Blue Vue

Offered by Blue Cross and Blue Shield of Kansas City

Vision Benefits Certificate for:

BLUE CROSS BLUE SHIELD OF KC

Group No: 10025000
EEM0020A
Effective Date: 01/01/2023

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

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

Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

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

	Effective Date: January 1, 2023
Group Name: BLUE CROSS BLUE SHIELD OF KC	**Dependent Limiting Age:** 26
Benefit Period(s): 12 months for Routine Vision Examinations, 12 months for Lenses or Contact Lenses, 12 months for Frames	

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

		PARTICIPATING PROVIDER	**NON-PARTICIPATING PROVIDER**
Covered Services		**Cost, Cost-Sharing, Reimbursement and Limitations**	**Cost, Cost-Sharing, Reimbursement and Limitations**
Routine Vision Examination (including dilation as necessary)		No Copayment *1 Per Benefit Period*	Reimbursement up to $30
Retinal Imaging		Up to $39	Not Covered
Contact Lens Examination		*1 Per Benefit Period*	
Standard Contact Lens Fit and Follow Up		Up to $55	Not Covered
Frames		No Copayment *$150 allowance per Benefit Period* *1 Per Benefit Period*	Reimbursement up to $75
Standard Plastic Lenses (in lieu of Contact Lenses)		*1 set(s) Per Benefit Period*	
Standard Plastic Lenses	Single Vision	No Copayment	Reimbursement up to $25
	Bifocal	No Copayment	Reimbursement up to $40
	Trifocal	No Copayment	Reimbursement up to $55
	Lenticular	No Copayment	Reimbursement up to $55
Contact Lenses (in lieu of frames and lenses)		*1 set(s) per Benefit Period*	
Contact Lenses	Conventional	No Copayment *$150 allowance per Benefit Period*	Reimbursement up to $120

			PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Covered Services			**Cost, Cost-Sharing, Reimbursement and Limitations**	**Cost, Cost-Sharing, Reimbursement and Limitations**
	Disposable		No Copayment *$150 allowance per Benefit Period*	Reimbursement up to $120
	Medically Necessary		No Copayment	Reimbursement up to $210
Covered Lens Options			*1 Per Benefit Period*	
Covered Lens Options	UV Treatment		$15	Not Covered
	Tint (solid and gradient)		$15	Not Covered
	Standard Scratch-Resistance		No Copayment	Up to $5
	Standard Polycarbonate (age 19 and over)		$40	Not Covered
	Standard Polycarbonate (age 18 and younger)		No Copayment	Up to $5
	Standard Anti-reflective Coating		$45	Not Covered
	Premium Anti-reflective Coating	Tier 1	$57	Not Covered
		Tier 2	$68	Not Covered
	Standard Progressive		$65 Copayment	Reimbursement up to $40
	Premium Progressive	Tier 1	$85 Copayment	Reimbursement up to $40
		Tier 2	$95 Copayment	Reimbursement up to $40
		Tier 3	$110 Copayment	Reimbursement up to $40
		Tier 4	$65 Copayment *$120 allowance per Benefit Period*	Reimbursement up to $40

		PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Covered Services		**Cost, Cost-Sharing, Reimbursement and Limitations**	**Cost, Cost-Sharing, Reimbursement and Limitations**
	Photochromatic/ Plastic Transitions	$75	Not Covered

SECTION A. DEFINITIONS

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

Allowable Charge

Means the dollar amount upon which Benefits will be determined for Covered Services. 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 a Participating Provider and the terms of that provider's contract with Us.

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

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

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

The Allowable Charge is the lesser of:

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

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

c. The provider's billed charges.

2. For Ophthalmologists, Opticians, Optometrists or other covered professionals practicing within the scope of their license, who are Non-Participating Providers;

The Allowable Charge is the lesser of:

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

b. Our basic participating fee schedule amount for the same services or supplies for such provider type; or

c. The provider's billed charges.

Allowance	Means a maximum dollar amount, maximum number of supplies, or a maximum number of visits or sessions for which Benefits for Covered Services are provided for a Covered Person in any one Benefit Period. Once an Allowance for a specific Covered Service is met, no more Benefits for such Covered Services will be provided during the same Benefit Period.
Adverse Determination	Means a determination by Us that an availability of care or other Vision Service has been reviewed and, based upon the information provided, does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is therefore denied, reduced, or terminated.
Ambulatory Review	Means Utilization Review of Health Care Services performed or provided in an outpatient setting.
Annual Enrollment Period	Means a period of time mutually agreed upon by the Employer and Us during which eligible persons who have not enrolled with Us may do so.
Benefits	Means the amount of Allowable Charges We pay for Covered Services
Benefit Period	Means the period beginning on the Date of Service a particular Benefit was received. Benefits may be subject to an Allowance during a Benefit Period. Benefit Periods, if any, for individual Benefits, are listed in the Benefit Schedule.
Benefit Schedule	Means a listing of certain Covered Services specifying cost, Cost-Sharing, reimbursement, and limitations under the Contract.
Blue Cross and Blue Shield of Kansas City	Means the company legally responsible for providing the Benefits under the Contract. Blue Cross and Blue Shield of Kansas City is referred to as "We", "Us" and "Our", and includes third-party administrators providing administrative and claims processing services with whom Blue Cross and Blue Shield of Kansas City has entered into a written agreement.
Calendar Year	Means January 1 through December 31 of the same year.
Certificate	Means this booklet and any amendments.
Certification	Means a determination by Us that an availability of care or other Vision Service has been reviewed and, based on the information provided, satisfies Our requirements for Medical Necessity, appropriateness, health care setting, level of care and effectiveness.
Claim	Means a request for: (1) payment for Covered Services made in accordance with the procedures outlined in the How to File a Claim Section; or (2) an appeal of a benefit determination ("Grievance") made in accordance with the procedures outlined in the Complaint and Grievance Procedures Section.

Concurrent Review Means Utilization Review conducted during a patient's course of treatment.

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

Copayment Means the dollar amount of a charge that a Covered Person must pay for certain Covered Services.

Cost Sharing Means the applicable Copayment that must be paid by the Covered Person for a Covered Service. Cost-Sharing does not include Premiums, amounts incurred for non-Covered Services, or any amount above the Allowable Charge.

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

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

Benefits are payable for Covered Services that are provided on the date the Covered Service is provided.

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

Domestic Partner Means a partner of a covered Employee, who is sharing an intimate, committed relationship of mutual caring and which meets all of the following criteria:

a. The Employee and the partner share the same principal residence;

b. The Employee and the partner agree to be responsible for each other's basic living expenses during their Domestic Partnership; and that anyone who is owed these expenses can collect from either of them;

c. The Employee and the partner are not so closely related by blood that legal marriage would otherwise be prohibited, nor are they legally married to any one, and are the sole partners of each other;

d. The Employee and the partner are at least 18 years of age or older and are mentally competent to consent to contract;

e. The Employee and the partner have signed the Affidavit of Domestic Partnership before a notary; and

f. The Employee and the partner may be of the same sex.

Means a partner of the covered Employee, who meets the Employer's documented criteria for establishing and maintaining a domestic partnership. These criteria must be agreed to in writing by Us.

Due Date Means the first day of each month when Premiums are due and payable.

Effective Date Means the date coverage begins for a Covered Person under the Contract.

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

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

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

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

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

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

Medically Necessary (Medical Necessity) Means any Vision Services or supplies You receive for Your vision condition:

1. Must agree with Your Ophthalmologist, Optician, or Optometrist's diagnosis and treatment of the vision condition; and

2. Must be consistent with accepted standards of vision practice as determined by Our established vision review processes.

NOTE: We will determine whether services or supplies are Medically Necessary. This means that services or supplies will not automatically be considered Medically Necessary because they are prescribed by Your Ophthalmologist, Optician, or Optometrist. We may consult with a professional vision consultant or other appropriate source for recommendations regarding the Medical Necessity of services or supplies.

Non-Participating Provider Means an Ophthalmologist, Optician, or Optometrist who is not a Participating Provider and does not have a contract with Us to provide vision care to Covered Persons.

Ophthalmologist

Means a person or a doctor of medicine (M.D.) or osteopathy (D.O.) who specializes in the comprehensive care of the eyes and visual system to prevent, diagnose, and treat any eye disease, disorder, or injury.

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 vision care and treatment when the services performed are within the lawful scope of the practitioner's license and are provided pursuant to applicable laws.

Optician

Means a person who is licensed to fit, adjust, and dispense eyeglasses and other optical devices on the written prescription of a licensed Ophthalmologist or Optometrist.

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 vision care and treatment when the services performed are within the lawful scope of the practitioner's license and are provided pursuant to applicable laws.

Optometrist

Means a doctor of optometry (O.D.) who is trained to detect and correct vision problems primarily by prescribing eyeglasses or contact lenses.

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 vision care and treatment when the services performed are within the lawful scope of the practitioner's license and are provided pursuant to applicable laws.

Participating Provider

Means an Ophthalmologist, Optician, or Optometrist who has entered into a contract that defines the method We will use to determine the Allowable Charges for Covered Services. Participating Providers have agreed to accept Our Allowable Charge as payment in full for Covered Services. However, You are responsible for the payment of any Cost-Sharing amounts, non-Covered Services and amounts in excess of any Benefit maximums of the Contract.

Such Participating 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 Ophthalmologist, Optician, or Optometrist except for any Cost-Sharing amounts for which You are responsible.

Post-Service Claim

Means a request for payment for Vision Services rendered.

Premium(s)

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

Prior Authorization or Prior Authorized	Means the procedure whereby We determine whether any service to be performed is reasonable and Medically Necessary for the condition being treated and the type of services to be provided.
Prospective Review	Means Utilization Review conducted prior to a course of treatment.
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 Contact Us to determine the geographic area We serve
Utilization Review	Means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, Vision Services, procedures, or settings. Techniques may include Ambulatory Review, Prospective Review, Second Opinion, Certification, Concurrent Review, or Retrospective Review. Utilization Review shall not include elective requests for clarification of coverage.
Waiting Period	Means the length of time the Employee must continuously work for the Employer before he is eligible to enroll for coverage under the Contract.
Vendor	Means the third party vendor Blue Cross and Blue Shield has contracted with to provide administrative and/or claims processing services for this plan pursuant to a written agreement.
Vision Service	Means a service for the routine examination, vision correction, or provision of vision supplies.
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, or where appropriate, its vision claims administrator.
You, Your	Refers to the Covered Person.

SECTION B. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

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

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

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

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

a. The Employee's legal spouse as defined by the Employer; or the Employee's Domestic Partner;

b. The Employee's or Employee's legal spouse's, or Domestic Partner's child. Such child includes:

(1) a child by birth;

(2) an adopted child;

(3) a child under the age of 18 who has been placed with the Employee for the purpose of adoption for whom the Employee has a legal obligation to support; or

(4) a child under the age of 18 who has been placed under the Employee’s legal guardianship.

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

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

We must receive satisfactory proof of the Dependent’s handicap within 31 days after the Dependent reaches the limiting age, or within 31 days after the Dependent is enrolled for coverage under the Contract to continue coverage beyond the Dependent Limiting Age. In addition, We must receive satisfactory proof annually of the handicap, following the Dependent’s attainment of the limiting age.

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

Dependents will not be eligible for coverage unless the Employee is covered under the Contract.

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3. Enrollment

a. Annual Enrollment Period

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

b. Initial Enrollment Period for a Newly Eligible Employee

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

c. Special Enrollment Periods

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

Notwithstanding the above paragraph, if the Employee previously has elected Dependent coverage and such coverage is in effect on the date of the newborn child's birth, then the Employee's newborn child will be covered automatically for 31 days from the moment of birth. No additional Premium will be assessed for coverage for these 31 days. If additional Premium is due, the Employee must submit to Us a completed Employee application requesting

coverage for such newborn to be added within 31 days of the child's birth in order to continue such child's coverage beyond the initial 31 days. Coverage for such a newborn will be subject to all of the terms and conditions of the Contract.

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

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

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

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

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

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

a. (i) The employer's contributions toward such coverage were terminated;

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

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

1. Legal separation, divorce, no longer qualifying as a dependent under the other coverage, death of an Employee, termination of employment or reduction in the number of hours of employment.

2. Reaching a Lifetime Maximum on all Benefits under coverage offered by an Employer.

3. An Employer no longer offers any health coverage to a class of similarly situated individuals.

b. Except as provided below, the Employee must submit to Us a completed Employee application and any additional Premium due within 31 days after the loss of such other coverage and provide appropriate documentation verifying the loss of such other coverage, if requested.

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

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

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

d. Guardianship

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

e. Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued, We must receive a completed Employee application and any additional Premium due

within 31 days of the date of the court order. If the child is not enrolled within 31 days of the date of the court order, then the child will be considered a Late Enrollee.

f. Employee Application

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

g. Domestic Partnerships

The Domestic Partner and the Domestic Partner's children may apply for coverage within 31 days of when the Employee first becomes eligible for coverage under the Contract. No Benefits will be paid unless a valid Affidavit of Domestic Partnership is on file or submitted at the time of the request. The partners agree to notify Us in writing if there is any change of circumstances attested to in the Affidavit within 30 days of such change. If the Domestic Partner and/or the Domestic Partner's children do not enroll within 31 days of becoming eligible, then that Domestic Partner and/or the Domestic Partner's children may enroll during the next Annual Enrollment Period.

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4. Effective Date of Coverage

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

a. Annual Enrollment Period

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

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

b. Initial Enrollment Period for a Newly Eligible Employee

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

c. Special Enrollment Period

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

(a) In the case of marriage or establishment of a Domestic Partnership the date of the marriage or the date of establishment of the Domestic Partnership.

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

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

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

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

d. Late Enrollees

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

e. Guardianship

In the case of a child placed for guardianship, the Effective Date of coverage is the date the court order awarding guardianship is legally effective.

f. Qualified Medical Child Support Order

Notwithstanding any provision in the Contract to the contrary, children who are the subject of a "Qualified Medical Child Support Order" will

be eligible for coverage in accordance with such order, provided the order is "qualified" in accordance with Section 609 of ERISA.

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

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

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

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

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

g. Extension of Benefits from Prior Plan

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

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5. Section 125 Eligibility

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

SECTION C. COVERED SERVICES

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

Covered Services

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

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

1. Incurred for a Covered Person while coverage is effective;
2. Performed, prescribed or ordered by an Optometrist, Ophthalmologist, or Optician;
3. Medically Necessary for the treatment of Your vision disease, defect or other condition;
4. Not excluded under the Contract; and
5. Received in accordance with the requirements of the Contract;

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

Benefits

All Covered Services are subject to the maximums and other limits and conditions specified in the Contract.

For Services Received from a Participating Provider

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

For Services Received from a Non-Participating Provider

If You receive services from an Optometrist, Ophthalmologist, or Optician **who is a Non-Participating Provider**, You will be responsible for any Cost-Sharing listed in the Non-Participating Provider column of Your Benefit Schedule in addition to amounts in excess of the Allowable Charge and any non-Covered Services.

Allowance

You may have an Allowance for services received from Participating Providers. If Covered Services are available from Non-Participating

Providers, the Allowance will apply to Covered Services received from both Participating and Non-Participating Providers. The Benefit Schedule will list the applicable Allowance for the Covered Service, if any.

Prior Authorization

Services that must be Prior Authorized by Us will state so in the applicable Covered Service provision. Please visit www.bluekc.com/pa for the current list of services that must be Prior Authorized. The following explanation outlines Your responsibilities for obtaining such approval and the consequences of obtaining such services when they have not been Prior Authorized.

Services Received from Preferred Providers – If these services are not Prior Authorized, the Ophthalmologist, Optician, Optometrist, or other covered professionals practicing within the scope of their license will be responsible for the cost associated with such services, regardless of Medical Necessity.

Services Received from Non-Preferred Providers – If these services are not Prior Authorized, You will be responsible for the cost associated with such services.

The following information provides a detailed description of Covered Services:

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1. Lenses

Where the vision exam shows new lenses or frames or both are a visual necessity, benefits for lenses and frames include:

(1) Prescribing and ordering proper lenses;

(2) Assisting with selection of frames;

(3) Verifying accuracy of finished lenses; and

(4) Proper fitting and adjustments.

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2. Frames

Participating Providers will show You the frames that this Contract covers in full. If You select a frame that costs more than the Allowable Charge under this Contract, You will be responsible for the difference in cost.

Where the vision exam shows new lenses or frames or both are a visual necessity, benefits for lenses and frames include:

(1) Prescribing and ordering proper lenses;

(2) Assisting with selection of frames;

(3) Verifying accuracy of finished lenses; and

(4) Proper fitting and adjustments.

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3. Standard Contact Lens Fit and Follow-Up

Benefits include spherical clear contact lenses in conventional wear and planned replacement.

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4. Premium Contact Lens Fit and Follow-Up

Benefits include all lens designs, materials, and specialty fittings other than standard contact lenses.

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5. Contact Lenses

Contact lenses are provided in lieu of all other lens and frame benefits available herein. When You receive Benefits for contact lens in a Benefit Period, Benefits for lens and frames will not be available during the same Benefit Period. Future eligibility for lenses and frames will be determined as if spectacle lenses and frames were obtained in the current Benefit Period.

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6. Contact Lens Materials When Medically Necessary

Benefits will be paid for one pair of contact lenses under the following circumstances and **only if Prior Authorization from Us is obtained**:

(1) Following cataract surgery without intraocular lens;

(2) Correction of extreme visual acuity problems not correctable with glasses;

(3) High ametropia of either +10D or -10D in any meridian;

(4) Anisometropia greater than 5.00 diopters and aesthenopia or diplopia, with spectacles;

(5) Diagnosis of Keratoconus supported by medical record documentation consistent with a two line improvement of visual acuity with contact lenses as the treatment of choice; or

(6) Monocular aphakia and/or binocular aphakia where the provider certifies contact lenses are Medically Necessary for safety and rehabilitation to a productive life.

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 patient education services.

2. For charges or expenses incurred before Your Effective Date or after the date coverage under this Contract terminates.

3. Not specifically covered under the Contract.

4. For interest charges, document processing or copying fees, mailing costs, handling fees, collection fees, telephone consultations, charges for missed appointments, charges for completion of forms or other non-vision charges.

5. Charges for take-home supplies, personal care or convenience items.

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

7. For injuries or illnesses related to Your job to the extent You are covered or are required to be covered by a state or Federal worker's compensation law for work-related injuries or illness whether or not You file a claim. If You enter into a settlement giving up Your right to recover future vision 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.

8. For free services or supplies received where there is no legal obligation for payment or for care or treatment for which no charge has been made.

9. Not Medically Necessary.

10. Experimental or investigative as determined by Us.

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

12. Charges for care provided by any medical or non-medical facility.

13. For Cosmetic purposes.

14. For hypnotism, hypnotic anesthesia, acupuncture, acupressure or any other form of alternative treatment.

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

16. For treatment resulting from any intentionally self-inflicted injury or bodily illness.

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

18. For orthoptic or vision training.

19. For subnormal vision aids and associated testing.

20. For any implant procedures performed.

21. For oversized lenses.

22. For aniseikonic lenses.

23. For plano lenses.

24. For eye exercises and/or therapy.

25. For medical or surgical treatment of eye, or supporting structures.

26. For any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this Contract.

27. For non-prescription sunglasses.

28. For two pair of glasses in lieu of bifocals.

29. For services or materials provided by any other group benefit plans providing vision care.

30. For solutions and/or cleaning products for glasses or contact lenses.

31. For pathological treatment.

32. For non-prescription items.

33. For costs associated with securing materials.

34. For pre- and post-operative services.

35. For orthokeratology.

36. For routine maintenance of materials.

37. For refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the Contract.

38. For artistically painted lenses.

39. For infection control procedures and supplies.

40. For localized delivery of chemotherapeutic agents.

41. For the replacement of lost, stolen, damaged or misplaced vision materials, unless otherwise covered under this Contract.

42. Services or supplies that are considered obsolete and no longer meeting accepted standards of vision practice.

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

44. For court-ordered examinations and treatment, unless Medically Necessary.

45. For sales tax.

46. For services, supplies, equipment or care received in connection with a non-covered service, supply, equipment or care.

SECTION E. HOW TO FILE A CLAIM

1. Claim Procedures

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

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

a. The reason or reasons for the denial,

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

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

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

2. Claims for Vision Services

Post-Service Claims must be filed with Us. You can obtain a Post-Service Claim form from Our Customer Service Department. The form will give You instructions for filing the Post-Service Claim. If such forms are not furnished to You within 15 days after Your requesting the forms, You will have complied with the requirements of this Contract as to proof of loss upon submitting, within the required time period herein mentioned for filing Claims, such other written proof covering the occurrence, the character, and the extent of the loss for which Claim is made.

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

b. Non-Participating Providers will not file Your Claim for You. You must obtain a Claim form from Our Customer Service Center. You must pay the total charge at the time of service.

3. Time Limits for Filing Post-Service

We must receive proof of a Post-Service Claim for reimbursement for Covered Services no later than 365 days after the end of the Calendar Year

Claims	in which the service was received, except if it was not reasonably possible to give notice of proof within this time. We will deny any Post-Service Claim not received within this time limit.

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

SECTION F. PREMIUM PAYMENT, GRACE PERIOD AND CHANGES

1. Premium Payment

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

2. Grace Period

The Employer shall have a grace period of 31 days for the payment of any Premium, during which time the Contract shall continue in force. In no event shall the grace period extend beyond the date the Contract terminates. The Contract will automatically terminate on the last day of the period for which Premiums have been paid if the grace period expires and any Premium remains unpaid.

3. Reinstatement

If coverage under the Contract is terminated for nonpayment of Premiums, We have the right to decide whether or not to reinstate the Contract. Such decision will occur in writing within 45 days of receiving Your resubmission of a new application and payment of a reinstatement fee.

4. Changes in Premiums

We reserve the right to change Premiums upon 31 days prior written notice to the Employer. Notwithstanding the foregoing, We may change the Premiums at any time upon 31 days prior written notice whenever the terms of the Contract are changed.

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

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

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

SECTION G. TERMINATION

1. Terminating a Covered Person's Coverage

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

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

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

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

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

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

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

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

h. When a Domestic Partner's coverage is terminated, coverage for the children of a Domestic Partner will also be terminated on the last day of the month following termination of the Domestic Partner's coverage, except if the Domestic Partner's children are considered to be eligible Dependent children of the Employee as provided in the "Dependent Eligibility" provision Number 2. of Section B. of the Certificate.

When a Covered Person's coverage terminates, he may have continuation of coverage or conversion rights. See "Continuation and Conversion" section of the Contract.

SECTION H. CONTINUATION AND CONVERSION

1. Continuation of Coverage

Certain persons whose group vision coverage is terminated may be allowed to continue that coverage for a limited time, in accordance with state or federal COBRA laws.

Federal and State Continuation and any rights to Conversion do not apply to Domestic Partners and the Domestic Partner's children.

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

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

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

a. Qualifying Events

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

1. Termination of employment (other than for gross misconduct);
2. Reduction in work hours;
3. Death of the Employee;
4. The Employee becomes entitled (eligible and enrolled) to Medicare Benefits;

5. Divorce or legal separation;

6. A Dependent child ceases to qualify as a Dependent under the terms of the Plan; or

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

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

b. Qualified Beneficiary

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

c. Maximum Coverage Period

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

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

d. Second Qualifying Event

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

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

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

e. Social Security Disability

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

If the Social Security Administration later determines that an individual is no longer disabled, that individual must notify the Employer within 30 days after the date of that second determination. The individual and other qualified beneficiaries' right to the 11-month extension of

continuation coverage will terminate as of the first day of the month that begins more than 30 days after the second determination is issued. However, if another qualifying event occurs giving rise to 36 months of continuation coverage during the 11 month disability extension, the qualified beneficiaries receive the full 36 months of coverage beginning from the initial date of continuation coverage. This extension cannot be shortened if disability ceases.

f. Electing Continuation Coverage

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

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

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

g. Effective Date of Continuation Coverage

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

h. Coverage Changes

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

The qualified beneficiary has the same right to change benefit programs as the active Employees. If the active Employee is allowed to change to another benefit program during the Employer's Annual Enrollment Period or under a Special Enrollment Period under the Health Insurance

Portability and Accountability Act (HIPAA), a qualified beneficiary is allowed the same opportunity.

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

i. Termination of Continuation Coverage

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

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

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

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

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

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

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

7. For retirees, in the case of a qualifying event that is the Chapter

11 bankruptcy of an Employer, the earlier of the date of the qualified beneficiary's death or the date that is 36-months after the death of the retired covered Employee.

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

9. The date the Contract terminates.

j. Extension of COBRA Continuation for Spouses

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

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

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

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

1. The date coverage terminates under the Contract for failure to

make timely payment of the required Premium; if the individual fails to make payment on any Due Date;

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

3. The date the person becomes covered under any other group health plan; or

4. The spouse's 65th birthday

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3. Continuation Coverage under Uniformed Services Employment and Reemployment Act of 1994 (USERRA)

The following USERRA continuation provisions apply to all Employers regardless of size. The USERRA provisions of the Contract conform with the minimum requirements of the USERRA law, provided that the Employer and Covered Person(s) comply with the USERRA requirements. Coverage under this Contract will not be continued if the Employer or the Covered Person(s) do not comply with the USERRA requirements.

Apart from other rights to continued coverage provided under the Contract, if coverage would terminate for an Employee due to a leave for uniformed service, the Employee and his covered Dependents may be entitled to up to 24 months of continuation of such coverage, and certain reinstatement rights following a period of uniformed service.

a. Eligibility

An Employee who is absent from employment from his Employer due to uniformed service may continue his Employee and Dependent coverage beginning on the date on which the Employee is first absent from employment by reason of uniformed service.

Any election made by an Employee applies to the Employee and the Employee's Dependents who otherwise would lose coverage under the Contract. No separate election may be made by any Dependent. The coverage that Employees are allowed to continue on behalf of themselves and their Dependents will be the same as that provided to Employees and their Dependents under the Contract. Except in connection with circumstances that permit other Employees to make changes, an Employee may continue only the type of coverage that he or she was receiving on the day before the Employee first was absent from employment.

b. Electing USERRA Continuation Coverage

An Employee who wishes to continue coverage must complete an election form and be postmarked within 60 days after the Employee's coverage would terminate due to a leave for qualified uniformed service, or 60 days after the Employer or plan administrator sends notice of the USERRA continuation rights; whichever is later. An individual must then pay the initial Premium within 45 days after electing USERRA continuation coverage.

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

c. Coverage Changes

If the terms of the Contract are changed, the USERRA coverage is also subject to the amended terms of the Contract.

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

d. Premium Payment

The premium charged for USERRA continuation coverage will be the same for all similarly situated Employees electing coverage under this provision. When the period of uniformed service is less than 31 days, the Employer is required to pay its normal share of the Premium for coverage. When the period of uniformed service is 31 days or more, the Employee will be responsible for both the Employee's portion and Employer's portion, determined in the same manner as COBRA continuation coverage under the Contract.

e. Termination of USERRA Coverage

Coverage will end on the earliest of the following dates:

(1) 24 months from the date USERRA continuation coverage began;

(2) The date the Employee fails to apply for or return to a position of employment;

(3) The date coverage terminates under the Contract for failure to make timely payment of the required Premium; if the individual fails to make the required Premium payment within the grace

period (payment of Premium must be postmarked no later than the last day of the grace period); or

(4) The date the Contract terminates.

f. COBRA and USERRA Continuation Rights

You may be eligible for both COBRA and USERRA continuation rights simultaneously

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4. Continuation of Coverage Pursuant to a Leave of Absence

If an Employee's coverage would terminate because of a leave of absence approved by the Employer (including absences under the Family and Medical Leave Act (FMLA), if eligible), coverage may be continued if the Employer:

(1) forwards the Premium for such continued coverage; and

(2) provides continued coverage to all Employees in the same class as the Employee whose coverage would otherwise terminate because of an approved leave of absence.

Such continuation of coverage shall terminate no later than:

(1) 90 days after the Employee's coverage would have otherwise terminated were it not for this continuation coverage; or

(2) If an Employee is eligible for FMLA leave to care for an injured or ill service member, 180 days after the Employee's coverage would have otherwise terminated were it not for this continuation coverage; or

If an Employee is eligible for FMLA leave for service member-related qualified exigencies, 90 days after the Employee's coverage would have otherwise terminated were it not for this continuation coverage.

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5. Conversion Coverage

The following individuals are entitled to convert to Our conversion plan designed for the classification applicable to them provided they have been covered as an Employee or Dependent under the Contract for 3 months, (except that a surviving Dependent of a deceased Employee will be offered an opportunity to enroll in Our conversion plan without regard to the 3 month coverage requirement if the Dependent was covered under the Employee's family coverage at the time of the Employee's death):

a. Employees and Dependents whose coverage under the Contract is ending because the Contract is terminated and is not reinstated or replaced within 31 days.

b. Employees or Dependents who have continued coverage for the maximum time allowed under state law or federal law (COBRA), whichever is applicable.

c. Persons whose continuation coverage terminates because the Contract is discontinued and not replaced within 31 days by similar group coverage.

Any waiting period required under the new contract will be reduced by the period of time You had been continuously covered under the Contract. If You had no required Waiting Period under the Contract, then You have no required waiting period under the conversion coverage.

A Covered Person has 31 days after termination of such group coverage to apply for conversion coverage and to make the required Premium payment for the period beginning with the day following the date coverage would otherwise terminate. No gap in coverage will be permitted.

SECTION I. GENERAL INFORMATION

1. Terms and Conditions of the Contract

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

2. Statements

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

3. Vision Examination

To fulfill the obligations under this Contract, We may require, during the pendency of the claim, a Covered Person to have a vision examination by an Ophthalmologist, Optician, or Optometrist of Our choice and at Our expense.

4. Release of Records

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

a. A complete current vision charting. The dates of any work previously done should be shown.

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

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

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

5. Reimbursement to Us

a. Workers' Compensation

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

Us for any Benefits paid to You or on Your behalf for claims paid or payable for any past or future vision benefits that are the subject of or related to that settlement.

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

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

b. Errors

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

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6. Legal Actions

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

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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.

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8. Commission or Omission

No Ophthalmologist, Optician, or Optometrist 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 Ophthalmologist, Optician, or Optometrist or Ophthalmologist, Optician, or Optometrist's agent or employee; or (b) the Employer or the Employer's agent or employee.

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9. Clerical Errors

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

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10. Notice

Written notice given by Us to an authorized representative of the Employer is deemed notice to all affected Employees and their covered Dependents in the administration of the Contract, including termination of

the Contract. The Employer is responsible for giving notice to Employees.

11. Authority to Change the Contract

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

12. Assignment

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

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

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

13. Medicaid

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

14. ERISA Statement of Rights

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

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

ERISA provides that all plan participants shall be entitled to:

a. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the plan with the United States Department of

Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

b. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The plan administrator may charge a reasonable fee for the copies.

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

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

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

If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

If You have any questions about the plan, You should contact the plan administrator. If You have any questions about this statement or Your rights under ERISA, or if You need assistance in obtaining documents from the plan administrator, You should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

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

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15. Authority to Construe Terms of the Contract

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

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16. Plan Sponsor and Plan Administrator

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

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17. Special Programs

As an individual covered under the Contract, You may have the opportunity to take advantage of special programs offered at no additional cost to You. These programs are designed to help You with Your health care, vision 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 business. Changes in these arrangements and/or their discontinuance may occur at any time in the future at Our discretion.

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18. Independent Licensee

The Contract constitutes a Contract solely between the Employer and Blue Cross and Blue Shield of Kansas City. Blue Cross and Blue Shield of Kansas City is an independent corporation operating under an agreement

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

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19. Gender

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

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20. Titles

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

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21. Entire Contract

The Employer application, the Employee applications, and Certificate(s) issued to the Employee are incorporated by reference in this document and made a part of the Contract. Any conflict between the Contract and the Certificate(s) will be resolved according to the terms which are most favorable to the Covered Person. The definitions contained in the Contract will have the defined meaning when used in this document with the first letter capitalized. The Contract and any amendments or riders thereto constitute the entire agreement between the parties and any change in the Contract must be signed by an officer of the Company to be valid. No agent or representative has the authority to change the Contract or waive any of the provisions.

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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 the coverage or reduces Benefits unless the statement was material to the risk assumed and contained in a written application. Furthermore, after the Covered Person's coverage has been in force for two (2) years from the Effective Date, no statement, except fraudulent statements he has made will void the coverage or reduce the Benefits. A copy of the written application form is provided to the Employee. No claim for loss incurred or disability (as defined in the policy) commencing after twelve months from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss has existed prior to the effective date of coverage of this policy.

23. Vision Provider Directory

At no additional cost, Vision Provider Directories are provided by Us and upon request when You call the Customer Service Department phone number on your identification card. In addition, You may access Our Vision Provider Directory on Our website at www.eyemed.com.

24. Right to Recover Payment

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

a. Any 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

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

SECTION J. UTILIZATION REVIEW

Utilization Review may be undertaken for any vision care services. Such review is performed using nationally licensed medical criteria. Please contact Us at the toll free telephone number on the back of Your identification card for questions regarding Utilization Review.

1. Initial Determination

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

In the case of a determination to certify a 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.

We will notify the provider rendering the service within 24 hours for Urgent Care Services and within 5 working days for non-Urgent Care Services after Our receipt of the request for Prior Authorization if the request was incorrectly filed or additional information is needed. If additional information is needed in order to make a determination, You have 48 hours from the time You are notified to provide Us with the requested information for Urgent Care Services, and 45 calendar days from the date You are notified to provide Us with the requested information for non-Urgent Care Services.

Failure to provide the information within 48 hours for Urgent Care Services and within 45 calendar days for non-Urgent Care Services will result in the denial of Your request. Upon receipt of the requested information, We will make the determination within 48 hours.

Urgent Care Services are:

a. Those services that if not provided could seriously jeopardize Your life, health or the ability to regain maximum function; or

b. Those that in the opinion of a physician with knowledge of Your medical condition would subject You to severe pain that cannot be adequately managed without the requested care or treatment.

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 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 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. If additional information is needed in order to make a determination, We will notify You as soon as possible, but no later than 24 hours after receipt of the request for additional services.
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 Retropective 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.

SECTION K. COMPLAINT AND GRIEVANCE PROCEDURES

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

1. Definitions Applicable to this Section

Inquiry - 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, Post-Service 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 to Our Appeals Department regarding (a) the availability, delivery or quality of Covered Services, including a Complaint regarding an Adverse Determination made pursuant to Utilization Review; (b) Post-Service 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: (a) would seriously jeopardize the life or health of a Covered Person; (b) would jeopardize the Covered Person's ability to regain maximum function; or (c) in the opinion of a physician with knowledge of the Covered Person’s medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the requested care or treatment. 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.

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. For Employee Welfare Benefit Plans subject to the Employee Retirement Income Security Act (ERISA) You must file a first level Grievance before You can bring a civil action under ERISA Section 502(a). Call Your Employer to find out if You are subject to ERISA.

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

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

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5. Procedures to Request an Expedited Review

If the time frame of the standard Grievance procedure: (a) would seriously jeopardize the life or health of the Covered Person; (b) would jeopardize the Covered Person's ability to regain maximum function; or (c) in the opinion of a physician with knowledge of the Covered Person's medical

condition, would subject the Covered Person to severe pain that cannot be adequately managed without the requested care or treatment, 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 calendar days of providing oral notification of Our decision.

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6. ERISA Exhaustion of Internal Procedures

If Your plan is subject to ERISA and Your request for coverage or Benefits is denied or any other ERISA statutory claim is denied, You have the right to bring a civil action under ERISA Section 502(a) provided You have exhausted Your first level Grievance rights.

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7. External Review

You or Your representative has the right to file a grievance concerning an Adverse Determination with the Missouri Department of Insurance ("Department"). If the Department determines a grievance is unresolved after completion of its consumer complaint process, the Department will refer the unresolved grievance to an independent review organization ("IRO").

A. Assignment to an IRO

The Department will provide the IRO with copies of all medical records and any other relevant documents. You and/or Your representative also may submit additional information to the Department which will be forwarded to the IRO. All additional information must be received within 15 working days from the postmark date the Department mailed the information to the IRO. The Department may, but is not required, to accept additional information after the 15 working days.

The IRO will review all the documents and provide the Department its opinion of the issues reviewed within 20 calendar days after the IRO receives the request for the external review. The IRO can request an extension of time, not to exceed five (5) calendar days.

B. IRO Decision

After the Department receives the IRO's opinion, it will issue a decision which will be binding upon You and Us. The decision will be in writing and provided to You and Us within 25 calendar days of receiving the opinion. In no event will the time between the date the IRO receives the request and the date of the Department's decision be longer than 45 days.

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8. Expedited External Review

A. Request for an Expedited External Review

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

1. An Adverse Determination that involves an admission, availability of care, continued stay, or Covered Service for which You received Emergency Services, but have not been discharged from the facility; or

2. An Adverse Determination that involves a medical condition for which the delay of the standard external review would jeopardize Your life or health or would jeopardize Your prognosis or ability to regain maximum function.

B. Preliminary Review

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

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9. Denial of Coverage for Experimental or Investigational

If a request for external review of an Adverse Determination involves a denial of coverage based on a determination that a health care service or treatment recommended or requested is Experimental or Investigational, the following requirements must be met:

A. The IRO shall make a preliminary determination as to whether the requested health care service or treatment is a Covered Service under this Contract except for the fact that We determined that the service or treatment is Experimental or Investigational for a particular medical condition; and is not explicitly listed as an exclusion under this Contract.

B. The request for external review of an Adverse Determination involving a denial of coverage based on Our determination that the health care service or treatment is Experimental or Investigational must include a certification from Your Physician that:

1. Standard health care services or treatments have not been effective in improving Your condition; or

2. Standard health care services or treatments are not medically appropriate for You; or

3. There is no available standard health care service or treatment covered under the Contract that is more beneficial than the recommended or requested health care service or treatment; and

The request shall also include documentation (a) that Your Physician has recommended a health care service or treatment that the Physician certifies, in writing, is likely to be more beneficial to You, in the Physician's opinion, than any available standard health care services or treatments; or (b) Your Physician, who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat Your condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by You is likely to be more beneficial to You than any available standard health care services or treatments.

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10. Department of Insurance

You may also contact the Missouri Department of Insurance, P.O. Box 690, Jefferson City, MO 65102-0690 or call them toll free at 1-800-726-7390, for assistance at any time with a Complaint or Grievance or for any other matter.

BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

PRIVACY PRACTICES NOTICE

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

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

Summary of Our Privacy Practices

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

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

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

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

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

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

Contact Information

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

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

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

Organizations Covered by this Notice

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

Blue Cross and Blue Shield of Kansas City

Good Health HMO, Inc.

Blue-Advantage Plus of Kansas City, Inc.

Missouri Valley Life and Health Insurance Company

Our Legal Duty

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

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

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

Uses and Disclosures of Your Medical Information

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

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

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

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

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

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. To the extent (if any) that we maintain or receive psychotherapy notes about you, most disclosures of these notes require your authorization. Also, to the extent (if any) that we use or disclose your information for our fundraising practices, we will provide you with the ability to opt out of future fundraising communications. In addition, most (but not all) uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of protected health information, require your authorization. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice.

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

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

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Your Employer: We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

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

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

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

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

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

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

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

Your Rights

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

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

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

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

We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to your additional requests. Contact our Privacy Office for information about our fees.

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

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

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

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

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

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

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

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Complaints

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

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

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

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 Human Resources, PO Box 419169, Kansas City, MO 64141-6169, 816-395-2830, section1557aca@bluekc.com You can file a grievance in person or by mail, or email. If You need help filing a grievance, please contact Human Resources using one of the methods noted above. 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, ຫຼືຄົນທ່ານກໍາລັງຊ່ວຍເຫຼືອ, ມີຄໍາຖາມກ່ຽວກັບ Blue KC, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ ໂທຫາ 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

AMENDMENT ISSUED BY
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

AMENDMENT: VPPO-200-18-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