
Group Insurance Benefits

Evangelical Lutheran Education Association dba ELEA

Group Dental Insurance

Class 01



**KANSAS CITY LIFE
INSURANCE COMPANY**



**KANSAS CITY LIFE
INSURANCE COMPANY**

Certificate of Dental Insurance

Kansas City Life Insurance Company certifies that in accordance with and subject to the terms of the Group Master Policy, the Insured Individual is insured for the coverage described in this certificate. The Group Master Policy provides the coverage described in this certificate for certain Insured Individuals covered under the Policy.

This certificate describes the Dental Insurance coverage provided by the Group Master Policy. This certificate supersedes and replaces any which may have been issued to you previously.

Signed for Kansas City Life Insurance Company, a stock company, at its Home Office, 3520 Broadway, Kansas City, Missouri 64111.

Secretary

President, CEO and Chairman

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Schedule of Benefits

POLICYHOLDER

Evangelical Lutheran Education Association dba ELEA

Group Number

25515

SUBSIDIARIES, DIVISIONS OR AFFILIATES

Participating schools shown on file

Classes of Eligible Individuals

Class 01: All full-time active employees of association member schools enrolled in High Plan working 20 hours or more per week who are legal residents or citizens of the U.S., excluding temporary and seasonal employees.

Probationary Waiting Period

Current Individuals: None

New Individuals: 30 Days

After completing the probationary waiting period, the first of the month effective date applies.

Employee contribution is required for insured individual and required for insured dependents.

Employees with contributory coverage have 31 days to enroll for coverage after serving the probationary waiting period before being considered a late applicant.

Plan Description – Class 1 High Plan

	<u>Participating Provider</u>	<u>Non-Participating Provider</u>
<u>Calendar Year Deductible</u>		
Individual Type 1 (Preventive)	None	None
Individual Type 2&3 (Basic & Major)	\$50	\$50
Family Deductible Maximum	3 x Individual	3 x Individual
<u>Coinsurance</u>	MAC*	UCR**
Type 1 (Preventive)	100%	100%
Type 2 (Basic)	80%	80%
Type 3 (Major)	50%	50%
<u>Maximums</u>		
Types 1, 2, 3 Calendar year Maximum	\$1,500	\$1,500
<u>Benefit Waiting Periods</u>		
Type 1 (Preventive)	0 months	0 months
Type 2 (Basic)	0 months	0 months
Type 3 (Major)	0 months	0 months

Provisions for Current Insured Individuals are provided. Previous carrier – Reliance Standard

*MAC – Maximum Allowable Charge

**UCR – Usual, Customary and Reasonable Charge

Definition of Certain Terms

Actively-at-Work

You will be considered to be actively-at-work with your Employer on a day, which is one of your Employer's scheduled workdays if you are performing, in the usual way, all of the regular duties of your job on a full time basis on that day. You will be deemed to be actively-at-work on a day, which is not one of your Employer's scheduled workdays only if you were actively-at-work on the preceding scheduled workday.

Active Full-time Employee

An employee who works for the Employer on a regular basis in the usual course of the Employer's business. The employee must work the number of hours in the Employer's normal workweek. This must be at least the number of hours indicated in the Schedule of Benefits. Eligible employees do not include temporary, leased or seasonal employees.

Benefit Waiting Period

The amount of time you or your dependent(s) must be covered under the Policy before certain benefits are payable.

Covered Dental Expenses

Charges for those Dental Services listed under Covered Dental Services if done by or under the direction of a licensed provider. Not included are charges that are determined to be in excess of the usual, customary and reasonable (UCR) charge or Maximum Allowable Charge (MAC) as determined in the Schedule of Benefits. Covered dental services also include the UCR or MAC charges for a less expensive mode of treatment to provide a professionally adequate result.

Current Insured Individual

Any Insured Individual (or dependent) who is insured for dental care expenses on the policy's effective date and who was insured for dental care expenses under the employer's previous group dental plan on the day just before that.

Dental Service

Each service listed in the Covered Dental Services. A temporary dental service will be deemed to be a part of the final dental service.

Eligibility Date

The date a full-time employee in an eligible class satisfies the probationary waiting period shown on the Schedule of Benefits.

Insured Individual

An individual whose insurance is in force under the terms of the Policy.

Directors, proprietors, or partners may be eligible for insurance if working at least 30 hours each week for the Policyholder.

Kansas City Life

Kansas City Life Insurance Company, a Missouri corporation, with its Home Office located at 3520 Broadway, Kansas City, Missouri 64111 and the telephone number is (816) 753-7000.

Late Applicant

An employee who enrolls for dental benefits more than 31 days after the eligibility date.

Length of Time Covered

The total amount of time an Insured Individual has been continuously covered under the Policy.

Maximum Allowable Charge (MAC)

The fee for a service as negotiated with a contracted Participating Provider.

New Individual

A newly hired individual or an existing employee that enters into an eligible class because of a change in status.

Participating and Non-Participating Providers

The Insured Individual may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to Insured Individuals. A Non-Participating Provider is any other Provider.

Policy

The contract of insurance made by Kansas City Life and the policyholder.

Policyholder

The firm or other organization in whose name the Policy is issued. The term Policyholder will include only those subsidiaries, divisions and affiliates listed in the Policy.

Previous Policy

The Policy issued to the Policyholder by the previous insurer that is replaced by this coverage on the policy effective date. The previous insurer (if any) is shown on the Schedule of Benefits.

Probationary Waiting Period

The amount of time an individual must be employed by the Policyholder before being eligible for insurance. The probationary waiting period is shown on the Schedule of Benefits.

Provider

An individual who is licensed by the law of the state in which treatment is provided within the scope of the license.

Usual, Customary and Reasonable Charge (UCR)

The fee for a service, determined by Kansas City Life, which is not higher than the usual charge made by the provider of the care or supply and which does not exceed the fee ordinarily charged by most Providers in the locality where the charge is made.

You/Your

The individual who is insured under this plan. The words "you" and "your" with respect to any benefits, rights and privileges outlined in this certificate, refer to the employee.

General Provisions

Who can be insured?

All members of the eligible classes shown on the Schedule of Benefits can be insured.

When am I eligible to be insured?

You are eligible to be insured on the latest of:

- 1) the policy effective date;
- 2) the date you become a member of an eligible class shown on the Schedule of Benefits; or
- 3) the date you complete the probationary waiting period (if any).

The probationary waiting period may differ for current and new Insured Individuals. The probationary waiting periods are shown on the Schedule of Benefits.

When does my insurance begin?

To become insured, you must complete, sign and submit an enrollment card to the Policyholder within 31 days of your eligibility date.

Your insurance begins on the later of the following dates, but only if you are a member of an eligible class on the date insurance is to begin:

- 1) the first day of the policy month which coincides with or next follows the date you are first eligible, if you submit the enrollment card on or before the date you are first eligible; or
- 2) the first day of the policy month, which coincides with or next follows the date you submit the enrollment card, if you submit the enrollment card within 31 days after the date you are first eligible.

If you are not a member of an eligible class on the date insurance is to begin, such insurance will begin on the first day of the policy month following your entry into an eligible class.

Late Applicant

If the completed enrollment card for a new individual is submitted to the Policyholder more than 31 days after the individual became eligible, the individual is considered a Late Applicant. Benefits for Late Applicants are limited to Type I services for a minimum of 12 consecutive months. Late Applicants will be entitled to full benefits beginning with the next calendar year (January 1) following 12 consecutive months of continuous coverage.

An eligible individual who enrolls during the annual open enrollment period will not be considered a late applicant unless coverage was voluntarily terminated previously.

When am I eligible for insurance for my dependents?

You are eligible for insurance for your dependents on the later of:

- 1) the date you are eligible to be insured; or
- 2) the date you acquire an eligible dependent.

The date acquired for eligible dependents is as follows:

- 1) a spouse is deemed acquired on the date of marriage;
- 2) a natural child is deemed acquired on the date of birth;
- 3) an adopted child is deemed acquired on the date of placement for the purpose of adoption and continues to be eligible unless the placement is disrupted prior to legal adoption and the child is removed from placement;
- 4) a stepchild is deemed acquired on the date of marriage to the natural parent; and
- 5) a grandchild or other child is deemed acquired on the first date he or she meets the definition of "child" as shown below.

Who are eligible dependents?

Eligible dependents are:

- 1) your spouse; and/or
- 2) each unmarried child who is:
 - a) under 26 years of age (until the end of the month in which the child turns age 26);
 - b) age 26 or over if the child:
 - i) is incapable of earning a living due to mental or physical handicap on the day before reaching the age limit;
 - ii) depends on you for more than half of his or her support on that day; and
 - iii) remains incapacitated and dependent as described. You must submit proof of incapacity and dependency to Kansas City Life within 31 days after the child reaches the age limit. Kansas City Life can require proof of continued incapacity and dependency but not more than once each year after the two-year period following the child reaching that age limit.

Child includes only:

- 1) your natural child or adopted child; and/or
- 2) your stepchild, grandchild, or other child who lives with you in a regular parent-child relationship and for whom you (or your spouse who lives with you) have legal custody ordered by a court of competent jurisdiction.

No one can be insured as a dependent of more than one Insured Individual.

No one on active duty in the Armed Forces of any country can be insured as a dependent.

No one can be insured as a dependent if eligible for insurance as an Insured Individual, except if you and your spouse can be insured as an Insured Individual, one (and only one) of you may insure the other for dental care expenses.

When does insurance for dependents begin?

To insure your dependents, you must complete, sign and submit an enrollment card to the Policyholder within 31 days after your dependent becomes eligible. Your request must include all your dependents then eligible.

The dependent's insurance begins for each dependent then eligible on the later of:

- 1) the date your insurance begins; or
- 2) the first day of the policy month which coincides with or next follows:
 - a) the date you are first eligible for insurance for your dependents, if you submit the enrollment card on or before the date you are first eligible for insurance for your dependents; or

- b) the date you submit the enrollment card, if you submit the enrollment card within 31 days after the date you are first eligible for insurance for your dependents.

Late Applicant

If the completed enrollment card for a new dependent is submitted to the Policyholder more than 31 days after the dependent becomes eligible, the dependent is considered a Late Applicant. Benefits for Late Applicants are limited to Type I services for a minimum of 12 consecutive months. Late applicants will be entitled to full benefits beginning with the next calendar year (January 1) following 12 consecutive months of continuous coverage.

An eligible dependent of an insured individual who enrolls during the annual open enrollment period will not be considered a late applicant unless coverage was voluntarily terminated previously.

If a completed enrollment card is submitted prior to a child's third birthday, the Late Applicant provision will not apply.

You must inform Kansas City Life and the Policyholder in writing when your last dependent is no longer eligible. The Policyholder has forms available for this purpose. Kansas City Life will not give refunds or credits for your payment toward the cost of insurance for your dependents for any period before the later of:

- 1) the date your last dependent's insurance ends; or
- 2) 90 days before the date Kansas City Life is informed.

Dependents acquired after your coverage is effective.

Newborns are covered from the date of birth to the next premium due date that is at least 31 days after the child's birth. To continue coverage after this date you must request the coverage in writing and agree to make any required contributions.

All other dependents will be covered from the date of eligibility, if written request and payment of any required premium is submitted within 31 days.

When does insurance terminate?

Subject to the extension of benefits provision found within the Benefits Payable section, insurance under the Policy for you or your dependents will end on the earliest of:

- 1) the date the Policy terminates;
- 2) the date the Policy is amended or changed to end the insurance for the class of eligible individuals to which you belong;
- 3) the date you cease to be a member of a class for whom insurance is provided;
- 4) the date that ends the period for which you last made any required payment toward the cost of insurance for you or your dependents;
- 5) the date you cease to be actively-at-work as a full-time employee of the employer, if the Policy requires you to be actively-at-work;
- 6) the date your dependents cease to be eligible;
- 7) the date, which you or your dependent enters the Armed Forces, other than for reserve duty of 30 days or less.

If I terminate coverage when will I be eligible to re-enroll in coverage?

If you terminate your coverage or your dependent's coverage you will be allowed to re-enroll for coverage not less than 12 consecutive months after termination. Re-enrollees will be treated as Late Applicants upon re-enrollment. This provision includes termination of coverage due to non-payment of premium.

Can my coverage continue while I am not actively-at-work?

The Policyholder may (but is not required to) consider you a member of an eligible class (and continue insurance) even though you are:

- 1) temporarily laid-off and the Policyholder expects to call you back to work;
- 2) put on approved leave of absence; or
- 3) unable to work because of injury or sickness.

The Policyholder must treat all Insured Individuals the same for purposes of continuing insurance.

If your insurance is so continued, it will end on the earliest of:

- 1) the date the Policyholder notifies Kansas City Life that you are no longer a member of an eligible class; or
- 2) the date that ends the period for which the Policyholder last paid the premium for you; or
- 3) the date that ends the maximum continuation period for which the insurance can be continued.

The maximum continuation period is as follows:

- for temporary lay-off, part time employment or approved leave of absence – three months.
- for injury or sickness – one year from the date injury or sickness begins.

Benefits Payable

What benefits are payable?

Kansas City Life will pay the percentage payable as shown on the Schedule of Benefits for charges incurred during each calendar year after the deductible (if any) has been met.

If you transfer from the care of one provider to another provider during the course of treatment, or if more than one provider renders services for you or your dependents benefits are not payable for more than the amount that would have been covered if one provider rendered the service or services.

All benefits payable to or for any person will not exceed the Maximum Benefit Amount shown on the Schedule of Benefits.

Kansas City Life may request pre-operative dental X-rays to determine liability for procedures submitted. If X-rays are not provided, benefits will be made for procedures that result in professionally adequate restoration, replacement or treatment.

Unless We agree otherwise, Covered Charges will include only charges for procedures listed in this certificate. If a non-listed procedure is accepted, We will determine the amount payable from a list of procedures of comparable nature.

How can I determine in advance what benefits are payable?

Predetermination of dental benefits is a service available through your Kansas City Life dental plan. This benefit review in advance of treatment enables you and your provider to see what services are covered by the plan and what your portion of the charges will be.

Predetermination should not be requested unless total charges for a proposed treatment plan exceed \$400. Ask your provider to submit a predetermination request. Kansas City Life will then provide a summary of covered expenses and payable amounts.

Please note the service is not designed to be used for emergency treatments or routine preventive services such as exams, x-rays or cleaning.

What is the difference between a Participating and Non-Participating Provider?

Participating Providers have agreed to a negotiated fee schedule that is generally less than the Usual, Customary, and Reasonable charges of other providers in any given region. With select plans, in addition to potentially lower total charges, deductibles and coinsurance percentages for Participating Providers may differ from those for Non-Participating Providers.

Depending on the dental plan purchased by the Policyholder, the allowable charge for Non-Participating Providers may be determined on a Usual, Customary, and Reasonable (UCR) basis, or the Maximum Allowable Charge (MAC) schedule negotiated with Participating Providers. See the Schedule of Benefits for the specifics of your plan.

You are not required to see a Participating Provider, but doing so has the potential to reduce your total out-of-pocket cost.

The following is an example of a comparison of out-of-pocket costs between Participating and Non-Participating Providers. Actual charges may vary. For specific information regarding deductibles and coinsurance percentages for your plan, see the Schedule of Benefits.

	Participating Provider	Non-Participating Provider
Initial Charge	\$700	\$700
Allowable Charge	\$500 (Negotiated Fee)	\$650 (UCR Limit/Negotiated)

		Fee)
Deductible	\$50	\$50
Coinsurance Percentage	60%	50%
Amount Paid by Kansas City Life	\$270 ($\$500 - \50 Deductible) x 60%	\$300 ($\$650 - \50 Deductible) x 50%
Amount Paid by the Insured (Out-of-pocket)	\$230 ($\$500 \text{ Allowable Charge} - \270 paid by Kansas City Life)	\$400 ($\$700 \text{ Initial Charge} - \300 paid by Kansas City Life)

Participating Providers will never bill an insured individual for the balance between the initial charge and the allowable charge. Non-Participating Providers may choose to bill the insured for the balance between the initial charge and the allowable charge, a practice known as balance billing.

For a current list of Participating Providers in your area, refer to the website noted on your Dental Identification Card.

What is my deductible?

The deductible applies as shown on the Schedule of Benefits. The deductible must be met from covered dental expenses incurred during each calendar year and from the types of covered dental expenses to which it applies.

The amount of the deductible and the types of covered dental expenses to which it applies are shown on the Schedule of Benefits.

What is the maximum family deductible?

Once the family deductible (if any) has been met during a calendar year, covered dental expenses incurred by any other insured member of your family during the remainder of that calendar year will not be subject to a deductible. The family deductible is shown on the Schedule of Benefits.

Is coverage provided during a benefit waiting period?

Kansas City Life will not pay for (and covered dental expenses do not include) charges incurred by you or your dependents before you or your dependents complete the benefit waiting periods (if any).

The benefit waiting periods (if any) are shown on the Schedule of Benefits.

Will I receive credit for benefit waiting periods and deductibles if I had coverage under a previous plan?

If the Policy replaces the Policyholder's comparable previous dental coverage, Current Insured Individuals will receive credit for waiting periods and/or deductibles satisfied under the previous plan.

Credit will be given for the calendar year deductible (or any portion of it) and for any portion of a benefit waiting period satisfied under the previous plan if:

- 1) the statement "Provision for Current Insured Individuals is provided" is included on the Schedule of Benefits page;
- 2) a previous plan is shown on the Schedule of Benefits page; and
- 3) you and your dependents are Current Insured Individuals.

Are there limitations on expenses covered if the Policy replaces existing coverage?

Any benefits paid under the previous plan with respect to replaced coverage will be applied to and deducted from the maximum benefit payable.

Are there limitations on expenses covered if the previous plan extends benefits?

Kansas City Life will not pay benefits for any dental expenses for which benefits are paid or payable under any provision of the previous plan.

What are the provisions for extension of benefits?

The coverage under the Policy for covered dental expenses for you and your covered dependents will be extended after the date the coverage for such person terminates only if:

- 1) a covered dental expense for such services was incurred while covered; and
- 2) such services are completed within 31 days after coverage terminates.

A covered dental expense will be deemed incurred as follows:

- 1) for crowns, dentures or bridgework – on the date the impression is taken;
- 2) for root canal therapy -- on the date the pulp chamber is opened; or
- 3) for all other dental expenses -- on the date the service is rendered or the supply is furnished.

Limitations and Exclusions

What are the limitations and exclusions?

Kansas City Life will not pay for (and covered dental expenses do not include) charges:

- 1) for any care, services, supplies or treatment rendered on an experimental, investigational, or research basis not recognized as a generally accepted dental practice by the dental profession or The American Dental Association;
- 2) for services that, to any extent, are payable under any other group insurance or service plan (that provides coverage for medical charges) for which the Policyholder makes payroll deductions or pays all or part of the cost;
- 3) due to injury, sickness or disease that is covered under any Workers' Compensation Law, occupational disease law or similar laws;
- 4) made by any facility owned or operated by the United States or any of its agencies unless you are legally required to pay in the absence of insurance;
- 5) made by any government entity unless you are required to pay; or by any public entity from which coverage could have been obtained by application or enrollment even if application or enrollment was not actually made;
- 6) for which you do not legally have to pay or that would not be made if you were not insured under the Policy;
- 7) for services provided by a member of your immediate family (including spouse, siblings, parents, children, or grandparents either by blood, marriage, or legal adoption) or a member of your household;
- 8) which are incurred before insurance begins or after it ends;
- 9) for procedures started before the benefit waiting period has been met (other than orthodontia) which include but are not limited to:
 - a) crowns, inlays, onlays, bridges and prosthetic appliances (which are considered started when the initial impression is taken);
 - b) root canals (which are considered started when the pulp chamber is opened);
 - c) treatment or supplies that are for congenital or developmental malformations existing on your effective date;
- 10) for any dental procedure performed outside of the United States and its Territories;
- 11) that are more than the usual, customary and reasonable (UCR) charge;
- 12) for treatment or services that are not medically necessary, or not appropriate, or that are primarily for cosmetic reasons (unless noted in Type 5 Services Cosmetic);
- 13) for any duplicate device or appliance;
- 14) for duplication or repetition of non-surgical periodontal procedures (excluding periodontal maintenance) within any 12 consecutive month period and duplication or repetition of any surgical periodontal procedure within any 24 consecutive month period;
- 15) for instruction or supplies for plaque control, oral hygiene, or nutritional counseling or behavioral management;
- 16) for the use of materials (other than fluorides and sealants applied by your provider) to prevent tooth decay;
- 17) for bite registrations (study models);

- 18) for surgical implants or transplants of any type (including any prosthetic device attached to them);
- 19) for treatment of temporomandibular disorders;
- 20) for dentures, crowns, inlays, onlays, dental appliances, or procedures to:
 - a) alter vertical dimension;
 - b) restore or maintain occlusion;
 - c) splint or replace tooth structure lost as a result of abrasion, attrition, or erosion; or
 - d) treat temporomandibular disorders.
- 21) for prosthetic appliances or fixed bridges to replace missing teeth that were not extracted while this coverage was in force unless necessitated by the loss of one or more natural teeth while covered under this plan. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth. Benefits will be pro-rated;
- 22) for prosthetic appliances or fixed bridgework to replace non-functional teeth; (A non-functional tooth is a tooth that is not opposed in the opposite arch.)
- 23) for replacement of any prosthetic appliance or fixed bridge unless the existing prosthetic appliance or fixed bridge is at least 8 years old and cannot be made serviceable;
- 24) for replacement of any crown, inlay or onlay unless the crown, inlay or onlay is at least 8 years old and cannot be made serviceable;
- 25) for replacement of a lost or stolen appliance;
- 26) for intravenous sedation in conjunction with routine dental procedures;
- 27) for the following periodontal procedures: occlusal analysis, adjustments or guards, crown lengthening, provisional splinting, apically positioned flaps, local delivery of chemotherapeutic agents;
- 28) for adjustments and/or repairs to dentures or bridgework within the first 12 months;
- 29) for bacteriologic studies, caries susceptibility tests or pulp vitality tests;
- 30) for cephalometric x-rays;
- 31) analgesia;
- 32) for sedative fillings and temporary or provisional restorations;
- 33) for photographs;
- 34) for broken appointments;
- 35) for the completion of insurance forms;
- 36) for procedures or services not specifically addressed under the list of Covered Dental Services.

Covered Dental Services

What are my Covered Dental Services?

Only services that have been approved by the American Dental Association and conform to established ADA guidelines will be considered a covered dental expense.

Alternate Benefit Provision: Recognizing that dental conditions may be treated in many ways, benefits will be based on the procedure that will provide adequate dental care at the lowest cost to the insured. In making that determination, Kansas City Life Insurance Company will be guided by the national standards of the dental profession established by the American Dental Association.

Type I Services (Preventive/Diagnostic)

This type includes diagnostic or preventive services. The procedures included are:

Clinical Oral Examinations

Limit of two periodic oral evaluations per calendar year, only one of which may be a comprehensive oral evaluation or comprehensive periodontal evaluation.

X-rays including:

- 1) one full mouth series of at least 14 films or Panoramic film, including bitewings, if needed (limited to once in any 60 consecutive months period);
- 2) periapical x-rays, if needed to diagnose a specific dental condition (limited to a maximum of 12 in any 12 consecutive months);
- 3) other x-rays will be considered covered (or excluded) at the level of the specific dental condition being treated.

Bitewing X-rays

Limited to either a maximum of 4 bitewing films or a set (7-8 films) of vertical bitewings, in one visit, once in any 12 consecutive months.

Dental Prophylaxis

Scaling and polishing of teeth (oral prophylaxis) not to exceed 2 per calendar year. One additional prophylaxis may be available for an Insured Individual under the care of a medical professional during pregnancy.

Fluoride Treatments (for dependent children under the age of 19)

Limited to twice per calendar year.

Sealants (for dependent children under the age of 19)

Limited to unrestored, permanent molar teeth and limited to one treatment per tooth during any 36 consecutive month period.

Space Maintainers for Deciduous Teeth (for dependent children under the age of 19)

For the purpose of maintaining spaces created by the premature loss of primary teeth only. Limited to the initial appliance only (including any adjustments within the first 6 months).

Periodontal Maintenance

Periodontal maintenance procedures where periodontal treatment (such as osseous surgery, gingivectomy, gingivoplasty, or gingival curettage) has been previously performed, not to exceed a total of 4 procedures between periodontal maintenance and oral prophylaxes per calendar year. Benefits for the third and fourth periodontal maintenance procedures in one calendar year will be paid as oral prophylaxis per the Alternate Benefit Provision. Periodontal charts will be required every 24 months for ongoing periodontal maintenance.

Type II Services (Basic)

This type includes basic dental services. The procedures included are:

Palliative treatment of dental pain (including emergency office examinations).

Temporary restorations to relieve pain will be considered part of the final restoration. Hospital emergency room visits will be paid as emergency office visits under the Alternate Benefit Provision.

Consultation (Second Opinion)

Diagnostic consultation provided by a provider other than the primary practitioner providing service. Limited to examination and diagnosis, allowed once per calendar year per covered specialty.

Oral Cancer Screening

Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures - limited to one test in any 24 consecutive month period for covered persons age 40 and older.

Fillings

Includes use of non-cast filling materials such as amalgam and resin-based composite. Composite fillings on posterior teeth are included. Multiple restorations on the same tooth will be treated as one restoration with multiple surfaces. Limited to one benefit per surface per tooth within a 24 month period.

Simple Extractions

Includes non-surgical extractions (including treatment plan, local anesthetic, and post-treatment care). Extractions of orthodontic necessity will be considered part of an orthodontic treatment plan and procedures will be covered (or not covered) as indicated on the Schedule of Benefits. Benefits for extraction of impacted teeth will be coordinated with any applicable medical coverage with the medical plan considered the primary plan.

Surgical Extractions

Includes surgical extractions (including treatment plan, local anesthetic, and post-treatment care). Extractions of orthodontic necessity will be considered part of an orthodontic treatment plan and procedures will be covered (or not covered) as indicated on the Schedule of Benefits. Benefits for extraction of impacted teeth will be coordinated with any applicable medical coverage with the medical plan considered the primary plan.

Other Oral Surgical Procedures

Including treatment plan, local anesthetic, and post-treatment care. Many of these procedures may be covered under medical insurance and as such will be coordinated with any applicable coverage with the medical plan considered the primary plan.

Endodontics

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration. The procedures included are:

- 1) direct pulp capping is limited to permanent teeth and limited to one pulp cap per lifetime;
- 2) vital pulpotomy is covered only when root canal therapy is not the definitive treatment;
- 3) gross pulpal debridement;
- 4) pulpal therapy, limited to primary teeth only;
- 5) root canal treatment;
 - a) root canal therapy;
 - b) root canal retreatment, limited to once per tooth, per lifetime;
 - c) treatment of root canal obstruction with no surgical access;
 - d) incomplete endodontic therapy, inoperable or fractured tooth;
 - e) internal root repair of perforation defects;
- 6) other Endodontic services;
 - a) apexification, limited to maximum of 3 visits;
 - b) apicoectomy, limited to once per root per lifetime;
 - c) root amputation, limited to once per root per lifetime;
 - d) retrograde filling, limited to once per root per lifetime;
 - e) hemisection, including any root removal, once per tooth.

Non-Surgical Periodontics

Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved. The procedures included are:

- 1) scaling and root planing, per quadrant - limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss;
- 2) full mouth debridement - limited to once per lifetime and considered only when no diagnostic, preventive, periodontal service or periodontal surgery procedure has been performed previously.

Surgical Periodontics

Allowance includes the treatment plan, local anesthetic and post-surgical care.

The following treatment is limited to once per tooth, in any 36 consecutive months:

- 1) gingivectomy, per tooth (less than 3 teeth).

The following treatment is limited to a total of one of the following, once per quadrant, in any 48 consecutive months:

- 1) gingivectomy or gingivoplasty;
- 2) osseous surgery, including scaling and root planing, flap entry and closure;
- 3) gingival flap procedure, including scaling and root planing;
- 4) distal or proximal wedge, not in conjunction with osseous surgery;
- 5) surgical revision procedure, per tooth.

The following treatment is limited to a total of one of the following, once per quadrant in any 36 consecutive months:

- 1) pedicle or free soft tissue grafts, including donor site, or subepithelial connective tissue graft procedure, when the tooth is present.

The following treatment is limited to a total of one of the following, once per area or tooth, per 48 consecutive months:

- 1) guided tissue regeneration, resorbable barrier or nonresorbable barrier;
- 2) bone replacement grafts, when the tooth is present.

Tissue Conditioning

Limited to two treatments per arch within any 24 consecutive month period.

Anesthesia

Must be administered by licensed individual in a Provider's office. Payable in connection with a necessary cutting procedure and when underlying medical condition, age or health factors render anesthesia medically necessary. Not covered when benefits for accompanying surgical procedure are not payable or when administered due to patient anxiety. Covered under Type IV Services when in conjunction with orthodontic procedures.

Intravenous Sedation

Must be administered by licensed individual in a Provider's office. Payable in connection with a necessary cutting procedure and when underlying medical condition, age or health factors render anesthesia medically necessary. Not covered when benefits for accompanying surgical procedure are not payable or when administered due to patient anxiety. Covered under Type IV Services when in conjunction with orthodontic procedures.

Type III Services (Major)

This type includes major restorative services. The procedures included are:

Crown and Prosthodontic Restorative Services including:

- 1) crown and bridge repair;
- 2) recementations of inlay/onlay (following 12 months of initial installation);
- 3) addition of teeth to partial dentures (to replace extracted natural teeth);
- 4) denture repair;
- 5) denture rebase (limited to once in any 60 consecutive month period);
- 6) denture reline (limited to once in any 24 consecutive month period);
- 7) denture adjustment (following 6 months of initial setting).

Crowns, Inlays, Onlays, Labial Veneers, and Crown buildups

Covered only when needed because of decay or injury and only when the tooth cannot be restored with amalgam or composite filling material. Posts and cores are covered only when needed due to decay or

injury. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Covered procedures include:

- 1) single crowns;
 - a) resin with metal;
 - b) porcelain;
 - c) porcelain with metal;
 - d) full cast metal;
 - e) 3/4 cast metal crowns;
 - f) 3/4 porcelain crowns;
- 2) inlays;
- 3) onlays (including inlay);
- 4) labial veneers;
- 5) posts (covered only where there is root canal treatment and there is insufficient tooth structure to support a preparation);
- 6) buildups (covered only as part of a crown preparation procedure and only where there is insufficient tooth structure to support a preparation).

Initial Dentures and/or Bridgework

The initial denture or bridgework to replace teeth that are extracted while this coverage is in force will be considered an eligible expense. In the event that a bridge or denture replaces teeth that were extracted both before and after this coverage became effective, benefits will be pro-rated. The benefit will include the first 6 months of post-installation care.

Replacement Dentures and Bridgework

A replacement denture or bridgework will be considered an eligible expense if the existing denture or bridgework is at least 8 years old and cannot be made serviceable. The benefit will include the first 6 months of post-installation care.

Replacement Crown, Inlay or Onlay

A replacement crown, inlay or onlay will be considered an eligible expense if the existing crown, inlay or onlay is at least 8 years old and cannot be made serviceable. The benefit will include the first 6 months of post-installation care.

Coordination of Benefits

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** does not exceed 100% of the total **Allowable expense**.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

- (1) **Plan** includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses.

(2) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

(3) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

(4) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

(5) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.

B. (1) Except as provided in Paragraph (2), a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.

D. Each **Plan** determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or
- If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The **Plan** covering the **Custodial parent**;
- The **Plan** covering the spouse of the **Custodial parent**;
- The **Plan** covering the **non-custodial parent**; and then
- The **Plan** covering the spouse of the **non-custodial parent**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. Kansas City Life Insurance Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. Kansas City Life Insurance Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Kansas City Life Insurance Company any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, Kansas City Life Insurance Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. Kansas City Life Insurance Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Kansas City Life Insurance Company is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or

services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Claim Provisions

How do I file a claim?

To claim benefits you must complete a claim form. You can get a claim form from the Policyholder or from Kansas City Life.

When making a claim for dental care benefits, you must furnish proof of each charge. Attach itemized bills for services not shown on the claim form. Be sure the bills show:

- 1) name of patient;
- 2) date of treatment;
- 3) procedure code and description of service;
- 4) amount of charge; and
- 5) Provider's signature.

Send the completed claim form and bills to Kansas City Life. You may assign your dental care benefits.

When are benefits payable?

Kansas City Life will pay all benefits promptly upon receipt of due proof of loss.

When must a claim be filed to receive benefits?

You have 90 days from the date of the loss to file a claim. Kansas City Life will not deny a claim filed after 90 days from the date of the loss if the claim was filed as soon as it was reasonably possible and, except in the absence of legal capacity, is filed within one year from the date proof is otherwise required.

No action at law or inequity may be brought to recover under the Policy before 60 days after proof of loss has been filed nor will such action be brought at all unless brought within three years from the end of the time allowed for furnishing proof of loss.

What notification will you receive if your claim is denied?

If a claim for benefits is wholly or partly denied, you will be furnished with written notification of the decision. This written decision will:

- 1) give the specific reason(s) for the denial;
- 2) make specific reference to the policy provisions on which the denial is based;
- 3) provide a description of any additional information necessary to prepare a claim and an explanation of why it is necessary; and
- 4) provide an explanation of the review procedure.

What recourse do you have if your claim is denied?

On any denied claim, you or your representative may appeal to us for a full and fair review. You may:

- 1) request a review upon written application within 180 days of the claim denial;
- 2) review pertinent documents; and
- 3) submit issues and documents in writing.

We will make a decision no more than 60 days after the receipt of the request, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after the request for review is received. The written decision will include specific references to the policy provisions on which the decision is based.

Appeals Process for Kansas City Life Dental and Vision Coverage Information Packet

Please read this notice carefully. This notice contains important information about how to appeal decisions made by your insurer.

I. Levels of Review

You may ask your insurer to review its decisions involving your requests for service or your requests to have your claims paid. In general, the following four levels of review will be available to you:

- | | |
|----------------------------------|--------------------------------------|
| Level 1 Expedited Review | Level 3 Formal Appeal. |
| Level 2 Informal Reconsideration | Level 4 External, Independent Review |

These levels of review are discussed more fully below.

A. Expedited Review (Level 1)

1. Eligibility

a. Claim for a covered service not yet provided:

You may obtain Expedited Review of your denied request for a covered service that has not already been provided if:

- You have coverage with the insurer.
- Your insurer has denied your request for a covered service.
- Your treating provider certifies in writing and provides supporting documentation that the time required to process your request through the Informal Reconsideration process could cause a significant negative change in your vision/dental condition.

b. Claim for a covered service already provided but not paid for:

You may not obtain expedited review of your denied request for payment for a covered service that has already been provided. Instead, you may start the review process by seeking Formal Appeal (Level 3).

2. Decision

After reviewing the certification and the supporting documentation, the insurer has 1 business day to make a decision and mail a notice of that decision to you. The notice will include the criteria used, the clinical reasons for that decision and any references to supporting documentation. This notice will also be sent to your treating provider.

a. Denial upheld: If your insurer agrees that the covered service should have been denied, you may ask for further review through the Formal Appeal process (Level 3) discussed below.

b. Denial reversed: If your insurer agrees that the covered service should have been provided, your insurer must authorize the service.

B. Informal Reconsideration (Level 2)

1) Eligibility

If your insurer denies your request for a covered service and you do not qualify for an Expedited Review (Level 1), you may ask for Informal Reconsideration (Level 2) of that denial by calling, writing or faxing your request to the contact shown on the last page.

2) Deadlines Applicable to the Informal Reconsideration Process:

You have up to 2 years after your insurer denies your request for a covered service to request an Informal Reconsideration. Within 5 business days after receiving your request for Informal Reconsideration, your insurer will send you a notice showing that your request was received. You will also receive another copy of this information packet with that notice.

3) Decision

Your insurer has 30 days to make a decision and mail a notice of that decision to you. This notice will also be sent to your treating provider.

a) Denial upheld: If your insurer continues to agree that the covered service should have been denied, you will receive a notice of that decision. The notice will include a description of the criteria used, the clinical reasons for that decision and any references to supporting documentation. You may ask for further review through the Formal Appeal process (Level 3) discussed below.

b) Denial reversed: If your insurer agrees that the covered service should have been provided, your insurer must authorize the service.

c) External, Independent Review Option

During any Informal Reconsideration, your insurer may ask the Director of Insurance to immediately start the External, Independent Review process (Level 4). If your insurer elects this

option, the insurer will send you the written decision, a description of the criteria used, the clinical reasons for that decision and any references to supporting documentation. Your insurer will also send a copy of this information to your treating provider and the Director of Insurance.

C. Formal Appeal (Level 3)

1) Eligibility

a) Claim for a covered service not yet provided:

If your insurer denies your request for a covered service after either the Expedited Review (Level 1) or Informal Reconsideration (Level 2) you may send a written request for Formal Appeal within 60 days of the last denial to the contact shown on the last page. If you elect this option, you or treating provider must give the insurer any material justification or documentation to support your request for the service. At any time during the Formal Appeal process, the insurer may send your case directly to External, Independent Review.

b) Claim for a covered service already provided but not paid for:

If your insurer denies your claim for a covered service that has already been provided, you may send a written request for Formal Appeal within 2 years of the last denial to the contact shown on the last page. If you elect this option, you or treating provider must give the insurer any material justification or documentation to support your request for the service.

2) Deadlines Applicable to the Formal Appeal Process:

Within 5 business days after receiving your request for Formal Appeal, your insurer will send you a notice showing that your request was received. You will also receive another copy of this information packet with that notice.

a) Claim for a covered service not yet provided:

Your insurer has 30 days from the date it receives your appeal to make a decision and mail a notice of that decision to you, send you the written decision, a description of the criteria used, the clinical reasons for that decision and any references to supporting documentation. Your insurer will also send a copy of this information to your treating provider.

b) Claim for a covered service already provided but not paid for:

Your insurer has 60 days from the date it receives your appeal to make a decision and mail a notice of that decision to you, send you the written decision, a description of the criteria used, the clinical reasons for that decision and any references to supporting documentation. Your insurer will also send a copy of this information to treating provider.

3) Decision

a) Denial upheld: If your insurer continues to agree that the covered service or claim for a covered service should have been denied, you will receive a notice of that decision. You will also receive a notice of your option to proceed to External, Independent Review (Level 4).

b) Denial reversed: If your insurer agrees that the covered service should have been provided, or that your claim should have been paid, your insurer must authorize the service or pay the claim.

D. External, Independent Review (Level 4)

1) Eligibility

You may obtain External, Independent Review only after you have sought any available Expedited Medical Review (Level 1), Informal Reconsideration (Level 2), and Formal Appeal (Level 3), which are discussed above. You must send your request for External, Independent Review in writing, to the contact shown on the last page.

2) Deadlines Applicable to the External, Independent Review Process:

You have 30 days after you receive written notice from your insurer that your Formal Appeal has been denied to request External, Independent Review.

a) Necessity Issues

If the request for External, Independent Review involves an issue of necessity:

i) Your insurer must, within 5 business days of the request, mail a written notice to the Director of Insurance, you and your treating provider of the request for External, Independent Review.

ii) Your insurer must, within 5 business days of the request, choose one or more independent reviewers and forward notice of that choice to the Director of Insurance.

iii) Your insurer must, within 30 days of the request, send the external independent reviewer(s) all relevant dental/vision records and a description of the criteria used, the clinical reasons for that decision and any references to supporting documentation used by the insurer to make the decision, a summary description of the applicable issues including a statement of the utilization review agent's decision, and the relevant portions of the utilization review agent's utilization review plan.

- iv) Your insurer must, within 30 days of the request, send the Director of Insurance a summary description of the applicable issues including a statement of the utilization review agent's decision and any transmittal letter that is sent to the independent reviewer(s).
- v) Within 3 business days after receiving the independent reviewer's decision, the utilization review agent must mail to the Director of Insurance, you and your physician or treating provider a notice of the decision of the external, independent reviewer(s).

b) Coverage Issues

If your appeal involves an issue or question of whether your policy covers your request for a service or for the payment of a claim:

- i) Your insurer must, within 5 business days of the request, mail a written notice to the Director of Insurance, you and your treating provider of the request for External, Independent Review.
- ii) Your insurer must, within 5 business days of the request, send the Director of Insurance your policy, evidence of coverage or similar document and all relevant dental/ vision records and a description of the criteria used, the clinical reasons for that decision, the relevant portions of the utilization review agent's utilization review plan and any references to supporting documentation used by the insurer to make the decision.
- iii) The Director of Insurance must, within 5 business days of receiving information about your request from your insurer, determine if the service or claim is covered. If the Director is unable to determine issues of coverage, the Director of Insurance will direct that your case be submitted to External, Independent Review. If the Director of Insurance determines that no coverage exists, the request will not be sent to External, Independent Review.
- iv) If the Director of Insurance refers the request to External, Independent Review, within 30 days after this referral, your insurer must send the external independent reviewer(s) all relevant dental/vision records and a description of the criteria used, the clinical reasons for that decision and any references to supporting documentation used by the insurer to make the decision, a summary description of the applicable issues including a statement of the utilization review agent's decision, and the relevant portions of the utilization review agent's utilization review plan.
- v) Within 3 business days after receiving the independent reviewer's decision, the utilization review agent must mail to the Director of Insurance, you and you treating provider a notice of the decision of the external, independent reviewer(s).

3) Decision

Your insurer must provide any covered service or pay any covered claim determined to be necessary by the external independent reviewer(s) regardless of whether your insurer elects to seek judicial review of the decision of the external independent reviewer(s).

4) Judicial Review/Right to a Hearing

If you disagree with the final decision of the external independent reviewer(s), you may seek judicial review. If your insurer disagrees with the final decision of the external independent reviewer(s), it may seek judicial review. However, your insurer must provide any covered service or pay any covered claim determined to be necessary by the external independent reviewer(s) regardless of whether it elects to seek judicial review.

If you disagree with the final decision of the Director of Insurance for coverage issue determinations, you may request a hearing with the Office of Administrative Hearings. If your insurer disagrees with the Director's determination of coverage issues, it may request a hearing with the Office of Administrative Hearings. Hearings must be requested within 30 days of receiving the coverage issue determination.

II Obtaining Records

A. Requesting Dental/Vision Records

Arizona law permits you to ask for a copy of your dental/vision records. A.R.S. §12-2293. Your request must be in writing. Your request must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

B. Designated Decision Maker

If you have a designated health care decision maker, that person must send a written request for access to or copies of your dental/vision records. The records must be provided to your health care decision maker or a person designated in writing by your health care decision maker unless you limit access to your records only to yourself or your health care decision maker.

C. Confidentiality

Records disclosed under A.R. S. § 12-2293 remain confidential.

III Contact at Each Level of Review and Title of Person Responsible for Processing the Review

Group Claims Manager
Group Administration
3520 Broadway

PO Box 219425
Kansas City, MO 64121-9425
1-800-874-5254

IV Documentation for an Appeal

If you decide to file an appeal, you must give the person who will be responsible for processing the appeal any material justification or documentation for the appeal at the time the appeal is filed. You must also give that person the address and phone number where you can be contacted.

V The Role of the Director of Insurance

The law requires "any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed" by law. A.R.S. §20-2533(E).

The appeal process requires the Director to:

- 1) Oversee the appeals process.
- 2) Publish a list of independent reviewers.
- 3) Maintain copies of each utilization review plan submitted by insurers.
- 4) Receive, process, and act on request from an insurer for External, Independent Review of a claim.
- 5) Enforce the decisions of insurers.
- 6) Review decisions of insurers.
- 7) Report to the Legislature.
- 8) Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the Office of Administrative Hearings.
- 9) Issue a final administrative decision on coverage issues, including the notice of one's right to request a hearing.

VII Confidentiality

If you participate in the review process, the relevant portions of your dental/vision records may be disclosed only to people authorized to participate in the review process for the condition under review. These people may not disclose your dental/vision information to any other people.

VIII Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. As discussed above in Section V, "properly addressed" means your last known address.

IX Complaints to the Arizona Department of Insurance

The Director of Insurance shall require any member who files a complaint with the Arizona Department of Insurance relating to an adverse decision to pursue the review process established by the Legislature and your insurer.

COBRA CONTINUATION OF COVERAGE

(applies only to groups of 20 or more, as defined below)

What is COBRA Continuation?

It is a federal continuation of coverage requirement. Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to any employer (except the federal government and religious organizations) who:

- maintains a group health plan; and
- normally employs 20 or more employees on a typical business day during the preceding calendar year.

For this purpose, "employee" means all owners, partners, and common-law employees (full-time and part-time).

Federal law requires that certain group plans allow qualified persons who would otherwise lose coverage under the plan as a result of a qualifying event, to elect to continue group health coverage after it would otherwise end.

See your Employer for details on this continuation provision. All compliance obligations under COBRA are the responsibility of the Employer and Employee.

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.

As used in this notice, "WE" and "OUR" refer to the functions of Kansas City Life Insurance Company and its insurance subsidiaries, Old American Insurance Company and Sunset Life Insurance Company of America, which are covered by federal laws and regulations governing use and disclosure of personally identifiable health information ("protected health information" or "PHI"). The functions which are covered by these rules include: administration of Kansas City Life's group dental and group vision policies. "YOU" means a named insured of a group health insurance policy or an enrollee in the health or dental benefit plan.

Our Duties.

We are required by the Health Insurance Portability and Accountability Act of 1996 to maintain the privacy of your PHI and to provide you with this Notice of our privacy practices and legal duties. We must abide by the terms of this Notice. We reserve the right to change the terms of this notice and to make the new terms effective as to all of the PHI that we maintain about you. In that case we will provide you with a new Notice by mailing it to the address you have last provided us, or with your consent by sending it to you electronically.

Your Rights.

You have a right to access, inspect and copy the PHI we maintain about you. We may impose a reasonable fee where permitted by law.

You have the right to request that we amend your PHI. We may deny your request if we did not create the PHI you want us to amend, or for other reasons. If we do not agree to amend your PHI as you request, you may submit a short statement of dispute and we will include it with your records.

You have the right to an accounting of disclosures we have made of your PHI to others after April 14, 2003, except for disclosures related to your treatment, payment or other health care operations. We may impose a reasonable fee if you make such a request more than once in any 12-month period.

You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to additional restrictions.

You have the right to request that we communicate with you in confidence about your PHI by providing us with an alternate means or location. You must inform us that this is required to avoid endangering you.

If we provide you this Notice by electronic means, you have the right to request a paper copy.

You may exercise any of the rights stated in this section of the Notice by making your request in writing and sending it to us, postage prepaid, at the address shown at the end of this Notice.

Where We Get Your PHI.

We get most health history and treatment information from you or somebody you have authorized to provide it to us. For instance, we get medical information about you in order to pay a health insurance benefit or to pay providers of medical treatment.

Permitted Disclosures of Your PHI.

We are allowed to use and disclose your PHI without your authorization as necessary to conduct or service our business or when disclosure is legally required. For instance, we may use and disclose your PHI as needed to pay claims, set premiums, reinsure policies and underwrite for health care coverage. If you are an enrollee of an employee dental or medical benefit plan, we may disclose limited PHI to your plan's sponsor to permit the sponsor to perform plan administration functions. We may also disclose your PHI when we are required to do so by law (for instance, by subpoena, administrative order or discovery request), or as requested by the U.S. Department of Health and Human Services. If you want us to disclose your PHI to any other person or entity, you must give a written authorization. You may revoke your authorization at any time in writing.

We will not otherwise disclose your PHI to an affiliate or any third party who helps administer our business unless they agree in writing to maintain its confidentiality, use it only as intended and if feasible destroy it when no longer needed.

We do not sell your PHI or disclose it to anyone for purposes unrelated to our services.

We will comply with applicable health information privacy law of any state which is more stringent than and not pre-empted by federal law.

Complaints.

If you want further information or have any questions about our privacy practices, please contact us using the information provided in this section. You also may submit a written complaint to the Secretary of the Department of Health and Human Services. We will not retaliate against you in any way if you file a complaint.

Contact: Privacy Official, Legal Department, Kansas City Life Insurance Company, PO Box 219139, Kansas City, MO 64121-9139. Or, telephone us at 800-874-5254 ext. 6046.

Questions or Additional Information

Should you have any questions or want additional information about your coverage, this notice, or our privacy practices; please contact KCL Group Administration, PO Box 219425, Kansas City, MO 64121-9425, phone 1-800-874-5254 ext. 6046.