

COMMERCE BANCSHARES, INC.

GROUP DENTAL PLAN

SECTION I INTRODUCTION

Commerce Bancshares, Inc. and its affiliated entities (collectively “Commerce”) maintain the Commerce Bancshares, Inc. Group Dental Plan (the “Dental Plan” or “Plan”) for the purpose of providing eligible employees and their dependents dental coverage. This document constitutes both the legal plan document and the summary plan description.

Commerce has contracted on behalf of the Plan with dental provider networks in order to provide cost effective coverage for participants. In general, you are eligible to use the dental service provider of your choice. However, if you choose to receive benefits from a non-network provider, the amount paid to these providers may be limited to reasonable and customary charges as indicated in this document.

The Commerce Group Dental Plan is a self-insured Plan with claims, reserves and administrative expenses paid by Commerce Bancshares, Inc. and Participants. MetLife (hereafter referred to as the “claims administrator”) is responsible for the timely and correct processing of claims, and performing other administrative duties.

Every attempt has been made to explain the provisions of this Plan in a manner that may be easily understood. You are encouraged to read it carefully. If you have any questions, please contact CBI Employee Benefits or the claims administrator.

These provisions describe the Plan in effect as of January 1, 2012.

**SECTION II
COMMERCE GROUP DENTAL PLAN BENEFIT HIGHLIGHTS**

This section highlights the dental benefits provided under the Dental Plan. However, to obtain a more complete explanation of any topic and to learn more about the benefits and any limitations or restrictions which might apply, you should read the additional material in this Plan document.

COVERAGE: The Dental Plan pays the following percentage of Covered Charges (usual and customary amount) for your area, after satisfying annual calendar year deductible amounts.

PART 1	PREVENTIVE CARE Oral Examinations, Fluoride Treatments, Sealants, Prophylaxis, Space Maintainers, X- Ray & Pathology	100% Payment No Deductible
PART 2	BASIC DENTAL PROCEDURES Fillings Endodontics (root canal therapy) Periodontics (gum and tissue treatment) Maintenance of dentures, bridgework, etc. Oral Surgery (extractions) Anesthesia	80% Payment Individual Deductible \$50 Family Deductible \$150
PART 3	MAJOR DENTAL PROCEDURES Restorative work (inlays and crowns) Bridgework Periodontic Appliances Dentures and Partial Dentures	50% Payment Common Deductible with Part 2 Benefits
PART 4	ORTHODONTIC TREATMENT Coverage applies to dependent children only	50% Payment \$50 Orthodontic Deductible per child
PLAN MAXIMUMS	Annual Combined Maximum for Parts 1, 2 and 3 Benefits Lifetime Maximum for Part 4 Benefit	\$1,250.00 per Participant \$1,250.00 per child

PRE-DETERMINATION OF BENEFITS

Commerce recommends any dental work exceeding \$300.00 be reviewed and approved by the claims administrator prior to services. This pre-determination informs you of what Plan benefits will be payable.

**SECTION III.
ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS**

A. EMPLOYEE COVERAGE

1. Eligible Classes of Employees

All common law employees employed by Commerce who are regularly scheduled to work at least 35 or more hours per week are eligible for coverage. The following persons are specifically excluded from the Plan: persons employed as leased employees or independent contractors and persons who are classified by Commerce as part-time or temporary workers or who are regularly scheduled to work less than 35 hours a week.

2. Effective Date of Coverage

An eligible employee will be eligible to commence coverage as of the first day of the month following the completion of 30 days of employment. However, if an employee is not actively at work on the date coverage would otherwise be effective, coverage will not commence until the day the employee returns to active service.

3. Enrollment Requirement for Employee Coverage

In order for coverage to become effective, an eligible employee must enroll for coverage by completing a written enrollment form provided by Commerce or its designee. The enrollment form will include a payroll deduction authorization. If an employee does not timely enroll for coverage when first eligible to do so, then he or she may not enroll in the Plan until the next annual enrollment period unless the employee experiences a qualifying change in status as described below.

4. Contribution Requirement

Commerce will determine the portion of the cost of coverage to be paid by covered persons for employee and/or dependent coverage. This information will be separately communicated to employees from time to time. Employee contributions paid by payroll deduction paid through the Commerce Bancshares, Inc. Pre-Tax Premium Program will be deducted from pay on a pre-tax basis.

B. DEPENDENT COVERAGE

1. Eligible Classes of Dependents/Eligibility Requirement

Eligible dependents of an employee include:

You are eligible to enroll in the Plan if you are a regular full-time employee who is scheduled to work at least 35 hours per week.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your lawful Spouse, unless legally separated or divorced.

- your or your Spouse's child who is under age 26 and who is not eligible to enroll in an eligible employer-sponsored health plan (as defined by law), including a natural child, stepchild, a legally adopted child, or a child placed for adoption.
- an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under the Commerce Bancshares, Inc. Group Dental Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Commerce Bancshares, Inc. Group Dental Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom Dental coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section X, General Provisions.

Commerce reserves the right to rescind coverage for any individual enrolled who is found not to be eligible under the terms of the Plan.

2. Enrollment Requirement for Dependent Coverage

Coverage for dependents is not automatic; an employee must enroll his or her dependents in order for coverage to be effective. If an employee acquires a new dependent by marriage, birth, adoption or placement for adoption, then the employee must enroll that dependent within 30 days.

C. CHANGING COVERAGE DUE TO A CHANGE IN STATUS

In general, an eligible employee may only add or cancel coverage under this Plan during an annual enrollment period. However, if the employee incurs an eligible change in status as defined under the Commerce Bancshares, Inc. Pre-Tax Premium Program (e.g., marriage or divorce; birth or adoption of child; death of spouse), then the employee may request a change in coverage. An application for a change in coverage under this Plan must be made within 30 days of the employee's change in status. Supporting documentation satisfactory to Commerce may be required. Contact CBI Employee Benefits for a detailed list of eligible changes in status.

D. TERMINATION OF COVERAGE

1. When Employee Coverage Terminates

Employee coverage will terminate on the earliest of the following dates:

- the date the Plan is terminated;
- the last day of the pay period in which the employee's employment is terminated (e.g., if employee terminates on the 1st through the 15th of the month, coverage will end on the

15th of the month; if the employee terminates on the 16th through the 30th or 31st of the month, coverage will end on the 30th or 31st of the month);

- the last day of the pay period in which an employee ceases to be employed in an eligible class;
- the date the last contribution is made for employee coverage;
- the last day of the month if the employee elects to discontinue coverage due to an eligible change in status or annual enrollment;
- the date the employee fails to make timely payment when on an employer approved leave; or
- the date the employee enters the armed forces of any country on active duty.

2. Continuation of Coverage During Medical Leave of Absence

A person may remain eligible for a limited time if active, full-time work ceases due to a medical leave of absence. The continuance period will vary depending upon the employee's employment grade and length of service.

During the period of paid medical leave, contributions will be withheld from the employee's paycheck. Following the period of paid medical leave, coverage may be continued based on current leave of absence policies as defined in the Employee Handbook, provided the employee timely pays his or her share of the contributions to Commerce. While an employee is on an approved medical leave, coverage may be suspended at his request and reinstated upon return to active service.

While continued, coverage will be that which was in force on the last day worked as an active employee. Any changes in the benefits and/or the cost of coverage under this Plan will also apply to individuals who have continued coverage under this provision.

The foregoing provisions will be administered in a manner consistent with, the Family and Medical Leave Act of 1993.

3. When Dependent Coverage Terminates

Dependent coverage will terminate on the earliest of the following dates:

- the date the Plan is terminated;
- the date the employee's coverage terminates;
- the last day of the month in which dependent coverage ceases to be offered under the Plan;
- the last day of the month in which a dependent ceases to qualify as an "eligible dependent;"
- the last day of the month during which the last required contribution for dependent coverage was paid;
- the last day of the month if the employee elects to discontinue dependent coverage due to an eligible change in status or annual enrollment; or

- the date the dependent enters the armed forces of any country on active duty.

E. SURVIVING DEPENDENT COVERAGE

Any dependent coverage which is in effect under this Plan at the time of a covered employee's death will be continued after such death, without contributions for such coverage, until the earlier of:

- the date the Plan terminates; or
- the date coverage has been continued for 3 months.

This continuation period will be concurrent with COBRA (as described below).

F. UNIFORMED SERVICES EMPLOYMENT A REEMPLOYMENT RIGHTS ACT

Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to 18 months (24 months for elections made on or after December 10, 2004) of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage with no preexisting conditions exclusions applied in the Plan upon return from service. If the leave is less than 31 days, the employee is not required to pay more than he would have been required to pay if the employee had not been on leave. These rights apply only to employees covered under the Plan before leaving for military service.

Plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

G. COBRA CONTINUATION OPTION

1. Overview

This provision contains important information about an Employee's rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available when an Employee would otherwise lose his group health coverage. It can also become available to other members of the Employee's family who are covered under the Plan when they would otherwise lose their group health coverage.

Each Qualified Beneficiary (as defined below) who would lose coverage under the Plan as a result of a Qualifying Event (as defined below) is entitled to elect, within the election period, continued coverage under the Plan. COBRA coverage is identical to the coverage provided under the Plan to participants or beneficiaries who are not receiving COBRA.

2. Qualifying Event

For purposes of this provision only, a Qualifying Event will mean:

- with respect to a covered Employee, loss of coverage because of:
 - a reduction in the number of hours worked; or

- termination of employment for any reason other than gross misconduct.
- with respect to a covered Spouse of an Employee, loss of coverage because of:
 - a reduction in hours of the Employee's employment;
 - termination of the Employee's employment for any reason other than gross misconduct;
 - divorce or legal separation from the Employee. Also, if the Employee reduces or eliminates his Spouse's group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event;
 - the death of the Employee; or
 - the Employee becomes entitled to Medicare benefits (Part A, Part B, or both).
- with respect to a covered Dependent child of an Employee, loss of coverage because of:
 - a reduction in hours of the Employee parent's employment;
 - termination of the Employee parent's employment for any reason other than gross misconduct;
 - Employee parent's divorce or legal separation;
 - the death of the Employee parent;
 - the Dependent ceases to be a Dependent under the terms of this Plan; or
 - the Employee parent becomes entitled to Medicare benefits (Part A, Part B, or both).

Note: If an Employee takes FMLA leave and does not return to work at the end of the leave, the Employee (and the Employee's Spouse and Dependent children, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage within 18 months because of the Employee's failure to return to work at the end of the leave. COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination or employment and reduction of hours.

Special COBRA rights apply to certain Employees and former Employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible Employee or former Employee becomes eligible for TAA or ATAA, but only if the election is made within the six months immediately after the individual's group health plan coverage ended. **Contact the Plan Administrator promptly after qualifying**

for TAA or ATAA or the right to elect COBRA during a special second election period will be lost.

3. Qualified Beneficiary

For purposes of this provision only, a Qualifying Beneficiary will mean any individual who, on the day before a Qualifying Event, is covered under this Plan as:

- an Employee;
- the Spouse of an Employee; or
- the Dependent child of an Employee.

A Qualified Beneficiary also includes a child born to, adopted by or placed for adoption with a covered Employee during the period of COBRA coverage. The Qualifying Event for such a child is the Qualifying Event that triggered the COBRA continuation coverage period during which the child is born, adopted or placed for adoption. If a second Qualifying Event occurs before the child is born, adopted or placed for adoption, then the second Qualifying Event also applies to the newborn, adopted child or child placed for adoption. If the Employee parent who is the Qualified Beneficiary has not elected COBRA continuation coverage, then any newborn, adopted child or child placed for adoption of that Employee who is born, adopted or placed for adoption after the Qualifying Event is not a Qualified Beneficiary.

A child of the covered Employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Employer during the covered Employee's period of employment with the Employer is entitled to the same rights to elect COBRA continuation coverage as an eligible Dependent child of the covered Employee.

4. Type of Benefits Offered

Qualified Beneficiaries may elect to continue any or all of the group health components in force on the day before the Qualifying Event occurs. Any changes in the benefits and/or the cost of coverage under this Plan will also apply to Qualified Beneficiaries who have continuation coverage under this provision.

COBRA coverage is the same coverage that the Plan gives to other participants under the Plan who are not receiving COBRA coverage. Each Qualified Beneficiary who elects COBRA will have the same rights under the Plan as other participants under the Plan, including annual open enrollment and special enrollment rights.

5. Maximum Duration of Coverage

When the Qualifying Event is the death of the Employee, the Employee's divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When coverage is lost due to termination of employment or reduction of hours worked, COBRA continuation coverage will be offered for a maximum of 18 months, except as follows:

- If another Qualifying Event occurs during the 18 months of COBRA coverage, continuation coverage for a Spouse or Dependent child can be extended for an additional 18 months, for a maximum of 36 months. The second Qualifying Event (death of the Employee, the Employee's divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child) must be an event that would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

In the event of a second Qualifying Event, the Employee, Spouse or Dependent child must notify the COBRA Administrator within 60 days after the later of:

- the date of the second Qualifying Event; or
- the date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of the second Qualifying Event (if it had occurred while the Qualified Beneficiary was still covered under the Plan).

If the second Qualifying Event extension notice does not follow the procedures specified under Qualifying Event Notification Procedures and is not provided by this due date, there will be no extension of COBRA continuation coverage due to a second Qualifying Event.

- If the Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA coverage for a Spouse or Dependent child who lose coverage as a result of the Qualifying Event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).
- If a Qualified Beneficiary has been determined to be disabled by the Social Security Administration at the time of a Qualifying Event, which is the termination of employment or reduction in hours, or at any time during the first 60 days of COBRA continuation coverage, coverage may be extended from 18 months to 29 months. Each Qualified Beneficiary will be entitled to the disability extension if one of them qualifies. Notice of such disablement must be given to the COBRA Administrator prior to the conclusion of the 18 months of COBRA continuation coverage and within 60 days after the latest of:
 - the date of the Social Security Administration's disability determination;
 - the date of the Covered Employee's termination of employment or reduction of hours; and
 - the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the Covered Employee's termination of employment or reduction of hours.

If the disability extension notice does not follow the procedures specified under Qualifying Event Notification Procedures and is not provided by this due date, there will be no disability extension of COBRA continuation coverage.

6. Qualifying Event Notification Procedures

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment, or the death of the Employee, the Employer (if not the Plan Administrator) must notify the Plan Administrator of the Qualifying Event.

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), the Employee, Spouse or Dependent child must notify the Plan Administrator within 60 days after the later of:

- the date of the Qualifying Event; or
- the date coverage is lost.

The notification must be provided in writing and mailed or hand-delivered to:

Commerce Bancshares, Inc.

**Attn: Benefits Department
8000 Forsyth Boulevard
St. Louis, MO 63105-1797**

The written notice must be received by the above individual or, if mailed, postmarked no later than the last day of the required notice period. Oral communications and electronic (including e-mailed and faxed) notices are not acceptable. The notice must include all of the following:

- the name of the Plan;
- a description of the Qualifying Event;
- the date the Qualifying Event occurred;
- the names and address(es) of the covered Employee and all Qualified Beneficiaries;
- if the Qualifying Event is a divorce, the notice must include a copy of the divorce decree;
- in the event of a second Qualifying Event, the notice must include:
 - a description of the second Qualifying Event, and
 - the date of the second Qualifying Event;
- disability notification must include:
 - the name of the disabled Qualified Beneficiary,
 - the date when the Qualified Beneficiary became disabled,
 - the date the Social Security Administration made its determination, and
 - a copy of the Social Security disability determination.

If the notice does not follow the procedures specified above, and is not provided by the due date, the right to elect or extend COBRA continuation coverage will be lost.

7. COBRA Election Procedures

A Qualified Beneficiary may elect COBRA continuation coverage within the 60 day period beginning on the later of:

- the date coverage is lost under the Plan; or
- the date notification is made to the Qualified Beneficiary by the Plan Administrator or the duly authorized COBRA Administrator.

The COBRA election notice must be provided in writing and mailed or hand-delivered to:

**Tri-Star Systems
Attn: COBRA-ER240
14323 S. Outer 40 Rd.
SUITE 200 SOUTH
Chesterfield, MO 63017**

The notice must be received by the above individual or, if mailed, postmarked no later than the last day of the required election notice period. Oral communications and electronic (including e-mailed and faxed) notices are not acceptable. **If the Employee, or his Spouse or a Dependent child does not submit a written election notice following these specified procedures and it is not provided by this due date, the right to elect COBRA continuation coverage will be lost.**

A Qualified Beneficiary who rejects his right to COBRA continuation coverage in writing can subsequently change his mind as long as the election notice is received by the due date. Coverage will be provided retroactively to the date of the Qualifying Event and premiums must be paid for the period of time from the Qualifying Event through the date of revocation.

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Qualified Beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected.

8. Termination of COBRA Coverage

COBRA Continuation coverage will be terminated before the end of the maximum coverage period if:

- any required premium is not paid in full on time;
- after electing COBRA, the Qualified Beneficiary becomes covered under another group health plan which does not contain any enforceable exclusion or limitation with respect to a Pre-Existing Condition of such Qualified Beneficiary, unless such pre-existing exclusion or limitation does not apply to (or is satisfied by) the Qualified Beneficiary, taking into account prior creditable coverage as required by law;
- after electing COBRA, the Qualified Beneficiary becomes entitled to Medicare benefits (Part A, Part B or both);
- the Employer ceased to provide any group health plan for its Employees;
- during a disability extension period, the disabled Qualified Beneficiary is no longer considered disabled by the Social Security Administration.

The COBRA Administrator must be notified within 30 days if, after electing COBRA, a Qualified Beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. The Plan reserves the right to retroactively cancel COBRA continuation coverage and in

that case will require reimbursement of all benefits paid after the date of Medicare entitlement or commencement of other group health plan coverage.

The COBRA Administrator must be notified within 30 days after a disabled Qualified Beneficiary is determined to no longer be disabled. Coverage for all Qualified Beneficiaries will terminate as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled.

9. Cost of COBRA Continuation Coverage

Each Qualified Beneficiary is required to pay the entire cost of COBRA continuation coverage plus an administrative charge. The required payment for COBRA continuation coverage may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. If coverage is extended to 29 months due to disability, the COBRA premium may be as much as 150% of the applicable premium for the 19th month through 29th month of continuation coverage.

The Trade Act of 2002 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 (eligible individuals). Under the new tax provisions, eligible individuals can take a tax credit equal to 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. For questions about these new tax provisions, call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

10. Payment of COBRA Continuation Coverage

If COBRA continuation coverage is elected, payment is not required with the election form. However, the first payment must be made within 45 days after the date of the election (this is the date the election notice was post-marked, if mailed). This initial payment must cover the cost of COBRA coverage from the time coverage under the Plan would have otherwise have been terminated. It is the responsibility of the Qualified Beneficiary to make sure that the amount of the first payment is enough to cover this entire period. Contact the COBRA Administrator to confirm the correct amount of the first payment.

If the first payment is not received in full within that 45-day period, all rights to COBRA continuation coverage under the Plan will be lost.

After making the first payment for COBRA continuation coverage, monthly payments are required for each subsequent month of COBRA continuation coverage. The amount due for each month for each Qualified Beneficiary will be disclosed in the election notice provided at the time of the Qualifying Event. Under the Plan, each of these monthly payments for COBRA continuation coverage is due on the first day of the month for that month's COBRA continuation coverage. If monthly payments are made on or before the first day of the month to which it applies, the COBRA continuation coverage under the Plan will continue for that month without any break. The Plan will send periodic notices of payments due for these coverage periods. Whether or not a notice is received, it is the Qualified Beneficiary's responsibility to pay the COBRA premiums on time. Although monthly premiums are due on the first day of each month, the Plan provides a grace period of 30 days to make each monthly payment. If premiums are not paid before the end of the grace period, the Plan reserves the right to retroactively cancel COBRA continuation coverage and in that case will require reimbursement of all benefits paid after the premium due date.

Failure to make a monthly payment before the end of the grace period for that month will result in loss of all rights to COBRA continuation coverage under the Plan.

11. COBRA Continuation Coverage Questions

Any questions about this Plan's COBRA continuation coverage should be addressed to:

**Tri-Star Systems
Attn: COBRA-ER240
14323 S. Outer 40 Rd.
SUITE 200 SOUTH
Chesterfield, MO 63017**

For more information about COBRA rights, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Note: Employees should keep the COBRA Administrator informed of any change in addresses of family members in order to protect their family's rights. Employees should also keep a copy for their records of any notices they send to the Plan Administrator or COBRA Administrator.

K. MEDICARE COORDINATION

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under the Dental Plan.

Where required by Federal law, benefits payable under the Plan for a Participant age 65 or older or the Dependent spouse age 65 or older of a Participant will be determined before the benefits payable under Medicare.

**SECTION IV
DENTAL BENEFITS**

The Dental Plan provides payment for a wide range of dental expenses (called Covered Charges). These Covered Charges must be incurred and charged to you or your Eligible Dependent while Dental Plan Participants.

Covered Charges are not recognized by the Dental Plan when the expenses are related to or incurred during work at any job for pay.

Prior to payment of Covered Charges by the Dental Plan, the Participant must first satisfy deductible payments and co-payment percentages.

A. DEDUCTIBLES AND PLAN MAXIMUMS

Individual Deductible

A Participant must satisfy a deductible amount each calendar year for Parts 2, 3 and 4 before the Dental Plan makes payment for Covered Charges. The deductible is the amount of Covered Charges the Participant must first pay each year. After the deductible amount is satisfied, the Dental Plan pays the applicable percentage of Covered Charges for the rest of that calendar year. There is also a family deductible, and the amount of individual deductible a Dental Plan Participant satisfies in a calendar year will count toward the family deductible.

Family Deductible

In place of individual deductibles, a family maximum deductible amount may be applied. When the family maximum is satisfied for a calendar year, the Dental Plan benefits will be payable as if the individual deductibles had been satisfied for each Participant in the family.

The amount of the calendar year Deductibles are:

PART 1	PREVENTIVE CARE No Deductible required
PART 2	BASIC DENTAL PROCEDURES Individual Deductible \$ 50 Family Deductible \$150
PART 3	MAJOR DENTAL PROCEDURES Common Deductible with Part 2 Benefits
PART 4	ORTHODONTIC TREATMENT \$50 Deductible per child

Plan Maximums per Participant

The Dental Plan's maximum calendar year payment is \$1,250 per participant for Parts 1, 2 and 3, combined. For Part 4, child orthodontia, the Dental Plan has a \$1,250 lifetime maximum payment per child. This lifetime payment is separate from the \$1,250 annual maximum payment.

B. PRE-DETERMINATION OF BENEFITS

When the total cost of Covered Charges for treatment under the Dental Plan is expected to exceed \$300, the Dental Practitioner's Treatment Plan should be sent to the claims administrator before the date treatment begins. Based on the Treatment Plan, the claims administrator will provide an estimate of the benefits which will be available if treatment is performed. Benefits will be paid on the basis of the Covered Charges which are incurred while a Dental Plan Participant. A Treatment Plan is not needed for Emergency Dental Care or Accidental Dental Injuries, but may be furnished when the Participant or Dental Practitioner wishes an estimate of the benefits available. The claims administrator will respond to the Participant regarding the Treatment Plan within 14 working days of the date the Treatment Plan is received by the claims administrator or as soon as administratively practicable thereafter.

C. COVERED DENTAL PROCEDURES

The following is the list of dental procedures which are considered Covered Charges under this Dental Plan. Coverage of dental procedures not listed below may apply if such procedures are considered to be appropriate dental care performed according to accepted standards of dental practice for the condition being treated. Coverage available for unlisted dental procedures will be based on a customary and appropriate treatment for a given condition included in the list below, as determined by the claims administrator.

Part 1 Care - PREVENTIVE DENTAL PROCEDURES (100% Dental Plan Reimbursement; No Deductible)

Fluoride Treatments, Sealants and Prophylaxis

- Prophylaxis for individuals age 14 or over, treatments to include minor scaling and polishing (limited to 2 treatments per calendar year.)
- Prophylaxis for children under age 14 (limited to 2 treatments per calendar year.)
- Topical application of fluoride including prophylaxis: per treatment (limited to one treatment per calendar year for children under age 19.)
- Topical application of sealants for permanent nondecayed, nonrestored bicuspid and molars, excluding third molars (limited to one treatment per each 36 months for children under age 14.)

Space Maintainers and Corrective Appliances

Allowance includes all adjustments within 6 months after installation (limited to initial appliances only and to children under age 16.)

- Fixed, unilateral (band or stainless steel crown type)
- Fixed, unilateral, cast type
- Removable bilateral type
- Removable inhibiting appliance to correct thumbsucking
- Fixed or cemented inhibiting appliance to correct thumbsucking

Oral Examinations

- Limited to 2 periodic oral examinations per calendar year

X-Ray and Pathology

Except for injuries, the allowance includes diagnosis.

- Full mouth series consisting of at least 14 films including bitewings if necessary

(limited to once in any given period of 36 consecutive months)

- Single film - Initial
- Additional films (up to 12) – each
- Intra-oral, occlusal view, maxillary or mandibular - each
- Bitewing films, two (limited to 2 times per calendar year)
- Bitewing films, four (limited to 2 times per calendar year)
- Panoramic survey, maxillary and mandibular, single film (considered a full mouth series - limited to once in any given period of 36 consecutive months)
- Diagnostic casts
- Biopsy and examination of oral tissue

Part 2 Care - BASIC DENTAL PROCEDURES

(80% Dental Plan Reimbursement following deductible)

Non-Routine Visits

- Emergency palliative treatment - per visit
- Consultation (by other than Dental Practitioner providing treatment)
- Office visit during regular office hours for treatment and observation of injuries to teeth and supporting structure (other than for routine operative procedures)
- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)

RESTORATIVE DENTISTRY

Multiple restorations in one surface will be considered as a single restoration. Inlays, onlays and crowns other than stainless steel are covered under Major Dental Procedures, if any.

Amalgam Restorations - Primary Teeth

- Cavities involving one surface
- Cavities involving 2 surfaces
- Cavities involving 3 or more surfaces

Amalgam Restorations - Permanent Teeth

- Cavities involving one surface
- Cavities involving 2 surfaces
- Cavities involving 3 or more surfaces

Synthetic Restorations

- Silicate cement filling - per restoration
- Acrylic or plastic filling - per restoration
- Composite resin - per restoration
- Composite resin - involving incisal angle

Pins

- Pin retention - exclusive of restorative material (used in lieu of cast restoration)

Other Restorative Procedures

- Stainless steel crown (when tooth cannot be restored with filling material)

Recementation

- Inlay
- Crown
- Bridge

Endodontics

- Pulp capping - direct, excluding final restoration
- Remineralization (Calcium Hydroxide, temporary restoration) as a separate procedure only, excluding final restoration
- Vital pulpotomy, excluding final restoration
- Therapeutic apical closure (apexification)

Root Canals

Treatment for non-vital teeth. Allowance includes necessary x-rays and cultures but excludes final restoration.

Anterior Teeth

- Traditional root canal therapy
- Medicated paste - (N-2)

Bicuspid Teeth

- Traditional root canal therapy
- Medicated paste - (N-2)

Molar Teeth

- Traditional root canal therapy
- Medicated paste - (N-2)

Apicoectomy

Allowance includes retrograde filling, when performed.

- Apicoectomy (performed as separate surgical procedure)
- Apicoectomy (performed in conjunction with endodontic procedure)

Periodontics

Allowance includes post-surgical visits.

- Gingivectomy or gingivoplasty per quadrant
- Gingivectomy - treatment per tooth (fewer than 6 teeth)
- Subgingival curettage, root planing - per quadrant, maximum of 4 quadrants within 12 consecutive months (not prophylaxis)
- Osseous surgery, including gingival flap - per quadrant
- Muco gingival surgery (pedicle soft tissue graft, sliding horizontal flap)
- Occlusal adjustment, performed in conjunction with periodontal surgery - per quadrant, maximum of 4 quadrants within 12 consecutive months

Complete and Partial Denture Repairs, Acrylic

- Repair dentures, no teeth damage
- Repair dentures and replace one broken tooth
- Replace additional teeth - each tooth
- Replace broken teeth on denture, no other repair

Denture Relinings & Rebasings

Allowable only after 6 months from installation of original appliance. Allowance for relines or rebases includes adjustments within 6 months.

- Denture Duplication (jump case) - per denture (limited to once in a period of 36 consecutive months)
- Denture Reline - (includes complete and partial), office, cold cure (limited to once in a period of 12 consecutive months)
- Denture Reline - (includes complete and partial), laboratory (limited to once in a period of 12 consecutive months)
- Tissue Conditioning - Complete and Partial Dentures (maximum of 2 treatments per arch; limited to once in a period of 12 consecutive months)

Denture Adjustments (Complete and Partial)

Adjustment to a denture more than 6 months after installation, or if performed by other than the Dentist providing appliance.

Oral Surgery

Allowance includes local anesthesia, pre-operative work-up and routine post-operative care.

Extractions

- Uncomplicated (single)
- Each additional tooth
- Surgical removal of erupted tooth (involving tissue flap and bone removal)
- Post-operative visit (sutures and complications after multiple extractions or impactions)

Impacted Teeth

- Removal of tooth (soft tissue)
- Removal of tooth (partially bony)
- Removal of tooth (completely bony)

Alveolar or Gingival Reconstructions

- Alveolectomy (in addition to removal of teeth) - per quadrant
Alveolectomy (edentulous) - per quadrant
- Stomatoplasty with ridge extension - per arch
- Excision of pericoronal gingiva - per tooth
- Removal of palatal torus
- Removal of mandibular tori - per quadrant
- Excision of hyperplastic tissue - per arch

Cysts and Neoplasms

- Removal of cyst or tumor, up to 1.25 cm
- Removal of cyst or tumor over 1.25 cm
- Incision and drainage of abscess

Other Oral Surgical Procedures

- Closure of oral fistula of maxillary sinus
- Replantation of tooth or tooth bud
- Crown exposure for orthodontia
- Removal of foreign body from soft tissue

- Removal of foreign body from bone (independent procedure) Sequestrectomy for osteomyelitis or bone abscess, superficial Maxillary sinusotomy for removal of tooth fragment or foreign body
- Suture of soft tissue injury
- Treatment of trigeminal neuralgia by injection into second and third divisions
- Frenectomy
- Sialolithotomy - removal of salivary calculus
- Closure of salivary fistula
- Dilation of salivary duct

Anesthesia

- General, in conjunction with surgical procedures only

Drugs

- Injectable antibiotic

Part 3 Care - MAJOR DENTAL PROCEDURES (50% Dental Plan Reimbursement following deductible)

Benefits for a Covered Dental Procedure for replacement of an appliance or prosthetic device, crown, cast restoration or fixed bridge will be based on an appropriate allowance for a like prosthesis.

RESTORATIVE

Cast restorations and crowns are covered only when necessitated by decay and traumatic injury and the tooth cannot be restored with a routine filling material.

Inlays and Onlays

- One surface
- Two surfaces
- Three or more surfaces
- Only, in addition to inlay allowance

Crowns and Posts

- Acrylic (permanent, processed)
- Acrylic with gold
- Acrylic with semi-precious metal
- Porcelain
- Porcelain with gold
- Porcelain with semi-precious metal
- Full Cast - gold
- Full Cast - semi-precious metal
- Three-quarter Cast - gold
- Cast post and core (in addition to crown)
- Steel post
- Composite or amalgam (in addition to crown)

Fixed Prosthodontics

Bridge Abutments (See Inlays and Crowns)

Pontics

- Cast gold (sanitary)
- Cast with semi-precious metal (sanitary)
- Slotted facing
- Slotted pontic
- Porcelain fused to gold
- Porcelain fused to semi-precious metal
- Plastic processed to gold
- Plastic processed to semi-precious metal

Other Fixed Prosthodontic Services

- Simple stress breakers, extra per unit

Periodontic Appliances

- Occlusal guard — allowance includes adjustments within 6 months

Dentures and Partial Dentures

Allowance for dentures and partial dentures includes adjustments and relines within 6 months after installation. Specialized techniques and characterizations are not covered. Allowance for partial dentures include base, all clasps, rests and teeth.

- Complete maxillary denture
- Complete mandibular denture
- Upper partial, with two chrome clasps with rests, acrylic base
- Lower partial, with two chrome clasps with rests, acrylic base
- Upper partial with chrome palatal bar and clasps, acrylic base
- Lower partial with chrome lingual bar and clasps, acrylic base
- Stayplate base, upper (anterior teeth only)
- Stayplate base, lower (anterior teeth only)

Removable Bridge (Unilateral Partial)

- One piece chrome casting, clasp attachment (all types) - per unit including pontics

Adding Teeth to Partial Denture to Replace Extracted Natural Teeth

- First tooth
- First tooth with clasp
- Each additional tooth and clasp

Repairs, Partial Dentures

- Partial denture repairs (metal) - allowance based upon extent and nature of damage and type of materials involved

Repairs, Crowns and Bridges

- Repairs (metal) - allowance based upon extent and nature of damage and type of materials involved

Part 4 - ORTHODONTIC BENEFITS

(50% Dental Plan Payment following deductible)

Orthodontic Benefits will be paid only for treatment to a covered dependent child who is less than 19 years of age on the date the active orthodontic appliance is first placed.

The maximum amount payable for expenses incurred for orthodontic treatment will not exceed the lesser of:

- the Dental Practitioner's Usual Charge; or
- the Usual and Customary Charge,

for the orthodontic treatment multiplied by the Copayment Percentage for orthodontic treatment.

Benefits are also subject to the Lifetime Maximum Benefit Limit shown on the Schedule of Benefits.

The benefit is payable in equal payments based on the time period shown in the Dental Practitioner's Treatment Plan. The first benefit payment is payable as of the date the active orthodontic appliance is first placed.

Limitation for Late Entrants

A Late Entrant must be covered under the Dental Plan for 24 consecutive months before becoming eligible for orthodontic benefits. A *Late Entrant* means a person who does not enroll for the coverage under the Dental Plan within 30 days of the date he or she is first eligible, but who later becomes covered. A Late Entrant may be a person who also request reinstatement of coverage which was terminated while he or she remained eligible for coverage under the Dental Plan.

Extension of Benefits for Orthodontic Treatment

If, for any reason other than death, and Employee ceases to be covered under this Dental Plan, Orthodontic Benefits for the covered dependent child receiving orthodontic treatment will be paid until the end of the month in which the Employee's coverage terminates. The final payment will be determined on a pro rata basis.

If the covered dependent child no longer meets the definition of a covered dependent child, Orthodontic Benefits will continue to be paid as long as:

- the active orthodontic appliance was first placed while the covered dependent child was covered for this benefit; and
- the covered dependent child continues to receive orthodontic treatment; and
- coverage for the Employee under this Plan remains in force.

D. COMMERCE COMPREHENSIVE MEDICAL PLAN COVERAGE

When dental treatment is necessary as a direct result of an accident to repair damage to the jaw and natural teeth, the Commerce Bancshares, Inc. Comprehensive Medical Plan provides coverage (if you are a participant in that plan).

E. ALTERNATIVE BENEFITS

In determining any amounts payable under the Dental Plan, the Plan has the option to make payment based on the level of benefits for one or more alternate dental procedures that would be appropriate for the dental condition being treated by the Dental Practitioner and according to accepted standards of dental practice. Benefits will be based on the procedure with the lowest Usual and Customary Charge.

F. PLAN EXCLUSIONS

The following services are not Covered Charges under the Dental Plan:

- Treatment on or to the teeth or gums for cosmetic purposes or enamel hypoplasia unless it is needed because of an Accidental Dental Injury received while covered. Facings on crowns or pontics behind the second bicuspid and characterization of dentures will always be deemed cosmetic; or
- Dental care arising out of or in the course of employment for pay or profit or which is covered under any Worker's Compensation Insurance or occupational disease law; or
- Expenses incurred for oral hygiene instructions, a plaque control program or dietary instructions; or
- Any loss caused by war or act of war whether declared or undeclared or for which Covered Dental Expenses are incurred while engaged in the Armed Forces; or
- Replacement of a broken lost or stolen prosthetic device; or
- Replacement of an appliance or prosthetic device, crown, cast restoration or a fixed bridge within 5 years of the date it was last placed, or if such appliance, device, crown, cast restoration or fixed bridge can be made serviceable. This exclusion will not apply if replacement is due to an Accidental Dental Injury received while covered under this Dental Plan; or
- Expenses incurred for services or supplies which are paid for directly or indirectly by a national, state or local government, or any agency thereof; or expenses incurred for which payment by the participant is not legally required in the absence of coverage; or expenses incurred for which free care is provided, or for which care is provided by law such as Medicare; except that benefits of the Dental Plan will not be denied because the expense for the covered service and supply was incurred in a Veterans' hospital. However, the Participant receiving the services and supplies must be a Veteran and the services and supplies are for the treatment of a nonservice-connected sickness or injury; and benefits of the Dental Plan will not be denied because the expense for the covered service and supply was incurred in a military hospital by an armed services retiree or such person's covered dependent; or
- Orthodontic diagnosis or treatment except as provided under the "Orthodontic Benefits" provision, if any; or
- Temporomandibular joint dysfunction syndrome diagnosis or treatment; or
- Procedures, appliances or restorations that are performed to alter, restore or maintain occlusion, including but not limited to:
 - alteration of vertical dimension;
 - replacing or stabilizing tooth structure lost by attrition or abrasion;

- periodontal splinting; and
- specialized techniques; or
- Expenses incurred for the initial placement of a complete or partial denture or for fixed bridgework if it involves the replacement of one or more natural teeth missing or lost prior to the date the Participant became covered under the Dental Plan. This exclusion will not apply if the denture or bridgework customarily includes replacement of natural teeth extracted while covered under the Dental Plan; or
- Broken appointments; or
- Services or supplies covered by any other plan sponsored by Commerce Bancshares, Inc.; or
- Expenses incurred for dental care which is not customarily performed or which is experimental in nature.

SECTION V CLAIM FILING PROCEDURES

A. HOW TO FILE A CLAIM

All expenses should be filed with the claims administrator at the address appearing on the Dental Plan claim form. If the provider submits the charge directly to the address on the claim form, it will aid in correct claims submission and timely claims processing.

All billings, whether submitted by the employee or the provider, must include the following:

- the employee's name and social security number;
- the patient's name;
- a description of services or supplies provided, detailing the charge for each supply or service;
- the diagnosis;
- the date(s) of service;
- the provider's name and degree, address, telephone number, and tax identification number.

If another plan is the primary payer, a copy of their Explanation of Benefits (EOB) must accompany the charges submitted to this Plan.

Additional information may be requested by the claim administrator in order to process the claim.

B. WHEN TO FILE A CLAIM

A claim should be filed as soon as administratively possible after a covered expense has been incurred and in no event later than ***June 30th of the calendar year following the calendar year*** in which the expense was incurred. Claims filed later than that date will be declined or reduced unless it is not reasonably possible to submit the claim in that time.

C. HOW BENEFITS ARE PAID

The Plan normally reimburses a service provider directly for the provision covered services. However, if services are received from a non-network provider and the covered person is required by the provider to pay for the services at that time, then Plan will reimburse the covered person.

D. APPEAL PROCEDURE

If an expense is denied in whole or in part by the claims administrator, then the covered person or his or her physician or other service provider may appeal that decision to the claims administrator. A request for reconsideration should be made as soon as practicable following receipt of the denial and in no event later than 60 days after receiving the denial. The covered person or his or her designee should contact the claims administrator at the address or telephone number listed on the back of the claim form. The claimant will be asked to explain (in writing if requested) why he or she believes the claim should not have been denied and to provide any additional material or information necessary to support the claim. Following review, the claims administrator will issue a decision on review and if the claim is denied, the claims administrator

will furnish a written statement identifying the specific reason(s) for denial, including reference to the specific Plan provision(s) on which the denial is based.

If, after exhausting the appeals process with the claims administrator, a claimant is still not satisfied with the result, he or she (or the designee) may appeal the claim directly to Commerce. The appeal must be initiated in writing within 60 days of the claims administrator's final decision on review. As part of the appeal process, a claimant has the right to submit additional proof of entitlement to benefits and to examine any pertinent documents relating to the claim.

In the normal case, Commerce will make a determination on the basis of the supporting file documents and written statement as submitted. However, Commerce may require or permit submission of additional written information.

After considering all the evidence before it, Commerce will issue a final decision on appeal within 60 days (or 120 days in unusual circumstances) of receiving the request for review. If the claim is denied, the decision will be in writing and will include the specific reasons for the decision. Commerce's decision on review will be conclusive and binding on the covered person and all other parties.

If a covered person's circumstance warrants an expedited appeals procedure, then the covered person should contact CBI Employee Benefits immediately.

SECTION VI COORDINATION OF BENEFITS

A. OVERVIEW

The following coordination of benefits (COB) provision applies when a person has health care coverage under more than one plan.

The order of benefit determination rules below determine which plan will pay as the primary plan and which plan is secondary. The primary plan pays a claim first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

B. DEFINITIONS

1. For purposes of this provision, a "plan" includes group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; No Fault Automobile Insurance (by whatever name it is called); and Medicare or other governmental benefits, as permitted by law. A "plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); hospital indemnity insurance, school accident type coverage, benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under the above is a separate plan. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

2. The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.

When this Plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this Plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

3. "Allowable expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:
 - If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms) is not an allowable expense.

- If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary charges, any amount in excess of the highest of the usual and customary charges for a specific benefit is not an allowable expense.
 - If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
 - If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary charges and another plan that provides its benefits or services on the basis of negotiated fee, the primary plan's payment arrangements shall be the allowable expense for all plans.
4. "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision of a similar provision takes effect.
 5. "Closed panel plan" is a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
 6. "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

C. ORDER OF BENEFIT DETERMINATION RULES

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

1. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
2. A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
3. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
4. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.
 - Non-dependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the

order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

- Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one plan is:

< The primary plan is the plan of the parent whose birthday is earlier in the year if:

- The parents are married;
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.

< If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

< If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The plan of the custodial parent;
- The plan of the spouse of the custodial parent;
- The plan of the noncustodial parent; and then
- The plan of the spouse of the noncustodial parent.

- Active or inactive employee. The plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and a dependent of an actively working spouse will be determined under the first bullet of this rule 4.
- Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- Longer or shorter length of coverage. The plan that covered the person as an employee, member, subscriber or retiree longer is primary.
- If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this

regulation. In addition, this plan will not pay more than it would have paid had it been primary.

D. EFFECT ON THE BENEFITS OF THIS PLAN

1. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expense. As each claim is submitted, this Plan will:
 - Determine its obligation to pay or provide benefits under its contract; and
 - Determine whether there are any unpaid allowable expenses during that claims determination period.
2. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The claims administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The claims administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the claims administrator any facts it needs to apply those rules and determine benefits payable.

F. FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this Plan. If such a payment is made by another plan, the claims administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The claims administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

G. RIGHT OF RECOVERY

If the amount of the payments made by the claims administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

"This Plan" means only those parts of This Plan which provide benefits or services for dental care. The provisions of This Plan which limit benefits based on benefits or services provided under:

1. Government Plans; or
2. Plans which the Employer (or an affiliate) contributes to or sponsors; will not be affected by these Coordination of Benefits provisions.

For the purpose of applying these provisions, if both spouses are covered as EMPLOYEES under This Plan, each spouse will be considered as covered under separate Plans.

SECTION VII GLOSSARY

Several words and phrases used to describe the Dental Plan are capitalized whenever used in the Summary Plan Description. These words and phrases have special meanings as described in this section.

Active Work; *Actively at Work* means the active performance of all of an Employee's normal job duties at Commerce Bancshares, Inc. usual place or places of business.

Accidental Dental Injury is an injury to the mouth or structures within the oral cavity which is caused by an external traumatic force. It does not include damage to the teeth which is the result of biting into food or other substances.

Cosmetic Surgery means surgery to change:

- the texture or appearance of the skin; or
- the relative size or position of any part of the body; or
- when such surgery is not needed to correct or improve a bodily function.

Covered Charges will be the lesser of the Dental Practitioner's actual charge or the usual and customary charge for dental services and supplies charged to each Plan Participant. In order for the service or supply charge to be covered it must be:

- Required for treatment; and
- Recommended and approved by the attending Dentist.

A *Covered Charge* for a dental procedure will be deemed incurred as follows:

- for appliances or changes to appliances — on the date the master impression is made; and
- for a crown, bridge or a cast restoration — on the date the tooth is or teeth are prepared; and
- for root canal therapy — on the date the pulp chamber is opened; and
- for all other dental charges — on the date the service is performed or the supply is furnished.

Dental Hygienist means a person who is:

- licensed to practice dental hygiene; and
- practicing within the scope of his or her license; and
- not a member of the Participant's immediate family.

Dental Plan means the Commerce Bancshares, Inc. Group Dental Plan as set forth in this document and as amended from time to time.

Dental Practitioner means a Dentist, Dental Hygienist, or Denturist.

Dental Services means any confinement, treatment or service, including periodontal and osseous surgery, provided to diagnose, prevent or correct:

- malocclusion; and

- craniomandibular joint disorders; and
- all other ailments or defects of the teeth and supporting tissue.

Dentist means a person who is:

- licensed to practice dentistry or oral surgery; and
- practicing within the scope of his or her license; and
- not a member of the Participant's immediate family.

Denturist means a person who is:

- licensed to make, fit or repair dentures; and
- practicing within the scope of his or her license; and
- not a member of the Participant's immediate family.

Dependent (See Dependent Coverage under Section III).

Emergency Dental Care means an urgent and unplanned visit for the care of the a dental condition.

Hospital means an institution that is licensed as a hospital by the proper authority of the state in which it is located; but not including any institution, or part thereof, that is used primarily as a clinic, convalescent home, rest home, home for the aged, nursing home, custodial care facility or training center.

Immediate Family means the Participant, the Participant's spouse, and the covered children, brothers, sisters and parents of the Participant or of the Participant's spouse.

Medicare means the health insurance programs under Title XVIII of the United States Social Security Act of 1965, as then constituted and as later amended.

Orthodontic Treatment means the movement of teeth through bone, by means of active appliances, to correct the position of maloccluded or malpositioned teeth.

Participant means an Employee, former Employee and/or his or her Dependent(s) who are eligible for, have enrolled in and pay for membership in the Dental Plan.

Treatment Plan means the Dental Practitioner's report to the claims administrator which:

- lists the dental care recommended by him or her for the Participant; and
- shows his usual charge for each dental procedure; and
- includes preoperative x-rays and all necessary data needed by the claims administrator; and
- is prepared on the form approved by the claims administrator.

Usual and Customary Charge means a charge that is not more than the normal level of charges made by Dental Practitioners in the area where the dental procedure is performed. The claims administrator will use factors such as similar training and experience to determine the size of the area needed to get an accurate cross-section of data.

Usual Charge means the Dental Practitioner's normal fee for a dental procedure.

SECTION VIII RECOVERY PROVISIONS

A. REFUND OF OVERPAYMENTS

If the Plan overpays an amount to or on behalf of a covered person, the Plan will retain the contractual right to receive the overpayment. The covered person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a covered person, the amount of overpayment may be deducted from future benefits payable to the covered person or any of his or her family members. The Plan may have other rights in addition to the right to reduce future benefits.

B. SUBROGATION AND REIMBURSEMENT

If a covered person incurs a covered expense due to an injury, illness or sickness which is caused by or relates to the act or omission of a third party, then the covered person may have a claim against that third party (or the insurer of the third party) for payment of services and supplies covered by this Plan. By accepting benefits under this Plan, each covered person automatically assigns to the Plan his or her rights against any third party or insurer when this provision applies and agrees to promptly repay to the Plan any benefits paid on his or her behalf out of the recovery (as defined below) made from the third party or insurer. Each covered person also agrees to allow the Plan to pursue any claim which the covered person has against any third party or insurer, whether or not the covered person chooses to pursue that claim. The Plan may make a claim directly against the third party or insurer, or receive reimbursement of any recovery directly from the covered person.

The Plan will have a lien on any recovery received by the covered person, irrespective of how such recovery may be characterized in any settlement agreement, judgment, pleading or other document or statement and irrespective of whether or not such recovery is designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The term “recovery” as used under this section means any monies paid to the covered person by way of judgment, settlement, or otherwise to compensate for all losses caused by the covered person’s injuries or sickness whether or not such losses reflect medical charges covered by the Plan. The Plan will not be responsible for a covered person’s attorney fees or other costs unless the plan administrator has agreed in writing to pay such fees or costs. In other words, any recovery paid to the Plan shall not be reduced by any deduction, reduction or payment of or for costs or attorneys’ fees unless Commerce or its designee has agreed otherwise in writing.

The Plan’s right to subrogation and reimbursement under this sum provides it with a first priority over any funds paid by a third party to a covered person directly or indirectly related to the covered person’s injury, illness or sickness, including a priority over any claim for non-medical charges, attorney fees, or other costs and expenses.

Notwithstanding its priority to funds, the Plan’s subrogation and reimbursement rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical charges as well as any costs and fees associated with the enforcement of its rights under the Plan.

When a right of recovery exists, the covered person must execute and deliver all required instruments and papers and take any additional action needed to secure the Plan’s right of subrogation and reimbursement as a condition to having the Plan make payments. In addition,

the covered person shall not take any action to prejudice the right of the Plan to subrogate or seek reimbursement.

The Plan's right of subrogation and reimbursement also applies when a covered person recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

If a covered person receives or collects any recovery and the Plan has a right of subrogation or reimbursement, and if the covered person does not pay the entire amount due to the Plan pursuant to the Plan's right within 10 days of his receipt of such amount, the Plan or Commerce may, at Commerce's option and to the extent of its right of subrogation or reimbursement, offset such collection against any amount due at the time of such collection or thereafter as benefits under the Plan for the covered person or any of his or her family members.

Commerce may also request that any recovery received by a covered person shall be placed in escrow for the Plan's benefit until it is reasonably expected that no further benefits will be due.

SECTION IX ERISA DISCLOSURES

A. STATEMENT OF RIGHTS UNDER ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Continue Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

3. Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

4. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

5. Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

B. PLAN DESCRIPTION

PLAN NAME:	Commerce Bancshares, Inc. Group Dental Plan
EMPLOYER ID. NO.:	43-0889454
PLAN SPONSOR:	Commerce Bancshares, Inc. 8000 Forsyth Boulevard St. Louis, MO 63105-1797
PLAN NUMBER:	508
PLAN ADMINISTRATOR:	Commerce Bancshares, Inc. 8000 Forsyth Boulevard St. Louis, MO 63105-1797
AGENT FOR SERVICE OF LEGAL PROCESS:	Commerce Bancshares, Inc. Attn: General Counsel's Office 8000 Forsyth Boulevard

St. Louis, MO 63105-1797

PLAN YEAR ENDS:

The twelve month period ending December 31.

FUNDING METHOD:

Funded through contributions by the Employer and/or the covered persons. This is a self-insured benefit plan.

**SECTION X
GENERAL PROVISIONS**

A. PLAN ADMINISTRATION AND INTERPRETATION.

Commerce is the “plan administrator” and the “named fiduciary” under the Plan and ERISA responsible for the operation and administration of the Plan. Commerce has the exclusive authority to interpret and construe the Plan, to correct defects, to supply omissions, to reconcile inconsistencies, to make factual determinations to the extent necessary to effectuate the Plan, and to determine all questions that arise in connection with the operation and administration of the Plan, in its sole and absolute discretion, including without limitation, all questions regarding eligibility for coverage and eligibility for and the amount of any benefits paid or payable under the Plan. Commerce’s interpretations and decisions shall be controlling, binding and final on all covered persons and all other parties. This provision shall apply for all purposes under the Plan, regardless of whether or not the Plan specifically provides that any particular action by Commerce shall be in its sole discretion. Commerce, in its sole discretion, may designate, appoint or employ any number of persons or entities that it deems necessary and appropriate to assist it in the operation and administration of the Plan.

Commerce shall adopt rules for the administration of the Plan as it considers desirable, provided such rules do not conflict with the Plan. All rules, decisions and designations under the Plan shall be made in a nondiscriminatory manner and persons similarly situated shall be treated alike.

The responsibility for the administration of the Plan shall be exercised with care, skill, prudence and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of a like character and with like aims.

For purposes of eligibility under the Plan, Commerce’s employment classification of an individual shall be binding and controlling for all purposes and shall apply regardless of any contrary employment classification of such individual by the Internal Revenue Service or any other federal or state agency, a court of competent jurisdiction, or any other person or entity.

B. AMENDING AND TERMINATING THE PLAN.

Commerce Bancshares, Inc., by approval of its Board of Directors or the Compensation and Benefits Committee of the Board, reserves the right to amend or terminate the Plan in whole or in part at any time and from time to time; provided that no such amendment or termination shall affect in any way the amount of or the terms of any benefits payable under the Plan prior to the effective date of such amendment or termination. If the Plan is terminated, the rights of covered persons shall be limited to covered charges incurred before termination. No covered person shall have or attain any vested right, contractual or otherwise, to any further contributions to the Plan by Commerce after the Plan has been terminated. Employees can not and shall not rely on employer contributions to the Plan as a form of compensation for past or future service.

C. DELEGATION OF FIDUCIARY RESPONSIBILITY.

Commerce may delegate to any person or entity any of its fiduciary powers or duties under the Plan. Such delegation shall be in writing and, to the extent of any such delegation, the delegate shall become the named fiduciary responsible for the administration of this Plan and have the discretionary authority to determine eligibility for benefits or to construe the terms of the Plan (if the delegate is a fiduciary be reason of the delegation). Any action by Commerce in assigning of

any of its responsibilities to specific persons who are officers or employees of Commerce shall not constitute a delegation of Commerce's responsibilities but rather shall be treated as the manner in which Commerce has determined internally to discharge such responsibilities.

D. COOPERATION.

Circumstances may arise in which Commerce or the claims administrator may require a covered person or beneficiary to furnish information concerning a covered service or supply, or any other information that directly or indirectly relates to benefits paid or payable from the Plan. Each covered person or beneficiary, in consideration of the coverage provided by the Plan, must fully cooperate and provide any and all information requested and execute any and all documents that will enable Commerce or the claims administrator to access such information. In the event a covered person or beneficiary fails to comply with this cooperation provision within 30 days of a request or provides false information in response to such request, payment of all benefits under the Plan (whether or not such benefits relate to the requested information) may be suspended and/or coverage may be terminated either retroactively or prospectively in Commerce's sole discretion. In addition, Commerce or the claims administrator may pursue any other remedy available to it, including obtaining an injunction to require cooperation, or recovering from the covered person or beneficiary damages for any loss incurred by it as a result of the failure to cooperate or the provision of false information.

E. LEGAL ACTIONS

No action at law or in equity shall be brought to recover under the Plan prior to exhausting the Plan's claims procedures set forth herein, nor shall any such action be brought at all unless brought within six months (6) months from the date Commerce issues its final decision an appeal with respect to any such claim.

F. NOT WORKERS' COMPENSATION INSURANCE

The coverage provided by the Plan is not in lieu of and does not affect any requirements of coverage by Workers' Compensation Insurance.

G GENDER AND NUMBER.

When used in this Plan, the masculine includes the feminine, the singular the plural and the plural the singular.

H. ASSIGNMENT OF BENEFITS AND CLAIMS OF CREDITORS

A covered person may assign the benefits under this Plan only to such place or person rendering services or furnishing supplies for which benefits are payable. Commerce shall not be responsible for the validity of any such assignment. Any payment made according to such assignment and in good faith by Commerce will discharge Commerce to the extent of any such payment.

I. INDEMNIFICATION.

Commerce shall indemnify any employee to whom it has delegated fiduciary duties against any and all claims, losses, damages, expenses and liabilities arising from responsibilities in connection with this Plan, unless the same is determined to be due to gross negligence or willful misconduct.

J. RECORDS AND REPORTS.

Commerce shall keep, or cause to be kept, a record of all such proceedings and actions as far as they relate to the Plan and shall maintain all books of account, records, and other data as shall be necessary to administer the Plan properly and to meet the disclosure and reporting requirements of ERISA and the Internal Revenue Code. Commerce shall maintain records which shall contain all relevant data pertaining to covered persons and their rights under the Plan. Such records pertaining solely to a particular covered person shall become available for examination by such covered person.

K. FUNDING THE PLAN AND PAYMENT OF BENEFITS.

The Plan is a self-insured arrangement with funding derived from funds of Commerce and contributions made by the covered persons. The level of any contributions to be paid by covered persons will be set by Commerce in its discretion. Such contributions will be used in funding the cost of the Plan as soon as practicable after they have been received or withheld from the employee's pay through payroll deduction. Benefits are paid directly from the Plan through the third party claims administrator.

L. QUALIFIED MEDICAL CHILD SUPPORT ORDER.

This Plan shall comply with the applicable requirements of any qualified medical child support order as defined in Section 609 of the Employee Retirement Income Security Act of 1974. To be a "qualified" order, the following information must be included:

- the name and last known mailing address of the Plan participant and each alternate recipient;
- a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient; or the manner in which the type of coverage is to be determined;
- the period to which the order applies; and
- each Plan to which the order applies.

The Plan's procedures and guidelines for determining whether a medical child support order is a "qualified" order are set forth in Appendix A.

M. TRUST AGREEMENT.

Commerce may enter into a trust agreement with a trustee for the purpose of carrying out the provisions of this Plan. The terms and provisions of any such trust agreement, and any amendments thereto, shall be incorporated into this Plan by reference.

N. PLAN IS NOT AN EMPLOYMENT CONTRACT.

The Plan shall not be deemed a contract between Commerce and any employee as consideration for, or an inducement or condition of employment of any employee. Nothing in this Plan shall be deemed to give any employee the right to be retained in the service of Commerce or to interfere with the right of Commerce to discharge an employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by Commerce with the bargaining representative of any employee.

O. CLERICAL ERROR.

Any clerical error in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

P. GOVERNING LAW.

Except to the extent preempted by ERISA or other federal law, the plan shall be governed by the laws of the State of Missouri.

SECTION XI
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

A. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Notwithstanding any provision in this Plan to the contrary, the Plan will use and disclose Protected Health Information only to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations (45 C.F.R. Parts 160-164). Specifically, the Plan will use and disclose Protected Health Information for purposes related to health care treatment, payment for health care and health care operations.

B. SPECIAL DEFINITIONS

Individually Identifiable Health Information means health information that is created or received by the Plan or Commerce which relates to the past, present or future physical or mental health or condition of an individual or the past, present or future provision of health care to an individual, and which identifies (or provides a reasonable basis for identifying) such individual.

Plan Administration Functions means administration of functions performed by Commerce on behalf of the Plan (including functions related to payment, treatment or health care operations as defined in the HIPAA regulations) but excluding functions performed by Commerce in connection with any other benefit or benefit plan of Commerce.

Protected Health Information means Individually Identifiable Health Information except as specifically excluded from this definition, that is (i) transmitted by electronic media; (ii) maintained in any medium described in the definition of electronic media at 45 C.F.R. § 162.103 (i.e., which includes the Internet, Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disc, or compact disc media); or (iii) transmitted or maintained in any other form or medium. Protected Health Information excludes Individually Identifiable Health Information in (a) education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (b) records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (c) employment records held by a covered entity in its role as employer.

C. CERTIFICATION BY THE EMPLOYER

Neither the Plan nor any health insurance issuer or business associate servicing the Plan shall disclose a participant's Protected Health Information to Commerce unless Commerce certifies that the Plan has been amended to incorporate HIPAA's privacy provisions and agrees to abide by such privacy provisions.

D. EMPLOYER COVENANTS

Commerce agrees to:

- not use or further disclose Protected Health Information other than as permitted or required by the Plan document or as required by law;
- ensure that any agents, including a subcontractor, to whom Commerce provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to Commerce with respect to such Protected Health Information;
- not use or disclose Protected Health Information for employment-related actions and decisions unless authorized by an individual;
- not use or disclose Protected Health Information in connection with any other benefit or employee benefit plan of Commerce unless authorized by the individual with respect to whom the Protected Health Information relates;
- report to the Plan any use or disclosure of Protected Health Information of which it becomes aware that is not permitted under the Plan's privacy policies and procedures or the HIPAA privacy regulations;
- make Protected Health Information available to an individual in accordance with HIPAA's access requirements;
- make Protected Health Information available for amendment by the individual who is the subject of that information and incorporate any amendments to Protected Health Information in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and
- return or destroy all Protected Health Information received from the Plan that Commerce still maintains in any form, and retain no copies of such Protected Health Information when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

E. ADEQUATE SEPARATION BETWEEN THE PLAN AND THE EMPLOYER MUST BE MAINTAINED

In accordance with HIPAA, only the following employees or classes of employees of Commerce may be given access to Protected Health Information:

- the Privacy Officer; and
- staff designated by the Privacy Officer.

F. LIMITATIONS OF PROTECTED HEALTH INFORMATION ACCESS AND DISCLOSURE

The persons described in paragraph E may only have access to and use and disclose Protected Health Information for Plan Administration Functions that Commerce performs for the Plan.

G. NONCOMPLIANCE MECHANISM

The employees or classes of employees identified in paragraph E of this section will be subject to disciplinary action and sanctions, including termination of employment or affiliation with Commerce, for any use or disclosure of Protected Health Information and breach or violation of or noncompliance with the provisions of this section. Commerce will promptly report such breach, violation or noncompliance to the Plan as required in paragraph D, above, and will cooperate with the 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 person, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance

H. ELECTRONIC PROTECTED HEALTH INFORMATION

If the Plan discloses electronic Protected Health Information to Commerce (other than summary health information or enrollment/disenrollment information disclosed pursuant to 45 C.F.R. § 164.504(f)(1)(ii) or (iii) or information permitted to be disclosed pursuant to an individual authorization under 45 C.F.R. § 164.508), Commerce will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information that Commerce creates, receives, maintains or transmits on behalf of the Plan;
- Ensure that adequate separation required by 45 C.F.R. § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- Ensure that any agent, including subcontractor, to whom Commerce provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information; and
- Report to the Plan any security incident of which Commerce becomes aware.

“Electronic Protected Health Information” means individually identifiable health information that is transmitted by Electronic Media; maintained in electronic media; or transmitted or maintained in any other form or medium. Notwithstanding the foregoing Electronic Protected Health shall exclude individually identifiable health information in education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. § 1232g; and employment records held by an employer in its role as such.

“Electronic Media” means (1) electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or (2) transmission media used to exchange information already in an electronic storage media. Transmission media includes, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including paper via facsimile and of voice via telephone, are not considered to be transmissions via electronic media because the information being exchanged did not exist in electronic form before the transmission.

APPENDIX A

PROCEDURES FOR HANDLING QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Plan will follow these procedures upon receipt of an order which is purported to be a qualified medical child support order (“QMCSO”) within the meaning of Section 609(a) of the Employee Retirement Income Security Act (“ERISA”).

1. Notice. Upon receipt of a purported qualified order, Commerce or its designee will promptly notify the relevant participant and the proposed alternate recipient(s) designated in the order (at the address(es) included in the order) of the receipt of the order and of the Plan’s procedures for determining whether the order is qualified.
2. Original or Certified Copy of Order Required. Notwithstanding any other provision in these procedures to the contrary, an order shall not be considered a QMCSO unless and until Commerce or its designee has received an executed original of the order or a certified copy, issued by a court of competent jurisdiction.
3. Review of Order; Final Determination. Commerce or its designee will review the order within a reasonable time to determine its qualified status. During such review period, Commerce or its designee may suggest revisions to the order for the purpose of assisting the parties in amending the order to comply with the requirements under Section 609(a) of ERISA. Any such suggestions shall not be construed as a final determination that the order is not a QMCSO. The participant and each purported alternate recipient will be notified of the final determination as to whether or not the order is a QMCSO.
4. Notice to Alternate Recipient’s Custodial Parent or Legal Guardian. Any notice required by these procedures to be provided to an alternate recipient may be addressed to the alternate recipient in courtesy of the alternate recipient’s custodial parent or legal guardian, as the case may be.
5. Designation of Representative of Alternate Recipient. An alternate recipient under an order may designate a representative for receipt of copies of notices that are sent to the alternate recipient.
6. Determination Order is a QMCSO. If Commerce or its designee determines the order is a QMCSO:
 - a. The Plan will recognize the alternate recipient’s right to receive benefits in accordance with the terms of the Plan and to the extent provided in the order.
 - b. Any payments for benefits made by the Plan 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 and not the participant. Any payments for benefits made by the Plan in reimbursement for expenses paid by a participant on behalf of an alternate recipient shall be made to the participant, unless the order requires such reimbursement to be made to the alternate recipient or the alternate recipient’s custodial parent or legal guardian.

7. Determination Order is Not a QMCSO. If Commerce or its designee determines the order is not a QMCSO, the Plan will not recognize the order for any purpose.
8. Assistance of Legal Counsel. Commerce or its designee may consult with the Plan's legal counsel in case of questions which arise with respect to the interpretation of any provision of the order or with respect to the qualified status of the order.