefit Year Deductible: the amount, if any, listed on the Schedule of Benefits that must be paid by the Member each Benefit Year before the Employer's Group Health Plan will pay Covered Expenses. The Benefit Year Deductible is subtracted from the Allowable Charge before Coinsurance is calculated. Members must refer to the Schedule of Benefits to determine if the Benefit Year Deductible applies to the Out-of-Pocket Maximum.

Benefit(s): medical services or Medical Supplies that are:

1. Medically Necessary;
2. Preauthorized (when required under this Plan of Benefits or the Schedule of Benefits);
3. Included in this Plan of Benefits;
4. Not limited or excluded under the terms of this Plan of Benefits.

Benefits available under this Plan of Benefits are listed in Article II.

Benefits Checklist: the document completed by the Employer and submitted to the Corporation which outlines the Benefits to be offered under the Employer's Group Health Plan. The Corporation shall administer the Group Health Plan in accordance with the terms of the Benefits Checklist.

Billed Charges: the actual charges as billed by a Provider.

BlueCard® Program: a program in which all members of the BCBSA participate. Details of the BlueCard Program are more fully set forth in Article IX.

Brand Name Drug: a Prescription Drug that is manufactured under a registered trade name or trademark.

Care Coordination: organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.

Care Coordinator: an individual within a Provider organization who facilitates Care Coordination for patients.

Care Coordinator Fee: a fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination under a VBP.

Claims Amount: the amount paid (or payable) for Members' claims (including fees such as Access Fees, AEA Fees and amounts paid as part of a VBP or in settlement of claims or in satisfaction of a judgement).

Clinical Trials: an approved Clinical Trial is one that is approved or funded through the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services (CMS), the Department of Defense (DOD), the Department of Veterans Affairs (VA), a qualified non-governmental research entity identified in the guidelines issued by the NIH or is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA).

COBRA: those provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended, which require certain Employers to offer continuation of healthcare coverage to Employees and dependents of Employees who would otherwise lose coverage.

COBRA Administrator: the Corporation or its designated subcontractor (who the Corporation has contracted with to provide administrative Services related to COBRA). For purposes of this Agreement, the COBRA Administrator may also provide Direct Billing Services as outlined in the Agreement and Plan of Benefits if applicable.

Coinsurance: the sharing of Covered Expenses between the Member and the Employer's Group Health Plan. After the Member's Benefit Year Deductible requirement is met, the Employer's Group Health Plan will pay the percentage of Allowable Charges as set forth on the Schedule of Benefits. The Member is responsible for the remaining percentage of the Allowable Charge. Coinsurance is calculated after any applicable Benefit Year Deductible or Copayment is subtracted from the Allowable Charge based upon the network charge or the lesser charge of the Provider.

For Prescription Drug Benefits, Coinsurance means the amount payable by the Member calculated as follows:

1. The percentage listed on the Schedule of Benefits; multiplied by,
2. The amount listed in the Participating Provider's schedule of allowance for that item calculated at the time of sale;

Without regard to any Credit or allowance that may be received by the Corporation.

Companion Benefit Alternatives (CBA): a behavioral healthcare company. CBA is responsible for managing behavioral healthcare Services, including pre-certifying Mental Health and Substance Use Disorder Benefits for inpatient and outpatient Services. CBA is an independent company that provides behavioral healthcare on behalf of BCBSKC.

Concurrent Care: an ongoing course of treatment to be provided over a period of time or number of treatments.

Congenital Disorder/Congenital Disease: a condition documented as existing at birth regardless of cause.

Continued Stay Review: the review that must be obtained by a Member (or the Member's representative) regarding an extension of an Admission to determine if an Admission for longer than the time that was originally Preauthorized is Medically Necessary (when required). The Continued Stay Review process is outlined in Article II.

Copayment: the amount, if any, specified on the Schedule of Benefits that the Member must pay directly to the Provider each time the Member receives Benefits.

Corporation: Blue Cross and Blue Shield of Kansas City (BCBSKC).

Covered Expenses: the amount payable by the Employer's Group Health Plan for Benefits. The amount of Covered Expenses payable for Benefits is determined as set forth in this Plan of Benefits and at the percentages set forth on the Schedule of Benefits. Covered Expenses are subject to the limitations and requirements set forth in the Plan of Benefits and on the Schedule of Benefits. Covered Expenses will not exceed the Allowable Charge.

Credit(s): rebates and/or other amounts which may be received by the Corporation from drug manufacturers and/or through a Pharmacy Benefit Manager. Credits are not payable to Members and will be retained by the Corporation to help stabilize overall rates and to offset expenses.

Reimbursements to a Participating Pharmacy, or discounted prices charged at pharmacies, are not affected by these Credits. Any Coinsurance that a Member must pay for Prescription Drugs is based upon the Allowable Charge at the pharmacy, and does not change due to receipt of any Credit by the Corporation. Prescription Drug Copayments are not affected by any Credit.

Custodial Care: non-skilled services that are primarily for the purpose of assisting an individual with daily living activities or personal needs (e.g., bathing, dressing, eating), which is not specific therapy for any illness or injury.

Discount Services: from time to time Benefits in the form of discounts for certain Provider Services or products will be provided to Members by networks of complementary healthcare Providers with which the administrator has an agreement for various programs. **This discount applies to services the health Plan does not cover.** The Corporation will not be responsible for any costs associated with these programs. The services available may include, but are not limited to: chiropractors, massage therapists, acupuncturists, fitness clubs and hearing aids.

To find a participating network hearing aid Provider in your area, call 1-800-235-8663 or you may check the Corporation's website. To find any other participating network Provider in your area for the services listed above, you may call 1-877-327-2746 or you may check the Corporation's website for a list of participating network Providers. You only need to show your ID card when you receive the service. The discount will be given to you at that time and there will be no claims to be filed.

Durable Medical Equipment (DME): medical equipment that:

1. Can withstand repeated use;
2. Is Medically Necessary;
3. Is customarily used for the treatment of a Member's illness, injury, disease or disorder;
4. Is appropriate for use in the home;
5. Is not useful to a Member in the absence of illness or injury;
6. Does not include appliances that are provided solely for the Member's comfort or convenience;
7. Is a standard, non-luxury item (as determined by the Employer's Group Health Plan); and,
8. Is ordered by a licensed medical doctor, oral surgeon, podiatrist or osteopath.

Prosthetic Devices, Orthopedic Devices and Orthotic Devices are considered Durable Medical Equipment when the required Preauthorization is obtained.

Emergency: an unexpected and usually dangerous situation that calls for immediate action.

Emergency Admission Review: the review that must be obtained by a Member (or the Member's representative) within twenty-four (24) hours of or by the end of the first working day after the commencement of an Admission to a Hospital to treat an Emergency Medical Condition. The Emergency Admission Review process is outlined in Article II.

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

1. Placing the health of the Member, or with respect to a pregnant Member, the health of the Member or her unborn child, in serious jeopardy;
2. Serious impairment to bodily functions; or,
3. Serious dysfunction of any bodily organ or part.

Emergency Services: services, supplies and treatment for stabilization, evaluation and/or initial treatment of an Emergency Medical Condition when provided on an outpatient basis at a Hospital Emergency room or department.

Employee: any Employee of the Employer who is eligible for coverage and who is so designated to the Corporation by the Employer, even if such classification is determined to be erroneous or is retroactively revised.

Employer: the entity providing this Plan of Benefits.

Employer's Effective Date: the date the Corporation begins to provide Services under this Agreement.

Employer's Group Health Plan: the Group Health Plan adopted by the Employer as the Plan Sponsor. This Plan of Benefits outlines certain terms of the Employer's Group Health Plan.

ERISA: the Employee Retirement Income Security Act of 1974, as amended.

Generic Drug: a Prescription Drug that has a chemical structure that is identical to and has the same bio-equivalence as a Brand Name Drug but is not manufactured under a registered brand name or trademark or sold under a brand name. The Pharmacy Benefit Manager has the discretion to determine if a Prescription Drug is a Generic Drug.

Global Payment/Total Cost of Care: a payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and Prescription Drugs.

Group Health Plan: an Employee welfare Benefit Plan to the extent that such Plan provides health Benefits to Employees or their dependents, as defined under the terms of such Group Health Plan, directly or through insurance, reimbursement or otherwise. This Plan of Benefits is a Group Health Plan.

HIPAA: the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Agency: an agency or organization licensed by the appropriate state regulatory agency to provide Home Health Care.

Home Health Care: part-time or intermittent nursing care, health aide services, or physical, occupational or speech therapy provided or supervised by a Home Health Agency and provided to a home-bound Member in such Member's private residence.

Hospice Care: care for terminally ill patients under the supervision of a licensed medical doctor, and is provided by an agency that is licensed or certified as a hospice or Hospice Care agency by the appropriate state regulatory agency.

Hospital: a short-term, acute care facility licensed as a Hospital by the state in which it operates. A Hospital is primarily engaged in providing medical, surgical or acute behavioral health diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of licensed Providers, and continuous twenty-four (24) hour-a-day services by licensed, registered, graduate nurses physically present and on duty. The term Hospital does not include Long Term Acute Care Hospitals, chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Hospital. A Hospital may participate in a teaching program. This means medical students, interns or residents participating in a teaching program may treat Members.

Identification Card: the card issued by the Corporation to a Member that contains the Member's identification number.

Incapacitated Dependent: a child who is:

1. Incapable of financial self-sufficiency by reason of mental or physical disability; and,
2. Dependent upon the Employee for at least fifty-one (51) percent of his or her support and maintenance.

A child must meet both of these requirements to qualify as an Incapacitated Dependent. The Employee will update items (1) and (2) each year or upon the Corporation's request. A child who is not incapacitated by the maximum dependent child age will not be covered.

Investigational or Experimental: surgical or medical procedures, supplies, devices or drugs which, at the time provided, or sought to be provided, are in the judgment of the Corporation, not recognized as conforming to generally accepted medical or behavioral health practice in the United States, or the procedure, drug or device:

1. Has not received required final approval in the United States to market from appropriate government bodies;
2. Is one about which the peer-reviewed medical literature in the United States does not permit conclusions concerning its effect on health outcomes;
3. Is not demonstrated in the United States to be superior to established alternatives;
4. Has not been demonstrated in the United States to improve net health outcomes; or,
5. Is one in which the improvement claimed is not demonstrated in the United States to be obtainable outside the Investigational or Experimental setting.

Legal Intoxication/Legally Intoxicated: the Member's blood alcohol level was at or in excess of the amount established under applicable state law to create a presumption and/or inference that the Member was under the influence of alcohol, when measured by law enforcement or medical personnel.

Long-Term Acute Care Hospital: a long-term, acute care facility licensed as a long term care Hospital by the state in which it operates and which meets the other requirements of this definition. A Long-Term Acute Care Hospital provides highly skilled nursing, therapy and medical treatment to Members (typically over an extended period of time) although such Members may no longer need general acute care typically provided in a Hospital. A Long-Term Acute Care Hospital is primarily engaged in providing diagnostic services and medical treatment to Members with chronic diseases or complex medical conditions. The term Long-Term Acute Care Hospital does not include chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Long-Term Acute Care Hospital. A Long-Term Acute Care Hospital may participate in a teaching program. This means medical students, interns, or residents participating in a teaching program may treat Members.

Mail Service Pharmacy: a pharmacy maintained by the Pharmacy Benefit Manager that fills prescriptions and sends Prescription Drugs by mail.

Maximum Payment: the maximum amount the Employer's Group Health Plan will pay (as determined by the Corporation) for a particular Benefit. The Maximum Payment will not be affected by any Credit. The Maximum Payment will be one of the following as determined by the Corporation in its discretion:

1. The actual charge submitted to the Corporation for the service, procedure, supply or equipment by a Provider;
2. An amount based upon the reimbursement rates established by the Plan Sponsor in its Benefits Checklist;
3. An amount that has been agreed upon in writing by a Provider and the Corporation or a member of the Blue Cross and Blue Shield Association;
4. An amount established by the Corporation, based upon factors including, but not limited to, (i) governmental reimbursement rates applicable to the service, procedure, supply or equipment, or (ii) reimbursement for a comparable or similar service, procedure, supply or equipment, taking into consideration the degree of skill, time and complexity involved; geographic location and circumstances giving rise to the need for the service, procedure, supply or equipment; or,
5. The lowest amount of reimbursement the Corporation allows for the same or similar service, procedure, supply or equipment when provided by a Participating Provider.

Medical Child Support Order: any judgment, decree or order (including an approved settlement agreement) issued by a court of competent jurisdiction or a national medical support notice issued by the applicable state agency which:

1. Provides child support with respect to a child or provides for health benefit coverage to a child, is made pursuant to a state domestic relations law (including a community property law) and relates to the Plan of Benefits;
2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a Group Health Plan.

A Medical Child Support Order must clearly specify:

1. The name and the last known mailing address (if any) of each participant Employee and the name and mailing address of each Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Group Health Plan to each such Alternate Recipient or the manner in which such type of coverage is to be determined;

3. The period to which such order applies; and,
4. Each Group Health Plan to which such order applies.

If the Medical Child Support Order is a national medical support notice, the order must also include:

1. The name of the issuing agency;
2. The name and mailing address of an official or agency that has been substituted for the mailing address of any Alternate Recipient; and,
3. The identification of the underlying Medical Child Support Order.

A Medical Child Support Order meets the requirement of this definition only if such order does not require a Group Health Plan to provide any type or form of the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993).

Medical Supplies: supplies that are:

1. Medically Necessary;
2. Prescribed by a Provider acting within the scope of his or her license;
3. Are not available on an over-the-counter basis (unless such supplies are provided to a Member in a Provider's office and should not (in the Corporation's discretion) be included as part of the treatment received by the Member); and,
4. Are not prescribed in connection with any treatment or Benefit that is excluded under this Plan of Benefits.

Medically Necessary/Medical Necessity: health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical or behavioral health practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
3. Not primarily for the convenience of the patient, patient's caregiver(s) or Provider; and,
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

All requirements of the above-referenced definition must be met in order for a health care service to be deemed Medically Necessary. The failure of a health care service to meet any one of the above referenced requirements means, in the discretion of the Corporation or CBA, the health care service does not meet the definition of Medically Necessary/Medical Necessity.

For the purposes of determining Medically Necessary/Medical Necessity:

1. The Corporation and CBA have the discretion to utilize and rely upon any medical and behavioral health (which includes substance use and mental health) standards, policies, guidelines, criteria,

protocols, manuals, publications, studies or literature (herein collectively referred to as "criteria"), whether developed by them or others, which in their discretion are determined to be generally accepted by the medical and/or behavioral health community;

2. "Generally accepted standards of medical or behavioral health practice" means United States standards that are based on credible scientific evidence published in peer-reviewed medical and/or behavioral health literature generally recognized by the relevant United States medical or behavioral health community, physician or behavioral health specialty society recommendations, and/or any other factors deemed relevant in the discretion of the Corporation or CBA; and,
3. The Corporation and CBA may use, including but not limited to, Corporate Administrative Medical ("CAM") Policies, Technology Evaluation Center ("TEC") Assessments, Behavioral Health Care Utilization Management Criteria and/or any Care Guidelines or criteria by MCG Health, LLC or affiliated companies which reflect and are clinically appropriate health care services and generally accepted standards of medical and behavioral health practice. MCG Health, LLC and/or its affiliated companies are independent companies that develop evidence based guidelines and criteria for medical, behavioral health and insurance industries to interpret clinical determinations and determine the Medical Necessity and appropriateness of requested services, procedures, devices and supplies.

Member: an Employee or dependent who has enrolled under this Plan of Benefits.

Mental Health Services: treatment (except Substance Use Disorder Services) that is defined, described or classified as a psychiatric disorder or condition in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and which is not otherwise excluded by the terms and conditions of this Plan of Benefits.

Natural Teeth: teeth that:

1. Are free of active or chronic clinical decay;
2. Have at least 50% bony support;
3. Are functional in the arch; and,
4. Have not been excessively weakened by multiple dental procedures; or,
5. Teeth that have been treated for one (1) or more of the conditions referenced in 1-4 above, and as a result of such treatment have been restored to normal function.

Negotiated Arrangement/Negotiated National Account Arrangement: an agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

Non-Participating Provider: any Provider who does not have a current, valid Provider Agreement with the Corporation or another member of the BCBSA.

Non-Preferred Drug: a Prescription Drug that bears a recognized brand name of a particular manufacturer but does not appear on the list of Preferred Brand Drugs and has not been chosen by the Corporation or its designated Pharmacy Benefit Manager to be a Preferred Drug, including any Brand Name Drug with an "A" rated Generic Drug available.

Orthopedic Device: any ridged or semi-ridged leg, arm, back or neck brace and casting materials that are directly used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

Orthotic Device: any device used to mechanically assist, restrict or control function of a moving part of the Member's body.

Out-of-Pocket Maximum: the maximum amount (if listed on the Schedule of Benefits) of otherwise Covered Expenses incurred during a Benefit Year that a Member will be required to pay.

Over-the-Counter Drug: a drug that does not require a prescription.

Participating Pharmacy: a pharmacy that has a contract with the Corporation, Employer or with the Pharmacy Benefit Manager to provide Prescription Drugs to Members.

Participating Provider: a Provider who has a current, valid Provider Agreement related to this Plan of Benefits.

Patient-Centered Medical Home (PCMH): a model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

Pharmacy Benefit Manager: an entity that has contracted with the Employer or with the Corporation and is responsible for the administration of the Prescription Drug Benefit in accordance with the Employer's Group Health Plan.

Plan: any program that provides Benefits or services for medical or dental care or treatment, including:

1. Individual or group coverage, whether insured or self-insured. This includes, but is not limited to, prepayment, group practice or individual practice coverage; and,
2. Coverage under a governmental Plan or coverage required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan for purposes of this Plan of Benefits. If a Plan has two (2) or more parts and the coordination of benefit rules in Article IV apply only to one (1) of the parts, each part is considered a separate Plan.

Plan Administrator: the entity charged with the administration of the Plan of Benefits. The Employer is the Plan Administrator of this Plan of Benefits.

Plan of Benefits: the Benefit booklet provided by the Corporation to the Employer which, attached hereto as Exhibit A, reflects the Corporation's understanding of the Benefits offered under the Employer's Group Health Plan based on the Benefits Checklist completed by the Employer and submitted to the Corporation. The Plan of Benefits includes the Schedule of Benefits and all endorsements, amendments, riders or addenda.

Plan of Benefits Effective Date: 12:01 a.m. on the date listed on the Schedule of Benefits.

Plan Sponsor: the party sponsoring a Plan of Benefits. The Employer is the Plan Sponsor of the Employer's Group Health Plan.

Post-Service Claim: any claim for a Benefit that is not a Pre-Service Claim.

PPACA: the Patient Protection and Affordable Care Act of 2010, as amended.

Preadmission Review: the review that must be obtained by a Member (or the Member's representative) prior to all Admissions that are not related to an Emergency Medical Condition. The Preadmission Review process is outlined in Article II.

Preauthorized/Preauthorization: the approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Member. Preauthorization means only that the Benefit is Medically Necessary. Preauthorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Member. Notwithstanding Preauthorization, payment for Benefits is subject to a Member's eligibility and all other limitations and exclusions contained in this Plan of Benefits. A Member's entitlement to Benefits is not determined until the Member's claim is processed. The Preauthorization process is outlined in Article II.

Preferred Brand Drug: a Prescription Drug that bears a recognized brand name of a particular manufacturer and appears on the list of Preferred Brand Drugs.

Preferred Drug: a Prescription Drug that has been reviewed for cost effectiveness, clinical efficacy and quality that is preferred by the Pharmacy Benefit Manager, for dispensing to Members. Preferred Drugs are subject to periodic review and modification by the Corporation, or its designated Pharmacy Benefit Manager, and include Brand Name Drugs and Generic Drugs.

Prescription Drug: a drug or medicine that is:

1. Required to be labeled that it has been approved by the Food and Drug Administration; and,
2. Bears the legend "Caution: Federal Law prohibits dispensing without a prescription" prior to being dispensed or delivered, or labeled in a similar manner; or,
3. Insulin.

Additionally, to qualify as a Prescription Drug, the drug must:

1. Be prescribed by a licensed Provider acting within the scope of his or her license;
2. Not be entirely consumed at the time and place where the prescription is dispensed; and,
3. Be purchased for use outside a Hospital.

Certain Over-the-Counter Drugs may be designated as Prescription Drugs, at the discretion of the Corporation. Such designated Over-the-Counter Drugs will be listed on the PDL.

Prescription Drug List (PDL): a listing of drugs approved for a specific level of Benefits by the Corporation, under the Plan of Benefits. This list shall be developed and subject to periodic review and modification by the Corporation. The most up-to-date version of the PDL is available on the Corporation's website.

Prescription Drug Preauthorization Program: programs that prohibit patients from obtaining medications until approvals have been obtained.

Pre-Service Claim: any request for a Benefit where Preauthorization must be obtained before receiving the medical care, service or supply.

Primary Plan: a Plan whose Benefits must be determined without taking into consideration the existence of another Plan.

Private Duty Nursing (PDN): hourly or shift skilled nursing care provided in a patient's home. PDN provides more individual and continuous skilled care than can be provided in a skilled nurse visit through a Home Health Agency. The intent of PDN is to assist the patient with complex direct skilled nursing care, to develop caregiver competencies through training and education, and to optimize patient health status and outcomes. The frequency and duration of PDN services is intermittent and temporary in nature and is not intended to be provided on a permanent ongoing basis. PDN is not long-term care.

Prosthetic Device: any device that replaces all or part of a missing body organ or body member, except a wig, hairpiece or any other artificial substitute for scalp hair.

Protected Health Information (PHI): has the same meaning as the term is defined under HIPAA.

Provider: any person or entity licensed by the appropriate state regulatory agency and legally entitled to practice within the scope of such person or entity's license in the practice of any of the following:

1. Medicine;
2. Dentistry;
3. Optometry;
4. Podiatry;
5. Chiropractic services;
6. Behavioral health;
7. Physical therapy;
8. Oral surgery;
9. Speech therapy;
10. Occupational therapy; or,
11. Osteopathy.

The term Provider also includes a Hospital, a Rehabilitation Facility, a Skilled Nursing Facility, a physician assistant and nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a licensed medical doctor or oral surgeon. The term Provider does not include interns, residents, in-house physicians, physical trainers, lay midwives or masseuses.

Provider Agreement: an agreement between the Corporation (or another member of the BCBSA) and a Provider under which the Provider has agreed to accept an allowance (as set forth in the Provider Agreement) as payment in full for Benefits and other mutually acceptable terms and conditions.

Provider Incentive: an additional amount of compensation paid to a healthcare Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

Provider Services: includes the following services:

- A. When performed by a Provider or a Behavioral Health Provider within the scope of his or her license, training and specialty and within the scope of generally acceptable medical standards as determined by the Corporation:

1. Office visits, which are for the purpose of seeking or receiving care for an illness or injury; or,
 2. Basic diagnostic services and machine tests.
- B. When performed by a licensed medical doctor, osteopath, podiatrist or oral surgeon, but specifically excluding such services when performed by a chiropractor, optometrist, dentist, physical therapist, speech therapist, occupational therapist or licensed psychologist with a doctoral degree:
1. Benefits rendered to a Member in a Hospital or Skilled Nursing Facility;
 2. Benefits rendered in a Member's home;
 3. Surgical Services;
 4. Anesthesia services, including the administration of general or spinal block anesthesia;
 5. Radiological examinations;
 6. Laboratory tests; and,
 7. Maternity services, including consultation, prenatal care, conditions directly related to pregnancy, delivery and postpartum care, and delivery of one (1) or more infants. Provider Services also include maternity services performed by certified nurse midwives when supervised by a licensed medical doctor.
- C. Additionally, Provider Services shall include behavioral health services when performed by a Behavioral Health Provider, nurse practitioner, physician assistant, licensed professional counselor, masters level licensed social worker, licensed marriage and family therapist or other licensed Behavioral Health Provider approved by the Corporation.

Qualified Medical Child Support Order: a Medical Child Support Order that:

1. Creates or recognizes the existence of an Alternate Recipient's right to enroll under this Plan of Benefits; or,
2. Assigns to an Alternate Recipient the right to enroll under this Plan of Benefits.

Qualifying Event: for continuation of coverage purposes under Article V, a Qualifying Event is any one of the following:

1. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked that renders the Employee no longer actively at work and therefore ineligible for coverage under the Plan of Benefits;
2. Death of the Employee;
3. Divorce or legal separation of the Employee from his or her spouse;
4. A child ceasing to qualify as a dependent under this Plan of Benefits;
5. Entitlement to Medicare by an Employee or by a parent of a child; or,
6. A proceeding in bankruptcy under Title 11 of the United States Code with respect to an Employer from whose employment an Employee retired at any time.

Quantity versus Time (QVT) Limits: limits that restrict the quantity of Prescription Drugs that are covered under a Member's Benefit within a certain time frame. The limits established for these drugs are based on Food and Drug Administration (FDA) approved indication.

Rehabilitation Facility: licensed facility operated for the purpose of assisting Members with neurological or other physical injuries to recover as much restoration of function as possible.

Residential Treatment Center (RTC): a licensed institution, other than a Hospital, which meets all six (6) of these requirements:

1. Maintains permanent and full-time facilities for bed care of resident patients;
2. Has the services of a psychiatrist (addictionologist, when applicable) or physician extender available at all times and is responsible for the diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once/week and as needed as indicated;
3. Has a registered nurse (RN) present onsite who is in charge of patient care along with one (1) or more RNs or licensed practical nurses (LPNs) onsite at all times twenty-four (24) hours per day and seven (7) days per week;
4. Keeps a daily medical record for each patient;
5. Is primarily providing a continuous structured therapeutic program specifically designed to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, half-way house, sober living residence, wilderness camp or any other facility that provides Custodial Care; and,
6. Is operating lawfully as a RTC in the area where it is located.

Retail Pharmacy: a prescription or refill purchased from a participating pharmacy will be subject to the applicable deductibles for each Generic or Brand drug purchased. Any prescription or refill purchased from a non-participating pharmacy will not be covered. Only covered Prescription Drugs and diabetic supplies are eligible under these Benefits.

Schedule of Benefits: the pages of this Plan of Benefits so titled, which specify the coverage provided and the applicable Copayments, Coinsurance, Benefit Year Deductibles and Benefit limitations.

Second Surgical Opinion: the medical opinion of a board-certified surgeon regarding an elective surgical procedure. The opinion must be based on the surgeon's examination of the patient. The examination must be performed after another licensed medical doctor has proposed to perform surgery, but before the surgery is performed. The second licensed medical doctor must not be associated with the primary licensed medical doctor.

Secondary Plan: a Plan that is not a Primary Plan. When this Plan of Benefits constitutes a Secondary Plan, availability of Benefits are determined after those of the other Plan and may be reduced because of benefits payable under the other Plan.

Skilled Nursing Facility: an institution other than a Hospital that is certified and licensed by the appropriate state regulatory agency as a Skilled Nursing Facility.

Special Care Unit: a specially equipped unit of a Hospital, set aside as a distinct care area, staffed and equipped to handle seriously ill Members requiring extraordinary care on a concentrated and continuous basis such as burn, intensive or coronary care units.

Specialist: a licensed medical doctor who specializes in a particular branch of medicine.

Specialty Drugs: Prescription Drugs that treat a complex clinical condition and/or require special handling, such as refrigeration. They generally require complex clinical monitoring, training and expertise. Specialty Drugs include, but are not limited to, infusible Specialty Drugs for chronic diseases, injectable and self-injectable drugs for acute and chronic diseases and specialty oral drugs. Specialty Drugs are used to treat acute and chronic disease states (e.g., growth deficiencies, Hemophilia, Multiple Sclerosis, Rheumatoid Arthritis, Gaucher's Disease, Hepatitis, cancer, organ transplantation, Alpha 1-Antitrypsin Disease and immune deficiencies).

Substance Use Disorder: the continued use, abuse and/or dependence of legal or illegal substance(s), despite significant consequences or marked problems associated with the use (as defined, described, or classified in the most current version of *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association).

Substance Use Disorder Services: services or treatment relating to Substance Use Disorder.

Surgical Services: an operative or cutting procedure or the treatment of fractures or dislocations. Surgical Services include the usual, necessary and related pre-operative and post-operative care when performed by a licensed medical doctor.

Telehealth: the exchange of Member information during which Members can have a telephone or video consultation with a licensed health care professional. Telehealth does not require two-way audio or video consultations between a referring Provider and/or Specialist.

Telemedicine: the exchange of Member information from one eligible referring licensed Provider (for purposes of Telemedicine outlined herein, the "Referring Provider") site to another eligible consulting licensed Provider (for purposes of Telemedicine outlined herein, the "Consulting Provider") site for the purpose of providing medical care to a Member in circumstances in which in person, face-to-face contact with the Consulting Provider is not necessary. The exchange must occur via two-way, real-time, interactive, HIPAA-compliant, electronic audio and video telecommunications systems.

Urgent Care Claim: any claim for medical care or treatment where making a determination under other than normal time frames could seriously jeopardize the Member's life or health or the Member's ability to regain maximum function; or, in the opinion of a licensed medical doctor or oral surgeon with knowledge of the Member's medical condition, would subject the Member to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

USERRA: the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Value-Based Program (VBP): a healthcare delivery model such as a patient-centered medical home ("PCMH"), accountable care organization ("ACO"), capitation arrangements or episode-based arrangements aimed at improving patient health quality and outcomes with respect to certain diseases and/or conditions. These services are facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment. The VBP is described further in this Agreement and the Plan of Benefits.

Value-Based Shared Savings: a payment mechanism in which the Provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

Well Baby Care/Well Child Care: care for dependents. Benefits are payable as specified on the Schedule of Benefits.

ARTICLE II – BENEFITS

A. PAYMENT

The payment of Covered Expenses for Benefits is subject to all terms and conditions of the Plan of Benefits and the Schedule of Benefits. In the event of a conflict between the Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. Oral statements cannot alter the terms of the Plan of Benefits or Schedule of Benefits. Covered Expenses will only be paid for Benefits:

1. Performed or provided on or after the Member effective date;
2. Performed or provided prior to termination of coverage;
3. Provided by a Provider within the scope of his or her license;
4. For which the required Preadmission Review, Emergency Admission Review, Preauthorization and/or Continued Stay Review has been requested and Preauthorization was received from the Corporation (the Member should refer to the Schedule of Benefits for services that require Preauthorization);
5. That are Medically Necessary;
6. That are not subject to an exclusion under Article III of this Plan of Benefits; and,
7. After the payment of all required Benefit Year Deductibles, Coinsurance and Copayments.

B. PREAUTHORIZATION

All Admissions and some Benefits (as indicated herein or on the Schedule of Benefits) require Preauthorization to determine the Medical Necessity of such Admission or Benefit. The Employer's Group Health Plan reserves the right to add or remove Benefits that are subject to Preauthorization. If Preauthorization is not obtained for an Admission or if an Admission is not Preauthorized and the Member is still admitted, Benefits may be reduced. Specific penalties are listed on the Schedule of Benefits. Preauthorization is obtained through the following procedures:

1. For all Admissions that are not the result of an Emergency Medical Condition, Preauthorization is granted or denied in the course of the Preadmission Review;
2. For all Admissions that result from an Emergency Medical Condition, Preauthorization is granted or denied in the course of the Emergency Admission Review;
3. For Admissions that are anticipated to require more days than approved through the initial review process, Preauthorization is granted or denied for additional days in the course of the Continued Stay Review;
4. For specific Benefits that require Preauthorization, Preauthorization is granted or denied in the course of the Preauthorization process; and,
5. For items requiring Preauthorization, the Corporation must be called at the numbers given on the Identification Card.

C. ASSIGNMENT OF COVERED EXPENSES

Payment for Covered Expenses may not be assigned to Non-Participating Providers.

D. SPECIFIC COVERED BENEFITS

If all of the following requirements are met, the Employer's Group Health Plan will provide the Benefits described in Article II:

1. All of the requirements of Article II must be met;
2. The Benefit must be listed in Article II;
3. The Benefit must not have a "**Non-Covered**" notation associated with it on the Schedule of Benefits;
4. The Benefit (separately or collectively) must not exceed the dollar or other limitations contained on the Schedule of Benefits; and,
5. The Benefit must not be subject to one or more of the exclusions set forth in Article III.

E. BENEFITS

ABA RELATED TO AUTISM SPECTRUM DISORDER

The Employer's Group Health Plan will pay Covered Expenses for ABA related to Autism Spectrum Disorder as set forth on the Schedule of Benefits. Services must be provided by or under direction of an approved Participating Provider. Preauthorization requests and treatment plans must be submitted to CBA.

ALLERGY INJECTIONS

The Employer's Group Health Plan will pay Covered Expenses for allergy injections as set forth below:

1. For patients with demonstrated hypersensitivity that cannot be managed by medications or avoidance;
2. To ensure the potency and efficacy of the antigens, the provision of multiple dose vials is restricted to sufficient antigen for twelve (12) weeks at either once per week or twice per week dosing; and,
3. When any of the following conditions are met:
 - a. The patient has symptoms of allergic rhinitis and/or asthma after natural exposure to the allergen;
 - b. The patient has a life threatening allergy to insect stings;
 - c. The patient has skin test and/or serologic evidence of a potent extract of the antigen; or,
 - d. Avoidance or pharmacologic (drug) therapy cannot control allergic symptoms.

AMBULANCE SERVICES

The Employer's Group Health Plan will pay Covered Expenses for professional ground and air ambulance services to the nearest network Hospital in case of an accident or Emergency Medical Condition. The following requirements apply to all ground and air ambulance services and transports:

1. The transport is Preauthorized as Medically Necessary and reasonable under the circumstances;

2. A Member is transported;
3. The destination is local within the United States; and,
4. The facility is medically appropriate to treat the Member's condition.

The Employer's Group Health Plan will pay Covered Expenses for ground ambulance transport between two Hospitals only when such ground ambulance transport has been Preauthorized and the Corporation confirms that the receiving Hospital is the closest facility that can provide medically appropriate care to treat the Member's condition. However, no Benefits are available for ground or air ambulance services or transport if a Member is transferred from one facility to a new facility for the purpose of the Member obtaining a lower level of care at the new receiving facility. A Non-Participating Provider may balance bill the Member for charges not paid by the Employer's Group Health Plan. Repatriation is excluded and is not a Benefit for which Covered Expenses are payable.

If a Member seeks Preauthorization to be transported as an inpatient from one Hospital to a second Hospital using an air ambulance, the following requirements must be met:

1. The first Hospital does not have the needed Hospital or skilled nursing care to treat the Member's illness or injury (such as burn care, cardiac care, trauma care, and critical care);
2. The second Hospital is the nearest medically appropriate facility to treat the Member's illness or injury;
3. A ground ambulance transport would endanger the Member's medical condition; and,
4. The transport is not related to a hospitalization outside the United States.

CARDIAC REHABILITATION

The Employer's Group Health Plan will pay Covered Expenses for cardiac rehabilitation as set forth on the Schedule of Benefits.

CHIROPRACTIC SERVICES

The Employer's Group Health Plan will pay Covered Expenses for services and Medical Supplies required in connection with the detection and correction, by manual or mechanical means, of structural imbalance, distortion, or subluxation in the human body, for purposes of removing nerve interference and the effects of such nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

CLEFT LIP OR PALATE

The Employer's Group Health Plan will pay Covered Expenses for the care and treatment of a congenital cleft lip or palate, or both, and any physical condition or illness that is related to or developed as a result of a cleft lip or palate.

Benefits shall include but not be limited to:

1. Oral and facial Surgical Services, surgical management and follow-up care;
2. Prosthetic Device treatment, such as obturators, speech appliances and feeding appliances;
3. Orthodontic treatment and management;

4. Prosthodontia treatment and management;
5. Otolaryngology treatment and management;
6. Audiological assessment, treatment and management, including surgically implanted amplification devices; and,
7. Physical therapy assessment and treatment.

Benefits for a cleft lip or palate must be Preauthorized. If a Member with a cleft lip or palate is covered by a dental policy, then teeth capping, prosthodontics and orthodontics shall be covered by the dental policy to the limit of coverage provided under such dental policy prior to coverage under this Employer's Group Health Plan. Covered Expenses for any excess medical expenses after coverage under any dental policy is exhausted shall be provided as for any other condition or illness under the terms and conditions of this Employer's Group Health Plan.

CLINICAL TRIALS

The Employer's Group Health Plan will pay Covered Expenses for clinical trials as set forth on the Schedule of Benefits.

COCHLEAR IMPLANTS

The Employer's Group Health Plan will pay Covered Expenses for cochlear implants as set forth on the Schedule of Benefits. Covered expenses will be paid for a second (2nd) implant after ten (10) years from the initial placement, when the currently used component is no longer functional or cannot be repaired or the component renders the implant recipient unable to adequately and safely perform age appropriate activities of daily living.

Benefits will be paid for cochlear implants when cochlear implants are used according to the U.S. Food and Drug Administration (FDA) labeled indications, bilateral or unilateral cochlear implantation is proven for patients who meet all of the following criteria:

1. Diagnosis of bilateral prelingual or postlingual moderate-to-profound-sensorineural hearing impairment with limited benefit for appropriate hearing (or vibrotactile) aids;
2. Ability to follow or participate in a program of aural rehabilitation;
3. Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system; and,
4. No contraindications to surgery.

Cochlear hybrid implants (e.g., Duet Electronic-Acoustic System (EAS) Hearing System or Nucleus Hybrid cochlear implant) are investigational because these implants have not been approved by the FDA.

The above indications apply also to Medical Necessity review. See the U.S. (FDA) section for FDA indications for each cochlear implant device. Specific criteria vary with the device.

The above indications under Coverage Rationale apply also to medical necessity review. See the U.S. Food and Drug Administration (FDA) section for FDA indications for each cochlear implant device. Specific criteria vary with the device.

DENTAL CARE FOR ACCIDENTAL INJURY

The Employer's Group Health Plan will pay Covered Expenses for dental services to Natural Teeth required because of accidental injury. For purposes of this section, an accidental injury is defined as an injury caused by a traumatic force, such as a car accident or a blow by a moving object. No Covered Expenses will be paid for injuries that occur while the Member is in the act of chewing or biting. Services for conditions that are not directly related to the accidental injury are not covered. The first visit to a dentist does not require Preauthorization; however, the dentist must submit a plan for any future treatment to the Corporation for review and Preauthorization before such treatment is rendered if Covered Expenses are to be paid. Benefits are limited to treatment for only one (1) year from the date of the accidental injury.

DIABETES EDUCATION

The Employer's Group Health Plan will pay Covered Expenses for outpatient self-management training and education for Members with diabetes mellitus provided that such training and educational Benefits are rendered by a Provider whose program is recognized by the American Diabetes Association.

DURABLE MEDICAL EQUIPMENT

The Employer's Group Health Plan will pay Covered Expenses for Durable Medical Equipment. The Employer's Group Health Plan will decide (in its discretion) whether to buy or rent equipment and whether to repair or replace damaged or worn Durable Medical Equipment. The Employer's Group Health Plan will not pay Covered Expenses for Durable Medical Equipment that is solely used by a Member in a Hospital or that the Employer's Group Health Plan determines (in its discretion) is included in any Hospital room charge.

EMERGENCY SERVICES

The Employer's Group Health Plan will pay Covered Expenses for care that is necessary as a result of an Emergency Medical Condition. Benefits are only available to treat an Emergency Medical Condition provided on an outpatient basis at a Hospital Emergency room or department and only for as long as the condition continues to be considered an Emergency.

The Maximum Payment for Emergency Medical Conditions at a Non-Participating Provider will be the greatest of the following:

1. The amount negotiated with Participating Providers for the particular Emergency Services (reduced by any in-network Copayment or Coinsurance);
2. The amount for Emergency Services calculated using the same method the Corporation uses for out-of-network services but substituting the relevant in-network Copayment or Coinsurance for the out-of-network Copayment or Coinsurance requirements; or,
3. The amount for Emergency Services that would be paid under Medicare, reduced by any in-network Copayment or Coinsurance for the services.

GENDER DYSPHORIA

The Employer's Group Health Plan will pay Covered Expenses for Medical Supplies, services or charges related to the diagnosis or treatment of gender dysphoria as outlined in the Corporation's medical policy and the Schedule of Benefits.

GENDER REASSIGNMENT

The Employer's Group Health Plan will pay Covered Expenses for gender reassignment as set forth on the Schedule of Benefits.

GYNECOLOGICAL EXAMINATION

The Employer's Group Health Plan will pay Covered Expenses for routine gynecological examinations each Benefit Year for female Members.

HABILITATION

The Employer's Group Health Plan will pay Covered Expenses for habilitation, including assisting a child with achieving developmental skills when impairments have caused delaying or blocking of initial acquisition of the skills. Habilitation can include fine motor, gross motor or other skills that contribute to mobility communication and performance of activities of daily living. The services will be described in an individual's plan of care.

HEARING AIDS AND EXAMS

The Employer's Group Health Plan will pay Covered Expenses for hearing aids and examinations for the prescription or fitting of hearing aids as set forth on the Schedule of Benefits.

HOME HEALTH CARE

The Employer's Group Health Plan will pay Covered Expenses for Home Health Care when rendered to a homebound Member in the Member's current place of residence.

HOSPICE CARE

The Employer's Group Health Plan will pay Covered Expenses for Hospice Care.

HOSPITAL SERVICES

The Employer's Group Health Plan will pay Covered Expenses for Admissions as follows:

1. Semiprivate room, board, and general nursing care;
2. Private room, at semiprivate rate as determined by the Employer's Group Health Plan;
3. Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit rather than in another portion of the Hospital;
4. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;
5. Diagnostic services, including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms; and,
6. In a Long-Term Acute Care Hospital.

Benefits for Admissions may be subject to the requirements for Preadmission Review, Emergency Admission Review and Continued Stay Review.

The day on which a Member leaves a Hospital, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless such Member returns to the Hospital by midnight of the same day. The day a Member enters a Hospital is treated as a day of Admission. The days during which a Member is not physically present for inpatient care are not counted as Admission days.

HUMAN ORGAN AND TISSUE TRANSPLANTS

1. The Employer's Group Health Plan will pay Covered Expenses for certain Preauthorized human organ and tissue transplants. To be covered, such transplants must be provided from a human donor to a Member and provided at a transplant center approved by the Employer's Group Health

Plan. Covered Expenses shall only be provided for the human organ and tissue transplants as set forth on the Schedule of Benefits.

2. The payment of Covered Expenses for living donor transplants will be subject to the following conditions:
 - a. When donor is donating organs to the Employee or Employee's dependents.
3. Benefits for human organ and tissue transplants may be subject to the Benefit Year Deductible amount and will be provided according to the percentage and/or dollar maximum specified on the Schedule of Benefits.
4. Human organ and tissue transplant coverage includes expenses incurred for legal donor organ and tissue procurement and all inpatient and outpatient Hospital and medical expenses for the transplant procedure and related pre-operative and post-operative care, including immunosuppressive drug therapy and air ambulance expenses.
5. Transplants of tissue as set forth below (rather than whole major organs) are Benefits under the Employer's Group Health Plan, subject to all of the provisions of the Employer's Group Health Plan as follows:
 - a. Blood transfusions;
 - b. Autologous parathyroid transplants;
 - c. Corneal transplants;
 - d. Bone and cartilage grafting; and,
 - e. Skin grafting.

IN-HOSPITAL MEDICAL SERVICE

The Employer's Group Health Plan will pay Covered Expenses for a licensed medical doctor or Behavioral Health Provider's visits to a Member during a Medically Necessary Admission for treatment of a condition other than that for which Surgical Service or obstetrical service is required as follows:

1. In-Hospital medical Benefits primarily for Mental Health Services and Substance Use Disorder Services;
2. In-Hospital medical Benefits in a Skilled Nursing Facility will be provided for visits of a Provider, limited to one (1) visit per day, not to exceed the number of visits if set forth on the Schedule of Benefits.
3. Where two (2) or more Providers of the same general specialty render in-Hospital medical visits on the same day, payment for such services will be made only to one (1) Provider.
4. Concurrent medical and surgical Benefits for in-Hospital medical services are only provided:
 - a. When the condition for which in-Hospital medical services requires medical care not related to Surgical Services or obstetrical service and does not constitute a part of the usual, necessary and related pre-operative or post-operative care, but requires supplemental skills not possessed by the attending surgeon or his/her assistant; and,
 - b. When the surgical procedure performed is designated by the Employer's Group Health Plan as a warranted diagnostic procedure or as a minor surgical procedure.

5. When the same Provider renders different levels of care on the same day, Benefits will only be provided for the highest level of care.

INFERTILITY

The Employer's Group Health Plan will pay Covered Expenses for services and supplies related to infertility treatment as set forth on the Schedule of Benefits.

MAMMOGRAPHY TESTING

The Employer's Group Health Plan will pay Covered Expenses for mammography testing regardless of Medical Necessity for Members that are within the appropriate age guidelines. The Employer's Group Health Plan will pay Covered Expenses for additional mammograms during a Benefit Year based on Medical Necessity.

MEDICAL SUPPLIES

The Employer's Group Health Plan will pay Covered Expenses for Medical Supplies provided that the Employer's Group Health Plan will not pay Covered Expenses separately for Medical Supplies that are (or in the Corporation on behalf of the Employer's Group Health Plan's determination, should be) provided as part of another Benefit.

MENTAL HEALTH SERVICES

The Employer's Group Health Plan will pay Covered Expenses for the inpatient and outpatient treatment for Mental Health Services.

OBESITY RELATED PROCEDURES

The Employer's Group Health Plan will pay Covered Expenses for the following if set forth on the Schedule of Benefits:

Services, supplies, treatment or medication for the management of morbid obesity, obesity, weight reduction, weight control or dietary control (collectively referred to as "obesity-related treatment") including, but not limited to, gastric bypass or stapling, intestinal bypass and related procedures or gastric restrictive procedures. Also included are services, supplies or charges for the treatment or correction of complications from obesity-related treatment. Services, supplies or charges for the reversal of obesity-related treatments and reconstructive procedures necessitated by weight loss are covered.

OBSTETRICAL SERVICES

The Employer's Group Health Plan will pay Covered Expenses for Preauthorized obstetrical services. Midwives licensed and practicing in compliance with the Nurse Practices Act in a Hospital will be covered under this Benefit.

Under the terms of the Newborn and Mother's Health Act of 1996, the Employer's Group Health Plan generally may not restrict Covered Expenses for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery (not including the day of delivery) or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, the Employer's Group Health Plan may not require that a Provider obtain authorization from the Corporation for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours as applicable. However, Preauthorization is required to use certain Providers or facilities or to reduce out-of-pocket costs.

ORTHOPEDIC DEVICES

The Employer's Group Health Plan will pay Covered Expenses for Orthopedic Devices.

ORTHOTIC DEVICES

The Employer's Group Health Plan will pay Covered Expenses for Orthotic Devices that are not available on an over-the-counter basis and are not otherwise excluded under this Plan of Benefits.

OSTOMY SUPPLIES

The Employer's Group Health Plan will pay Covered Expenses for ostomy supplies as set forth on the Schedule of Benefits.

OUTPATIENT HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES

The Employer's Group Health Plan will pay Covered Expenses for Surgical Services and diagnostic services including radiological examinations, laboratory tests and machine tests, performed in an outpatient Hospital setting or an Ambulatory Surgical Center.

OUTPATIENT REHABILITATION SERVICES

The Employer's Group Health Plan will pay Covered Expenses, subject to the following paragraph, for physical therapy, occupational therapy and rehabilitation services as set forth on the Schedule of Benefits.

Covered Expenses for outpatient rehabilitation services will be paid only following an acute incident involving disease, trauma or surgery that requires such care.

OXYGEN

The Employer's Group Health Plan will pay Covered Expenses for oxygen. Durable Medical Equipment for oxygen use in a Member's home is covered under the Durable Medical Equipment Benefit.

PAP SMEAR

The Employer's Group Health Plan will pay Covered Expenses for a Pap smear as part of a gynecological examination regardless of Medical Necessity. The Employer's Group Health Plan will pay Covered Expenses for additional Pap smears during a Benefit Year based on Medical Necessity.

PHYSICAL EXAMINATION

The Employer's Group Health Plan will pay Covered Expenses for Physical Examinations for Members that are within the appropriate age guidelines regardless of Medical Necessity.

PRESCRIPTION DRUGS

1. Unless expressly excluded under Article III, the Employer's Group Health Plan will pay Covered Expenses for Prescription Drugs (as specified on the Schedule of Benefits) that are listed as covered on the PDL and are used to treat a condition for which Benefits are otherwise available. This may include certain Over-the-Counter Drugs designated by the Corporation as Prescription Drugs and listed as covered on the PDL. If so designated, these Over-the-Counter Drugs must be prescribed by a Provider. Any Coinsurance percentage for Prescription Drugs is based on the Allowable Charge and does not change due to receipt of any Credits by the Employer's Group Health Plan or the Corporation. Copayments likewise do not change due to receipt of any Credits by the Employer's Group Health Plan or the Corporation.

For more information about Prescription Drugs, please refer to the PDL which can be found on the Corporation's website. A list of drugs that are not covered by the Corporation is also on the PDL.

In certain instances, the Corporation provides for an exception process that allows a Member or his or her designee (or the prescribing Provider) to request and obtain access, on an expedited basis, to clinically appropriate drugs that otherwise are not covered on the PDL. For more information about this exception process, please contact the Corporation at the number provided on your Identification Card.

2. If a Provider prescribes a Brand Name Drug and an equivalent Generic Drug or Over-the-Counter Drug is available and listed on the PDL, any difference between the cost of the covered Generic Drug or Over-the-Counter Drug and the higher cost of the Brand Name Drug shall be the responsibility of the Member. However, if the Provider indicates in the prescription that a substitution is not allowed, then the cost difference of the Brand Name Drug will not be the responsibility of the Member. This is in addition to any Copayment or Coinsurance appropriate to the Brand Name Drug being purchased. In no instance will the Member be charged more than the actual retail price of the drug.
3. Insulin shall be treated as a Prescription Drug whether injectable or otherwise.
4. The Employer's Group Health Plan may, in its discretion, place quantity limits on Prescription Drugs.

PREVENTIVE LAB WORK

The Employer's Group Health Plan will pay Covered Expenses for preventive lab work as set forth on the Schedule of Benefits.

PREVENTIVE SERVICES

The Employer's Group Health Plan will pay for preventive health services required under the PPACA as follows:

1. Evidence based services that have a rating of A or B in the current United States Preventive Services Task Force (USPSTF) recommendations;
2. Immunizations as recommended by the CDC; and,
3. Preventive care and screenings for children and women as recommended by the Health Resources and Services Administration (HRSA).

The USPSTF, CDC and the HRSA are independent companies that provide health information on behalf of BCBSKC. These Benefits are provided without any cost-sharing by the Member when the services are provided by a Participating Provider. Any other covered preventive screenings will be provided as specified in the Schedule of Benefits.

PROSTATE EXAMINATION

The Employer's Group Health Plan will pay Covered Expenses for prostate examinations per Benefit Year regardless of Medical Necessity as set forth on the Schedule of Benefits for Members that are within the appropriate age guidelines. The Employer's Group Health Plan will pay Covered Expenses for additional prostate examinations during a Benefit Year based on Medical Necessity.

PROSTHETIC DEVICES

The Employer's Group Health Plan will only pay Covered Expenses for Prosthetic Devices when prescribed for the alleviation or correction of conditions caused by physical injury, trauma, disease or birth defects and is an original replacement for a body part. Covered Expenses will only be paid for standard, non-luxury items (as determined by the Employer's Group Health Plan) as a replacement of a Prosthetic Device when such Prosthetic Device cannot be repaired for less than the cost of replacement or when a change in the Member's condition warrants replacement.

PROVIDER SERVICES

The Employer's Group Health Plan will pay Covered Expenses for Provider Services, provided that when different levels (as determined by the Corporation on behalf of the Employer's Group Health Plan) of Provider Services are provided on the same day, Covered Expenses for such Benefits will only be paid for the highest level (as determined by the Corporation on behalf of the Employer's Group Health Plan) of Provider Services.

PULMONARY REHABILITATION THERAPY

The Employer's Group Health Plan will pay Covered Expenses for pulmonary rehabilitation therapy as set forth on the Schedule of Benefits.

RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES

In the case of a Member who is receiving Covered Expenses in connection with a mastectomy the Employer's Group Health Plan will pay Covered Expenses for each of the following (if requested by such Member):

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and,
3. Prosthetic Devices and physical complications at all stages of the mastectomy, including lymphedema.

REHABILITATION

The Employer's Group Health Plan will pay Covered Expenses for participation in a multidisciplinary team rehabilitation program only following severe neurologic or physical impairment as specified on the Schedule of Benefits if the following criteria are met:

1. All such treatment must be ordered by a licensed medical doctor;
2. All such treatment may require Preauthorization and must be performed by a Provider and at a location designated by the Employer's Group Health Plan;
3. The documentation that accompanies a request for rehabilitation Benefits must contain a detailed Member evaluation from a licensed medical doctor that documents that to a degree of medical certainty the Member has rehabilitation potential such that there is an expectation that the Member will achieve an ability to provide self-care and perform activities of daily living; and,
4. All such rehabilitation Benefits are subject to periodic review by the Employer's Group Health Plan.

After the initial rehabilitation period, continuation of rehabilitation Benefits will require documentation that the Member is making substantial progress and that there continues to be significant potential for the achievement of the established rehabilitation goals.

RESIDENTIAL TREATMENT CENTERS

The Employer's Group Health Plan will pay Covered Expenses for a Preauthorized Residential Treatment Center as set forth on the Schedule of Benefits.

SKILLED NURSING FACILITY SERVICES

The Employer's Group Health Plan will pay Covered Expenses for Admissions in a Skilled Nursing Facility as follows:

1. Semiprivate room, board, and general nursing care;
2. Private room, at semiprivate rate as determined by the Employer's Group Health Plan;
3. Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit;
4. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;
5. Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms; and,
6. In a Long-Term Acute Care Hospital.

Benefits for Admissions may be subject to the requirements for Preadmission Review, Emergency Admission Review, and Continued Stay Review.

The day on which a Member leaves a Skilled Nursing Facility, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless such Member returns to the Skilled Nursing Facility by midnight of the same day. The day a Member enters a Skilled Nursing Facility is treated as a day of Admission. The days during which a Member is not physically present for inpatient care are not counted as Admission days.

SPECIALTY DRUGS

The Employer's Group Health Plan will pay Covered Expenses for certain Specialty Drugs. Certain Specialty Drugs may only be covered under the pharmacy Benefit. Certain Specialty Drugs may require Preauthorization. For any Specialty Drug, the Benefit Year Deductible, Out-of-Pocket Maximum and/or Benefit maximum may apply. A list of Specialty Drugs, as well as information about any related requirements and/or restrictions, may be obtained by contacting the Corporation at the number listed on the Identification Card or at www.MyHealthToolkitKC.com.

In certain instances, the Corporation provides for an exception process that allows a Member or his or her designee (or the prescribing Provider) to request and obtain access to clinically appropriate drugs that otherwise are not covered on the PDL. For more information about this exception process, please contact the Corporation at the number provided on your Identification Card.

SPEECH THERAPY

The Employer's Group Health Plan will pay Covered Expenses for speech therapy as set forth on the Schedule of Benefits.

SUBSTANCE USE DISORDER SERVICES

The Employer's Group Health Plan will pay Covered Expenses for Substance Use Disorder Services as set forth on the Schedule of Benefits.

SURGICAL SERVICES

The Employer's Group Health Plan will pay Covered Expenses for Surgical Services performed by a licensed medical doctor or oral surgeon, as applicable, for treatment and diagnosis of disease or injury or for obstetrical services, as follows:

1. Surgical Services, subject to the following:
 - a. If two (2) or more operations or procedures are performed at the same time, through the same surgical opening or by the same surgical approach, the total amount covered for such operations or procedures will be the Allowable Charge for the major procedure only.
 - b. If two (2) or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be the Allowable Charge for the operation or procedure bearing the highest Allowable Charge, plus one-half of Allowable Charge for all other operations or procedures performed.
 - c. If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, fifty (50%) percent for the procedure bearing the second and third highest Allowable Charges, twenty-five (25%) percent for the procedures bearing the fourth through the eighth highest Allowable Charges, and, ten (10%) percent for all other procedures. Provided, however, if the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, and fifty (50%) percent of the charge for each subsequent procedure.
 - d. If an operation or procedure is performed in two (2) or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowable Charge set forth for such operation or procedure.
 - e. If two (2) or more medical doctors or oral surgeons perform operations or procedures in conjunction with one another, other than as an assistant surgeon or anesthesiologist, the Allowable Charge, subject to the above paragraphs, will be coverage for the services of only one (1) medical doctor or oral surgeon (as applicable) or will be prorated between them by the Employer's Group Health Plan when so requested by the medical doctor or oral surgeon in charge of the case.
 - f. Certain surgical procedures are designated as separate procedures by the Employer's Group Health Plan, and the Allowable Charge is payable when such procedure is performed as a separate and single entity; however, when a separate procedure is performed as an integral part of another surgical procedure, the total amount covered will be the Allowable Charge for the major procedure only.

2. Assistant Surgeon services that consists of the Medically Necessary service of one (1) medical doctor or oral surgeon who actively assists the operating surgeon when a covered Surgical Service is performed in a Hospital, and when such surgical assistant service is not available by an intern, resident or in-house physician. The Employer's Group Health Plan will pay charges at the percentage of the Allowable Charge set forth on the Schedule of Benefits for the Surgical Service, not to exceed the medical doctor's or oral surgeon's (as applicable) actual charge.
3. Anesthesia services that consists of services rendered by a medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or his or her assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation or loss of consciousness. Additional Benefits will not be provided for pre-operative anesthesia consultation.

SUSTAINED HEALTH BENEFITS

The Employer's Group Health Plan may offer certain routine annual Benefits (known as Sustained Health Benefits) as set forth on the Schedule of Benefits. These Benefits are designed to cover costs associated with routine care and are provided in addition to the Preventive Services covered under the PPACA. Because these are additional Benefits, age and monetary limitations may be imposed and cost-sharing may be required by the Member.

TELEHEALTH

The Employer's Group Health Plan will pay Covered Expenses for Telehealth services which are initiated by either a Member or Provider and are provided by licensed health care professionals who have been credentialed as eligible Telehealth Providers.

TELEMEDICINE

The Employer's Group Health Plan will pay Covered Expenses for Telemedicine services as follows:

Office and outpatient visits that are conducted via Telemedicine are counted towards any applicable Benefit limits for these services.

Consulting and referring Providers must be Participating Providers who have been credentialed as eligible Telemedicine Providers.

Telemedicine services will be covered by the Employer's Group Health Plan under the following circumstances:

1. The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the Member's need; and,
2. The medical care can be safely furnished, and there is no equally effective, more conservative and less costly treatment available.

Examples of interactions that are not reimbursable Telemedicine services and will not be reimbursed are:

1. Telephone conversations;
2. E-mail messages;
3. Facsimile transmissions; or,
4. Internet-based audio-video communication that is not secure and HIPAA-compliant (e.g., Skype).

URGENT CARE

The Employer's Group Health Plan will pay Covered Expenses for urgent care as set forth on the Schedule of Benefits.

WIGS

The Employer's Group Health Plan will pay Covered Expenses for wigs as set forth on the Schedule of Benefits.

ARTICLE III - EXCLUSIONS AND LIMITATIONS

THE EMPLOYER'S GROUP HEALTH PLAN WILL NOT PAY ANY AMOUNT FOR THE SERVICES AND PRODUCTS LISTED IN THIS ARTICLE III EXCEPT: (1) SERVICES ARE RENDERED BY A HEALTH CARE PROVIDER AS PART OF A VALUE-BASED PROGRAM OR (2) IF REQUIRED BY LAW.

ACTS OF WAR

Illness contracted or injury sustained as a result of a Member's participation as a combatant in a declared or undeclared war, or any act of war, or while in military service.

ACUPUNCTURE

Acupuncture treatment or services.

ADMISSIONS THAT ARE NOT PREAUTHORIZED

If Preauthorization is not received for an otherwise Covered Expense related to an Admission, Benefits may be reduced as set forth on the Schedule of Benefits.

AUTO ACCIDENTS

This Plan does not provide coverage for claims paid or payable under an automobile insurance policy or any other type of liability insurance policy. Automobile insurance policies include, but are not limited to, no fault, personal injury protection, medical payments, liability, uninsured and underinsured policies, umbrella or any other insurance coverage which may be paid or payable for the injury or illness.

BEHAVIORAL, EDUCATIONAL OR ALTERNATE THERAPY PROGRAMS

Any behavioral, educational or alternative therapy techniques to target cognition, behavior language and social skills modification, including:

1. ABA therapy unless Medically Necessary for the treatment of Autism Spectrum Disorder;
2. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;
3. Higashi schools/daily life;
4. Facilitated communication;
5. Floor time;

6. Developmental Individual-Difference Relationship-based model (DIR);
7. Relationship Development Intervention (RDI);
8. Holding therapy;
9. Movement therapies;
10. Music therapy; and,
11. Animal assisted therapy.

BENEFITS PROVIDED BY STATE OR FEDERAL PROGRAMS

Any service or charge for a service to the extent that the Member is entitled to payment or benefits relating to such service under any state or federal program that provides healthcare benefits, including Medicare, but only to the extent that benefits are paid or are payable under such programs. This exclusion includes, but is not limited to, benefits provided by the Veterans Administration for care rendered for a service-related disability or any state or federal hospital services for which the Member is not legally obligated to pay.

BIO-FEEDBACK SERVICES

Bio-feedback when related to psychological services.

COMPLICATIONS FROM FAILURE TO COMPLETE TREATMENT

Complications that occur because a Member did not follow the course of treatment prescribed by a Provider, including complications that occur because a Member left a Hospital against medical advice.

COMPLICATIONS FROM NON-COVERED SERVICES

Complications arising from a Member's receipt or use of either services or Medical Supplies or other treatment that are not Benefits, including complications arising from a Member's use of Discount Services.

CONTRACEPTIVES

Medical Supplies, services or devices for the purpose of contraception, except as specified on the Schedule of Benefits.

COPYING CHARGES

Fees for copying or production of medical records and/or claims filing.

COSMETIC AND RECONSTRUCTIVE SERVICES

- A. This Plan of Benefits excludes cosmetic or reconstructive procedures, and any related services or Medical Supplies, which alter appearance but do not restore or improve impaired physical function. Examples of services that are cosmetic or reconstructive, which are not covered include, but are not limited to, the following:
 1. Rhinoplasty (nose);
 2. Mentoplasty (chin);

3. Rhytidoplasty (face lift);
 4. Glabellar rhytidoplasty (forehead lift);
 5. Surgical planing (dermabrasion);
 6. Blepharoplasty (eyelid);
 7. Mammoplasty (reduction, suspension or augmentation of the breast);
 8. Superficial chemosurgery (chemical peel of the face);
 9. Rhytidectomy (abdomen, legs, hips, buttocks or elsewhere including lipectomy or adipectomy).
- B. A cosmetic or reconstructive service may, under certain circumstances (in the Corporation's discretion), be considered restorative in nature for which Benefits are available, but only if the following requirements are met:
1. The service is intended to correct, improve or restore a bodily function; or,
 2. The service is intended to correct, improve or restore a malappearance or deformity that was caused by physical trauma or accident, congenital anomaly or covered surgical service; and,
 3. The proposed service must be Preauthorized.

CRIME/ILLEGAL ACTS

Any illness or injury received while committing or attempting to commit a crime, felony or misdemeanor or while engaging or attempting to engage in an illegal act or occupation.

CUSTODIAL CARE

Services or supplies related to Custodial Care, except as specified on the Schedule of Benefits.

DENTAL SERVICES

Any dental procedures involving tooth structures, excision or extraction of teeth, gingival tissue, alveolar process, dental X-rays, preparation of mouth for dentures, or other procedures of dental origin. However, that such procedures may be covered if the need for dental services results from an accidental injury within one (1) year prior to the date of such services.

DISCOUNT SERVICES

Any charges that result from the use of Discount Services including charges related to any injury or illness that results from a Member's use of Discount Services. Discount Services are not covered under the Plan of Benefits and Members must pay for Discounted Services.

EYEGLASSES

Eyeglasses or contact lenses of any type, even those dispensed by a prescription (except after cataract surgery).

FOOD SUPPLEMENTS

Food supplements unless such food supplements are available by prescription only and are prescribed by a Provider and are not used for weight control or loss.

FOOT CARE

Routine foot care such as paring, trimming or cutting of nails, calluses or corns, except in conjunction with diabetic foot care.

HUMAN ORGAN AND TISSUE TRANSPLANTS

Human organ and tissue transplants that are not:

1. Preauthorized;
2. Performed by a Provider as designated by the Corporation;
3. Listed as covered on the Schedule of Benefits; and,
4. Performed at a Blue Distinction Center of Excellence or a transplant center approved by the Corporation in writing.

IMPACTED TOOTH REMOVAL

Services or Medical Supplies for the removal of impacted teeth.

IMPOTENCE

Services, supplies or drugs related to any treatment for impotence, including but not limited to penile implants.

INCAPACITATED DEPENDENTS

Any service, supply or charge for an Incapacitated Dependent that is not enrolled by the maximum dependent child age.

INFERTILITY

Services, supplies or drugs related to any treatment for infertility, including, but not limited to, fertility drugs, gynecological or urological procedures the purpose of which is primarily to treat infertility, artificial insemination, in-vitro fertilization, reversal of sterilization procedures and surrogate parenting, except as specified on the Schedule of Benefits.

INPATIENT DIAGNOSTIC AND EVALUATIVE PROCEDURES

Inpatient care and related Provider Services rendered in conjunction with an Admission, which is principally for diagnostic studies or evaluative procedures that could have been performed on an outpatient basis are not covered unless the Member's medical condition alone required Admission.

INTOXICATION OR DRUG USE

Any service (other than Substance Use Disorder Services), Medical Supplies, charges or losses resulting from a Member being Legally Intoxicated or under the influence of any drug or other substance, or taking some action the purpose of which is to create a euphoric state or alter consciousness. The Member, or Member's representative, must provide any available test results showing blood alcohol and/or drug/substance levels upon request by the Corporation. If the Member refuses to provide these test results, no Benefits will be provided.

INVESTIGATIONAL OR EXPERIMENTAL SERVICES

Services or supplies or drugs that are Investigational or Experimental.

LIFESTYLE IMPROVEMENT SERVICES

Services or supplies relating to lifestyle improvements including, but not limited to, nutrition counseling or physical fitness programs.

LONG-TERM CARE SERVICES

Admissions or portions thereof for long-term care, including:

1. Rest care;
2. Long-term acute or chronic psychiatric care;
3. Care to assist a Member in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication);
4. Custodial or long-term care; or,
5. Psychiatric or Substance Use Disorder treatment including: therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes.

MEMBERSHIP DUES AND OTHER FEES

Amounts payable (whether in the form of initiation fees, annual dues or otherwise) for membership or use of any gym, workout center, fitness center, club, golf course, wellness center, health club, weight control organization or other similar entity or payable to a trainer of any type, except as specified on the Schedule of Benefits.

MISSED PROVIDER APPOINTMENTS

Charges for a Member's appointment with a Provider that the Member did not attend.

NO LEGAL OBLIGATION TO PAY

Any service, supply or charge the Member is not legally obligated to pay.

NOT MEDICALLY NECESSARY SERVICES OR SUPPLIES

Any service or supply that is not Medically Necessary. However, if a service is determined to be not Medically Necessary because it was not rendered in the least costly setting, Covered Expenses will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.

OBESITY RELATED PROCEDURES

1. Services, supplies, treatment or medication for the management of morbid obesity, obesity, weight reduction, weight control or dietary control (collectively referred to as "obesity-related treatment"), including, but not limited to, gastric bypass or stapling, intestinal bypass and related procedures or gastric restrictive procedures, except as specified on the Schedule of Benefits.
2. Also, the treatment or correction of complications from obesity-related treatment are non-covered services, regardless of Medical Necessity, prescription by a Provider or the passage of time from a Member's obesity-related treatment, except as specified on the Schedule of Benefits. This includes the reversal of obesity-related treatments and reconstructive procedures necessitated by weight loss.
3. Membership fees to weight control programs, except as specified on the Schedule of Benefits.

ORTHOGNATHIC SURGERY

Any service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication or orthognathic deformities, regardless of cause, except as specified on the Schedule of Benefits.

OUTPATIENT SERVICES THAT ARE NOT PREAUTHORIZED

If Preauthorization is not received for an otherwise Covered Expense related to an outpatient service, Benefits may be reduced as set forth on the Schedule of Benefits.

OVER-THE-COUNTER DRUGS

Drugs that are available on an over-the-counter basis or are otherwise available without a prescription, except for Over-the-Counter Drugs that are designated as Prescription Drugs by the Corporation, listed as covered on the PDL accordingly and are prescribed by a Provider.

PAIN MANAGEMENT PROGRAMS

Chronic pain management programs or multi-disciplinary pain management programs.

PARTICIPATING PROVIDER CHARGES NOT PREAUTHORIZED

For all participating inpatient Hospital Admissions (including Mental Health Services and Substance Use Disorder Services and inpatient physical rehabilitation), the penalty for not obtaining Preauthorization will vary from state to state, depending on the contractual agreements the BCBS Plan has with its local Providers in that state. Generally, this is a penalty to the Provider, but in some cases, the Member may be held liable.

PHYSICAL THERAPY ADMISSIONS

All Admissions solely for physical therapy, except as provided in Article II.

PREMARITAL AND PRE-EMPLOYMENT EXAMINATIONS

Charges for services, supplies or fees for premarital or pre-employment examinations.

PREOPERATIVE ANESTHESIA CONSULTATION

Charges for preoperative anesthesia consultation.

PRESCRIPTION DRUG EXCLUSIONS

Charges for:

1. Prescription Drugs that are specifically listed on the PDL as excluded;
2. Prescription Drugs that have not been prescribed by a Provider acting within the scope of his or her license;
3. Drugs not approved by the Food and Drug Administration (FDA);
4. Prescription Drugs for non-covered therapies, services or conditions;
5. Prescription Drug refills in excess of the number specified on the Provider's prescription order or Prescription Drug refills dispensed more than one (1) year after the original prescription date;
6. More than a thirty-one (31) day supply for Prescription Drugs (ninety (90) day supply for Prescription Drugs obtained through a Mail Service Pharmacy), except as specified on the Schedule of Benefits or unless the quantity is limited by a Quantity versus Time (QVT) program;
7. Any type of service or handling fee (with the exception of the dispensing fee charged by the pharmacist for filling a prescription) for Prescription Drugs, including fees for the administration or injection of a Prescription Drug;
8. Dosages that exceed the recommended daily dosage of any Prescription Drug as determined by the Corporation based on the following guidelines as described in the current:
 - a. United States Pharmacopeia (USP);
 - b. Facts and Comparisons;
 - c. Physician's Desk References; and/or,
 - d. National Formulary.
9. Prescription Drugs used for or related to cosmetic purposes, including hair growth and skin wrinkles, except as specified on the Schedule of Benefits;
10. Prescription Drugs related to any treatment for infertility or impotence (except when prescribed for benign prostatic hypertrophy), including but not limited to, fertility drugs, except as specified on the Schedule of Benefits;
11. Prescription Drugs administered or dispensed in a Provider's office, Skilled Nursing Facility, Hospital or any other place that is not a pharmacy licensed to dispense Prescription Drugs in the state where it is operated;
12. Over-the-Counter Drugs and over-the-counter supplies or supplements, except for Over-the-Counter Drugs that are designated by the Corporation as Prescription Drugs and are listed as covered on the PDL and are prescribed by a Provider;

13. Prescription Drugs that are being prescribed for a specific medical condition that are not approved by the FDA for treatment of that condition (except for (i) Prescription Drugs for a specific medical condition that have at least two (2) formal clinical studies or (ii) Prescription Drugs for the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one (1) standard, universally accepted reference compendia or is found to be safe and effective in formal clinical studies, the results of which have been published in peer reviewed professional medical journals);
14. Prescription Drugs that are not consistent with the diagnosis and treatment of a Member's illness, injury or condition, or are excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care;
15. Prescription Drugs or services that require Preauthorization by the Corporation and Preauthorization is not obtained;
16. Prescription Drugs for injury or disease that are paid by worker's compensation benefits (if a worker's compensation claim is settled, it will be considered paid by worker's compensation benefits);
17. Prescription Drugs for obesity or weight control;
18. Prescription Drugs that are not authorized when part of a Step Therapy Program;
19. Prescription Drugs which are new to the market and which are under clinical review by the Corporation shall be listed on the PDL as excluded until the clinical review has been completed and a final determination has been made as to whether the drug should be covered;
20. Prescription Drugs, regardless of therapeutic class, that are determined to offer no clinical or cost effective advantage over the comparable Prescription Drugs already covered under the PDL; and,
21. Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind, except for prescription prenatal vitamins or prescription vitamins B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency.

PRIVATE DUTY NURSING

PDN services.

PROVIDER CHARGES

Charges by a Provider for blood and blood derivatives and for charges for Prescription Drugs that are not consumed at the Provider's office.

PSYCHOLOGICAL AND EDUCATIONAL TESTING

Psychological or educational diagnostic testing to determine job or occupational placement, school placement or for other educational purposes, or to determine if a learning disability exists.

RELATIONSHIP COUNSELING

Relationship counseling, including marriage counseling, for the treatment of premarital, marital or relationship dysfunction.

REPATRIATION

Services and supplies received as the result of transporting a Member, regardless of cause, from a foreign country to the Member's residence in the United States.

SELF-INFLICTED INJURY

Services and supplies received as the result of any intentionally self-inflicted injury that does not result from a medical condition or domestic violence.

SERVICES FOR CERTAIN DIAGNOSES OR DISORDERS

Medical Supplies or services or charges for the diagnosis or treatment of learning disorders, dissociative disorders, developmental speech delay, communication disorders, developmental coordination disorders, intellectual disabilities or vocational rehabilitation.

SERVICES FOR COUNSELING OR PSYCHOTHERAPY

Counseling and psychotherapy services for the following conditions are not covered:

1. Feeding and eating disorders in early childhood and infancy;
2. Tic disorders, except when related to Tourette's disorder;
3. Elimination disorders;
4. Mental disorders due to a general medical condition;
5. Sexual function disorders; except as specified in Article II" to the end of the Sex Change exclusion.
6. Sleep disorders;
7. Medication induced movement disorders; or,
8. Nicotine dependence, unless specifically listed as a Benefit in Article II of this Plan of Benefits or on the Schedule of Benefits.

SERVICES NOT LISTED AS COVERED BENEFITS

Medical Supplies or services or other items not specifically listed as a Benefit in Article II of this Plan of Benefits or on the Schedule of Benefits.

SERVICES PRIOR TO MEMBER EFFECTIVE DATE OR AFTER TERMINATION

Any charges for Medical Supplies or services rendered to the Member prior to the Member's effective date, the Employer's Effective Date or after the Member's coverage terminates.

SERVICES RENDERED BY FAMILY

Any Medical Supplies or services rendered by a Member to him or herself or rendered by a Member's immediate family (parent, child, spouse, brother, sister, grandparent or in-law).

SEX CHANGE

Any Medical Supplies, services or charges incurred for consultation, therapy, surgery or any procedures related to changing a Member's sex except as specified in Article II.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDER

Any service for the treatment of dysfunctions or derangements of the temporomandibular joint, regardless of cause. This exclusion also applies to orthognathic surgery for the treatment of dysfunctions or derangements of the temporomandibular joint, regardless of cause, except as specified on the Schedule of Benefits.

TOBACCO CESSATION TREATMENT

Medical Supplies, services or Prescription Drugs for treatment for tobacco cessation.

TRAVEL

Travel, whether or not recommended by a Provider unless directly related to human organ or tissue transplants when Preauthorized and except as specified on the Schedule of Benefits.

VISION CARE SERVICES

Any Medical Supply or service rendered to a Member for vision care.

WORKERS' COMPENSATION

This Plan does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member or Employer elected exemption from available workers' compensation coverage, waived entitlement to workers' compensation benefits for which he/she is eligible, failed to timely file a claim for workers' compensation benefits or the Member sought treatment for the injury or illness from a Provider which is not authorized by the Member's Employer or Workers' Compensation Carrier.

If the Plan pays Benefits for an injury or illness and the Plan determines the Member also received a recovery from the Employer or Employer's Workers' Compensation Carrier by means of a settlement, judgment or other payment for the same injury or illness, the Plan shall have the right of recovery as outlined in Article VII of this Plan of Benefits.

ARTICLE IV - COORDINATION OF BENEFITS

A. APPLICABILITY

The coordination of benefits rules are intended to prevent duplicate payments from different Plans that otherwise cover a Member for the same Covered Expenses. The rules determine which is the Primary Plan and which is the Secondary Plan.

Generally, unless a specific rule applies, where a claim is submitted for payment under this Plan of Benefits and one or more other Plans, this Plan of Benefits is the Secondary Plan. Additionally, special rules for the coordination of benefits with Medicare may also apply.

B. COORDINATION OF BENEFITS WITH AUTO INSURANCE

This is a self-funded ERISA Plan which does not provide benefits for claims which are paid or payable under automobile insurance coverage. Automobile insurance coverage shall include, but is not limited to, no-fault, personal injury protection, medical payments, liability, uninsured and

underinsured coverage, umbrella or any other insurance coverage which may be paid or payable for the injury or illness.

Although benefits for claims which are paid or payable under automobile insurance coverage are not covered by this Plan of Benefits, the Employer's Group Health Plan/Corporation may, in its sole discretion, agree to extend Benefits to a Member for the injury or illness. In this instance, if a Member has automobile no-fault, personal injury protection or medical payments coverage, or if such coverage is extended to the Member through a group or their own automobile insurance carrier, that coverage is primary to the Plan. The Plan will always be secondary to automobile no-fault, personal injury protection or medical payments coverage plans and the Plan will coordinate benefits for claims which are payable under those automobile policies.

If the Member resides in a state where automobile no-fault, personal injury protection or medical payments coverage is mandatory and the Member does not have the state mandated automobile coverage, the Plan will deny Benefits up to the amount of the state mandated automobile coverage.

This coordination of benefits provision applies whether or not the Member submits a claim under the automobile no-fault, personal injury protection or medical payments coverage.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Employer's Group Health Plan/Corporation of an injury or illness for which automobile insurance coverage may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;
2. Execute and deliver an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;
3. Deliver to the Employer's Group Health Plan/Corporation a copy of your Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so;
4. Deliver to the Employer's Group Health Plan/Corporation a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within ninety (90) days of being requested to do so; and,
5. Cooperate fully with the Employer's Group Health Plan/Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Employer's Group Health Plan/Corporation.

Failure to cooperate with the Plan as required under this section will entitle the Employer's Group Health Plan/Corporation to invoke the Auto Accident Exclusion and deny payment for all claims relating to the injury or illness up to the amount of available or state mandated coverage.

C. ORDER OF DETERMINATION RULES FOR EMPLOYEE MEMBERS

When a Member's claim is submitted under the Employer's Group Health Plan and another Plan, the Employer's Group Health Plan is a Secondary Plan unless:

1. The other Group Health Plan has rules coordinating its benefits with those of the Employer's Group Health Plan;
2. There is a statutory requirement establishing that the Employer's Group Health Plan is the Primary Plan and such statutory requirement is not pre-empted by ERISA; or,

3. Both the other Plan's rules and the Employer's Group Health Plan's rules require that benefits be determined under the Employer's Group Health Plan before those of the other Plan.

D. ADDITIONAL ORDER OF DETERMINATION RULES

The Employer's Group Health Plan coordinates Benefits using the first of the following rules that apply:

1. Dependents

- a. The Plan that covers an individual as an Employee or retiree is the Primary Plan.

2. Dependent Child - Parents not Separated or Divorced

When the Employer's Group Health Plan and another Plan cover the same child as a dependent then benefits are determined in the following order:

- a. The Plan of the parent whose birthday falls earlier in the year (month and date) is the Primary Plan.
- b. If both parents have the same birthday, the Plan that has covered a parent longer is the Primary Plan.
- c. If the other Plan does not have the rule described in (a) above but instead has a rule based upon the gender of the parent and if, as a result, the Plan and the Corporation do not agree on the order of benefits, the gender rule in the other Plan will apply.

The "birthday rule" does not use the years of the parents' birth in determining which has the earlier birthday.

3. Dependent Child - Separated or Divorced Parents

If two (2) or more Plans cover a person as a dependent child of divorced, separated, or unmarried parents, benefits for the child are determined in the following order:

- a. First, the Plan of the parent with custody of the child;
- b. Second, the Plan of the parent's spouse with the custody of the child;
- c. Third, the Plan of the parent not having custody of the child;
- d. Fourth, the Plan of the parent's spouse not having custody of the child.

Notwithstanding the foregoing, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses (or health insurance coverage) of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, that Plan is the Primary Plan. If the parent with responsibility for healthcare expenses has no health insurance coverage for the dependent child, but that parent's spouse does have coverage, the spouse's Plan is the Primary Plan. This paragraph does not apply with respect to any claim determination period or plan year during which any Benefits are actually paid or provided before the Plan has actual knowledge of the existence of an applicable court decree.

If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the healthcare expenses of the child (or if the order provides that both parents are responsible), the Plans covering the child shall follow the order of determination rules outlined in Article IV(D)(2).

4. Active and Inactive Employees

The Plan that covers a person as an Employee who is neither laid off nor retired or as that Employee's dependent is the Primary Plan. If the Secondary Plan does not have this rule, and if, as a result, the Plans do not agree on the order of Covered Expenses, this rule does not apply.

5. Medicare

The Employer's Group Health Plan is a Primary Plan except where federal law mandates that the Employer's Group Health Plan is the Secondary Plan. Any claims where Medicare is primary must be filed by the Member after Medicare payment is made.

6. Longer and Shorter Length of Coverage

If none of the above rules determines the order of benefits, the Plan that has covered the Member longer is the Primary Plan.

7. COBRA

COBRA allows coverage to begin or continue under certain circumstances if the Member already has or obtains coverage under a Group Health Plan. In these instances, two policies may cover the Member, and the Plan providing COBRA coverage will be the Secondary Plan.

E. EFFECT ON BENEFITS OF THIS PLAN OF BENEFITS

1. The Employer's Group Health Plan as Primary Plan

When the Employer's Group Health Plan is the Primary Plan, the Benefits shall be determined without consideration of the benefits of any other Plan.

2. The Employer's Group Health Plan as Secondary Plan

When the Employer's Group Health Plan is a Secondary Plan, the Benefits will be reduced when the sum of the following exceeds the Covered Expenses in a Benefit Year:

- a. The Covered Expenses in the absence of this coordination of benefits provision; plus
- b. The expenses that would be payable under the other Plan, in the absence of provisions with a purpose like that of this coordination of benefits provision, whether or not a claim is made.

When the sum of these two (2) amounts exceeds the maximum amount payable for Covered Expenses in a Benefit Year, the Covered Expenses will be reduced so that they and the Benefits payable under the Primary Plan do not total more than the Covered Expenses. When the Covered Expenses of the Employer's Group Health Plan are reduced in this manner, each Benefit is reduced in proportion and then charged against any applicable limit of the Employer's Group Health Plan. The benefits payable by the Primary Plan and the Benefits payable by the Employer's Group Health Plan will not total more than what the Employer's Group Health Plan would pay in absence of the other plan.

3. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be a Covered Expense.

4. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not a Covered Expense unless the Member's Admission in a private Hospital room is Medically Necessary. When benefits are reduced under a Primary Plan because a Member does

not comply with the Primary Plan's requirements, the amount of such reduction in benefits will not be a Covered Expense.

F. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

The Employer's Group Health Plan (including through the Corporation) is entitled to such information as it deems reasonably necessary to apply these coordination of benefit provisions and the Member and the Employer must provide any such information as reasonably requested.

G. PAYMENT

A payment made under another Plan may include an amount that should have been paid under the Employer's Group Health Plan. In such a case, the Employer's Group Health Plan may pay that amount to the organization that made such payment. That amount will then be treated as though it had been paid under the Employer's Group Health Plan. The term "payment" includes providing Benefits in the form of services, in which case "payment" means the reasonable cash value of the Benefits provided in the form of services.

H. RIGHT OF RECOVERY

If the amount of the payments made by the Employer's Group Health Plan is more than the Employer's Group Health Plan should have paid under this Coordination of Benefits section, the Employer's Group Health Plan may recover the excess or overpayment from the Member on whose behalf it has made payments, from a Provider, from any group insurer, Plan, or any other person or organization contractually obligated to such Member with respect to such overpayments.

ARTICLE V – CONTINUATION OF COVERAGE

A. CONTINUATION

1. COBRA

a. Plan Administrator and Sponsor

The Employer is both the Plan Administrator and Plan Sponsor for the Employer's Group Health Plan. The Employer agrees to offer continuation of coverage pursuant to the provisions of COBRA, if required, to eligible Members while the Employer's Group Health Plan is in force. COBRA requires the Employer to allow eligible individuals to continue their health coverage for eighteen (18), twenty-nine (29) or thirty-six (36) months, depending on the Qualifying Event.

b. Disabled Members

To be eligible for up to twenty-nine (29) months of continuation of coverage due to disability, an Employee or dependent who:

- i. is determined to be disabled under Title II or XVI of the Social Security Act,
- ii. with a disability onset date either before the COBRA event or within the first sixty (60) days of the COBRA continuation coverage must provide a copy of the notice of the determination of disability to the Employer within:
 - aa. sixty (60) days of the determination of disability; and,

bb. before the end of the first eighteen (18) months of COBRA coverage.

Such Employee or dependent must also notify the Employer within thirty (30) days of any determination that the Employee or dependent is no longer disabled.

c. Notice of Qualifying Event by the Member

Each Member is responsible for notifying the Employer within sixty (60) days of such Member's Qualifying Event due to divorce, legal separation or when a dependent ceases dependency. If the Member does not give such notice, the Member is not entitled to continuation coverage.

d. Notice by the Employer to the Member

The Employer must notify the COBRA Administrator no later than thirty (30) days after the date the Member loses coverage due to a COBRA event. The COBRA Administrator must send a COBRA Election Notice to each Member no later than fourteen (14) days after receipt of the notice from the Employer. Notice to the dependent spouse is deemed notice to any dependent of the spouse.

e. Election of Coverage

Continuation coverage is not automatic. The Member must elect continuation coverage within sixty (60) days of the later of:

- i. The date the Member's coverage under the Employer's Group Health Plan ceases because of the Qualifying Event;
- ii. The date the Member is sent notice by the Employer of the right to elect continuation coverage; or,
- iii. The date the Member becomes an "eligible individual" (as that term is used in the Trade Act of 2002) provided that such election is made not later than six (6) months after the Qualifying Event that gives rise to eligibility under the Trade Act of 2002.

f. Premium Required

The Member will be required to pay a premium for the continuation coverage and shall have the option to make payment in monthly installments. The Member has forty-five (45) days from the date of election to pay the first premium, which includes the period when coverage commenced, regardless of the date that the first premium is due.

The Trade Act of 2002 (TAA) created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of a percentage of the premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282. More information about the TAA is also available at www.doleta.gov/tradeact/.

g. Length of COBRA Coverage

The maximum period for continuation coverage for a Qualifying Event involving termination of employment or a reduction in hours is generally eighteen (18) months. An Employee or dependent who is determined to be disabled under Title II or XVI of the Social Security Act before the COBRA event or within the first sixty (60) days of COBRA continuation coverage is entitled to twenty-nine (29) months of continuation coverage, but only if such Employee or dependent has provided notice of the determination of disability within sixty (60) days after determination is issued and before the end of eighteen (18) months of coverage. If a second Qualifying Event occurs within this period of continuation coverage, the coverage for any affected dependent who was a Member under the Employer's Group Health Plan both at the time of the first and the second Qualifying Events may be extended up to thirty-six (36) months from the first Qualifying Event. For all other Qualifying Events, the maximum period of coverage is thirty-six (36) months. Below is a list of circumstances and the period of COBRA coverage for each circumstance.

- i. Eighteen (18) months for Employees whose working hours are reduced, from full-time to part-time for instance and any dependents who also lose coverage for this reason.
- ii. Eighteen (18) months for Employees who voluntarily quit work and any dependents who also lose coverage for this reason.
- iii. Eighteen (18) months for Employees who are part of a layoff and any dependents who also lose coverage for this reason.
- iv. Eighteen (18) months for Employees who are fired, unless the firing is due to gross misconduct, and any dependents who also lose coverage for this reason.
- v. Twenty-nine (29) months for Employees and all covered dependents who are determined to be disabled under the Social Security Act during the first sixty (60) days after termination of employment or reduction of hours of employment. Notice of the Social Security Disability determination must be given to the COBRA Administrator within sixty (60) days of the determination of disability and before the end of the first eighteen (18) months of continuation of coverage.
- vi. Thirty-six (36) months for Employees' widows or widowers and their dependent children.
- vii. Thirty-six (36) months for legally separated or divorced husbands or wives and their dependent children.
- viii. Thirty-six (36) months for dependent children who lose coverage because they no longer meet the Plan's definition of a dependent child.
- ix. Thirty-six (36) months for dependents who are not eligible for Medicare when the Employee is eligible for Medicare and no longer has coverage with the Employer. This does not apply to any Employees or their dependents if the Employee voluntarily quit work. See Article V(A)(1)(g)(ii) of this section for coverage for Employees who voluntarily quit.

- x. For Plans providing coverage for retired Employees and their dependents, a special rule applies for such persons who would lose coverage due to the Employer filing for Title 11 Bankruptcy. (Loss of coverage includes a substantial reduction of coverage within a year before or after the bankruptcy filing.) Upon occurrence of such an event, retired Employees and their eligible dependents may continue their coverage under the Plan until the date of death of the retiree. If a retiree dies while on this special continued coverage, surviving dependents may elect to continue coverage for up to thirty-six (36) additional months.

2. USERRA

- a. In any case in which an Employee or any of such Employee's dependents has coverage under the Plan of Benefits, and such Employee is not actively at work by reason of active duty service in the uniformed services, the Employee may elect to continue coverage under the Plan of Benefits as provided in this Article V(A)(2). The maximum period of coverage of the Employee and such Employee's dependents under such an election shall be the lesser of:
 - i. The twenty-four (24) month period beginning on the date on which the Employee's absence from being actively at work by reason of active duty service in the uniformed services begins; or,
 - ii. The day after the date on which the Employee fails to apply for or return to a position of employment, as determined under USERRA.

The continuation of coverage period under USERRA will be counted toward any continuation of coverage period available under COBRA.

- b. An Employee who elects to continue coverage under this section of the Employer's Group Health Plan must pay one hundred and two percent (102%) such Employee's normal premium. Except that, in the case of an Employee who performs service in the uniformed services for less than thirty-one (31) days, such Employee will pay the normal contribution for the thirty-one (31) days.
- c. An Employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the Employer's Group Health Plan upon re-employment. Except as otherwise provided in this Article upon re-employment and reinstatement of coverage no new exclusion or probationary period will be imposed in connection with the reinstatement of such coverage if an exclusion would normally have been imposed. This Article applies to the Employee who is re-employed and to a dependent who is eligible for coverage under the Employer's Group Health Plan by reason of the reinstatement of the coverage of such Employee.
- d. The Article V(A)(2)(c) shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

B. QUALIFIED MEDICAL CHILD SUPPORT ORDER

The Employer's Group Health Plan shall pay Covered Expenses in accordance with the applicable requirements of any Qualified Medical Child Support Order.

1. Procedural Requirements

a. Timely Notifications and Determinations

In the case of any Medical Child Support Order received by the Employer's Group Health Plan:

- i. The Employer as the Plan Administrator shall promptly notify the Employee and each Alternate Recipient of the receipt of the Medical Child Support Order and the Corporation's procedures for determining whether Medical Child Support Orders are Qualified Medical Child Support Orders; and,
- ii. Within a reasonable period after receipt of such Qualified Medical Child Support Order, the Employer shall determine whether such order is a Qualified Medical Child Support Order and notify the Employee and each Alternate Recipient of such determination.

b. Establishment of Procedures for Determining Qualified Status of Orders

The Employer as the Plan Administrator shall establish reasonable procedures to determine whether Medical Child Support Orders are Qualified Medical Child Support Orders and to administer the provision of Covered Expenses under such qualified orders. The Employer's procedures:

- i. Shall be in writing;
- ii. Shall provide for the notification of each person specified in a Medical Child Support Order as eligible to receive Benefits under the Plan of Benefits (at the address included in the Medical Child Support Order) of the Employer's procedures promptly upon receipt by the Plan Administrator of the Medical Child Support Order; and,
- iii. Shall 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.

c. Actions Taken by Fiduciaries

If a Plan fiduciary for the Employer's Group Health Plan acts in accordance with these procedural requirements in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then the Employer's Group Health Plan obligation to the Member and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

2. Treatment of Alternate Recipients

a. Under ERISA

A person who is an Alternate Recipient under any Medical Child Support Order shall be considered a beneficiary under the Employer's Group Health Plan for purposes of any provisions of ERISA, as amended, and shall be treated as a participant under the reporting and disclosure requirements of ERISA.

b. Direct Provision of Benefits Provided to Alternate Recipients

Any payment for Covered Expenses made by the Employer's Group Health Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

c. Plan Enrollment and Payroll Deductions

If an Employee remains covered under the Employer's Group Health Plan but fails to enroll an Alternate Recipient under the Plan of Benefits after receiving notice of the Qualified Medical Child Support Order from the Employer, the Employer shall enroll the Alternate Recipient and deduct the additional premium from the Employee's paycheck.

d. Termination of Coverage

Except for any coverage continuation rights otherwise available under the Employer's Group Health Plan, the coverage for the Alternate Recipient shall end on the earliest of:

- i. The date the Employee's coverage ends;
- ii. The date the Qualified Medical Child Support Order is no longer in effect;
- iii. The date the Employee obtains other comparable health coverage through another insurer or Plan to cover the Alternate Recipient; or,
- iv. The date the Employer eliminates family health coverage for all of its Employees.

ARTICLE VI – SUBROGATION AND REIMBURSEMENT

A. BENEFITS SUBJECT TO THIS PROVISION

This provision shall apply to all Benefits provided under any section of the Plan of Benefits. All Benefits under this Plan are being provided by a self-funded ERISA plan.

B. STATEMENT OF PURPOSE

Subrogation and Reimbursement represent significant Plan assets and are vital to the financial stability of the Plan. Subrogation and Reimbursement recoveries are used to pay future claims by other Plan members. Anyone in possession of these assets holds them as a fiduciary and constructive trustee for the benefit of the Plan. The Employer's Group Health Plan has a fiduciary obligation under ERISA to pursue and recover these Plan assets to the fullest extent possible.

C. DEFINITIONS

1. Another Party

Another Party shall mean any individual or entity, other than this Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Member's injuries or illness.

Another Party shall include the party or parties who caused the injuries or illness; the liability insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Member's own insurance coverage, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other insurer; a workers' compensation insurer or governmental entity; or, any other individual, corporation, association or entity that is liable or legally responsible for payment in connection with the injuries or illness.

2. Member

As it relates to the Subrogation and Reimbursement Provision, a Member shall mean any person, dependent or representatives, other than the Plan, who is bound by the terms of the Subrogation and Reimbursement Provision herein. A Member shall include but is not limited to any beneficiary, dependent, spouse or person who has or will receive Benefits under the Plan, and any legal or personal representatives of that person, including parents, guardians, attorneys, trustees, administrators or executors of an estate of a Member, and heirs of the estate.

3. Recovery

Recovery shall mean any and all monies identified, paid or payable to the Member through or from Another Party by way of judgment, award, settlement, covenant, release or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. A Recovery exists as soon as any fund is identified as compensation for a Member from Another Party. Any recovery shall be deemed to apply, first, for Reimbursement of the Plan's lien. The amount owed from the Recovery as Reimbursement of the Plan's lien is an asset of the Plan.

4. Reimbursement

Reimbursement shall mean repayment to the Plan of recovered medical or other Benefits that it has paid toward care and treatment of the injuries or illness for which there has been a Recovery.

5. Subrogation

Subrogation shall mean the Plan's right to pursue the Member's claims for medical or other charges paid by the Plan against Another Party.

D. WHEN THIS PROVISION APPLIES

This provision applies when a Member incurs medical or other charges related to injuries or illness caused in part or in whole by the act or omission of the Member or another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness; or Another Party may otherwise make a payment without an admission of liability. If so, the Member may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Member agrees, as a condition of receiving Benefits from the Plan, to transfer to the Plan all rights to recover damages in full for such Benefits.

E. DUTIES OF THE MEMBER

The Member will execute and deliver all required instruments and papers provided by the Employer's Group Health Plan/Corporation, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other Benefits will be paid by the Plan for the injuries or illness. The Employer's Group Health Plan/Corporation may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Plan will remain entitled to Subrogation and Reimbursement. In addition, the Member will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines. A Member who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the portion of the Recovery subject to the Plan's lien to the Plan under the terms of this provision. A Member who receives any such Recovery and does not immediately tender the Plan's portion of the Recovery to the Plan will be deemed to hold the Plan's portion of the Recovery in constructive trust for the Plan, because the Member is not the rightful owner of the Plan's portion of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed. The portion of the Recovery owed by the Member for the Plan's lien is an asset of the Plan.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Employer's Group Health Plan/Corporation of an injury or illness for which Another Party may be liable, legally responsible or otherwise makes a payment in connection with the injuries or illness;

2. Execute and deliver an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;
3. Deliver to the Employer's Group Health Plan/Corporation a copy of the Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so;
4. Deliver to the Employer's Group Health Plan/Corporation a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within ninety (90) days of being requested to do so;
5. Authorize the Plan to sue, compromise and settle in the Member's name to the extent of the amount of medical or other Benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Member's rights to Recovery when this provision applies;
6. Include the Benefits paid by the Plan as a part of the damages sought against Another Party. Immediately reimburse the Plan, out of any Recovery made from Another Party, the amount of medical or other Benefits paid for the injuries or illness by the Plan up to the amount of the Recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;
7. Immediately notify the Employer's Group Health Plan/Corporation in writing of any proposed settlement and obtain the Employer's Group Health Plan/Corporation's written consent before signing any release or agreeing to any settlement; and,
8. Cooperate fully with the Employer's Group Health Plan/Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Employer's Group Health Plan/Corporation.

F. FIRST PRIORITY RIGHT OF SUBROGATION AND/OR REIMBURSEMENT

Any amounts recovered will be subject to Subrogation or Reimbursement. The Plan will be subrogated to all rights the Member may have against that other person or Another Party and will be entitled to first priority Reimbursement out of any Recovery to the extent of the Plan's payments. In addition, the Plan shall have a first priority equitable lien against any Recovery to the extent of Benefits paid and to be payable in the future. The Plan's first priority equitable lien supersedes any right that the Member may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Member procures or may be entitled to procure regardless of whether the Member has received full compensation for any of his or her damages or expenses, including attorneys' fees or costs and regardless of whether the Recovery is designated as payment for medical expenses or otherwise. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative or contributory negligence, limits of collectability or responsibility, characterization of Recovery as pain and suffering or otherwise. As a condition to receiving Benefits under the Plan, the Member agrees that acceptance of Benefits is constructive notice of this provision.

G. WHEN A MEMBER RETAINS AN ATTORNEY

An attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) for an injury or illness in which the Plan has paid or will pay Benefits, has an absolute obligation to immediately tender the portion of the Recovery subject to the Plan's equitable lien to the Plan under the terms of this provision. As a possessor of a portion of the Recovery, the Member's attorney holds the Recovery as a constructive trustee and fiduciary and is obligated to tender the Plan's portion of the Recovery immediately over to the Plan. A Member's attorney who receives any such Recovery and does not immediately tender the Plan's portion of the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because neither the Member nor the attorney is the rightful owner of the portion of the Recovery subject to the Plan's lien. The portion of the Recovery owed for the Plan's lien is an asset of the Plan.

If the Member retains an attorney, the Member's attorney must recognize and consent to the fact that this provision precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine against the Plan in his or her pursuit of Recovery. The Plan will not pay the Member's attorneys' fees and costs associated with the recovery of funds, nor will it reduce its Reimbursement pro rata for the payment of the Member's attorneys' fees and costs, without the expressed written consent of the Corporation.

H. WHEN THE MEMBER IS A MINOR OR IS DECEASED OR INCAPACITATED

This Subrogation and Reimbursement Provision will apply with equal force to the parents, trustees, guardians, administrators, or other representatives of a minor, incapacitated, or deceased Member and to the heirs or personal and legal representatives, regardless of applicable law. No representative of a Member listed herein may allow proceeds from a Recovery to be allocated in a way that reduces or minimizes the Plan's claim by arranging for others to receive proceeds of any judgment, award, settlement, covenant, release or other payment or releasing any claim in whole or in part without full compensation therefore or without the prior written consent from the Employer's Group Health Plan/Corporation.

I. WHEN A MEMBER DOES NOT COMPLY

When a Member does not comply with the provisions of this section, the Employer's Group Health Plan/Corporation shall have the authority, in its sole discretion, to deny payment of any claims for Benefits by the Member and to deny or reduce future Benefits payable (including payment of future Benefits for other injuries or illnesses) under the Plan by the amount due as satisfaction for the Reimbursement to the Plan. The Employer's Group Health Plan/Corporation may also, in its sole discretion, deny or reduce future Benefits (including future Benefits for other injuries or illnesses) for the Member under any other group benefits plan maintained by the Employer. The reductions will equal the amount of the required Reimbursement; however, under no circumstances shall the Reimbursement, denial or reduction of Benefits exceed the amount of the Recovery. If the Plan must bring an action against a Member to enforce the provisions of this section, then the Member agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

J. PRIOR RECOVERIES

In certain circumstances, a Member may receive a Recovery that exceeds the amount of the Plan's payments for past and/or present expenses for treatment of the injuries or illness that is the subject of the Recovery. In other situations, based on the extent of the Member's injuries or illness, the Member may have received a prior Recovery for treatment of the injuries or illness that is the subject of a claim for Benefits under the Plan. In these situations, the Plan will not provide Benefits for any expenses related to the injuries or illness for which compensation was provided through a current or previous Recovery. The Member is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses. To the extent a Member's Recovery exceeds the amount of the Plan's lien, the Plan is entitled to deny that amount as an offset against any claims for future Benefits relating to the injuries or illness. In those situations, the Member will be solely responsible for payment of medical bills related to the injuries or illness. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

The Employer's Group Health Plan/Corporation has sole discretion to determine whether expenses are related to the injuries or illness to the extent this provision applies. Acceptance of Benefits under the Plan for injuries or illness which the Member has already received a Recovery may be considered fraud, and the Member will be subject to any sanctions determined by the Employer's Group Health Plan/Corporation, in their sole discretion, to be appropriate, including denial of present or future Benefits under the Plan.

ARTICLE VII - WORKERS' COMPENSATION PROVISION

This Plan does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member or the Employer elected exemption from available workers' compensation coverage; waived entitlement to workers' compensation benefits for which he/she is eligible; failed to timely file a claim for workers' compensation benefits; or the Member sought treatment for the injury or illness from a Provider not authorized by the Member's Employer or Workers' Compensation carrier.

Although treatment for work-related or alleged work-related injuries or illness is excluded under this Plan of Benefits, the Employer's Group Health Plan/Corporation may, in its sole discretion, agree to extend Benefits to a Member for the injury or illness. In this instance, the Member agrees, as a condition of receiving Benefits, to reimburse the Plan in full from any workers' compensation recovery as described herein. The Member further agrees as a condition of receiving Benefits, to execute and deliver all required instruments and papers provided by the Employer's Group Health Plan/Corporation, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Plan's right of recovery, before any medical or other Benefits will be paid by the Plan for the injuries or illness. The Employer's Group Health Plan/Corporation may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Plan will remain entitled to reimbursement from any workers' compensation recovery the Member may receive.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Employer's Group Health Plan/Corporation of an injury or illness for which his/her Employer and/or Employers' Workers' Compensation carrier may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;

2. Execute and deliver an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;
3. Deliver to the Employer's Group Health Plan/Corporation a copy of the police report, incident or accident report or any other reports issued as a result of the injury or illness within ninety (90) days of being requested to do so;
4. Assert a claim or lawsuit against the Employer and/or Employer's Workers' Compensation carrier or any other insurance coverage to which the Member may be entitled;
5. Include the Benefits paid by the Plan as a part of the damages sought against his/her Employer and/or Employer's Workers' Compensation carrier. Immediately reimburse the Plan, out of any recovery made from the Employer and/or Employer's Workers' Compensation carrier, the amount of medical or other Benefits paid for the injuries or illness by the Plan up to the amount of the recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;
6. Immediately notify the Employer's Group Health Plan/Corporation in writing of any proposed settlement and obtain the Employer's Group Health Plan/Corporation's written consent before signing any release or agreeing to any settlement; and,
7. Cooperate fully with the Employer's Group Health Plan/Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Employer's Group Health Plan/Corporation.

The Employer's Group Health Plan/Corporation has sole discretion to determine whether claims for Benefits submitted to the Plan are related to the injuries or illness to the extent this provision applies. If the Employer's Group Health Plan/Corporation pays Benefits for an injury or illness and the Employer's Group Health Plan/Corporation determines the Member also received a recovery from the Employer and/or Employer's Workers' Compensation carrier by means of a settlement, judgment, or other payment for the same injury or illness, the Member shall reimburse the Plan from the recovery for all Benefits paid by the Plan relating to the injury or illness. However, under no circumstances shall the Member's reimbursement to the Plan exceed the amount of such recovery.

If the Member receives a recovery from the Employer and/or Employer's Workers' Compensation carrier, the Plan's right of reimbursement from the recovery will be applied even if: liability is denied, disputed or is made by means of a compromised, doubtful and disputed, clincher or other settlement; no final determination is made that the injury or illness was sustained in the course of or resulted from the Member's employment; the amount of workers' compensation benefits due to medical or healthcare is not agreed upon or defined by the Member, Employer or the Workers' Compensation carrier; or, the medical or healthcare benefits are specifically excluded from the settlement or compromise.

Failure to reimburse the Plan from the recovery as required under this section will entitle the Employer's Group Health Plan/Corporation to invoke the Workers' Compensation exclusion and deny payment for all claims relating to the injury or illness.

ARTICLE VIII - CLAIMS FILING AND APPEAL PROCEDURES

A. CLAIMS FILING PROCEDURES

1. 1. Where a Participating Provider renders services, generally the Participating Provider should either file the claim on a Member's behalf or provide an electronic means for the Member to file a claim while the Member is in the Participating Provider's office. However, the Member is responsible for ensuring that the claim is filed.

2. Written notice of receipt of services on which a claim is based must be furnished to the Corporation, at its address listed in the booklet, within twenty (20) days of the beginning of services, or as soon thereafter as is reasonably possible. Failure to give notice within the time does not invalidate nor reduce any claim if the Member can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, the Corporation will furnish or cause a claim form to be furnished to the Member. If the claim form is not furnished within fifteen (15) days after the Corporation receives the notice, the Member will be deemed to have complied with the requirements of this Plan of Benefits as to proof of loss. The Member must submit written proof covering the character and extent of the services within the policy time fixed for filing proof of loss.
3. For Benefits not provided by a Participating Provider, the Member is responsible for filing claims with the Corporation. When filing the claims, the Member will need the following:
 - a. A claim form for each Member. Members can get claim forms from a member services representative at the telephone number indicated on the Identification Card or via the Corporation's website, www.MyHealthToolkitKC.com.
 - b. Itemized bills from the Provider (s). These bills should contain all the following:
 - i. Provider's name and address;
 - ii. Member's name and date of birth;
 - iii. Member's Identification Card number;
 - iv. Description and cost of each service;
 - v. Date that each service took place; and
 - vi. Description of the illness or injury and diagnosis.
 - c. Members must complete each claim form and attach the itemized bill(s) to it. If a Member has other insurance that already paid on the claim(s), the Member should also attach a copy of the other Plan's Explanation of Benefits notice.
 - d. Members should make copies of all claim forms and itemized bills for the Member's records since they will not be returned. Claims should be mailed to the Corporation's address listed on the claim form.
4. The Corporation must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Member shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than twelve (12) months following the date services were received.
5. Receipt of a claim by the Corporation will be deemed written proof of loss and will serve as written authorization from the Member to the Corporation to obtain any medical or financial records and documents useful to the Plan of Benefits. The Plan of Benefits, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to the Corporation in support of a Member's claim will be deemed to be acting as the agent of the Member. If the Member desires to appoint an Authorized Representative in connection with such Member's claims, the Member should contact the Corporation for an Authorized Representative form.

6. Notice of Determination

- a. If the Member's claim is filed properly, and the claim is in part or wholly denied, the Member will receive notice of an Adverse Benefit Determination, in a culturally and linguistically appropriate manner, that will:
 - i. Include information sufficient to identify the claim involved (including date of service, healthcare Provider, claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;
 - ii. State the specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim;
 - iii. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Member's claim;
 - iv. Reference the specific Plan of Benefits provisions on which the determination is based;
 - v. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;
 - vi. Describe the claims review procedures and the Plan of Benefits and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;
 - vii. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request); and,
 - viii. If the reason for denial is based on a lack of Medical Necessity or Investigational or Experimental Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
 - ix. Disclose any internal rule, guideline or protocol relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request);
 - x. Provide a description of available internal appeals and external review processes, including information regarding how to initiate such appeals;
 - xi. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review process;
 - xii. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA.
- b. The Member will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings, associated with the Adverse Benefit Determination.
- c. No decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support the denial of Benefits.
- d. The Member will also receive a notice if the claim is approved.

B. IF YOUR CLAIM IS DENIED

1. If a claim for Benefits is denied in part or in whole, the Member may call BCBS at the number on the Member's ID card before requesting a formal appeal. If BCBS cannot resolve the issue to the Member's satisfaction over the phone, the Member has the right to file a formal appeal as described below.
2. How to Appeal a Denied Claim
 - a. If the Member wishes to appeal a denied pre-service request for Benefits or Post-Service Claim as described below, the Member or an authorized representative must submit the Member's appeal in writing within one-hundred eighty (180) days of receiving the denial. This written communication should include:
 - i. the patient's name and ID number as shown on the ID card;
 - ii. the provider's name;
 - iii. the date of medical service;
 - iv. the reason the Member disagree with the denial; and
 - v. any documentation or other written information to support the Member's request.
 - b. The Member or enrolled dependent may send a written request for an appeal to:
BlueCross BlueShield
Post Office Box 100121
Columbia, South Carolina 29202
3. For urgent care requests for Benefits that have been denied, the Member or Provider can call BCBS at the toll-free number on the Member's ID card to request an appeal.
4. Review of an Appeal
 - a. BCBS will conduct a full and fair review of the Member's appeal. The appeal may be reviewed by:
 - i. an appropriate individual(s) who did not make the initial Benefit determination; and
 - ii. a health care professional with appropriate expertise who was not consulted during the initial Benefit determination process.
 - b. Once the review is complete, if BCBS care upholds the denial, the Member will receive a written explanation of the reasons and facts relating to the denial.
5. Filing a Second Appeal
 - a. The Member's Plan offers two levels of appeal. If Member is not satisfied with the first level appeal decision, the Member has the right to request a second level appeal from Commerce Bancshares, Inc. within sixty (60) days from receipt of the first level appeal determination. Commerce Bancshares, Inc. must notify the Member of the appeal determination within fifteen (15) days after receiving the completed appeal for a pre-service denial and thirty (30) days after receiving the completed post-service appeal.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. Commerce Bancshares, Inc. will review all claims in accordance with the rules established by the U.S. Department of Labor. Commerce Bancshares, Inc.'s decision will be final.

6. External Review Program

- a. If, after exhausting internal appeals, the Member is not satisfied with the final determination, the Member may choose to participate in the External Review Program. This program only applies if the Adverse Benefit Determination is based on:
 - i. clinical reasons;
 - ii. the exclusions for Experimental or Investigational Services or Unproven Services; or
 - iii. as otherwise required by applicable law.
- b. This External Review Program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to Members after exhausting the appeals process identified above and receiving a decision that is unfavorable, or if Commerce Bancshares, Inc. fails to respond to a Member's appeal in accordance with applicable regulations.
- c. If the above conditions are satisfied, the Member may request an independent review of the Adverse Benefit Determination. Neither the Member nor Commerce Bancshares, Inc. will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.
- d. All requests for an independent review must be made within four (4) months of the date the Member received the second level appeal Adverse Benefit Determination. The Member or an authorized designated representative may request an independent review by contacting the toll-free number on the Member's ID card or by sending a written request to the address on the Member's ID card.
- e. The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a Covered Health Service under the Plan. The Independent Review Organization (IRO) has been contracted by BCBS and has no material affiliation or interest with Commerce Bancshares, Inc. BCBS will choose the IRO based on a rotating list of appropriately accredited IROs.
- f. In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.
- g. Within applicable timeframes of Commerce Bancshares, Inc.'s receipt of a request for independent review, the request will be forwarded to the IRO, together with:
 - i. all relevant medical records;
 - ii. all other documents relied upon by Commerce Bancshares, Inc. in making a decision on the case; and
 - iii. all other information or evidence that the Member or Physician has already submitted to Commerce Bancshares, Inc.

- h. If there is any information or evidence the Member or Physician wish to submit in support of the request that was not previously provided, the Member may include this information with the request for an independent review, and Commerce Bancshares, Inc. will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if the Member meets the criteria for an expedited external review as defined by applicable law.
- i. The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide the Member and Commerce Bancshares, Inc. with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.
- j. If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide Benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.
- k. The Member may contact BCBS at the toll-free number on the Member's ID card for more information regarding the Member's external appeal rights and the independent review process.

7. Timing of Appeals Determinations

- a. Separate schedules apply to the timing of claims appeals, depending on the type of claim.
- b. There are three types of claims:
 - i. Urgent care request for Benefits - a request for Benefits provided in connection with urgent care services, as defined in the Definitions and Coverage Requirements section;
 - ii. Pre-service request for Benefits - a request for Benefits which the Plan must approve or in which the Member must notify BCBS before non-urgent care is provided; and
 - iii. Post-service - a claim for reimbursement of the cost of non-urgent care that has already been provided.
- c. The tables below describe the time frames which the Member and BCBS are required to follow.

8. Types of claims

- a. The timing of the claims appeal process is based on the type of claim the Member are appealing. If the Member wishes to appeal a claim, it helps to understand whether it is an:
 - i. urgent care request for Benefits;
 - ii. pre-service request for Benefits;
 - iii. Post-Service Claim; or
 - iv. concurrent claim.

| Urgent Care Request for Benefits* | |
|---|--|
| Type of Request for Benefits or Appeal | Timing |
| If the Member request for Benefits is incomplete, BCBS must notify the Member within: | 24 hours |
| The Member must then provide completed request for Benefits information to BCBS within: | 48 hours after receiving notice |
| If BCBS denies the Member's initial request for Benefits, they must notify the Member of the denial: | |
| ■ if the initial request for Benefits is complete, within: | 72 hours |
| ■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within: | 48 hours |
| The Member must appeal the request for Benefits denial no later than: | 180 days after receiving the denial |
| BCBS must notify the Member of the appeal decision within: | 72 hours after receiving the appeal |

*The Member does not need to submit urgent care appeals in writing. The Member should call BCBS as soon as possible to appeal an urgent care request for Benefits.

| Pre-Service Request for Benefits | |
|---|---|
| Type of Request for Benefits or Appeal | Timing |
| If the Member request for Benefits is filed improperly, BCBS must notify the Member within: | 5 days |
| If the Member's request for Benefits is incomplete, BCBS must notify the Member within: | 15 days |
| | |
| The Member must then provide completed request for Benefits information to BCBS within: | 45 days after receiving an extension notice* |
| If BCBS denies the Member's initial request for Benefits, they must notify the Member of the denial: | |
| ■ if the initial request for Benefits is complete, within: | 15 days |
| ■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within: | 15 days |
| The Member must appeal the request for Benefits denial no later than: | 180 days after receiving the denial |
| BCBS must notify the Member of the first level appeal decision within: | 15 days after receiving the first level appeal |

| Pre-Service Request for Benefits | |
|--|--|
| Type of Request for Benefits or Appeal | Timing |
| The Member must appeal the first level appeal (file a second level appeal) within: | 60 days after receiving the first level appeal decision |
| Commerce Bancshares, Inc. must notify the Member of the second level appeal decision within: | 15 days after receiving the second level appeal* |

* BCBS may require a one-time extension of no more than fifteen (15) days only if more time is needed due to circumstances beyond their control.

| Post-Service Claims | |
|--|--|
| Type of Claim or Appeal | Timing |
| If the Member's claim is incomplete, BCBS must notify the Member within: | 30 days |
| The Member must then provide completed claim information to BCBS within: | 45 days after receiving an extension notice* |
| If BCBS denies the Member's initial claim, they must notify the Member of the denial: | |
| ■ if the initial claim is complete, within: | 30 days |
| ■ after receiving the completed claim (if the initial claim is incomplete), within: | 30 days |
| The Member must appeal the claim denial no later than: | 180 days after receiving the denial |
| BCBS must notify the Member of the first level appeal decision within: | 30 days after receiving the first level appeal |
| The Member must appeal the first level appeal (file a second level appeal) within: | 60 days after receiving the first level appeal decision |
| Commerce Bancshares, Inc. must notify the Member of the second level appeal decision within: | 30 days after receiving the second level appeal |

* BCBS may be entitled to a one-time extension of no more than fifteen (15) days only if more time is needed due to circumstances beyond their control.

9. Concurrent Care Claims

- a. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and the Member's request to extend the treatment is an urgent care request for Benefits as defined above, the Member's request will be decided within seventy-two (72) hours, provided the Member's request is made at least twenty-four (24) hours prior to the end of the approved treatment. BCBS will make a determination on the Member's request for the extended treatment within seventy-two (72) hours from receipt of the Member's request.
- b. If the Member's request for extended treatment is not made at least twenty-four (24) hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and the Member's request to extend treatment in a non-urgent circumstance, the Member's request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

10. Limitation of Action

- a. The Member cannot bring any legal action against Commerce Bancshares, Inc. or the Claims Administrator to recover reimbursement until ninety (90) days after the Member has properly submitted a request for reimbursement as described in this section and all required reviews of the Member's claim have been completed. If the Member wants to bring a legal action against Commerce Bancshares, Inc. or the Claims Administrator, the Member must do so within three (3) years from the expiration of the time period in which a request for reimbursement must be submitted or the Member loses any rights to bring such an action against Commerce Bancshares, Inc. or the Claims Administrator.
- b. The Member cannot bring any legal action against Commerce Bancshares, Inc. or the Claims Administrator for any other reason unless the Member first completes all the steps in the appeal process described in this section. After completing that process, if the Member wants to bring a legal action against Commerce Bancshares, Inc. or the Claims Administrator the Member must do so within three (3) years of the date the Member is notified of our final decision on the Member's appeal or the Member loses any rights to bring such an action against Commerce Bancshares, Inc. or the Claims Administrator.

ARTICLE IX - GENERAL PROVISIONS

ADMINISTRATIVE SERVICES ONLY

The Corporation provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The Employer's Group Health Plan is a self-funded health Plan and the Employer assumes all financial risk and obligation with respect to claims.

AMENDMENT

Upon thirty (30) days prior written notice, the Employer may unilaterally amend the Employer's Group Health Plan. Increases in the Benefits provided or decreases in the premium are effective without such prior notice. The Corporation has no responsibility to provide individual notices to each Member when an amendment to the Employer's Group Health Plan has been made.

AUTHORIZED REPRESENTATIVES

A Provider may be considered a Member's authorized representative without a specific designation by the Member when the Preauthorization request is for Urgent Care Claims. A Provider may be a Member's authorized representative with regard to non-Urgent Care Claims only when the Member gives the Corporation or the Provider a specific designation, in a format that is reasonably acceptable to the Employer's Group Health Plan to act as an authorized representative. If the Member has designated an authorized representative, all information and notifications will be directed to that representative unless the Member gives contrary directions.

BLUECARD PROGRAM

Out-of-Area Services.

BCBSKC has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Members access healthcare services outside the geographic area BCBSKC serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to BCBSKC for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this Agreement are described generally below.

Typically, Members, when accessing care outside the geographic area BCBSKC serves, obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from non-participating healthcare providers. BCBSKC's payment practices in both instances are described below.

A. BlueCard® Program

- (a) Under the BlueCard® Program, when Members access covered healthcare services within the geographic area served by a Host Blue (a Blue Cross and /or Blue Shield Licensee other than BCBSKC), BCBSKC will remain responsible to Purchaser for fulfilling BCBSKC's contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

(b) Liability Calculation Method Per Claim.

The calculation of the Member liability on claims for covered healthcare services processed through the BlueCard Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to BCBSKC by the Host Blue.

The calculation of the Purchaser's liability on claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to BCBSKC by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating healthcare provider(s) an inclusive allowance (e.g., per case or per day amount) for specific healthcare services.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to BCBSKC by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

- (i) an actual price. An actual price is a negotiated payment without any other increases or decreases, or
- (ii) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or
- (iii) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Member and Purchaser is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to BCBSKC is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

If a Host Blue uses either an estimated price or an average price on a claim, it may also hold some portion of the amount that Purchaser pays in a variance account, pending settlement with its participating healthcare providers. Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from Purchaser. Such payable or receivable would be eventually exhausted by healthcare provider settlements and/or through prospective adjustment to the negotiated prices. *Some Host Blues may retain interest earned, if any, on funds held in variance accounts.*

A small number of states require Host Blues either (i) to use a basis for determining Member liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge.

Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, BCBSKC would then calculate Member liability and Purchaser liability in accordance with applicable law.

(c) Return of Overpayments.

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by claim or prospective basis.

(d) BlueCard Program Fees and Compensation

Purchaser understands and agrees to reimburse BCBSKC for certain fees and compensation which BCBSKC is obligated under the BlueCard Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA), and/or to BlueCard Program vendors, as described below. Fees and compensation under the BlueCard Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by any Purchaser. Such revisions typically are made annually as a result of Program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with Purchaser's benefit period under this Agreement.

(e) BCBSKC will charge these fees as follows

Fees associated with claims processing:

- Access fees
- Administrative Expense Allowance (AEA) fees
- Per Contract Per Month (PCPM) fees
- Non-Standard AEA fees
- Central Financial Agency (CFA) fees
- ITS transaction fees

Other possible BlueCard Program-related fees:

- Toll-free (e.g., 800 number) number fees
- PPO provider directory fees

All BlueCard Program-related fees, including any access fees paid to Host Blues, are included in BCBSKC's Administrative Charge. See Schedule A (Fee Listing section of this Agreement).

B. Negotiated National Account Arrangements

As an alternative to the BlueCard Program, Members claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue.

If BCBSKC and the Purchaser have agreed that (a) Host Blue(s) shall make available (a) custom healthcare provider network(s) in connection with this Agreement, then the terms and conditions set forth in BCBSKC's negotiated National Account arrangement(s) with such Host Blue(s) shall apply. In negotiating such arrangement(s), BCBSKC is not acting on behalf of or as an agent for the Purchaser or for the Members.

The Purchaser agrees that BCBSKC will not have any responsibility in connection with the processing and payment of claims when Members access such network(s), except as may be set forth in the relevant participation agreement.

Members Liability Calculation

Members liability calculation will be based on the lower of either billed covered charges or negotiated price made available to BCBSKC by the Host Blue that allows Purchaser's Members access to negotiated participation agreement networks of specified participating healthcare providers outside of BCBSKC's service area.

Fees and Compensation

The Purchaser understands and agrees to reimburse BCBSKC for certain fees and compensation which BCBSKC is obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the Programs' standard procedures for revising such fees and compensation, which do not provide for prior approval by any Purchaser. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with the Purchaser's benefit period under this Agreement.

In addition, the participation agreement with the Host Blue may provide that BCBSKC must pay an administrative and/or a network access fee to the Host Blue, and the Purchaser further agrees to reimburse BCBSKC for any such applicable administrative and/or network access fees. For this type of negotiated participation arrangement, any such administrative and/or network access fees will not be greater than the comparable fees that would be charged under the BlueCard Program.

C. Non-Participating Providers Outside BCBSKC's Service Area

For information regarding payment of a Non-Participating Provider see the "DEFINITIONS AND COVERAGE REQUIREMENTS" section of the Plan of Benefits.

Fees and Compensation

The Purchaser understands and agrees to reimburse BCBSKC for certain fees and compensation which BCBSKC is obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the Programs' standard procedures for revising such fees and compensation, which do not provide for prior approval by any Purchaser. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with the Purchaser's benefit period under this Agreement.

In addition, BCBSKC must pay an administrative fee to the Host Blue, and the Purchaser further agrees to reimburse BCBSKC for any such administrative fee. See Schedule A for any applicable fees.

CLERICAL ERRORS

Clerical errors by the Corporation or the Employer will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

DISCLOSURE OF PHI TO PLAN SPONSOR

The Employer's Group Health Plan will disclose (or will require BlueCross BlueShield to disclose) Member's PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Employer's Group Health Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Plan Sponsor will be subject to and consistent with the provisions of paragraphs A and B of this section.

A. Restrictions on Plan Sponsor's Use and Disclosure of PHI.

1. The Plan Sponsor will neither use nor further disclose Member's PHI, except as permitted or required by the Plan Documents, as amended, or required by law.
2. The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Member PHI agrees to the restrictions and conditions of the Plan of Benefits, with respect to Member's PHI.
3. The Plan Sponsor will not use or disclose Member PHI for employment-related actions or decisions or in connection with any other benefit or Employee benefit Plan of the Plan Sponsor.
4. The Plan Sponsor will report to Employer's Group Health Plan any use or disclosure of Member PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.
5. The Plan Sponsor will make PHI available to the Member who is the subject of the information in accordance with HIPAA.
6. The Plan Sponsor will make Member PHI available for amendment, and will on notice amend Member PHI, in accordance with HIPAA.
7. The Plan Sponsor will track disclosures it may make of Member PHI so that it can make available the information required for the Employer's Group Health Plan to provide an accounting of disclosures in accordance with HIPAA.
8. The Plan Sponsor will make its internal practices, books and records, relating to its use and disclosure of Member PHI, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.
9. The Plan Sponsor will, if feasible, return or destroy all Member PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the Employer's Group Health Plan, including all copies of and any data or compilations derived from and allowing identification of any Member who is the subject of the PHI, when the Member's PHI is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, the Plan Sponsor will limit the use or disclosure of any Member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.
10. The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Employer's Group Health Plan.

11. The Plan Sponsor will ensure that any agent, including a subcontractor, to whom Plan Sponsor provides ePHI (that Plan Sponsor creates, receives, maintains or transmits on behalf of the Employer's Group Health Plan), agrees to implement reasonable and appropriate security measures to protect this information.
12. Plan Sponsor shall report any security incident of which it becomes aware to the Employer's Group Health Plan as provided below.
 - i. In determining how and how often Plan Sponsor shall report security incidents to Employer's Group Health Plan, both Plan Sponsor and Employer's Group Health Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, both Plan Sponsor and Employer's Group Health Plan agree that this Agreement shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the Parties consider the following to be illustrative (but not exhaustive) of unsuccessful security incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of ePHI or interference with an information system:
 - aa. Pings on a Party's firewall;
 - bb. Port scans;
 - cc. Attempts to log on to a system or enter a database with an invalid password or username;
 - dd. Denial-of-service attacks that do not result in a server being taken offline and,
 - ee. Malware (e.g., worms, viruses).
 - ii. Plan Sponsor shall, however, separately report to Employer's Group Health Plan (i) any successful unauthorized access, use, disclosure, modification or destruction of the Group Health Plan's ePHI of which Plan Sponsor becomes aware if such security incident either (a) results in a breach of confidentiality; (b) results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of Group Health Plan's ePHI; or (c) results in a breach of availability of Group Health Plan's ePHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after Plan Sponsor becomes aware of the impact of such security incident upon Group Health Plan's ePHI.

B. Adequate Separation between the Plan Sponsor and the Employer's Group Health Plan.

1. Only Employees or other workforce members under the control of the Plan Sponsor ("Employees") who, in the normal course of their duties, assist in the administration of Employee Benefits or the Employer's Group Health Plan or the Employer's Group Health Plan finances or other classes of Employees as designated in writing by the Plan Sponsor may be given access to Member PHI received from the Employer's Group Health Plan or business associate servicing the Employer's Group Health Plan.
2. These Employees will have access to Member PHI only to perform the Plan administration functions that the Plan Sponsor provides for the Employer's Group Health Plan.
3. These Employees will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Member PHI in breach or violation of or noncompliance with the provisions of this section to the Plan of Benefits. Plan Sponsor will promptly report such breach, violation or noncompliance to the Employer's Group Health Plan, and will cooperate with the Employer's Group Health Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each Employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Member, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.
4. The Plan Sponsor will ensure that the separation required by the above provisions will be supported by reasonable and appropriate security measures.

Plan Sponsor certifies that the Plan of Benefits contains and that the Plan Sponsor agrees to the provisions outlined above.

EMPLOYER IS AGENT OF MEMBERS

By accepting Benefits, a Member agrees that the Employer is the Member's agent for all purposes of any notice under Employer's Group Health Plan. The Member further agrees that notifications received from, or given to, the Employer by the Corporation are notification to the Employees except for any notice required by law to be given to the Members by the Corporation.

GOVERNING LAW

The Employer's Group Health Plan (including the Schedule of Benefits) is governed by and subject to applicable federal law. If and to the extent that federal law does not apply, the Employer's Group Health Plan is governed by and subject to the laws of the State of Missouri. If federal law conflicts with any state law, then such federal law shall govern. If any provision of the Employer's Group Health Plan conflicts with such law, the Employer's Group Health Plan shall automatically be amended solely as required to comply with such state or federal law.

IDENTIFICATION CARD

A Member must present his or her Identification Card prior to receiving Benefits.

Identification Cards are for identification only. Having an Identification Card creates no right to Benefits or other services. To be entitled to Benefits, the cardholder must be a Member whose premium has been paid. Any person receiving Covered Expenses to which the person is not entitled will be responsible for the charges.

INFORMATION AND RECORDS

The Corporation and the Employer are entitled to obtain such medical and Hospital records as may reasonably be required from any Provider incident to the treatment, payment and healthcare operations for the administration of the Benefits hereunder and the attending Provider's certification as to the Medical Necessity for care or treatment.

LEGAL ACTIONS

No Member may bring an action at law or in equity to recover on the Employer's Group Health Plan until such Member has exhausted the appeal process as set forth in Article VIII. No such action may be brought after the expiration of any applicable period prescribed by law.

NEGLIGENCE OR MALPRACTICE

The Corporation and Employer do not practice medicine. Any medical treatment, service or Medical Supplies rendered to or supplied to any Member by a Provider is rendered or supplied by such Provider and not by the Corporation or the Employer. The Corporation and Employer are not liable for any improper or negligent act, inaction or act of malfeasance of any Provider in rendering such medical treatment, service, Medical Supply or medication.

NOTICES

Except as otherwise provided in the Employer's Group Health Plan, any notice under the Employer's Group Health Plan may be given by United States registered or certified mail, postage paid, return receipt requested or nationally recognized carrier and addressed:

1. To the Corporation:

BlueCross BlueShield
P.O. Box 100121
Columbia, South Carolina 29202

2. To a Member: To the last known name and address listed for the Employee related to such Member on the membership application. Members are responsible for notifying the Corporation of any name or address changes within thirty-one (31) days of the change.
3. To the Employer: To the name and address last given to the Corporation. The Employer is responsible for notifying the Corporation and Members of any name or address change within thirty-one (31) days of the change.

NO WAIVER OF RIGHTS

On occasion, the Corporation (on behalf of the Employer's Group Health Plan) or the Employer may, at their discretion, choose not to enforce all of the terms and conditions of the Employer's Group Health Plan. Such a decision does not mean the Employer's Group Health Plan or Employer waives or gives up any rights under the Employer's Group Health Plan in the future.

OTHER INSURANCE

Each Member must provide the Employer's Group Health Plan (and its designee, including the Corporation) and Employer with information regarding all other health insurance coverage to which such Member is entitled.

PAYMENT OF CLAIMS

A Member is expressly prohibited from assigning any right to payment of Covered Expenses or any payment related to Benefits. The Employer's Group Health Plan may pay all Covered Expenses directly to the Member upon receipt of due proof of loss when a Non-Participating Provider renders services. When payment is made directly to the Member, the Member is responsible for any payment to the Provider. Where a Member has received Benefits from a Participating Provider, the Employer's Group Health Plan will pay Covered Expenses directly to such Participating Provider.

PHYSICAL EXAMINATION

The Employer's Group Health Plan has the right to have examined, at their own expense, a Member whose injury or sickness is the basis of a claim (whether pre-service, post-service, concurrent or urgent care). Such physical examination may be made as often as the Employer's Group Health Plan (through its designee, including the Corporation) may reasonably require while such claim for Benefits or request for Preauthorization is pending.

REPLACEMENT COVERAGE

If the Employer's Group Health Plan replaced the Employer's prior Plan, all eligible persons who were validly covered under that Plan on its termination date will be covered on the Plan of Benefits Effective Date of the Employer's Group Health Plan, provided such persons are enrolled.

INDEX

This index contains instances of the use of defined terms in the Employer's Group Health Plan. This index does not include Benefits or excluded items.

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Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188]。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보법에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در بارهی این برنامهی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شمارهی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)
