Blue-Care

A state qualified Health Maintenance Organization offered by Good Health HMO, Inc., a subsidiary of Blue Cross and Blue Shield of Kansas City

DIRECT ENROLLMENT
Health Benefits Contract

Kansas Blue-Care
BCK1111A
Contract Effective Date: January 1, 2020

NOTICE
The application, which You completed was delivered to You as a part of the Contract. The Contract was issued on the basis that answers to all questions and information shown on the application is correct and complete. Please read over Your copy of the application and carefully check it. Write to Us within 10 days, if an information shown on it is not correct and complete, or if any past medical history has been left out of the application.

You may return this Contract within 10 days of its receipt for full refund of any Premiums paid if, after examining it, You are not satisfied for any reason.

TABLE OF CONTENTS

Page

This Contract is guaranteed renewable subject to the termination provisions in Section G. We may modify the terms and conditions of this Contract so long as such modifications comply with applicable laws and modifications are effective on a uniform basis for all Covered Persons.

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

SECTION A. DEFINITIONS

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

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

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

Adverse Determination Means a determination by Us that a proposed or delivered Health Care Service which would otherwise be covered under the Contract is not or was not Medically Necessary or the health care treatment has been determined to be Experimental/Investigative and:

a. The requested service is provided in a manner that leaves the Covered Person with a financial obligation to the provider or providers of such service; or

b. The Adverse Determination is the reason for the Covered Person not receiving the requested services.

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

a. For Hospitals, other institutional health care facilities, Physicians or suppliers of medical goods and services which are HMO Providers-

   The Allowable Charge is the lesser of:

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

   (2) The provider's billed charges.

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

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

(2) The provider's billed charges.

c. For BlueCard Program providers outside Our Service Area-

When You obtain Emergency Services outside of Our Service Area through the BlueCard Program, the amount You pay for Emergency Services is, calculated on the lesser of:

(1) The billed charges for Your Covered Services, or

(2) The negotiated price for Your Emergency Services that the local Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to Us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with Your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with Your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over-estimation or underestimation of past prices. However, the amount You pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate that Your liability calculation method differ from the usual BlueCard Program method noted above or require a surcharge, We would then calculate Your liability for any Covered Services in accordance with the applicable state statute in effect at the time You received Your care.

d. For participating pharmacies –

The Allowable Charge is the lesser of:

(1) The negotiated rate the pharmacy has agreed to accept for Our members, if applicable; or

(2) The Usual and Customary Charge as described in the Outpatient Prescription Drug Benefit in the Covered Services Section.

Ambulance	Means a vehicle designed and operated to provide medical services and that is licensed by state and local laws.
Ambulatory Review	Means Utilization Review of Health Care Services performed or provided in an outpatient setting.
Approved in Advance or Prior Authorization	Means the procedure whereby We determine: (a) based on medically recognized criteria, whether or not an Admission to a Hospital as an inpatient is reasonable for the type of services to be received; or, (b) whether any service to be performed is reasonable and Medically Necessary for the condition being treated and the type of services to be provided.
Benefits	Means the amount of Allowable Charges We pay for Covered Services.
Benefit Schedule	Means a listing of certain Covered Services specifying Copayments and limitations under the Contract.
Blue-Care	Means the company legally responsible for providing the Benefits under the Contract. Blue-Care is referred to as "We," "Us" and "Our."
BlueCard Program	Means a national provider program offered by Blue Cross and Blue Shield of Kansas City and other participating Blue Cross and/or Blue Shield Plans across the country.
Calendar Year	Means January 1 through December 31 of the same year.
Calendar Year Maximum	Means a maximum dollar amount, or a maximum number of days, visits or sessions for which Benefits for Covered Services are provided for a Covered Person in any one Calendar Year. Once a Calendar Year Maximum for a specific Covered Service is met, no more Benefits for such Covered Services will be provided during the same Calendar Year. If the Contract replaces any health plan issued by Blue Cross and Blue Shield of Kansas City or any of its affiliates under which a Covered Person was covered, then this maximum will be reduced by the amount of Benefits a Covered Person received through the previous plan(s) during that Calendar Year.
Certificate of Creditable Coverage	Means a certificate issued from a former health plan or insurance company that documents the number of days of Creditable Coverage a person has had which may be used to determine whether an individual is to be considered an Eligible Individual.
Certification	Means a determination by Us that an Admission, availability of care, continued stay or other Health Care Service has been reviewed and, based on the information provided, satisfies Our requirements for Medical Necessity, appropriateness, health care setting, level of care and effectiveness.

Complications of Pregnancy	Means non-routine care (medical or surgical) required due to medical complications occurring as a result of or during the pregnancy. This does not include the actual obstetrical procedure itself which is defined as a normal delivery, cesarean section, or elective abortion.
Concurrent Review	Means Utilization Review conducted during a patient's Hospital stay or course of treatment.
Confinement	Means an uninterrupted stay following formal Admission to a Hospital or Skilled Nursing Facility. It starts with the Admission and ends the day the Covered Person is discharged from the Hospital or Skilled Nursing Facility.
Contract	Means the agreement between the Contractholder and Us that contains all of the terms of coverage. The Contract includes this booklet, Your application for coverage, and any amendments.
Contractholder	Means the person who originally applies for and is accepted for coverage by Us under the Contract.
Copayment	Means a specified charge that You must pay each time You receive a service of a particular type or in a designated setting. Except for prepaid services and prescription drugs, Copayments shall not exceed 50% of the total cost of providing any single service to a Covered Person.
Covered Person	Means the Contractholder or any of the Contractholder's Dependents whose coverage is in effect under the Contract.
Covered Services	Means services, supplies, equipment and care specifically listed in the "Covered Services" section of the Contract.
Custodial Care	Means care furnished mainly to train or assist in personal hygiene or other activities of normal daily living such as dressing, feeding, and walking, rather than to provide medical treatment.
Dependent	Means a person in the Contractholder's family who meets the Dependent eligibility requirements of the "Eligibility, Enrollment and Effective Date" section of the Contract.
Discharge Planning	Means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.
Due Date	Means the day of each month when Premiums are due and payable as indicated in the Benefit Schedule.
Effective Date	Means the date coverage begins for a Covered Person under the Contract.

Eligible Individual

Means an individual who meets all of the following conditions:

a. Has had at least 18 months of Creditable Coverage as of the date applying for coverage and has not had a 63 day or more gap in Creditable Coverage;

b. The most recent prior Creditable Coverage was under a group health plan, governmental plan or church plan;

c. The individual is not eligible for any group health plan, Medicare or Medicaid and does not have any other health insurance coverage;

d. The individual's most recent coverage was not terminated due to nonpayment of premiums, fraud or misrepresentation; and

e. If COBRA or state continuation was offered to the individual, it was elected and the maximum continuation period has been exhausted.

A child is considered an Eligible Individual if the child was covered under any Creditable Coverage within 30 days of birth, adoption, or placement for adoption, and the child has not had a 63 day or more gap in Creditable Coverage.

Emergency Medical Condition

Means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the individual's health in serious jeopardy.

Emergency Services

Means Ambulance services and health care items and services furnished or required to evaluate and treat an Emergency Medical Condition, as directed or ordered by a Physician.

Experimental / Investigative Services

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

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

a. The drug or device cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

b. Reliable evidence shows that the drug, device or medical treatment or procedure:

(1) is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the maximum tolerated dose, safety, toxicity, or efficacy as its objective;

(2) is provided pursuant to a written protocol or other document that lists an evaluation of its safety, toxicity, or efficacy as its objective; or

(3) is Experimental/Investigative per the informed consent document utilized with the drug, device, or medical treatment; or

c. The national Blue Cross and Blue Shield Association's uniform medical policy (as amended from time to time) has determined the device or medical treatment or procedure ("technology") is investigational based on the following criteria:

(1) Final approval from the appropriate governmental regulatory bodies has not been received; or

(2) Scientific evidence does not permit conclusions concerning the effect of the technology on health outcomes; or

(3) The technology does not improve the net health outcome; or

(4) The technology is not as beneficial as established alternatives; or

(5) The improvement is not attainable outside the investigational settings; or

d. To the extent paragraphs a., b., and c. above do not apply, Our local Medical Policy Committee, utilizing additional authoritative sources of information and expertise, has determined that the technology does not meet the criteria listed in paragraph c. 1-5 above or there is not sufficient evidence based peer reviewed studies published in medical literature to establish the safety and efficacy of the technology.

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

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

Health Maintenance Organization (HMO) Means an organization set up and operated to provide health services according to applicable federal or state HMO laws.

HMO Provider

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

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

Home Health Agency

Means an organization or entity that:

a. Contracts with Us to provide Health Care Services in the home; and

b. Operates pursuant to law.

Hospice

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

Hospital

Means a facility that:

a. Operates pursuant to law;

b. Provides 24-hour nursing services by Registered Nurses (R.N.'s) on duty or call; and

c. Provides Health Care Services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of a staff of Physicians.

Hospitals are classified as follows:

a. HMO Provider Hospital means a Hospital that has a Blue-Care Hospital contract with Us.

b. Non-HMO Provider Hospital means a Hospital that does not have a Blue-Care HMO Provider Hospital contract with Us.

IF YOU RECEIVE SERVICES IN A NON-HMO HOSPITAL, EXCEPT FOR EMERGENCY SERVICES, YOU WILL BE ENTIRELY RESPONSIBLE FOR THE COST OF THESE SERVICES.

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

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

Immediate Family Member

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

Institution of Higher Learning

Means any of the following accredited institutions:

a. State universities or colleges or community colleges;

b. Licensed private colleges or universities; or

c. Post-high school vocational or technical schools, nursing training schools, beautician schools, automotive schools, or any similar licensed training schools.

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

Lifetime Maximum

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

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

Medically Necessary (Medical Necessity)

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

a. appropriate and necessary for the symptoms, diagnosis and treatment of a medical or surgical condition;

b. consistent with acceptable medical practice according to the national Blue Cross and Blue Shield Association's uniform medical policy (as amended from time to time);

c. not primarily for the convenience of the Covered Person, nor the Covered Person's family, Physician or another provider;

d. consistent with the attainment of reasonably achievable outcomes; and

e. reasonably calculated to result in the improvement of the Covered Person's physiological and psychological functioning.

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

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

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

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

Organ Transplant Means surgically removing an organ or tissue from one person (donor) and placing it in another person (recipient) or returning the organ or tissue from the donor to the donor (same person), an autologous organ transplant.

Out-of-Pocket Maximum Means the total amount of any Coinsurance and/or Copayments a Covered Person must pay each Calendar Year for Covered Services before Benefits will be paid at 100%. The Out-of-Pocket Maximum does not include:

a. any amount that is above the Allowable Charge;

b. any amount that exceeds a specific maximum for Benefits;

c. prescription drug Copayments, if applicable;

d. office visit Copayments;

e. emergency room Copayments;

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

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

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

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

Post-Service Claim Means a request for payment for Covered Services rendered.

Premiums Means the amount paid on a periodic basis for Your coverage under the Contract.

Pre-Service Claim Means a request for services that require Approval in Advance.

Primary Care Physician (PCP) Means an internist, family practitioner, general practitioner or pediatrician You select from Our list of Blue Care Physicians to manage Your health care needs. If You do not select a PCP, one will be assigned.

Prospective Review Means Utilization Review conducted prior to an Admission or a course of treatment.

Reinstatement Means restoring a Contract that has been terminated (for example, because of nonpayment of Premiums).

Retrospective Review Means Utilization Review of Medical Necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Second Opinion Means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health services.

Service Area (Sometimes referred to as "Our Service Area") means the geographic area served by Us and approved by the appropriate regulatory agency. Contact Us to determine the geographic area We serve.

Skilled Nursing Facility Means a facility that:

a. Operates pursuant to law;

b. Provides 24-hour nursing services by registered nurses (R.N.'s) on duty or on call; and

c. Provides convalescent and long-term illness care with continuous nursing and other Health Care Services by, or under the supervision of, a staff of one or more Physicians and registered nurses.

The Skilled Nursing Facility may be operated either independently or as part of an accredited general Hospital.

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

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

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

Substance Abuse Means excessive use of a substance, but not at a level of dependence or addiction. For the purposes of the Contract, Substance Abuse will also include substance dependence or addiction which refers to prolonged and chronic use of a substance with increased tolerance. The actual diagnosis is based upon the substance that is being abused or that the user is dependent upon.

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

Utilization Review Means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, Health Care Services, procedures, or settings. Techniques may include Ambulatory Review, Prospective Review, Second Opinion, Certification, Concurrent Review, case management, Discharge Planning or Retrospective Review. Utilization Review shall not include elective requests for clarification of coverage.

We, Us, Our Means Blue-Care, the company legally responsible for providing the Benefits for Covered Services under the Contract.

You, Your Refers to the Covered Person.

SECTION B. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

1. Eligibility

To be eligible to enroll, the Contractholder must live within Our Service Area.

2. Dependent Eligibility

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

a. The Contractholder's legal spouse;

b. The Contractholder's or Contractholder's legal spouse's unmarried child who is dependent upon the Contractholder or Contractholder's legal spouse for at least one half of his financial support and maintenance. Such child includes a child by birth, an adopted child, a child under the age of 18 who has been placed with the Contractholder for the purpose of adoption for whom the Contractholder has a legal obligation to support, or a child placed under the Contractholder's legal guardianship. Coverage will be provided until the end of the Calendar Year in which such child reaches the Dependent limiting age or if a full-time student in an Institution of Higher Learning, the earlier of: (1) the end of the month in which the child ceases to meet the eligibility requirements; or (2) the end of the Calendar Year in which the child reaches the Dependent student limiting age; or

c. The Contractholder's or Contractholder's legal spouse's unmarried child (defined above) who has reached the limiting age but who cannot support himself because of a physical or mental handicap. The child's handicap must have started before the end of the Calendar Year in which the child reached the limiting age and the child must have been continuously covered by Us or a prior health plan at the time of reaching the limiting age.

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

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

3. Effects of Rescission on Eligibility

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

4. Enrollment

a. Initial Enrollment

A Contractholder may choose either individual coverage for himself, Contractholder and spouse only coverage, Contractholder and child(ren) only coverage or family coverage. A Contractholder must submit a properly completed application signed by himself and his spouse (if also requesting coverage), before the application will be considered for approval.

b. Children by Birth and Adopted Children

If a new Dependent child is acquired by the Contractholder due to birth of a child, adoption of a child, or placement for adoption of a child, the new Dependent child may be enrolled for coverage under the Contract. To enroll, the Contractholder must submit to Us a completed Contractholder application and any additional Premium due within 31 days after the date of birth, adoption, or placement for adoption. Documentation verifying the event must be provided, if requested.

Notwithstanding the above paragraph, a newborn child will be covered automatically for 31 days from the moment of birth, regardless of whether Dependent coverage was previously elected. No additional Premium will be assessed for coverage for these 31 days. If additional Premium is due, the Contractholder must submit to Us a completed Contractholder application requesting coverage for such newborn be added within 31 days of the child's birth in order to continue such child's coverage beyond the initial 31 days. Coverage for such newborn will be subject to all of the terms and conditions of the Contract, including receipt of services from the newborn's designated PCP. You must select a Primary Care Physician (PCP) to manage Your newborn's care regardless of whether You plan to continue coverage beyond the first 31 days. You may find a PCP by going to Our website at www.bluekc.com or by contacting the phone number listed on Your member identification card.

If a child placed for adoption is not legally adopted, coverage for such child will end the earlier of the date on which Your legal support obligation for the child ends or 280 days after such child's date of placement.

If the new Dependent child for which additional premium is due is not enrolled as a Dependent within 31 days of becoming eligible, then coverage for such Dependent will be subject to Our approval.

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

(1) Provide the Contractholder with forms and instructions; and

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

c. Other Dependents

Coverage for any other Dependents acquired by the Contractholder, (except newborns and adopted children who satisfy the above provisions), will be subject to Our approval.

d. Contractholder Application

The Contractholder must fully and accurately complete and sign the Contractholder application. False or intentionally misrepresented material information provided may cause coverage of a Contractholder and/or Dependents to be null and void from inception.

---

5. Effective Date of Coverage

a. Initial Enrollment

Coverage is effective at 12:01 a.m. on the first of the month following Our approval of the Contractholder's application and Our receipt of the required Premium.

The beginning of coverage for a hospital confined person, including adopted Dependents, will be postponed during that patient's Hospital Confinement if it began before the Effective Date. Coverage will be effective on the first day following the end of the Confinement. This does not apply to Eligible Individuals applying for coverage. An Eligible Individual must provide Us with a Certificate of Creditable Coverage.

b. Children by Birth and Adopted Children

Coverage for a newly acquired child by birth or adoption shall be effective as follows:

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

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

c. Other Dependents

Coverage for any other Dependents acquired by the Contractholder, (except a child by birth and an adopted child who satisfy the above provisions) will be subject to Our approval and will begin as follows:

(1) On the date the person becomes a Dependent if We receive notice before that date and approve the application.

(2) On the first day of the month following Our approval of the application if the request for coverage is received after the date the person becomes a Dependent or after the 31 day notification requirement for a child by birth or adopted child.

---

6. Other Changes in Coverage

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

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

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

When a Dependent child reaches the limiting age as provided in the Benefit Schedule, he will be issued his own coverage under Our then current standard direct enrollment Contract. He will not be required to complete an application provided he has been covered under the Contract for at least 6 months and currently resides within Our Service Area. When an individual is issued coverage in this manner, any references in the Contract to the individual having to complete an application will not apply. Such coverage will be effective the day following the date of termination of his previous coverage if he pays the required Premium for his new Contract within 31 days of the termination of his previous coverage. Any Dependents added later to his new coverage will be subject to all the provisions of the Contract.

When a Dependent child has been covered under this Contract for less than 6 months and reaches the Dependent limiting age as provided in the Benefit Schedule, We may offer him continuous Coverage in his name under Our then current standard direct enrollment Contract, provided he currently resides within Our Service Area. However, this individual will be required to submit a properly completed application within 31 days before the date on which such Dependent's coverage ends. Such application will be subject to Our approval.

If You choose to change Your coverage for any other reason, send Us a properly completed application. The change will be effective on the first day of the month following Our approval of the application.

---

7. Other

A Dependent child who was covered under a group contract issued by Us and who reaches the group contract's limiting age may be offered coverage in his name under Our then current standard direct enrollment contract. He will not be required to complete an application provided he has been covered under that group contract for at least 6 months and currently resides within Our Service Area. When an individual is issued coverage in this manner, any references in the Contract to the individual having to complete an application will not apply. Such coverage will be effective the day following the date of termination of his coverage under Our group contract if he pays the required Premiums for his new Contract within 31 days of the date of such termination. Any Dependents added later to his new coverage will be subject to all the provisions of the new Contract.

SECTION C. COVERED SERVICES

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

Covered Services

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

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

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

b. performed by Your PCP or by another Provider who is an HMO Provider;

c. Medically Necessary for the treatment of Your injury or illness, except for specifically listed routine preventive or diagnostic services;

d. not excluded under the Contract; and

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

Services from Non-HMO Providers are not covered except as described in the Emergency Services provision or if Approved in Advance by Us.

Referrals

If We do not have a health care provider with appropriate training and experience in Our network to meet Your particular health care needs, You may request Covered Services to be provided by a Non-HMO Provider. These requests will be reviewed by one of Our Medical Directors to determine whether such services are not available within Our network. If We refer You to a Non-HMO Provider, services obtained from the Non-HMO Provider shall be provided at no greater cost to You than if such services were obtained from an HMO Provider.

If You have a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, You may receive a referral to a specialty care center with expertise in treating such condition. If We, Your PCP or a Specialist, in consultation with one of Our Medical Directors, determines that Your care would be most appropriately provided by a specialty care center, We shall refer You to such center. Such referral shall be pursuant to a treatment plan developed by the specialty care center and approved by Us, in consultation with the PCP, if any, or a Specialist as designated previously, and You or Your designee. If We refer You to a specialty care center which is not an HMO Provider,

services provided pursuant to the approved treatment plan shall be provided at no greater cost to You than if such services were obtained from an HMO Provider. A specialty care center shall mean only such centers accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating such condition or disease for which it is accredited or designated.

Benefits

As a member of a Health Maintenance Organization, We have made arrangements for You to receive certain Covered Services. Benefits are subject to the payment of any Copayments listed in the Benefit Schedule. Benefits stated in this section are considered Covered Services only when such services are provided in accordance with the terms of the Contract. All Benefits are subject to the maximums and other limits, and conditions specified in the Contract.

Copayments

Copayments are a specified charge that You must pay each time You receive a service of a particular type or in a designated setting.

Copayments are shown in the Benefit Schedule.

Individual Lifetime Maximum

The amount of Benefits provided under the Contract shall not exceed the individual Lifetime Maximum shown in the Benefit Schedule. This maximum shall not be affected by any break in coverage; nor shall it be affected by a change in status from Dependent to Contractholder, or vice versa.

Approved in Advance

Services that must be Approved in Advance by Us will state so in the applicable Covered Service provision.

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

Benefits will be limited to the length of stay approved by Us. When the approved length of stay must be extended for Medically Necessary reasons, Your attending Physician, on Your behalf, must contact Us in advance to obtain Our approval for the additional days.

The following information provides a detailed description of Covered Services:

---

1. Accident-Related Dental Services/ Surgery

Accidental Injury

We provide Benefits for dental services only when such services are for treatment of an Accidental Injury. Covered Services are limited to treatment of natural teeth and the purchase, repair or replacement of dental

prostheses needed as a direct result of an Accidental Injury (except injury resulting from biting or chewing). Treatment must be completed within 12 months of the date of the Accidental Injury to be considered a Covered Service, unless the medical condition of the Covered Person prevents treatment from being rendered within 12 months of the date of the Accidental Injury.

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

We provide Benefits for:

Tooth Extractions

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

Dental Implants

Dental implants and bone grafts for the following conditions:

(1) The repair of defects in the jaw due to tumor/cyst removal;

(2) Severe atrophy in a toothless arch;

(3) Exposure of nerves;

(4) Non-union of a jaw fracture;

(5) Loss of tooth (teeth) due to an Accidental Injury; and

(6) Correction of a defect diagnosed within 31 days of birth.

Orthognathic Surgery

Orthognathic surgery for the following conditions:

(1) Correction of a defect diagnosed within 31 days of birth; or

(2) Correction of a defect due to an Accidental Injury. Treatment for correction of a defect due to an Accidental Injury must be completed within 12 months of the date of the Accidental Injury to be considered a Covered Service, unless the medical condition of the Covered Person prevents treatment from being rendered within 12 months of the date of the Accidental Injury or due to a correction of a defect diagnosed within 31 days of birth.

Dental prostheses over an implant are not covered unless the dental implant was due to an Accidental Injury.

Dental implants and bone grafts must be Approved in Advance by Us.

Temporomandibular Joint Disorder	We provide Benefits for the surgical treatment of temporomandibular joint disorder. We provide Benefits for the medical or dental management of temporomandibular joint disorder only in connection with acute dislocation of the mandible due to trauma, fractures or tumors.
Complications of Dental Treatment	We provide Benefits for inpatient Hospital services required as a result of complications of dental treatment. Covered Services are limited to services that cannot be adequately provided in an outpatient setting.

2. Allergy

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

You must pay the allergy testing Copayment if indicated in the Benefit Schedule.

3. Ambulance Service

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

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

Benefits for a ground Ambulance may be limited to an Ambulance Benefit Maximum for each usage if indicated in the Benefit Schedule. You must pay an Ambulance Copayment for each usage of an air Ambulance if indicated in the Benefit Schedule. For purposes of this paragraph, Ambulance Benefit Maximum means a maximum dollar amount for which Benefits for Ambulance Services are provided for a Covered Person for any single ground ambulance trip. Once the Ambulance Benefit Maximum is met, no more Benefits for ground Ambulance Services will be provided.

4. Anesthesia

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

Dental	We provide Benefits for general anesthesia materials and their administration for dental care if provided to the following Covered Persons: a. children age 5 and under; b. persons who are severely disabled; or c. persons who have medical or behavioral conditions requiring hospitalization or general anesthesia when dental care is provided; whether such services are provided in a Hospital, surgical center, or office. Covered Services must be provided by a Physician, Certified Registered Nurse Anesthetist (CRNA), or Dentist.
5. Bone Marrow Testing	We provide Benefits for bone marrow testing. Covered Services are limited to Human Leukocyte Antigen testing for A, B and DR antigens used in bone marrow transplantation. Covered Services may be limited to a bone marrow testing Lifetime Maximum if indicated in the Benefit Schedule.
6. Chemotherapy	We provide Benefits for chemical treatment (chemotherapy) of a disease, including the cost of the chemotherapy drug.
7. Cochlear Implants	We provide Benefits for cochlear implants. Covered Services are limited to the initial cochlear implant and related implant services. Covered Services do not include repairs, replacements or duplicates. **Cochlear implants must be Approved in Advance by Us.**
8. Diabetes	We provide Benefits for the treatment of diabetes. Covered Services are limited to self-management training (including diet counseling from a registered dietician or certified diabetes educator) and Physician prescribed Medically Necessary equipment and supplies used in the management and treatment of diabetes. Benefits are available only for Covered Persons with gestational, type I or type II diabetes. Insulin, oral anti-diabetic agents, syringes, test strips, lancets, needles and glucometers are Covered Services under the Outpatient Prescription Drug Benefit.
9. Diagnostic Services	We provide Benefits for diagnostic services including x-ray examinations, laboratory services, and other diagnostic procedures and tests required to diagnose an illness, injury, or other Covered Service.

10. Dialysis

We provide Benefits for hemodialysis and peritoneal dialysis services.

11. Durable Medical Equipment

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

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

b. We retain the right to possess the equipment and You agree to cooperate with Us in arrangements to return the equipment following Your authorized use; and

c. We have the right to stop covering the rental when the item is no longer Medically Necessary.

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

a. Hand-operated wheelchairs;

b. Hand-operated hospital-type beds;

c. Oxygen and the rental of equipment for its administration; and

d. Mechanical equipment for the treatment of chronic or acute respiratory failure (ventilators and respirators).

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

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

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

Covered Services do not include repair or replacement required as a result of abuse or misuse of DME. If repair or replacement of DME is authorized, We retain the option to determine whether to repair or replace the equipment. Covered Services do not include muscle stimulators; portable paraffin bath units; sitz bath units; stethoscopes, or blood pressure devices; nor items for comfort or convenience, such as but not limited to

spas, whirlpools, Jacuzzis, hot tubs, humidifiers, dehumidifiers and air conditioners. Covered Services also do not include DME that would normally be provided by a Skilled Nursing Facility. See the Exclusions section of the Contract for additional exclusions which may apply.

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

DME must be Approved in Advance by Us.

---

12. Elective Sterilization

We provide Benefits for elective sterilization.

---

13. Emergency Services and Supplies

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

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

Covered Services include Emergency Services in a Non-HMO Hospital for an Emergency Medical Condition.

Note: If You visit an emergency room and are kept at the Hospital for observation (usually less than 24 hours), You must pay the emergency room Copayment, but will not be required to pay the Hospital inpatient Copayment amount for the time You are kept for observation. If You are admitted to the Hospital following the observation stay, the Hospital inpatient Copayment amount will apply.

Copayments You pay for emergency room services will not apply to and will not be limited by Your Out-of-Pocket Maximum.

---

14. Formula & Food Products for Phenylketonuria (PKU)

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

Low protein modified food products are limited to those products specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the

dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

---

15. Hearing Care

We provide Benefits for one routine hearing examination per Calendar Year. You must pay Your office visit Copayment.

---

16. Home Health Services

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

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

b. The services are received as an alternative to inpatient Confinement in a Hospital or Skilled Nursing Facility; and

c. Your Physician determines that You need home health care and designs a home health care plan for You.

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

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

These services must be Approved in Advance by Us. Speech Therapy services must be Approved in Advance by Us.

You must pay the Home Health Services Copayment if indicated in the Benefit Schedule for each visit.

---

17. Hospice Services

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

Home Hospice

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

(1) Assessment and initial testing.

(2) Family counseling of Immediate Family Members.

(3) Non-prescription pharmaceuticals.

(4) Medical supplies.

(5) Respite care.

(6) Professional, medical, social, and pastoral counseling services provided by salaried employees of the Hospice.

(7) Supportive services to the bereaved family members for up to 3 months following the death of the Covered Person.

b. Covered Services do not include:

(1) Services for which there is no charge.

(2) Services related to organization or dispensation of nonmedical, personal, legal, and financial affairs such as, but not limited to, the execution of a will.

(3) Services received in a free standing Hospice facility, a Hospital-based Hospice, or provided to a Hospital bed patient except that Covered Services will be provided for an assessment visit, family counseling and supportive services to the bereaved Immediate Family Members.

(4) Services received by persons other than the Covered Person or his Immediate Family Members.

Inpatient Hospice

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

(1) Assessment and initial testing.

(2) Family counseling of Immediate Family Members.

(3) Professional, medical, social, and pastoral counseling services provided by salaried employees of the Hospice.

(4) Supportive services to the bereaved family members for up to 3 months following the death of the Covered Person.

b. Covered Services do not include:

(1) Services for which there is no charge.

(2) Services related to organization or dispensation of nonmedical, personal, legal, and financial affairs such as, but not limited to, the execution of a will.

(3) Services received by persons other than the Covered Person or his Immediate Family Members.

(4) Respite care.

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

Inpatient Hospice services must be Approved in Advance by Us.

---

18. Immunizations for Children

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

Covered Services for routine and necessary immunizations will be provided at 100% of the Allowable Charge and will not be subject to any Copayment requirements.

Any office visit charges incurred in conjunction with these immunizations will be subject to the office visit Copayment requirement of the Contract, the same as other services.

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

19. Infusion Therapy and Self-Injectables

Infusion Therapy

We provide Benefits for infusion therapy services and supplies.

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

a. If You did not receive infusion therapy at home or in Your Physician's office, You would have to receive such services in a Hospital or Skilled Nursing Facility;

b. The services are ordered by a Physician and provided by an infusion therapy provider designated by Us or Physician licensed to provide such services; and

Services are Approved in Advance by Us.

Injectables

We provide Benefits for self-injectables administered in the Physician's office or in the home setting**. These services must be Approved in Advance by Us.** Covered Services for growth hormones are limited to treatment for pediatric growth deficiency for Covered Persons under age 19. Most self-injectables are processed under Your outpatient prescription drug benefit; however, selected self-injectables may be processed under Your medical benefit. Please refer to the Prescription Drug List for a listing of self-injectables that are processed under Your medical benefit or visit Our website at www.bluekc.com for a current listing. This list is subject to change without prior notice and is based on the recommendations of community Physicians and pharmacists.

Allergy injections and insulin are not Covered Services under this Benefit. See the Allergy and Diabetes Benefits in the Contract for a description of how allergy injections and insulin are covered.

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

20. Inpatient Hospital Services

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

A hospitalist may coordinate Your care during Your inpatient stay.

Covered Services for inpatient Hospital services for the treatment of Mental Illness and Substance Abuse are limited as indicated in the Mental Illness and Substance Abuse Benefit.

You must pay the Inpatient Hospital Services Copayment per day if indicated in the Benefit Schedule.

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

If You are admitted as a bed patient in a Non-HMO Hospital inside Our Service Area, Hospital and Physician services will be provided for up to 2 day's care for conditions which are of sufficient severity to be considered an Emergency Medical Condition.

After the second day of Emergency Services care in a Non-HMO Hospital within Our Service Area, You will be entirely responsible for the cost of all services received from the Non-HMO Hospital and Physicians unless Our Medical Director in consultation with Your Physician determines it to be medically unsafe for You to be transported to an HMO Hospital. When You are Stabilized, We will arrange for transportation to an HMO Hospital.

21. Maternity Services and Related Newborn Care

We provide Benefits for maternity services. Covered Services are limited to pre-natal, obstetrical and postpartum services. Only one office visit Copayment shall apply for Physician obstetrical services per pregnancy. This Copayment will be assessed at the time of delivery and will be in addition to the Inpatient Hospital Services Copayment indicated in the Benefit Schedule. You must pay Your office visit Copayment for each visit to a Physician for Complications of Pregnancy.

Covered Services include an inpatient stay of at least 48 hours for a covered mother and a covered newborn child following any vaginal

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

Services provided for a covered newborn child and routine Hospital nursery services provided during the Hospital Confinement, are eligible for Benefits under the newborn child's Dependent coverage. Benefits shall also include coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. You must pay Your inpatient Copayment, if any, for these services. If both the mother and newborn child are covered under this Contract, You must pay only the mother's Copayment during the covered portion of the mother's Hospital Confinement.

Dependent daughters are not covered for maternity services.

Complications of Pregnancy

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

If a child is adopted by the Contractholder within 90 days of birth, Covered Services include obstetrical and delivery expenses only for the birth mother incurred at the time of the birth of such child.

Covered Services do not include elective pregnancy termination except when the life of the mother would be endangered if the fetus was carried to term.

See the Benefit Schedule and the Exclusions and Limitations section of the Contract for the waiting period applicable to Maternity Services and Related Newborn Care.

22. Mental Illness and Substance Abuse

We provide Benefits for the treatment of Mental Illness and Substance Abuse. New Directions Behavioral Health Care ("New Directions") performs intake services designed to provide crisis intervention, assessment, benefits management and referral services.

Mental Illness and Substance Abuse Services must be Approved in Advance by New Directions.

Outpatient Mental Illness and Substance Abuse Services:

Covered Services are limited to outpatient evaluation and treatment of Mental Illness and Substance Abuse. Treatment is limited to crisis intervention, stabilization and therapy for conditions which New Directions and We determine will substantially benefit You. Covered Services are limited to a 20 visit Calendar Year Maximum. You have no Copayment for the first 3 outpatient visits per Calendar Year. On Your 4th through 20th outpatient visit, You must pay the office visit Copayment for each visit if indicated in the Benefit Schedule.

Inpatient Mental Health and Substance Abuse Services:

Covered Services are limited to Hospital and Physician services Approved in Advance by New Directions for treatment of Mental Illness and Substance Abuse when You are confined in any Hospital or other residential facility licensed to provide such treatment. Covered Services are limited to a 30 day Calendar Year Maximum for treatment in any one or combination of facilities.

New Directions may, at its discretion, substitute 2 sessions of intermediate care (partial hospitalization) for one inpatient day. In no event will Benefits exceed the Calendar Year Maximum for the combined inpatient treatment of all conditions requiring Mental Illness and/or Substance Abuse Services. You must pay Your Hospital Copayment amount, if any, when You are admitted to any Hospital or residential facility.

---

23. Organ Transplants

We provide Benefits for Organ Transplants. **These services must be Approved in Advance by Us.** If it appears that You may need an Organ Transplant, We encourage You to review these Covered Services with Your Physician. Covered Services may be limited to an Organ Transplant Lifetime Maximum if indicated in the Benefit Schedule.

Covered Organ Transplant Services:

Covered Services are limited to services and supplies for Organ Transplants when ordered by a Physician, and provided at or arranged by a Designated Transplant Provider. Such services include, but are not limited to, Hospital charges, Physician charges, organ procurement, and ancillary services. Coverage is provided for Cornea, Kidney, Pancreas, Kidney/Pancreas, autologous Islet Cell, Small Bowel, Small Bowel/Liver, Liver, Liver/Kidney, Liver/Small Bowel/Kidney, Heart, Heart/Lung(s), Lung(s) and allogenic and autologous Bone Marrow and stem cell transplants for breast cancer and certain other conditions,, when such

transplants are Medically Necessary and rendered by a Designated Transplant Provider in accordance with Our policies for transplantation services. Contact Us for information on Designated Transplant Providers and Our policies for transplantation.

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

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

a. When both the recipient and the donor are covered under the Contract, Covered Services received by the donor and recipient will be provided up to the recipient's Organ Transplant Lifetime Maximum, if any. This means that both the donor and recipient's transplant related services will be combined and will apply to the recipient's Organ Transplant Lifetime Maximum, if any.

b. When only the recipient is covered under the Contract, both the donor and the recipient are entitled to the Covered Services of the Contract. The donor's Covered Services are limited to only those benefits which are not provided by or available to the donor from any other source. This includes but is not limited to, other health care plan coverage or any government program. Covered Services provided to a donor will be applied towards the recipient's Benefit limits under the Contract and will reduce the recipient's Organ Transplant Lifetime Maximum, if any, to the extent Covered Services are provided to the donor.

c. When only the donor is covered under the Contract, Covered Services are limited to only those services which are not provided by or available to the donor from any other source. This includes, but is not limited to, other health care plan coverage or any government program. No Covered Services will be provided to a transplant recipient who is not covered under the Contract.

d. If any organ or tissue is sold rather than donated to a recipient covered under the Contract, no Covered Services will be provided for the purchase price of such organ or tissue. However, other costs related to evaluation and organ "Procurement Services" are covered and subject to the Organ Transplant Lifetime Maximum, if any.

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

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

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

You must pay Your Inpatient Hospital Services Copayment, if any, for inpatient services.

Exclusions: You have no Benefits for services provided at facilities which are not Designated Transplant Providers.

You have no Benefit for a non-human or mechanical Organ Transplant.

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

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

---

24. Osteoporosis

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

---

25. Outpatient Prescription Drugs

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

For participating providers, You must always pay the lower of either: (a) Your applicable Prescription Drug Copayment, specified in the Benefit Schedule; or (b) the participating pharmacy's Usual and Customary Charge if the Usual and Customary Charge is less than Your Copayment. For purposes of this paragraph, Usual and Customary Charge means the amount that the participating pharmacy would have charged You if You were a cash paying customer. Such amount includes all applicable discounts, including, without limitation, senior citizen's discounts, coupon discounts, non-insurance discounts, or other special discounts offered to attract customers.

Drug Rebates and Credits:

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

We receive rebates from the PBM and may from time to time receive financial credits, and/or other amounts (collectively "Financial Credits") from network pharmacies, drug manufacturers, or the PBM. We retain sole and exclusive right to all Financial Credits and may use such Financial Credits in Our sole and absolute discretion (including, for example, to help stabilize overall rates and to offset expenses). Without limitation to the foregoing, the following rules apply to the Financial Credits: (a) You have no right to receive, claim or possess any beneficial interest in any Financial Credits; (b) Applicable drug benefit Copayment and/or maximum allowable benefits (including without limitation Calendar Year Maximum and Lifetime Maximum benefits) are in no way adjusted or otherwise affected as a result of any Financial Credits; (c) Any Deductible and/or Coinsurance that You must pay for prescription drugs is based upon the Allowable Charge at the pharmacy and does not change as a result of any Financial Credits; and (d) Amounts paid to pharmacies or any prices charged at pharmacies are in no way adjusted or otherwise affected as a result of any Financial Credits.

Covered Drugs:

Covered Services are limited to:

a. Legend drugs that, by federal or state law, can only be dispensed upon written prescription from an authorized prescriber

b. Compound medications that contain at least one legend drug in a therapeutic amount

c. Off-label use of prescription drugs when treatment of the indication is recognized in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature. Your Physician must submit documentation supporting the proposed off-label use or uses if requested by Us

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

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

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

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

d. Insulin, syringes, needles, lancets, test strips, oral anti-diabetic agents and glucometers

e. Oral and injectable contraceptive drugs

f. Contraceptive devices and implants which require a Physician's prescription.

Covered Services are limited to drugs and medicines that have been approved for use in the United States by the Federal Food and Drug Administration (FDA) regardless of where the drugs are obtained. Drugs or medicines approved by the FDA for Experimental or Investigative Services are not covered. We may impose administrative limits on the quantity or frequency by which a drug may be dispensed. These limits will be based on recommendations of the drug manufacturer or by community Physicians and pharmacists.

Participating Pharmacies:	You must obtain Your prescription from a participating pharmacy or it will not be considered a Covered Service. Prescriptions filled at non-participating pharmacies will be reimbursed, less the applicable Copayment, only if it is a prescription for an Emergency Medical Condition filled outside of Our Service Area. See Your provider directory for a listing of participating pharmacies.
Calendar Year Maximum:	Covered Services may be limited to a Calendar Year Maximum for each Covered Person if indicated in the Benefit Schedule. Selected outpatient prescription drugs may not apply to this Calendar Year Maximum. Please refer to the Prescription Drug List for a listing of drugs that do not apply towards the Calendar Year Maximum.
Short-Term Supplies:	Short-term prescriptions are for up to a 34 day supply. You must pay a Copayment for each short-term prescription if indicated in the Benefit Schedule. Call customer service for a copy of the Prescription Drug List or visit our website at www.bluekc.com for the most current information. The list of drugs is subject to change without prior notice based on the recommendations of community Physicians and pharmacists.
Long-Term Supplies:	We provide Benefits for long-term prescriptions when obtained from a participating pharmacy. For you convenience, these supplies may be obtained through a mail order prescription drug program. Call Us for instructions and forms for obtaining prescription drugs through the mail. Long-term prescriptions are for a 35 to 102 day supply. You must pay a Copayment for each long-term prescription if indicated in the Benefit Schedule. Call customer service for a copy of the Prescription Drug List or visit our website at www.bluekc.com for the most current information. The list of drugs is subject to change without prior notice based on the recommendations of community Physicians and pharmacists.
Specialty Pharmaceuticals	We provide Benefits for Specialty Pharmaceuticals when obtained from a designated specialty pharmacy. Refer to the Prescription Drug List for a listing of Specialty Pharmaceuticals and specialty pharmacies. In some cases, these drugs will be delivered to Your home. Specialty Pharmaceuticals means biotechnology drugs or other drug products that may require special ordering, handling, clinical monitoring and/or customer service. Specialty Pharmaceuticals are limited to a 34 day supply and are subject to the applicable Prescription Drug Copayment, if indicated in the Benefit Schedule.

Exclusions:

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

a. Tier 2 and Tier 3 drugs for the first 6 months following FDA approval unless a shorter exclusions period is recommended by Our Pharmacy and Therapeutics Committee, which includes community physicians and pharmacists

b. Drugs or medications obtained from non-participating pharmacies - except for Emergency Services outside the Service Area

c. Appetite suppressants, anorexiants and anti-obesity drugs

d. Compounded medications with ingredients that do not require a prescription

e. Experimental, Investigative or unproven services and medications; medications used for Experimental indications and/or dosage regimens determined by Us to be Experimental (including, but not limited to those labeled “caution - limited by federal law to investigational use” and drugs found by the Food and Drug Administration to be ineffective)

f. Medications for cosmetic purposes, such as but not limited to isotretinoin, tretinoin (Retin-A), topical minoxidil, and finasteride

g. Medications for smoking cessation or smoking deterrents (such as but not limited to nicotine replacement or other pharmacological agents used for smoking cessation) or antidepressants prescribed in conjunction with smoking cessation

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

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

j. Medications with no approved FDA indications

k. Immunization agents

l. Refills of prescription medications initially filled by a participating pharmacy whose status has changed to a non-participating pharmacy on the date the order or refill was dispensed

m. For prescription medications prescribed by a Non-HMO Provider unless the prescription is for an Emergency Medical Condition

n. Drugs related to treatment that is not a Covered Service under the Contract

o. Prescription drugs that are not Medically Necessary unless otherwise specified

p. Anabolic steroids, anti-wrinkle agents, dietary supplements, Fluoride supplements, growth hormones prescribed for anyone over age 18, blood or blood plasma, irrigational solutions and supplies

q. Lifestyle enhancing drugs, unless otherwise specified

r. Fertility drugs

s. Impotency medications and devices

t. Drugs and devices that are intended to induce an abortion.

u. Drugs obtained outside the United States for consumption in the United States.

---

26. Outpatient Surgery and Services

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

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

You must pay the Outpatient Surgery Copayment if indicated in the Benefit Schedule for any outpatient surgery.

---

27. Outpatient Therapy

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

Speech Therapy and Hearing Therapy

This is treatment for the loss or impairment of speech or hearing disorders provided by a speech pathologist, speech/language pathologist or audiologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both, and which fall within the scope of such license or certification. Covered

Services include examination, evaluation, counseling and any testing required to diagnose any loss or impairment of speech or hearing.

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

Speech and hearing therapy must be Approved in Advance by Us.

Physical Therapy

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

Occupational Therapy

Occupational Therapy Services provided by a Physician or Registered Occupational Therapist (O.T.R.) are covered when these services are expected to result in significant improvement in a Covered Person's condition. Except for treatment of neuromuscular disorders in Covered Persons under age 19, Covered Services are limited to treatment of acute illnesses and injuries. Occupational therapy is provided only for purposes of training Covered Persons to perform the activities of daily living. Covered Services do not include occupational therapy provided on a routine basis as part of a standard program for all patients.

Covered Services for Physical and Occupational Therapy services may be limited to a combined Calendar Year Maximum if indicated in the Benefit Schedule. This limit will not apply to physical, or occupational therapy services provided by a Home Health Care Agency pursuant to a home health plan of treatment Approved in Advance by Us. Such services will be subject to the limit, if any, for Home Health Services. Speech and Hearing Services are not subject to the Calendar Year Maximum.

---

28. Physician Services

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

a. Office Visits. We provide Benefits for Specialist office visits and Your PCP office visit. Other PCP office visits are not covered. You must pay the PCP office visit Copayment if indicated in the Benefit Schedule for each visit to Your PCP. You must pay the Specialist office visit Copayment if indicated in the Benefit Schedule for visits to a Specialist.

b. Electronic Physician Visits (e-visits). E-visits with Physicians through Our approved Internet portal are available only to Covered Persons who have an established relationship with a HMO Physician and whose

HMO Physician has agreed and been approved to provide Internet based e-visits through Our approved Internet portal ("Internet Ready"). E-visits for mental health and Substance Abuse are not covered.

c. Periodic health examinations including physical and emotional status and developmental assessment and routine preventive care provided by Your PCP, Obstetrician or Gynecologist.

We provide Benefits for routine preventive care as required by state or federal law. Covered Services are limited to the following:

(1) Prostate exams and prostate specific antigen (PSA) tests,

(2) Pelvic exams and pap smears, including those performed at the direction of a Physician in a mobile facility certified by Centers for Medicare and Medicaid Services (CMS),

(3) Mammograms if ordered by a Physician, including those performed at the direction of a Physician in a mobile facility certified by CMS,

(4) Colorectal cancer exams and laboratory tests consisting of a digital rectal exam and the following:

(a) fecal occult blood test;

(b) flexible sigmoidoscopy;

(c) colonoscopy;

(d) double contrast barium enema,

(5) Newborn hearing screening, audiological assessment and follow-up, and initial amplifications,

(6) Childhood immunizations as referenced in the Immunizations for Children Benefit of this Contract,

(7) Lead testing, and

(8) The related office visit.

We also provide the following Benefits for routine preventive care to evaluate and manage a well person's health status.

Covered Services are limited as follows:

(1) Physician Examinations

(2) Additional examinations, testing and services:

(a) Complete Blood Count (CBC)

(b) Metabolic screening

(c) Hearing exams

(d) Immunizations

Covered Immunizations are limited to the age ranges and gender recommended by the Advisory Committee on Immunization Practices and/or adopted by the Center for Disease Control.

i. Catch-up for Hepatitis B

ii. Catch-up for varicella

iii. Catch-up for MMR

iv. Tetanus boosters as necessary, including tetanus, diphtheria and pertussis; diphtheria and tetanus and tetanus only

v. Pneumococcal vaccine

vi. Influenza virus vaccine

vii. Menigococcal vaccine

viii. Catch-up for Hepatitis A

ix. HPV vaccine

x. Zoster vaccine

(e) Urinalysis

(f) Glucose screening

(g) Thyroid stimulating hormone screening

(h) Lipid cholesterol panel

(i) HIV Screening

(j) HPV Testing

(k) Chlamydia Trachomatis Testing

(l) Gonorrhea Testing

(m) Electrocardiogram (EKG)

(n) Chest X-Ray

d. Surgical and orthopedic services. Covered Services are limited to cutting and other operative procedures for treating illness or injury. The Allowable Charge for surgery includes care by the Physician before, during, and after surgery (preoperative and postoperative care).

e. Surgical assistant services provided by a Physician. Covered Services are limited to the assistance at the operating table which is given to the operating Physician by another Physician. This assistance must be Medically Necessary, as determined by Us and in connection with procedures that normally require assistance. Covered Services do not include any activities of internship or residency, or any type of training.

f. Inpatient Specialist services. Covered Services are limited to those that are provided when a Covered Person has a medical condition that is not in the attending Physician's specialty and the attending Physician asks the opinion of a Physician with that specialty. Covered Services do not include staff consultations required by Hospital rules and regulations.

g. Hospital bed patient care by a Physician.

(1) General care. Covered Services are limited to a Physician's visits to a Covered Person if the reason for the Hospital stay is strictly to treat a medical condition and no surgical, orthopedic or obstetrical services are performed during that Confinement.

(2) Preoperative care. Covered Services are limited to visits by a Physician with a specialty different than that of the operating Physician, assistant surgeon or anesthesiologist for treatment of a condition unrelated to surgery. Care by the operating Physician, assistant surgeon or anesthesiologist is considered to be part of the total Allowable Charge for the surgical service.

(3) Postoperative care. Covered Services are limited to visits by a Physician other than the operating Physician, assistant surgeon or anesthesiologist if the reason for the visits is to treat a Covered Person for an acute phase of a medical condition a Covered Person either had before the surgical services, or that first began during the postoperative period. Care by the operating Physician, assistant

surgeon or anesthesiologist is considered to be part of the total Allowable Charge for the surgical service.

(4) Intensive care. Covered Services are limited to visits by a Physician treating a Covered Person for a medical condition that requires constant attendance or frequent visits in a short period of time.

h. Home visits by a Physician.

---

29. Podiatry

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

Bone Surgery — We provide Benefits for bone surgery on the foot.

---

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

---

31. Prosthetic and Orthotic Appliances — We provide Benefits for prosthetics and orthotics, other than foot orthotics (including shoes).

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

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

b. An irreparable change in the condition of the device; or

c. The condition of the device requires repairs and the cost of such repairs would be more than 60% of the cost of the replacement device.

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

Repairs and replacements are not Covered Services if the need for repair or replacement is due to misuse or abuse of the device or to the extent the device is covered under any warranty. Covered Services also do not include replacement of prosthetic and orthotic devices due to changes in

technology. Prosthetics that may enhance function after initial purchase are not Covered Services.

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

Prosthetic and orthotic devices must be Approved in Advance by Us.

---

32. Radiation Therapy

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

---

33. Reconstructive Surgery / Prosthetic Devices Following a Mastectomy

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

---

34. Skilled Nursing Facility

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

These Benefits are not available unless Approved in Advance by Us. No Benefits are available under this provision for custodial care or for the care of a nervous or mental condition, drug addiction, alcoholism or Substance Abuse.

You must pay the Skilled Nursing Facility Copayment per day if indicated in the Benefit Schedule.

---

35. Urgent Care

We provide Benefits for urgent care services obtained at urgent care centers in Our Service Area. Urgent care services are Health Care Services required in order to prevent serious deterioration of Your health as a result of an unforeseen sickness or injury. Urgent care services provided in a Physician's office are covered under the Physician Services Benefit.

You must pay an Urgent Care Copayment if indicated in the Benefit Schedule for each visit to an urgent care center.

---

36. Vision Care

We provide Benefits for routine vision care. Routine vision care must be provided by an optometrist or Physician who participates in the designated vision network. Covered Services are limited to one complete eye exam per Calendar Year, including refraction, which is used to determine if You need prescription lenses. You must pay a vision care Copayment for these services if indicated in the Benefit Schedule.

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

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

SECTION D. EXCLUSIONS AND LIMITATIONS

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

1. For services or supplies received from a Non-HMO Provider or a PCP who is not Your PCP unless specifically covered under the Contract.

2. For any condition of or related to pregnancy, except for complications of pregnancy, for 24 consecutive months from the Effective Date, hereinafter referred to as the Maternity Waiting Period; provided however, coverage will be provided for services related to a miscarriage if the full term estimated due date for the pregnancy would have occured after the Maternity Waiting Period. Complications of pregnancy are covered the same as any other illness or condition.

3. For services or supplies received if there is no legal obligation for payment or for which no charge had been made; or for services or supplies received where a portion of the charge has been waived. This includes, but is not limited to full or partial waiver of any applicable Deductible, Coinsurance or Copayment amounts.

4. Subject to Our Approval in Advance requirement and such approval was not obtained.

5. For injuries or illnesses related to Your job to the extent You are covered or are required to be covered by a worker's compensation benefit whether or not You file a claim. If You enter into a settlement giving up Your right to recover future medical benefits under a worker's compensation benefit, medical benefits that would have been compensable except for the settlement will not be Covered Services.

6. Not Medically Necessary.

7. Not specifically covered under the Contract.

8. Experimental or Investigative as determined by Us.

9. For military service connected disabilities or conditions for which You are legally entitled to services and for which You have no obligation to pay.

10. For losses due in whole or in part to war or any action of war.

11. For Custodial, convalescent, or respite care except as specifically provided under the Home Hospice benefit, including but not limited to meals delivered to Your home, companionship, and homemaker services, that do not require services of licensed professional nurses in Our opinion even if provided by skilled nursing personnel.

12. For music therapy, remedial reading, recreational therapy, and other forms of education or special education except as specified under the Diabetes Benefit.

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

14. For cosmetic purposes, other than to correct birth defects or to correct a defect incurred through an Accidental Injury. Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Cosmetic rhinoplasty whether an independent procedure or done in conjunction with any other surgical procedure.

15. For any equipment or supplies that condition the air including environmental evaluations, heating pads, cooling pads (circulating or non-circulating), including hot water bottles, personal care items, wigs and their care, items for comfort and convenience, spas, whirlpools, Jacuzzis, and any other primarily nonmedical equipment, stethoscopes, blood pressure devices, and Durable Medical Equipment that would normally be provided by a Skilled Nursing Facility. Repairs and replacement of prosthetics and orthotic devices are Covered Services only when Medically Necessary and necessitated by normal anatomical changes or when necessitated as indicated in the Covered Services section.

16. For hypnotism, hypnotic anesthesia, acupuncture, acupressure, biofeedback (including neurofeedback), rolfing, massage therapy, aroma therapy and other forms of alternative treatment.

17. For genetic testing, screening exams or tests unless specifically covered under the Contract; examinations for or in connection with insurance, employment, extracurricular school activities or any recreational activities; exercise programs or equipment such as, but not limited to, bicycles or treadmills; examinations and testing specifically for the purpose of entering school, obtaining employment, licensing, insurance, adoption, immigration and naturalization, examinations precedent to engaging in recreational activities, or examinations or treatment ordered by a court or an employer; premarital blood testing. For immunizations unless specifically covered under the Contract, including but not limited to immunizations required only for travel, work-related immunizations, Anthrax vaccine and Lyme Disease vaccine.

18. Related to sex transformations.

19. For collection and storage of autologous (self-donated) blood, umbilical cord blood, or any other blood or blood product in the absence of a known disease or planned surgical procedure.

20. Provided by You, Your Immediate Family Members or members of Your immediate household.

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

22. Unless specifically covered under the Contract, for all dental services; complications of dental treatment; temporomandibular joint disorder; and orthognathic surgery. Injections for treatment of pain in close proximity to the teeth or jaw and due to a dental cause. For orthodontic treatment, or surgical correction of a malocclusion. For dental splints, dental prostheses, extractions or any treatment on or to the teeth, gums or jaws and other services customarily provided by a dentist. Services related to injuries caused by or arising out of the act of biting or chewing are also excluded.

23. For drugs and medicines that do not require a prescription for their use; drugs and medicines approved by the FDA for Experimental or Investigative use, or prescription drugs purchased from a Physician for self-administration outside a Hospital.

24. Chemosurgery, laser dermabrasion, chemical peel, salabrasion, collagen injections or other skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment of scarring secondary to acne or chicken pox.

25. For staff consultations required by Hospital rules and regulations.

26. For the treatment of obesity or morbid obesity, including but not limited to Mason Shunt, banding, gastroplasty, intestinal bypass, gastric balloons, stomach stapling, jejunal bypass, wiring of the jaw, as well as related office visits, laboratory services, prescription drugs, medical weight reduction programs, nutrients, and diet counseling (except as otherwise specified in the Contract) and health services of a similar nature whether or not it is part of a treatment plan for another illness. This exclusion also applies to any complications arising from any of the above.

27. For surgical procedures on the cornea including radial keratotomy and other refractive keratoplasty procedures, except when used to correct medical conditions other than refractive errors (such as nearsightedness) or following cataract surgery.

28. For hairplasty or hair removal, regardless of reason or diagnosis.

29. For, or related to the surgical insertion of a penile prosthesis including the cost of the prosthesis, regardless of diagnosis.

30. For orthotics unless otherwise specified.

31. For foot orthotics, including shoes.

32. For support/surgical stockings (for the lower extremities), including but not limited to custom made stockings.

33. For corrective shoes unless permanently attached to a brace.

34. For routine foot care, unless specifically covered under the Contract.

35. For, or related to an Organ Transplant not specifically covered in the Contract.

36. For health and dental services resulting from Accidental Injuries arising out of a motor vehicle accident to the extent such services are payable under any expense payment provisions (by whatever terminology used, including such benefits mandated by law) of any automobile insurance policy.

37. For lodging or travel to and from a health professional or health facility.

38. For services, supplies, equipment or care which are provided outside of the Service Area unless otherwise noted in the Contract.

39. For interest charges, document processing or copying fees, mailing costs, collection fees, telephone consultations, for charges when no direct patient contact is provided, including but not limited to Physician team conferences, charges for missed appointments, charges for completion of forms or other non-medical charges.

40. Provided for an Emergency Medical Condition Admission in excess of the first 48 hours if We are not notified within 48 hours of the Admission, or as soon as reasonably possible.

41. Provided for a maternity inpatient Admission in excess of the first 48 hours if We are not notified within 48 hours of the Admission for a vaginal birth or in excess of the first 96 hours of the Admission for a cesarean birth.

42. Obtained in an emergency room which are not Emergency Services.

43. Health services and associated expenses for megavitamin therapy; psychosurgery; nutritional-based therapy for alcoholism, Substance Abuse, or other medical conditions; services and supplies for smoking cessation programs and treatment of nicotine addiction, unless otherwise stated under the Outpatient Prescription Drugs benefit.

44. For learning disabilities, developmental delays, mental retardation, and autistic disorders.

45. Health services which are related to complications arising from treatments or services otherwise excluded under the Contract, except for complications related to maternity care as indicated in the Contract.

46. Mental Illness and/or substance abuse services when: (a) using methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol) Cyclazocine, or their equivalents; or (b) provided in connection with or to comply with involuntary outpatient, partial hospitalization or residential treatment, police detentions and other similar arrangements.

    Mental Illness and/or substance abuse services received from a Non-HMO Provider provided in connection with or to comply with involuntary inpatient commitments after the Covered Person has been screened and stabilized.

47. For non-prescription enteral feedings and other nutritional and electrolyte supplements. This does not apply to the treatment of phenylketonuria or any inherited disease of amino or organic acids.

48. For personal care and convenience items.

49. Occupational therapy provided on a routine basis as part of a standard program for all patients.

50. Received for, or in preparation for, any treatment (including drugs) for infertility by any name called and any related complications. 'Infertility' as used here means any medical condition causing the inability or diminished ability to reproduce. Treatment for infertility shall include, but not be limited to, reversal of sterilization, all artificial means of conception including but not limited to sperm collection and/or preservation, artificial insemination, in vitro fertilization, in vivo fertilization, embryo transplants, gamete intra fallopian transplant (GIFT), zygote intra fallopian transplant (ZIFT), and related tests and procedures, surrogate parenting, not Medically Necessary amniocentesis, and any other experimental fertilization procedure or fertility drugs.

51. For health services and associated expenses for elective pregnancy termination, except when the life of the mother would be endangered if the fetus was carried to term.

52. Received for or in preparation for any diagnosis or treatment (including drugs) of impotency and any related complications.

53. Services and supplies to the extent they are payable by Medicare.

54. For growth hormone therapy for the diagnosis of idiopathic or genetic short stature, intrauterine growth retardation or small for gestational age. Testing for growth hormone deficiencies in Covered Persons, age 19 or older.

55. For cranial (head) remodeling devices, including but not limited to Dynamic Orthotic Cranioplasty ("DOC Bands"), except for post-operative care of congenital birth defects and birth abnormalities caused by synostic plagiocephaly and craniosynostosis.

56. For speech therapy for behavioral problems, attention disorders, stammering and/or stuttering, conceptual handicap, psychosocial speech and conductive hearing loss due to otitis media and ear infections.

57. Except as specifically provided under Physician Services charges incurred as a result of virtual office visits on the Internet, including those for prescription drugs. A virtual office visit on the Internet occurs when a Covered Person was not physically seen or physically examined.

58. For services or supplies received from any provider in a country where the terms of any sanction, embargo, boycott, Executive Order or other legislative or regulatory action taken by the Congress, President or an administrative agency of the United States would prohibit payment or reimbursement by Us for such services.

59. For sales tax.

SECTION E. HOW TO FILE A CLAIM

You will rarely need to submit a claim; however, You may need to submit a claim for reimbursement for Ambulance services, durable medical equipment, private duty nursing and Emergency Services and supplies received outside Our Service Area. You can get claim forms by calling Our Customer Service Department.

Claims are Filed as Follows:

a. For Emergency Care Received Outside Our Service Area

Only claims for Emergency Services will be paid and these should be sent directly to Us. The address is shown on the back of Your coverage identification card. You may be asked to pay the bill. If You have paid the bill, You may make a claim for reimbursement by sending Us a completed claim form. We will make a determination of the amount due and payable to You in accordance with the Covered Services provided by the Contract. The form will give You instructions for filing the claim.

b. Professional Services Received Inside Our Service Area

You may be asked to pay the bill for Ambulance services, durable medical equipment or private duty nursing services. If You have paid the bill, You may make a claim for reimbursement by sending Us a completed claim form. We will make a determination of the amount due and payable to You in accordance with the Covered Services provided by the Contract. The form will give You instructions for filing the claim.

c. Time Limits for Filing Claims

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

d. Processing of the Filed Claim

We make Our reimbursement decisions based on the information We have at the time We receive a claim. We make every effort to process claims as quickly as possible. If the decision regarding Your claim is delayed for any reason, We will give You written notice of the reason for delay and the date We expect to make Our decision. If We deny all or any part of Your claim, We will send You a written notice telling You why it was denied under the terms of the Contract. You will have the right to appeal a claim decision as described in the "Complaint and Grievance Procedures" section of the Contract.

e. Claim Forms

You may obtain claim forms by requesting them from Our Customer Service Department. If such forms are not furnished to You within 15 days after You request them, You shall be deemed to have complied with the requirements of this policy as to proof of loss if You submit written proof covering the occurrence, the character and the extent of the loss for which claim is made within the Time Limits for Filing Claims.

SECTION F. PREMIUM PAYMENT, GRACE PERIOD AND CHANGES

1. Premium Payment

Initial Premiums are due and payable on or before the Contract effective date. Subsequent Premiums are due and payable on or before the monthly Due Date.

2. Grace Period

You shall have a grace period of 28 days for the payment of any Premium, during which time the Contract shall continue in force. In no event shall the grace period extend beyond the date the Contract terminates. The Contract will automatically terminate on the last day of the period for which Premiums have been paid if the grace period expires and any Premium remains unpaid.

3. Reinstatement

a. Reinstatement for Nonpayment of Premium

Except as provided below, if coverage under the Contract is terminated for nonpayment of Premiums, We have the right to decide whether or not to reinstate such Contract. Such decision will occur in writing within 45 days of receiving Your resubmission of a new application, if one is required, and payment of a Reinstatement fee.

b. Reinstatement for Individuals Deployed in Military Service

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

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

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

The effective date of the reinstated Contract will be the first of the month following receipt of the notice requesting reinstatement.

---

4. Changes in Premiums

We reserve the right to change Premiums upon 10 days prior written notice to You.

If under Your Contract, Your Premiums are age rated, We will automatically change the amount of Your Premiums on January 1 of the year in which the birthday occurs which places You into the next age classification upon which Premiums are based.

We will change the amount of Your Premium if You fall into a different risk classification. (Risk classification is the process of grouping individuals with similar medical characteristics so that differences in expected costs may be appropriately recognized.)

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

We may also change the amount of Your Premium on any monthly Due Date if the Premiums of Your entire age classification are changed. We will give You 10 days prior written notice before such changes in Premiums are made.

The amount of Your Premium will change if You move within Our Service Area between Our metro and rural areas.

SECTION G. TERMINATING THE CONTRACT

Terminating a Covered Person's Coverage

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

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

b. On the last day of the month a Dependent ceases to meet the eligibility requirements set forth in the "Dependent Eligibility" provision of the "Eligibility, Enrollment and Effective Date" section of the Contract;

c. On the date the Contract is terminated if a Covered Person performs an act of fraud or makes an intentional misrepresentation of a material fact in connection with the coverage;

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

e. On the last day of the month in which the Contract is terminated because the Contractholder no longer resides in Our Service Area;

f. On the last day of the month in which the Contract is terminated because the Contractholder changes his place of residence within Our Service Area to the state of Missouri. Contact customer service for other coverage that may be available to You;

g. On the last day of the month in which the Contract is terminated because We cease offering the particular type of coverage in the individual market provided by this Contract in accordance with applicable laws and regulations. If We discontinue offering this particular type of coverage, We will provide You 90 days written notice prior to the date coverage is discontinued and will offer You, on a guaranteed issue basis, the option to purchase any other individual health insurance coverage that We are currently offering;

h. On the last day of the month in which the Contract is terminated because We cease offering all individual health insurance coverage in Kansas in accordance with applicable laws and regulations. If We discontinue all individual health insurance coverage in Kansas, We will provide You 180 days written notice prior to the date all such coverage will terminate.

SECTION H. GENERAL INFORMATION

1. Terms and Conditions of the Contract

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

2. Statements

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

3. Medical Examination

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

4. Release of Records

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

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

5. Reimbursement to Us

a. Workers' Compensation

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

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

b. Errors

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

c. Misrepresentations

We have the right to recover payments from You for claims submitted on behalf of You or any Covered Person under the Contract in the event that We rescind Your Contract due to a misrepresentation by You or any Covered Person in Your application.

---

6. Legal Actions

No action at law or equity shall be brought after the expiration of 5 years after the time written proof of loss is required to be furnished.

---

7. Conformity with State Laws

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

---

8. Commission or Omission

No Hospital, Physician or other provider of service will be liable for any act of commission or omission by Us. We will not be liable for any act of commission or omission by: (a) any Hospital or Hospital's agent or employee; (b) any Physician or Physician's agent or employee; (c) any other providers of services or their agent or employee; or (d) You.

---

9. Clerical Errors

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

---

10. Notice

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

---

11. Authority to Change the Contract

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

---

12. Assignment

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

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

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

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

---

13. Medicaid

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

---

14. Special Programs

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

These programs are made possible through arrangements with various providers and cooperating businesses. Changes in these arrangements and/or their discontinuance may occur at any time in the future at Our discretion.

---

15. Independent Licensee

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

16. Choice and Change of Primary Care Physician (PCP); Physician Withdrawal from the Program

a. Each Covered Person has one PCP of his choice. You may choose any PCP from Our list of PCPs.

b. If You want to change Your PCP, You may do so, but not more than once a month. You may call Our Customer Service Department or submit Your request in writing. PCP changes must be requested before the 15th of each month for a 1st of the following month effective date.

c. If Your PCP withdraws or is terminated by Us from this program, We will notify You and will furnish You with a list of available PCPs so that You can choose a new one. If You do not choose a new PCP within 31 days of Our notification, We will assign You the PCP closest to Your previous PCP and of the same specialty as Your previous PCP. If You are not satisfied with the PCP that We assign You, You may request a change to a new PCP as provided above.

d. If Your PCP unexpectedly withdraws from this program, We will notify You and will furnish You with a list of available PCPs so that You can choose a new one. Until You have made Your choice, We will temporarily assign a PCP for You.

e. If You fail to follow Your PCP's recommended procedure and/or treatment plan, Your PCP has the right to request that You select another PCP. If You disagree with this action, You may follow the grievance procedure found in the "Complaint and Grievance Procedures" section.

---

17. Gender

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

---

18. Titles

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

---

19. Member Participation in Policy and Operational Matters

To afford You an opportunity to participate in matters of policy and operation, an advisory committee will be the vehicle in which You can express Your viewpoints and recommend and/or advise Us on such matters as health care delivery system, member complaints, plan design,benefits and/or services. You may call or write Our Customer Service Department with Your suggestions. You will receive a written response after the advisory committee has reviewed Your suggestion(s).

20. Second Opinion Policy

You have the right to seek a second medical opinion from an HMO Provider for the same Copayment You would otherwise pay for the initial medical opinion or consultation, (i.e., PCP office visit Copayment for a Primary Care Physician visit and Specialist Copayment for a Specialist visit). If You choose to seek a second medical opinion and there is no HMO Provider with the expertise necessary to provide a second medical opinion, We shall arrange for a referral to a Physician with the necessary expertise to provide a second opinion. We will also ensure that You obtain such Covered Service at no greater cost to You than if such service was obtained from an HMO Provider.

21. Entire Contract

The applications are incorporated by reference in this document and made a part of the Contract. The definitions contained in the Contract will have the defined meaning when used in this document with the first letter capitalized. The Contract and any amendments or riders thereto constitute the entire agreement between the parties and any change in the Contract must be signed by an officer of the Company to be valid. No agent or representative has the authority to change the Contract or waive any of the provisions.

22. Time Limit on Certain Defenses

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

23. HMO Provider Directory

At no additional cost, HMO Provider Directories are provided by Us and upon request when You call Our Customer Service Department. In addition, You may access Our HMO Provider Directory on Our website at www.bluekc.com

24. Right to Recover Payment

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

a. Any persons to, or for, or with respect to, whom such payments were made;

b. Any insurance companies or service Plans; or

c. Any other organizations

SECTION I. UTILIZATION REVIEW

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

1. Initial Determination

For initial determinations, We will make the determination within 2 working days of obtaining all necessary information regarding a proposed Admission, procedure or service requiring a review determination.

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

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

2. Concurrent Review Determination

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

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

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

3. Reconsideration

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

4. Retrospective Review Determinations

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

5. Case Management

Case management means a method of review whereby a Covered Person's health, or catastrophic or chronic or complex health problem or general health is evaluated and a plan of care is developed and implemented which meets that Covered Person's particular needs and is the most cost effective. Case management focuses primarily on providing an appropriate level of care in a non-acute setting. The intent of case management is to ensure the provision of Medically Necessary care in the most appropriate setting for a Covered Service. However, case management may also provide for reimbursement for alternative methods of care even if the Covered Person does not have Covered Services for the alternate care or setting. It may also include any plan of care set forth to promote health and prevent illness and injury of the Covered Person. This plan is not designed to extend extra-contractual Covered Services for alternative methods of care to persons who do not meet the plan standards and criteria.

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

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

New Directions, in its sole discetion, may reduce or waive outpatient Copayments for home visits provided by the Gillis Center following inpatient Mental Illness or Substance Abuse services if Approved in Advance by New Directions.

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

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

SECTION J. COMPAINT AND GRIEVANCE PROCEDURES

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

1. Definitions Applicable to this Section

Inquiry - A question or request for information or action. Usually an Inquiry can be resolved on initial contact with no follow-up action required.

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

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

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

2. Complaint Procedures

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

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

3. Procedures for Filing a First Level Grievance

If You prefer to file a formal Grievance, You may do so by requesting a Member Grievance Form from Our Customer Service Department, and submitting the form to Us. In order to request a first level Grievance, Your request must be filed within three hundred sixty-five (365) days from the date: (a) You received notice of an Adverse Determination made pursuant to Utilization Review, or (b) for Post-Service Claims, You received the Explanation of Benefits.

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

We will conduct a complete investigation of the Grievance within 20 working days or 30 calendar days, whichever is less, after receipt of the Grievance for Pre-Service Claims and within 20 working days after receipt of the Grievance for Post-Service Claims unless the investigation of the Post-Service Claim cannot be completed within this period of time. If the investigation for Post-Service claims cannot be completed within the 20 working days, We will notify You in writing before the 20th working day. The notice will state the reasons for which additional time is needed for the investigation. The investigation will be completed within 30 working days thereafter. We will notify You, Your representative, and the person who submitted the Grievance, provided such disclosure does not violate Title II of HIPAA, in writing of the Our decision within 5 working days from the day We make a determination. If the denial is upheld, the notification will include the principal reason for the denial and any clinical rationale. The notification will also explain the member's right to request a second level review and rights to appeal to the State Department of Insurance.

4. Procedures for Filing a Second Level Grievance

If You are dissatisfied with Our first level Grievance decision, You may request a second level review before a Grievance Advisory Panel (the "Panel"). In order to request a second level Grievance, Your request must be filed within three hundred sixty-five (365) days from the later of the date: (a) You are allowed to file a first level Grievance; or (b) You or Your representative, were sent notification of Our first level Grievance decision. Please note that the second level review is voluntary and We waive Our right to assert that You have failed to exhaust administrative

remedies because You did not elect to pursue a second level review. In addition, We agree that any statute of limitations or other defense based on timeliness is tolled during the time that You pursue a second level review. Furthermore, Your decision as to whether or not to submit a Benefit dispute to a second level review will have no effect on Your right to any other Benefit under the Contract. We will not charge You any fee if You elect to pursue a second level review and You have the right to representation at Your own expense.

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

---

5. Procedures to Request an Expedited Review

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

6. External Review of Adverse Determination

You have the right to request an independent external review of an Adverse Determination by the external review organization established by the Commissioner of Insurance. Your right to request an independent external review of an Adverse Determination applies only if:

a. You have exhausted all available review procedures listed above, unless You have an Emergency Medical Condition in which case the Expedited Review is utilized; or

b. You have not received a final decision from Us within 60 days of seeking the above available review procedures, except to the extent that the delay was requested by You.

Within 90 days of receiving a notice of an Adverse Determination, You, Your Provider with Your written authorization, or Your legally authorized representative may request an external review in writing to the Commissioner of Insurance. Your request shall include all information in Your possession pertaining to the Adverse Determination, an appeal form and a fully executed medical records release for the Commissioner of Insurance and the external review organization to obtain any necessary medical records.

The Commissioner of Insurance will determine whether Your request for an external review will be granted. If granted, the external review organization will issue a written decision regarding Your Adverse Determination to You within 30 business days. In the event that an Emergency Medical Condition exists, the external review organization will issue such decision within 7 business days.

You may also contact the Kansas Insurance Department by mail or telephone at 1300 SW Arrowhead Road, Topeka, KS 66604 or toll free at 1-800-432-2484.

AMENDMENT ISSUED BY
BLUE CARE

AMENDMENT: BCI-304-16-K

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

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

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

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

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

a. Spinal cord electrical stimulation and electrical stimulation for bone growth;

b. electrical stimulation of the spine as an adjunct to spinal fusion and sacral nerve neuromodulation;

c. spinal cord stimulation for chronic pain unresponsive to standard therapies;

d. electrical bone growth stimulation for fracture nonunions or congenital pseudoarthroses;

e. electrical bone growth stimulation of the spine as an adjunct to spinal fusion;

f. sacral nerve neuromodulation for urinary dysfunction;

g. vagus nerve stimulation for the treatment of refractory or intractable seizures;

h. Phrenic nerve stimulation; or

i. Deep brain stimulation for tremor associated with Parkinson's or essential tremor.

In Section C., Covered Services, the following is deleted under *Formula and Food Products for Phenylketonuria (PKU)*:

Covered Services for formula and low protein modified food products are limited to Covered Persons under the age of 6.

In Section C., Covered Services, the following is added under *Immunizations for Children*:

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

In Section C., Covered Services, Outpatient Therapy, *Physical Therapy* and *Occupational Therapy*, the following is deleted:

Except for treatment of neuromuscular disorders in Covered Persons under age 19, Covered Services are limited to treatment of acute illnesses and injuries.

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

Growth hormones prescribed for anyone over age 18.

In Section C., Covered Services, Routine Preventive Care, the following is deleted in its entirety:

Newborn hearing screening, audiological assessment and follow-up, and initial amplifications.

And replaced as follows:

Newborn hearing screening, audiological assessment and follow-up.

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

Related to sex transformations.

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

Testing for growth hormone deficiencies in Covered Persons age 19 or older.

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

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

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

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

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO

AMENDMENT ISSUED BY
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

AMENDMENT: BCI-303-19-K

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

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

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

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

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

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

a. Appropriate and necessary for the symptoms, diagnosis or treatment of a medical or surgical condition;

b. In accordance with Our local medical policies and the medical policies of Our Delegates;

c. Not primarily for the convenience of the Covered Person, nor the Covered Person's family, Physician or another provider;

d. Consistent with the attainment of reasonably achievable outcomes;

e. Reasonably calculated to result in the improvement of the Covered Person's physiological and psychological functioning; and

f. If more than one service or supply would meet the requirements a through e above, furnished in the most cost-effective manner which may be provided safely and effectively to the Covered Person.

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

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

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

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

(j) hypoglossal nerve stimulation;

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

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

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

1. For speech therapy for vocal cord training/retraining due to vocational strain and/or weak cords, conceptual handicap, psychosocial speech and conductive hearing loss due to otitis media and ear infections.

And replaced as follows:

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

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

c. Errors

If We determine that an erroneous payment for Benefits has been made, We have the right to correct Benefits paid in error, including any Benefits We paid that exceed the amount needed to satisfy Our obligation. We have the right to recover the excess amount from You or any other person or entity receiving the erroneous payment on Your behalf. Such individual or organization has the responsibility to return any overpayments to Us. In the event You, or any other person or entity receiving the erroneous payment on Your behalf do not return to Us the erroneous payment, We shall have the equitable right to recoup such erroneous payment. We have the responsibility to make additional payment if an underpayment is made.

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

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

And replaced as follows:

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

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

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

AMENDMENT ISSUED BY
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

AMENDMENT: BCI-301-18-MK

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

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

1. Amounts for services or supplies billed by Out-of-Network Providers that are Non-Participating that are not eligible for separate reimbursement according to Our payment policy.

2. Amounts for non-Emergency services billed by Out-of-Network Providers that are Non-Participating when proof of service is not established or supported by Your medical record.

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

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

AMENDMENT ISSUED BY
BLUE CARE

FOR MISSOURI RESIDENTS ONLY

AMENDMENT: BCI-307-19-K

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

Notwithstanding any provision to the contrary, the Calendar Year Maximum as indicated in the Benefit Schedule for Physical Therapy, Occupational Therapy, and Speech and Hearing Therapy shall not apply when such services are provided in connection with a Developmental or Physical Disability diagnosed by a licensed physician or licensed psychologist.

The following definition applies to this section:

Developmental or Physical Disability means a severe chronic disability that:

a) Is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness or autism spectrum disorder which results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services;

b) Manifests before the individual reaches age nineteen;

c) Is likely to continue indefinitely; and

d) Results in substantial functional limitations in three or more of the following areas of major life activities: (1) Self-care; (2) Understanding and use of language; (3) Learning; (4) Mobility; (5) Self-direction; or (6) Capacity for independent living.

Services that exceed the Calendar Year Maximum must be Prior Authorized by Us.

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO

AMENDMENT ISSUED BY
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

AMENDMENT: BCI-300-16-K

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

In Section C., Covered Services, *Autism Spectrum Disorder* is added as follows:

Autism Spectrum Disorder

The following definitions apply to this section:

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

Autism Service Provider means:

a) Any person, entity, or group that provides diagnostic or treatment services for Autism Spectrum Disorders who is licensed or certified by the state in which services were rendered to provide health care services; or

b) In states that do not have licensure and/or certification requirements, any person who is a Behavioral Analyst with national certification from the Behavior Analyst Certification Board;

c) Any person who is licensed by the Kansas Behavioral Sciences Regulatory Board as a licensed behavior analyst or a licensed assistant behavior analyst, or who is obtaining supervised field experience under a licensed behavior analyst.

Autism Spectrum Disorders means a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder as defined within the DSM-IV.

Diagnosis of Autism Spectrum Disorders means medically necessary assessments, evaluations, or tests performed by a licensed physician,

licensed psychologist, or licensed specialist clinical social worker in order to diagnose whether an individual has an Autism Spectrum Disorder.

Treatment for Autism Spectrum Disorder means care prescribed or ordered for an individual diagnosed with an Autism Spectrum Disorder by a licensed physician or licensed psychologist or licensed specialist clinical social worker, including equipment medically necessary for such care, pursuant to the powers granted under such licensed physician's or licensed psychologist's license.

We provide Benefits for the diagnosis and treatment of Autism Spectrum Disorders when prescribed or ordered for an individual diagnosed with an Autism Spectrum Disorder by a licensed physician or licensed psychologist, including equipment medically necessary for such care.

The Benefits for Applied Behavior Analysis are subject to the same Cost-Sharing as All Other Covered Services as specified in the Benefit Schedule. For Covered Persons diagnosed with an Autism Spectrum Disorder between birth and five years of age, ABA coverage is limited to 1,300 hours per Calendar Year for the first four years of such coverage. After the first four years of coverage, and for Covered Persons diagnosed with an Autism Spectrum Disorder after five years of age, ABA coverage is limited to 520 hours per Calendar Year until reaching age 12.

Coverage for Applied Behavior Analysis is limited to Medically Necessary treatment ordered by the treating physician or psychologist in accordance with the treatment plan for Covered Persons under the age of 12. An ABA therapy treatment plan must include all elements necessary for Us to pay the claim. Except for inpatient services, We have the right to review the treatment plan once every six months unless the treating physician agrees a more frequent review is necessary.

Notwithstanding any provision in the Certificate to the contrary, services provided by an Autism Service Provider for Speech Therapy, Occupational Therapy or Physical Therapy will not be subject to any visit limits and shall not be subject to the age limitations described in this subsection, except for Applied Behavior Analysis.

ABA services must be Prior Authorized by New Directions.

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

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

And replaced as follows:

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

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO

AMENDMENT ISSUED BY
BLUE CARE

AMENDMENT: BCI-305-10-MK

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

Notwithstanding any provision in the Contract to the contrary, the Emergency Services Copayment will be waived if a Covered Person is admitted to either an HMO Provider or Non-HMO Provider Hospital for the same condition within 24 hours.

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc.

AMENDMENT ISSUED BY
BLUE CARE

AMENDMENT: BCI-309-10-MK

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

Patient Protection Disclosures
We require the designation of a Primary Care Physician. You have the right to designate any Primary Care Physician (PCP) who participates in Our network and who is available to accept You or Your family members. Until You make this designation, We will designate one for You. For information on how to select a Primary Care Physician, and for a list of participating Primary Care Physicians, contact the Customer Service number on the back of Your ID card.

For Dependents who are children, You may designate a pediatrician who is an HMO Provider as a Primary Care Physician.

You do not need Prior Authorization from Us or from any other person (including Your Primary Care Physician) in order to obtain access to obstetrical or gynecological care from an HMO Provider who specializes in obstetrics or gynecology. The HMO Provider, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of HMO Providers who specialize in obstetrics and gynecology, contact the Customer Service number on the back of Your ID card.

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc.

AMENDMENT ISSUED BY
BLUE CARE

AMENDMENT: BCI-307-14-MK

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

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

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

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

Under Section G., Terminating the Contract, Subsection 1.d. is deleted in its entirety and replaced with the following:

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

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc.

AMENDMENT ISSUED BY
BLUE CARE, INC.

AMENDMENT: BCI-302-13-MK

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

In the Benefit Schedule, the following is added:

Covered Services		**HMO PROVIDER** **Copayment and Limitations**
Outpatient Prescription Contraceptives *If a generic version is not available or Prior Authorization is obtained, Preferred Drugs and Non-Preferred Drugs will be subject to the Cost-Sharing indicated for Generic Drugs.*	**Generic**	No Copayment
	Preferred	$35 Copayment
	Non-Preferred	$60 Copayment

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

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

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

Covered Services also include evidence-informed preventive care and screening for infants, children, and adolescents provided for in the HRSA comprehensive guidelines. Covered Services include immunizations for routine use in children, adolescents, and adults that have in effect a recommendation

from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

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

If the PPACA required preventive care services are received from a Preferred Provider, such services will not be subject to any Copayment, Deductible, and/or Coinsurance in a manner consistent with PPACA. However, if You obtain a Tier 2 or Tier 3 contraceptive drug without Prior Authorization, the drug will be subject to the applicable Copayment, Deductible, and/or Coinsurance indicated for Outpatient Prescription Drugs in the Benefit Schedule. A Copayment, Deductible, and/or Coinsurance will not apply to an office visit billed in conjunction with the preventive care services. However, if the primary reason for Your office visit is not for preventive care services, the office visit will be subject to the applicable Copayment, Deductible, and/or Coinsurance listed in the Benefit Schedule.

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

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

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

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

And replaced as follows:

Medications and other items available over-the-counter, including any medication that is equivalent to an over-the-counter medication, that do not require a prescription order or refill by federal or state law (whether provided with or without a prescription, except as otherwise specified in the Routine Preventive Care Benefit).

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

For Covered Persons age 65 and older with a history of falls, please see the Routine Preventive Care Benefit for physical or occupational therapy that will not be subject to the visit limits stated in the Benefit Schedule.

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

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

And replaced as follows:

For drugs and medicines that do not require a prescription for their use, except as otherwise specified in the Routine Preventive Care Benefit, or prescription drugs purchased from a Physician for self-administration outside a Hospital.

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc.

AMENDMENT ISSUED BY
BLUE CARE

AMENDMENT: BCI-304-15-K

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

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

We are committed to ensuring Your health and wellness. We may offer incentives to encourage You to access certain medical services and/or to participate in various wellness or disease management programs. Incentives may include, but are not limited to: services / supplies provided at no or minimal cost to You; contributions to a health savings or reimbursement account; gift cards; entries for a prize drawing; and/or merchandise. Eligibility for these incentive programs may be limited to Covered Persons with particular health factors. Participation in such programs has the potential to promote better health and to help prevent disease.

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

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO

AMENDMENT ISSUED BY
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

AMENDMENT: BCI-309-19-MK

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

Notwithstanding any provision to the contrary, outpatient therapy services provided for a Mental Illness or Substance Abuse Disorder diagnosis for Physical Therapy, Occupational Therapy, or Speech and Hearing Therapy will not be subject to any Calendar Year visit limits.

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO

AMENDMENT ISSUED BY
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

AMENDMENT: BCI-310-19-MK

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

Genetic Testing We provided Benefits for genetic testing in accordance with Our Medical Necessity criteria. Certain genetic tests for women who have a family history associated with an increased risk for mutations in the BRCA1 or BRCA2 genes are Covered Services under the Routine Preventive Care Benefit.

Genetic Testing must be Prior Authorized by Us.

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

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

AMENDMENT ISSUED BY
BLUE CARE

AMENDMENT: BCI-308-19-MK

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

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

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

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

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

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

Obtained in an emergency room which are not Emergency Services.

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO

AMENDMENT ISSUED BY
BLUE CARE, INC

AMENDMENT: BCI-302-17-MK

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

In Section C., Covered Services, Infusion Therapy and Self-Injectables, under *Injectables,* the following is added:

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

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

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

AMENDMENT ISSUED BY
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

AMENDMENT: BCI-301-17-MK

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

In the Benefit Schedule, the following is added:

	HMO PROVIDER
Covered Services	**Copayment, Coinsurance and Limitations**
Diabetes Self-Management Education and Training	$25 Copayment

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

Tier 2 and Tier 3 drugs for the first 6 months following FDA approval unless a shorter exclusion period is recommended by Our Pharmacy and Therapeutics Committee, which includes community physicians and pharmacists.

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

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

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

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

AMENDMENT ISSUED BY
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

AMENDMENT: BCI-300-14-K

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

In the Benefit Schedule, *Outpatient Mental Illness and Substance Abuse* and *Inpatient Mental Illness and Substance Abuse* are deleted in their entirety and replaced as follows:

Covered Services		**HMO PROVIDER** **Copayment, Deductible, and Limitations**
Outpatient Mental Illness	**Office Visit**	$25 Copayment
	Therapy	No Copayment
Inpatient Mental Illness		$400 Copayment
Outpatient Substance Abuse	**Office Visit**	$25 Copayment
	Treatment	No Copayment
Inpatient Substance Abuse		$400 Copayment

In Section A., Definitions, the definitions for *Mental Illness* is deleted in its entirety and replaced as follows:

Mental Illness and Substance Abuse	Means any disorder as such terms are defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994).

In Section A., Definitions, the definition for *Substance Abuse* is deleted in its entirety.

In Section C., Covered Services, *Mental Illness and Substance Abuse* is deleted in its entirety and replaced as follows:

Mental Illness and Substance Abuse	We provide Benefits for the treatment of Mental Illness and Substance Abuse as indicated in the Benefit Schedule. New Directions Behavioral Health ("New Directions") performs intake services designed to provide crisis intervention, assessment, benefits management and referral services. Covered Services are provided for Medically Necessary outpatient evaluation and treatment of Mental Illness and Substance Abuse. For coverage for psychotherapeutic drugs, please see the Outpatient Prescription Drugs Benefit. Services for outpatient treatment will be covered to the same extent as any other illness as indicated in the Benefit Schedule. Covered Services for inpatient services are limited to Hospital and Physician services when You are confined in any Hospital or other residential facility licensed to provide such treatment. Services for inpatient treatment will be covered to the same extent as any other illness as indicated in the Benefit Schedule. **Inpatient and Residential Mental Illness and Substance Abuse Services must be Prior Authorized by New Directions.**

In Section D., Exclusions, the following exclusions are deleted in their entirety:

1. Health services and associated expenses for megavitamin therapy; psychosurgery; nutritional-based therapy for alcoholism, Substance Abuse, or other medical conditions; services and supplies for smoking cessation programs and treatment of nicotine addiction, unless otherwise stated under the Outpatient Prescription Drugs benefit.

2. For learning disabilities, developmental delays, and mental retardation, and autistic disorders.

3. Mental Illness and/or substance abuse services when: (a) using methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol) Cyclazocine, or their equivalents; or (b) provided in connection with or to comply with involuntary outpatient, partial hospitalization or residential treatment, police detentions and other similar arrangements.

   Mental Illness and/or substance abuse services received from a Non-HMO Provider provided in connection with or to comply with involuntary inpatient commitments after the Covered Person has been screened and stabilized.

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

In Section D., Exclusions, the following exclusions are added:

1. Health Care Services and associated expenses for megavitamin therapy; nutritional-based therapy for alcoholism, chemical dependency, or other medical conditions; services and supplies for smoking cessation programs and treatment of nicotine addiction, except as otherwise specified under the Contract.

2. Speech therapy for vocal cord training/retraining due to vocational strain and/or weak cords.

3. For speech therapy due to otitis media and ear infections.

4. Mental Illness and/or Substance Abuse services received from a Non-HMO Provider provided in connection with or to comply with involuntary inpatient commitments after the Covered Person has been screened and stabilized, unless the Covered Person cannot be safely transferred or there is not an HMO Provider who will accept the transfer.

   For any assessment, evaluation, diagnostic test, or genetic test required by a diversion agreement or by order of a court to attend an alcohol or drug safety action program.

5. For assessments, evaluations, diagnostic tests, and genetic tests ordered or requested in connection with criminal actions, divorce, child custody, or child visitation proceedings.

6. Screening examinations or services available, arranged by, or received from any governmental body or entity, including school districts.

7. For the measurement of exhaled nitric oxide or exhaled breath condensate in the diagnosis and management of respiratory disorders.

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc.

AMENDMENT ISSUED BY
BLUE CARE, INC.

AMENDMENT: BCI-300-18-MK

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

In Section J., Complaint and Grievance Procedures, the following is added under *Complaint Procedures*:

We will ensure the independence and impartiality of the decision making process related to claims or appeals.

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

Exhaustion of Claims and Appeals Procedures

In the case of a claim for disability benefits, You will be deemed to have exhausted all claims and appeals procedures if We do not strictly adhere to Our procedures. However, You will not be deemed to have exhausted all claims and appeals procedures when the following are all true:

a. Our violation was a minor violation;
b. The violation does not cause and is not likely to cause harm or prejudice to You;
c. The violation is attributable to a good cause or matters beyond Our control;
d. The violation is during the ongoing good-faith exchange of information between You and Us; and
e. Not reflective of a pattern or practice of non-compliance by Us.

You may request a written explanation of Our rationale for asserting We meet this standard. We must provide this within 10 days of Your request.

In Section B., Eligibility, Enrollment, and Effective Date, the following is added under *Dependent Eligibility*:

For disabled dependents, if the Social Security Administration ("SSA") determines that such dependent is totally disabled, then such determination will be accepted as proof for a disabled dependent without further review. For disabled dependents with no SSA determination, or a determination of partial disability, an affidavit is required to be submitted as proof of the disability. The affidavit includes a physician attestation regarding the health of the dependent, as well as criteria regarding the duration of the disability and ability of the dependent to be gainfully employed.

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO

AMENDMENT ISSUED BY
BLUE CARE

AMENDMENT: BCI-306-14-MK

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

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

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

The Allowable Charge is the lesser of:

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

(2) An amount that is based on 150% of the Medicare fee schedule. This percentage will be periodically evaluated and adjusted if deemed appropriate by Blue KC. If the fee schedule does not include a specific code for the service provided, Blue KC will apply the same methodology used to establish an Allowable Charge for a Participating Provider; or

(3) The provider's billed charges.

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc.

AMENDMENT ISSUED BY
BLUE-CARE, INC.

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

AMENDMENT: BCI-302-11-MK

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

For hypnotism, hypnotic anesthesia, acupuncture, acupressure, biofeedback (including neurofeedback), rolfing, massage therapy, aroma therapy and other forms of alternative treatment.

And replaced as follows:

For hypnotism, hypnotic anesthesia, acupuncture, acupressure, biofeedback (including neurofeedback), rolfing, massage therapy and/or any services provided by a massage therapist, aromatherapy and other forms of alternative treatment.

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc.

AMENDMENT ISSUED BY
BLUE CARE

AMENDMENT: BCI-303-18-MK

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

In Section C., Covered Services, the following is added under Durable Medical Equipment:

> We provide Benefits for pediatric gait trainers (including posterior, anterior, and upright gait trainers, as well as other assistive walking devices), when Medically Necessary, for Covered Persons under age 19. **These services must be Prior Authorized by Us.**

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO

AMENDMENT ISSUED BY
BLUE-CARE

AMENDMENT: BCI-308-11-MK

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

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

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

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

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

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

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

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc.

AMENDMENT ISSUED BY
BLUE CARE, INC.

AMENDMENT: BCI-307-11-MK

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

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

> **Cochlear Implants**
>
> We provide Benefits for cochlear implants. Covered Services are limited to the initial cochlear implant and related implant services. Covered Services do not include repairs, replacements or duplicates.
>
> **Cochlear implants must be Prior Authorized by Us.**

and replaced as follows:

> **Cochlear Implants**
>
> We provide Benefits for cochlear implants. Covered Services include the initial cochlear implant, Medically Necessary repairs and replacements that are no longer covered under warranty, and related implant services (including batteries).
>
> **Initial and replacement cochlear implants must be Prior Authorized by Us. Implant repairs and replacement parts (including batteries) do not require Prior Authorization.**

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc.

AMENDMENT ISSUED BY
BLUE CARE

AMENDMENT: BCI-305-11-K

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

Section J., Complaint and Grievance Procedures is deleted in its entirety and replaced with the following:

SECTION J. COMPLAINT AND GRIEVANCE PROCEDURES

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

---

1. Definitions Applicable to this Section

Inquiry - A question or request for information or action. Usually an Inquiry can be resolved on initial contact with no follow-up action required.

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

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

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

Emergency Medical Condition – (1) The sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part or would place a person's health in serious jeopardy; (2) a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the insured or would jeopardize the insured's ability to regain maximum function; or (3) a medical condition for which coverage has been denied based on a determination that the recommended or requested health care service or treatment is experimental or investigational, if the insured's treating physician certifies, in writing, that the recommended or requested health care service or treatment for the medical condition would be significantly less effective if not promptly initiated.

---

2. Complaint Procedures

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

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

---

3. Procedures for Filing a Grievance

If You prefer to file a formal Grievance, You may do so by requesting a Member Grievance form from Our Customer Service Department, and submitting the form to Us. In order to request a first level Grievance, Your request must be filed within three hundred sixty-five (365) days from the date: (a) You received notice of an Adverse Determination made pursuant to Utilization Review, or (b) for Post-Service Claims, You received the Explanation of Benefits.

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

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

---

4. Procedures to Request an Expedited Review

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

---

5. External Review of Adverse Determination

You have the right to request an independent external review of an Adverse Determination by the external review organization established by the Commissioner of Insurance. Your right to request an independent external review of an Adverse Determination applies only if:

a. You have exhausted all available review procedures listed above, unless You have an Expedited Review Emergency Medical Condition in which case the Expedited Review is utilized; or

b. You have not received a final decision from Us within 60 days of seeking the above available review procedures, except to the extent that the delay was requested by You.

Within 120 days of receiving a notice of an Adverse Determination, You, Your Provider with Your written authorization, or Your legally authorized representative may

request an external review in writing to the Commissioner of Insurance. Your request shall include all information in Your possession pertaining to the Adverse Determination, an appeal form and a fully executed medical records release for the Commissioner of Insurance and the external review organization to obtain any necessary medical records.

The Commissioner of Insurance will determine whether Your request for an external review will be granted within 10 business days after receiving all necessary information. If granted, the external review organization will issue a written decision regarding Your Adverse Determination to You within 30 business days. In the event that an Expedited Review Emergency Medical Condition exists, the external review organization will issue such decision not more than 72 hours after the date of receipt of the request for an expedited external review, or as expeditiously as the Insured's medical condition or circumstances require.

In no event shall the Insured be held responsible for any portion of the external review organization's fee for performance.

Only 1 external review is available for any request arising out of the same set of facts during a period of 12 consecutive months beginning on the date of the initial request for external review.

You may also contact the Kansas Insurance Department by mail or telephone at 420 S.W. 9th Street, Topeka, KS 66612-1678 or toll free at 1-800-432-2484.

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc.

AMENDMENT ISSUED BY
BLUE CARE

AMENDMENT: BCI-300-15-MK

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

In Section A., Definitions, the definition of *Physician Extender* is added as follows:

Physician Extender	Means a Nurse Practitioner, Physician Assistant, Certified Registered Nurse Anesthetist, or Mid-wife. Services received from a Physician Extender will be subject to the Cost-Sharing applicable to the place of service where the service was rendered (e.g. services provided in a Specialist's office will be subject to the Cost-Sharing for a Specialist).

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

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

AMENDMENT ISSUED BY
BLUE-CARE, INC.

AMENDMENT: BCI-301-11-MK

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

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

a. Legend drugs that, by federal or state law, can only be dispensed upon written prescription from an authorized prescriber

and replaced with:

a. Legend drugs that, by federal law, can only be dispensed upon written prescription from an authorized prescriber

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc

AMENDMENT ISSUED BY
BLUE-CARE, INC.

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

AMENDMENT: BCI-303-11-MK

In Section E., Exclusions and Limitations, the exclusion is deleted and replaced as follows:

For injuries or illnesses related to Your job to the extent You are covered or are required to be covered by a state or Federal worker's compensation law for work-related injuries or illness whether or not You file a claim. If You enter into a settlement giving up Your right to recover past or future medical benefits under a worker's compensation law, We will not pay past or future medical benefits that are the subject of or related to that settlement.

In addition if You are covered by a workers' compensation program that limits benefits to certain authorized providers, We will not pay for services You receive from providers, authorized or unauthorized, by Your workers compensation program.

In Section H., General Information, the *Reimbursement to Us* provision is deleted and replaced as follows:

Reimbursement to Us

a. Workers' Compensation

As a Covered Person, You agree to reimburse Us for any Benefits We paid to You or on Your behalf for claims paid or payable for injuries or illnesses related to Your job to the extent You are covered or are required to be covered by a state or Federal worker's compensation law whether or not You file a claim. In addition, if You enter into a settlement giving up Your right to recover past or future medical benefits under a worker's compensation law, You agree to reimburse Us for any Benefits paid to You or on Your behalf for claims paid or payable for any past or future medical benefits that are the subject of or related to that settlement.

If You are covered by a workers' compensation program that limits certain authorized providers, You agree to reimburse Us for any Benefits We paid to You or on Your behalf for claims paid or payable for services You receive from providers, authorized or unauthorized, by Your workers' compensation program.

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

b. Errors

We have the right to correct Benefits paid in error. Hospitals, Physicians, other providers and/or You have the responsibility to return any overpayments to Us. We have the responsibility to make additional payment if an underpayment is made. We will not request a refund or offset against a claim from Your provider more than twelve months after We have paid the provider's claim except in cases of fraud or misrepresentation by the provider.

c. Misrepresentations

We have the right to recover payments from You for claims submitted on behalf of You or any Covered Person under the Contract in the event that We rescind Your Contract due to a misrepresentation by You or any Covered Person in Your application.

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc.

AMENDMENT ISSUED BY
BLUE-CARE, INC.

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

AMENDMENT: BCI-311-10-MK

In Section A. Definitions, the Definition of Allowable Charge, section f. For Participating Pharmacies is deleted and replaced as follows:

For participating pharmacies-

(1) The negotiated rate the pharmacy has agreed to accept for Our members; or

(2) The Usual and Customary Charge

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

In Section C. Covered Services, Outpatient Prescription Drugs, the Introduction/Prior Authorization language is deleted and replaced as follows:

Introduction/Prior Authorization:

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

For participating providers, You must always pay the lower of either: (1) Your applicable Prescription Drug Copayment, specified in the Benefit Schedule; or, (2) the Allowable Charge.

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc.

AMENDMENT ISSUED BY
BLUE-CARE

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

AMENDMENT: BCI-302-07-MK

In Section C., Covered Services, Organ Transplants, Covered Organ Transplant Services is deleted and replaced as follows:

Covered Services are limited to services and supplies for Organ Transplants when ordered by a Physician, and provided at or arranged by a Designated Transplant Provider. Such services include, but are not limited to, Hospital charges, Physician charges, organ procurement, and ancillary services. Coverage is limited to the following transplants only when such transplants are Medically Necessary and rendered in a Designated Transplant Provider in accordance with Our Policies for transplantation services:

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

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

Erin Stucky

President and Chief Executive Officer
Good Health HMO, Inc.

AMENDMENT ISSUED BY
BLUE-CARE

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

AMENDMENT: BCI-304-07-MK

In the Benefit Schedule, the following is added:

MRI, MRA, CT, and PET scans performed in a Physician's office, imaging center or other outpatient setting (including a hospital)	$75 Copayment Only one Copayment will apply for each provider on a specified date of service even if multiple scans are performed.

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

Diagnostic Services

MRI, MRA, CT, and PET scans

You must pay the Copayment indicated in the Benefit Schedule for these scans *unless* You are admitted for Inpatient Hospital Services at the time the scans are performed. Only one Copayment will apply for each provider on a specified date of service even if multiple scans are performed. This Copayment will not apply when You visit the Emergency Room or when performed on the same date of service, by the same provider as an Outpatient Surgical procedure.

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc.

AMENDMENT ISSUED BY
BLUE-CARE, INC.

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

AMENDMENT: BCI-304-11-MK

In the Benefit Schedule, the following is added:

		HMO PROVIDER
Covered Services		**Copayment and Limitations**
Prescription Oral Chemotherapy Drugs		Covered
Short-Term Supplies	**Tier 1**	No Copayment
	Tier 2	No Copayment
	Tier 3	No Copayment

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

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

Covered prescription oral chemotherapy drugs obtained at a pharmacy will be paid as indicated in the Benefit Schedule.

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc.

AMENDMENT ISSUED BY
BLUE-CARE

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

AMENDMENT: BCI-307-07-MK

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

Diabetes

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

In Section C. Covered Services, the following is added under Prosthetic and Orthotic Appliances:

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

In Section D. Exclusions, the following exclusion is deleted:

For foot orthotics, including shoes.

And replaced as follows:

For foot orthotics, including shoes, except as specifically covered under the Diabetes benefit.

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc.

AMENDMENT ISSUED BY BLUE-CARE

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

AMENDMENT: BCI-301-07-K

In Section B., Eligibility, Enrollment and Effective Date, subsection 4(b) of the *Enrollment provision* is deleted and replaced as follows:

b. Children by Birth and Adopted Children

If a new Dependent child is acquired by the Contractholder due to birth of a child, adoption of a child, or placement for adoption of a child, the new Dependent child may be enrolled for coverage under the Contract. To enroll, the Contractholder must submit to Us a completed Contractholder application and any additional Premium due within 31 days after the date of birth, adoption, or placement for adoption. Documentation verifying the event must be provided, if requested.

Notwithstanding the above paragraph, if the Contractholder has previously elected Dependent coverage and such coverage is in effect on the date of the newborn child's birth, then the Contractholder's newborn child will be covered automatically for 31 days from the moment of birth. No additional Premium will be assessed for coverage for these 31 days. If additional Premium is due, the Contractholder must submit to Us a completed Contractholder application requesting coverage for such newborn be added within 31 days of the child's birth in order to continue such child's coverage beyond the initial 31 days. Coverage for such newborn will be subject to all of the terms and conditions of the Contract, including receipt of services from the newborn's designated PCP. You must select a Primary Care Physician (PCP) to manage Your newborn's care. You may find a PCP by going to our website at www.bcbskc.com or by contacting the phone number listed on Your member identification card.

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

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

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

If a child placed for adoption is not legally adopted, coverage for such child will end on the date Your legal support obligation for the child ends or 280 days after such child's date of placement.

If the new Dependent child for which additional Premium is due is not enrolled as a Dependent within 31 days of becoming eligible, then coverage for such Dependent will be subject to Our approval.

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc.

AMENDMENT ISSUED BY
BLUE-CARE

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

AMENDMENT: BCI-303-07-MK

In Section L., Complaint and Grievances Procedures, Procedures for Filing a First Level Grievance is deleted and replaced with the following:

Procedures for Filing a First Level Grievance

If You prefer to file a formal Grievance, You may do so by requesting a Member Grievance form from Our Customer Service Department, and submitting the form to Us. In order to request a first level Grievance, Your request must be filed within three hundred sixty-five (365) days from the date: (a) You received notice of an Adverse Determination made pursuant to Utilization Review, or (b) for Post-Service Claims, You received the Explanation of Benefits.

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

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

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

Erin Stucky
President and Chief Executive Officer
Good Health HMO, Inc.

The following pages are not a part of this Contract, but contain important information and are provided here for your convenience in locating this information if needed.

COVERED PERSON'S RIGHTS AND RESPONSIBILITIES

1. You have the right to:

a. Receive considerate and courteous care with respect for personal privacy, dignity and confidentiality.

b. Choose a Primary Care Physician (PCP) from those available to coordinate Your health care, and change Your PCP as defined in the Contract.

c. Receive all Medically Necessary and appropriate care from Your PCP or a health care professional referred by Your PCP, as well as access for emergency services 24 hours per day, 7 days a week.

d. Receive information about Your HMO services, utilization review policies, clinical guidelines and member rights and responsibilities.

e. Receive information and diagnosis in clear and understandable terms and ask questions to ensure You understand what You are told by Your Physician and other medical personnel.

f. Receive full information about treatment options, regardless of cost, from providers and practitioners.

g. Participate with providers and practitioners in decisions about Your care, including accepting and refusing medical or surgical treatments.

h. Give informed consent to treatment and to make advance treatment directives, including the right to name a surrogate decision maker in the event You cannot participate in decision making.

i. Discuss Your medical records with Your PCP and have health records kept confidential, except when disclosure is required by law or to further Your treatment.

j. Be provided with information about Your HMO managed health care plan, its services, and the practitioners providing care.

k. Make recommendations regarding member’s rights and responsibilities policies for Your HMO managed care plan.

l. Communicate any concerns with Your HMO managed care plan regarding care or services You received, receive an answer to those concerns within a reasonable time, and initiate the complaint and grievance procedure if You are not satisfied.

2. You have the responsibility to:

a. Respect the dignity of other members and those who provide care and services through Your HMO managed health care plan.

b. Coordinate all health care services through Your PCP.

c. Contact Your PCP when You need care.

d. Ask questions of Your PCP or treating specialist physician or treatment provider until You fully understand the care You are receiving.

e. Make positive health choices to prevent acute illness; seek appropriate, needed care and comply with treatment and follow-up plans including those regarding medications. Be aware of the medical consequences of not following instructions.

f. Communicate openly and honestly with Your treatment provider regarding Your medical history, health conditions and the care You receive.

g. Participate in developing mutually agreed upon treatment plans and treatment goals to the extent possible.

h. Keep all scheduled health care appointments and provide advance notification to the appropriate provider if it is necessary to cancel an appointment.

i. Know how to use the services of Your HMO managed health care plan properly.

BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

PRIVACY PRACTICES NOTICE

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

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

Summary of Our Privacy Practices

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

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

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

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

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

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

Contact Information

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

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

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

Organizations Covered by this Notice

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

Blue Cross and Blue Shield of Kansas City

Good Health HMO, Inc.

Blue-Advantage Plus of Kansas City, Inc.

Missouri Valley Life and Health Insurance Company

Our Legal Duty

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

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

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

Uses and Disclosures of Your Medical Information

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

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

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

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

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

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

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

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

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Your Employer: We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

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

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

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

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

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

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

Your Rights

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

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

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

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

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

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

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

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

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

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

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

Complaints

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

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

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

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

Blue KC:

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

If you need these services, contact Customer Service, 844-395-7126 (Toll free), languagehelp@bluekc.com

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

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

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

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

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue KC, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-395-7126

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

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

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

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

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

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

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

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

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

Laotian: ຖ້າທ່ານ, ຫຼືຄົນ ທ່ານກໍາລັງຊ່ ວຍເຫຼືອ, ມ ີຄໍາຖາມກ ່ ຽວກ ັບ Blue KC, ທ ່ ານມ ີສ ິ ທ ່ ທຈະໄດ ້ ຮ ັ ບການຊ ່ ວຍເຫຼ ືອແລະ ຂ ້ ມ ູ ນຂ ່ າວສານ ທ ່ ເປ ັ ນພາສາຂອງທ ່ ານ ໍ ່ ບ ມ ຄ ່ າໃຊ ້ จ ่ าย. ການໂອ ້ ລ ົ ມກ ັ ບນ ายພ าสา, ใช ้ โทหา 1-844-395-7126.

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

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

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

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

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

Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association