BlueCross BlueShield of Kansas

An Independent Licensee of the
Blue Cross Blue Shield Association.

KANSAS STATE EMPLOYEES HEALTH CARE COMMISSION (KANSAS SENIOR PLAN C SELECT) GROUP CERTIFICATE

This Certificate describes the benefits provided in a Group Contract by Blue Cross and Blue Shield of Kansas, Inc. (herein called "Blue Cross and Blue Shield of Kansas" or "the Company") Topeka, Kansas, and the exclusions and limitations. This Certificate may be cancelled or Rescinded as described in this Certificate.

NOTICE OF 30-DAY RIGHT TO EXAMINE CONTRACT

Within 30 days after delivery to You, this Contract may be returned if You are not satisfied with it for any reason. Upon return, any premiums paid will be returned to You in a timely manner.

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How to Report Kansas Senior Plan C Select Claims

You should carry Your Identification Card with You at all times. When You receive a service, show Your Identification Card.

Your Medicare coverage always pays **first**. To collect Your Medicare benefits, follow the instructions in Your "Medicare and You" handbook.

The Kansas Senior Plan C Select Certificate pays **second**. In conjunction with the filing of proof of loss as required in the General section of this Certificate, You should send in the “Explanation of Medicare Benefits” form Medicare sent You for the service You received. Be sure to show Your Kansas Senior Plan C Select identification number on it.

The benefits of this Certificate assume that all Kansas Senior Plan C Select Insureds are eligible for and enrolled in both Medicare Part A and Medicare Part B. Regardless of whether You have Medicare coverage, Your benefits will still be determined on that basis. All coverage under this Certificate is subject to the conditions described in this Certificate, including exclusions.

SECTION 1. DEFINITIONS

This section gives You the meanings of words You will find in this Certificate.

A. Accidental Injury: an unintended injury to Your body caused through external means. Accidental Injury does **not** include disease or infection (except for infection that occurred from an accidental cut or wound).

Accidental Injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employers' liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

B. Benefit Period has the same meaning as in Medicare Part A, which is:

Your first Medicare Benefit Period starts the first time You enter a Hospital, or Skilled Nursing Facility, after Your Medicare Part A insurance begins. That Benefit Period ends when, for 60 days in a row, You have been out of a Hospital or Skilled Nursing Facility. A new Benefit Period would start the next time You go into a Hospital or Skilled Nursing Facility.

C. Certificate: a summary of the provisions of the Group Contract that affect Insureds. A Certificate is issued by the Company to the Contract Holder for delivery to each enrolling employee.

D. Charges: the reasonable charges for Hospital, Doctor, or other medical or health services under this Certificate. Medicare determines what a reasonable charge is.

E. Company: Blue Cross and Blue Shield of Kansas.

F. Company Service Area: the state of Kansas, except Johnson and Wyandotte Counties.

G. Contract or Group Contract: the Contract between the Company and the Contract Holder and includes: all of the forms issued to the Contract Holder by the Company, including endorsements, amendments, and riders.

H. Doctor: a licensed Doctor of Medicine, Doctor of Osteopathy, and Doctor of Dental Surgery.

1. Doctor also means the following practitioners who are licensed or certified to practice: Podiatrist; Optometrist; Chiropractor; Certified psychologist.
2. To qualify under this Certificate, the Doctor must also be classified as eligible under Medicare.

I. Home Health Agency: an agency that provides skilled nursing services and other therapeutic services in the patient's home and is certified to participate in the Medicare program.

J. Hospice: a Medicare-approved facility for people with a terminal illness.

K. Hospital: a facility that:

1. Is primarily engaged in providing, by or under the supervision of doctors of medicine or osteopathy, inpatient services for the diagnosis, treatment, and care or rehabilitation of persons who are sick, injured, or disabled;
2. Is not primarily engaged in providing skilled nursing care and related services for inpatients who require medical or nursing care;
3. Provides 24-hour nursing service in accordance with Medicare;
4. If it is a U.S. hospital, is licensed, or approved as meeting the standards for licensing, by the State or local licensing agency; and
5. If it is a foreign hospital, is licensed, or approved as meeting the standards for licensing, by the appropriate Canadian or Mexican licensing agency, and for purposes of furnishing non-emergency services to U.S. residents, is accredited by the Joint Commission on Accreditation of Hospitals (JCAH), or by a Canadian or Mexican program under standards that the Health Care Financing Administration finds to be equivalent to those of the JCAH.

L. Identification Card: a card issued to identify You as an Insured of the Company.

M. Insured: the person named on the Identification Card.

N. Medical Emergency: a sudden and, at the time, unexpected onset of a health condition that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect to require immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

O. Medically Necessary describes a service or supply that is:

1. performed, referred, and/or prescribed by a duly licensed provider; and
2. provided in the most appropriate setting and consistent with the diagnosis and treatment of the Insured's condition; and
3. in accordance with the current generally accepted standards of medical practice in the United States based on credible scientific evidence; and
4. not primarily for the convenience of the patient, physician or other health care provider; and
5. not more costly than an alternative service or supply or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the Insured's illness, injury or disease.

This definition may or may not be the same as that used by Medicare and only applies to emergency care in a foreign country and when you have exhausted Your Medicare Part A inpatient care coverage.

P. Medicare: the Health Insurance for the Aged Act (Title XVIII of the Social Security Act Amendments of 1965, as amended now and in the future). The term Medicare includes any rules and regulations authorized by that Act and any law designed specifically to replace that Act.

Q. Medicare Part A: the part of Medicare insurance that covers inpatient hospital stays, which consists of semi-private room and board, general nursing and miscellaneous services and supplies, care in a Skilled Nursing Facility, Hospice care, and some home health care. It is sometimes referred to as Medicare hospital insurance.

R. Medicare Part B: the part of Medicare insurance that covers inpatient or outpatient physician's services, outpatient hospital care, medical supplies and preventive services.

S. Network Hospital: a Hospital, or group of Hospitals, which have entered into a written agreement with the Company to provide benefits under a Kansas Senior Select Certificate.

T. Non-Network Hospital: a Hospital that does not have an agreement with the Company or has not been designated by the Company to provide hospital services for this Kansas Senior Select Certificate.

U. Rescission or Rescind: cancellation or discontinuance of coverage under this Certificate that has a retroactive effect.

V. Restricted Network Provision: any provision which conditions the payment of benefits, in whole or in part, on the use of Network Hospitals.

W. Service Area: the geographic area approved by the Kansas Insurance Department within which the Company is authorized to offer Medicare Select coverage. A map of the Service Area is attached hereto.

X. Sickness: illness or disease, regardless of the date of inception, which manifests itself after the date this coverage became effective.

Y. Skilled Nursing Facility: a licensed facility that is certified to participate in the Medicare program as an eligible provider of post-hospital extended care services.

Z. United States: all of the States; the District of Columbia; Puerto Rico; the Virgin Islands; Guam; American Samoa; the Northern Mariana Islands; and for purposes of services rendered on board ship, the territorial waters adjoining the land areas of the United States.

AA. You and **Your** refer to the definition of Insured.

SECTION 2. BENEFITS

This Section explains the benefits the Company will pay after Medicare. This Certificate is not designed to pay for all expenses not covered by Medicare. You have the right to select Your own Hospital or Doctor. However, the Company does not guarantee the availability of any service. This is a Kansas Senior Select Certificate and coverage contains a Restricted Network Provision.

A. Medicare Part A

1. **Medicare Part A Deductible**
   a. This policy covers Your Medicare Part A Deductible.
   b. Medicare Part A provides coverage for the first through 60th days of hospital inpatient care in each Benefit Period, except for the Medicare Part A Deductible. Medicare Part A Deductible means the portion of Medicare Part A covered services for which You are responsible before Medicare makes any payment. Medicare sets the amount of the Deductible, and it may change from year to year.
2. **Medicare Part A Coinsurance**
   a. **Inpatient Care**
      (1) This policy covers Your Medicare Part A Coinsurance amount applied to the 61st through 90th days of inpatient care each Benefit Period.
         (a) Medicare Part A Coinsurance amount for these days is a daily amount equal to one-fourth (1/4) of the Medicare Part A Deductible.
      (2) This policy covers Your Medicare Part A Coinsurance amount applied to the 91st day and beyond for 60 lifetime reserve days of hospital inpatient care.
         (a) The Medicare Part A Coinsurance amount for these days is a daily amount equal to one-half (1/2) of the Medicare Part A Deductible.
      (3) Once the lifetime reserve days are exhausted, this policy covers 100% of Medically Necessary Medicare eligible expenses for an additional lifetime maximum of 365 days of inpatient care.
      (4) There is no coverage beginning the 366th day of Inpatient care.
   b. **Skilled Nursing Facility Care**
      (1) This policy covers Your Medicare Part A Coinsurance amount applied to the 21st through 100th days of Skilled Nursing Facility care.
         (a) The Medicare Part A Coinsurance amount for these days is a daily amount equal to one-eighth (1/8) of the Medicare Part A Deductible.
         (b) There is no coverage beginning the 101st day of Skilled Nursing Facility care.
         (c) You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare approved facility within 30 days after leaving the hospital.
   c. **Hospice Care**
      (1) This policy covers Your Medicare Part A Copayments for eligible prescription drugs when provided during Hospice care
      (2) This policy covers 5% applied by Your Medicare Part A for respite care expenses.
      (3) The Medicare Part A covers Your eligible Hospice care expenses, the prescription drug expenses minus Your Copayment, and a percentage of Your respite care.
      (4) Your Doctor must certify You are terminally ill and You elect to receive these services.

d. **Blood**

(1) This policy covers the first three pints of blood per calendar year provided inpatient. This is a combined amount with outpatient care.

(2) Medicare provides coverage starting with the fourth pint per calendar year.

B. Medicare Part B

1. **Medicare Part B Deductible**

a. This policy covers Your Medicare Part B Deductible each calendar year, regardless of hospital confinement.

b. Medicare Part B Deductible means the portion of Medicare Part B covered services for which You are responsible before Medicare makes any payment.

2. **Medicare Part B Coinsurance**

a. After the Deductible has been met, this policy covers the Medicare Part B Coinsurance amount of 20% of the allowable charge for Medicare eligible expenses, regardless of hospital confinement.

(1) After the Medicare Part B Deductible, Medicare covers the Medicare Part B Coinsurance amount of 80% of allowable charge.

3. **Blood**

a. This policy covers the first three pints of blood per calendar year provided outpatient. This is a combined amount with inpatient care.

b. Starting with the fourth pint of blood provided in an outpatient setting per calendar year, blood will be subject to the Medicare Part B Deductible and/or Coinsurance amounts.

(1) This policy covers the Medicare Part B Deductible.

(2) This policy covers the 20% Coinsurance amount applied by Medicare Part B.

4. **Covered Services:** Medicare Part B eligible services are subject to the Deductible and/or Coinsurance amounts above and include:

a. medical supplies

b. outpatient hospital care

c. physical therapy

d. physician's services, inpatient or outpatient

e. preventive services

f. speech therapy

g. surgical services or supplies

C. Medically Necessary Emergency Care in a Foreign Country

1. This policy covers 80% Coinsurance of the billed charges for Medicare-eligible expenses after the $250 Deductible is met per calendar year, up to a lifetime maximum benefit of $50,000.

2. You are responsible for the $250 annual Deductible, the 20% Coinsurance up to $50,000 and any amount over $50,000 lifetime maximum.

3. For purposes of this benefit, emergency care shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset. Medically Necessary emergency care services must be received during the first 60 consecutive days of each trip outside the United States to be covered. Medicare-eligible services are those

services which would have been covered by Medicare had they been received in the United States.

SECTION 3. RESTRICTED NETWORK PROVISION

A. Services Provided by a Network Hospital: You must use Network Hospitals who participate in the Network program to receive the full Medicare Select benefits. In order to receive full benefits when Your Doctor does not have admitting privileges to a Network Hospital, You must have Your Doctor refer You to another Doctor or You may secure another Doctor who has admitting privileges to a Network Hospital.

B. Services Provided by a Non-Network Hospital: You are responsible for the Part A Deductible and the Part A Coinsurance if inpatient services are received at a Non-Network Hospital, except in the following situations:

1. When inpatient services are for a Medical Emergency or are immediately required for an unforeseen illness, injury or a condition, and it is not reasonable to obtain services through a Network Hospital.
2. If the Network Hospital(s) in the Service Area through which You were originally enrolled (see attached map) is not capable of providing the service You require and You obtain the service from a Non-Network Hospital.

C. Moving Outside of the Service Area: If You move outside of the Service Area, You may continue to use a Network Hospital as before, if it is convenient for You to do so. However, if You do not use a Network Hospital, You will be responsible for the Part A Deductible and Part A Coinsurance. If Your move is permanent and it is not convenient for You to use a Network Hospital in that area, You have the right to convert to a non-restricted Contract offered by the Company, see Section 5 for more information.

SECTION 4. COMPLAINT AND GRIEVANCE PROCEDURES

A. Purpose: The Company recognizes that from time to time You may encounter situations where the performance of the Company does not meet Your expectations. When this occurs, You may wish to call the matter to the attention of the Company representatives. It is the policy of the Company to promptly and fairly consider all Complaints and Grievances of its Insureds. The procedure outlined in this Section is established to define and assure this policy.

B. Definitions: For the purpose of this Complaint and Grievance Section, the following terms and their definitions apply:

1. **Claim for Benefits or Claim:** a request for treatment benefit or payment benefits made by You in accordance with Blue Cross and Blue Shield's procedure for filing claims. A Claim must have sufficient information upon which to base a decision regarding benefits according to all of the provisions of the Contract.
2. **Complaint:** a written expression of dissatisfaction concerning a Claim for Benefits.
3. **Grievance:** a written expression of dissatisfaction about something other than a Claim for Benefits.

C. Procedure for Filing a Complaint or Grievance

1. A Grievance may be directed to the Company by You in writing, expressing the details of the concern. Grievances will be handled by the Company's Customer Service Center who may involve other staff members of the Company or providers of care in resolving the issue. The objective is to handle the Grievance as quickly and as courteously as possible.
2. A Complaint is to be submitted by You in writing to the Company at 1133 SW Topeka Boulevard, Topeka, Kansas, 66629.

   Upon receipt of the Complaint, the Company Customer Service representative will conduct a thorough review of the situation within 30 days unless the review cannot be completed within such time period. Following completion of the review, a response to Your Complaint will be prepared and You will be notified of the Company's decision in writing.
3. If You are not satisfied with the decision of the Company, he/she may pursue normal remedies of law. Prior to the institution of any legal proceeding or action against the Company, the foregoing Complaint and Grievance Procedures shall be utilized by any party alleging a claim against the Company. In all events, such action or proceeding must be commenced not later than five (5) years after the date the notice of final determination under the Complaint and Grievance Procedures is provided to such party.

SECTION 5. CONVERSION

A. An Insured may be eligible to convert to another Medicare supplement contract offered by the Company that does not contain a Restricted Network Provision if the Insured wishes not to be covered by this Kansas Senior Plan C Select Certificate any longer. The Insured does not have to provide evidence of insurability in those conversion situations set forth below after the Certificate has been in force for six months.

For the purpose of this section, a Medicare supplement contract is considered to have comparable or lesser benefits unless it has one or more significant benefits not included in the contract being replaced. A significant benefit means coverage for Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

B. An Insured may be eligible to convert to Medicare supplement or Medicare select plans A, B, K or L from any insurance company that offers Medicare supplement insurance if the Kansas Senior Plan C Select Certificate is cancelled by the Contract Holder and not replaced with another group Medicare supplement policy purchased by the same Contract Holder. If the Insured was entitled to Medicare prior to 12/31/19, the Insured may enroll in Medicare supplement or Medicare select plans C or F, where available, in addition to plans A, B, K or L.

Coverage must be applied for within 63 days of termination of or disenrollment from other coverage related to specified events. The Insured may be required to present evidence of the date of termination of or disenrollment from coverage.

C. Notwithstanding any other provisions of this Section 5, if this coverage terminates because:

1. The Company discontinues the availability of this Plan 65 Select coverage in the Service Area in which the Insured resides,
2. The Insured loses eligibility for this Plan 65 Select coverage due to a change of residence,
3. The Company violates a material provision of this Plan 65 Select coverage, or
4. The Company materially misrepresented provisions of this Plan 65 Select coverage in the marketing process, then

   Medicare Supplement Plans A, B, K or L from any insurance company that offers Medicare Supplement insurance which does not contain a Restricted Network Provision. If the Insured is entitled to Medicare prior to 12/31/19, the Insured may enroll in Medicare Supplement Plans C or F, where available, in addition to Medicare Supplement Plans A, B, K or L. Coverage must be applied for within 63 days of termination of or disenrollment from other coverage related to specified events. The Insured may be required to present evidence of the date of termination of or disenrollment from coverage.

E. In the event the Secretary of Health and Human Services determines that Kansas Senior Select Certificates should be discontinued due to either the failure of the Kansas Senior Select program to be re-authorized or its substantial amendment, the Insured's Kansas Senior Select Certificate shall be converted, at their request, to a contract offered by the Company which has comparable or lesser benefits and which does not contain a Restricted Network Provision. The Insured will not have to provide evidence of insurability for this conversion.

SECTION 6. EXCLUSIONS

Please read the following list carefully. This is a list of services, which will not be covered.

A. You will not receive benefits for services to the extent that Medicare will pay for You. If You are not enrolled in Medicare Part A and/or Medicare Part B, the benefits of this Certificate are still available to You, but only in the same amount as if You were enrolled in Medicare Part A and/or Medicare Part B.

B. No payment will be made for services which are not listed as benefits in this Certificate.

C. No payment will be made for services and supplies which Medicare excludes, unless specifically covered as a benefit of this Certificate.

D. Difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.

SECTION 7. ELIGIBILITY, ENROLLMENT, EFFECTIVE DATES OF COVERAGE

A. ELIGIBILITY

To be eligible to enroll as an Insured, an individual must meet and continue to meet all eligibility requirements for participation in the health benefit program as determined by the Contract Holder.

B. ENROLLMENT

1. Notification must be made according to the enrollment requirements established by the Contract Holder.
2. It is required that each Insured be recorded on the records for benefits.

C. EFFECTIVE DATE OF COVERAGE

Coverage of an Insured shall become effective at 12:01 a.m. on the first day of compliance with the eligibility requirements and subject to applicable payment. If an Insured is confined in a Hospital on the effective date of coverage, the Company will cover the Hospital confinement beginning on the effective date of this coverage. The Insured must notify the Company of the Hospital confinement within forty-eight (48) hours of the effective date or as soon thereafter as reasonably possible.

SECTION 8. CANCELLATION AND RESCISSION

A. Cancellation of the Group Contract: The Group Contract can be cancelled effective the date to which premiums have been paid, for several reasons.

Cancellation by the Company:

1. Nonpayment of premiums by the Contract Holder. The Contract Holder has a grace period of 10 days following the due date for payment of premiums. Unless premiums are received by the end of the stated grace period, coverage under this Certificate cancels as of the payment-due date.
2. Fraud or intentional misrepresentation of a material fact by the Contract Holder, or employer

Cancellation for the foregoing reasons will be effective on the date specified by the Company in a written notice of cancellation.

Cancellation by the Contract Holder:

The Contract Holder may cancel the Group Contract by giving the Company 30 days advance written notice.

B. Cancellation of an Individual Insured's Coverage under the Group Contract: The coverage of an individual Insured will cancel in the following situations:

1. When the Company is notified that an Insured's coverage is to be removed from the group, the Insured's coverage under this Certificate will end as of the date to which the Insured's premiums are paid. The Insured is not entitled to a grace period.
2. If an Insured permits the use of their or any other Insured's Blue Cross and Blue Shield of Kansas Identification Card by any other person, or uses another Insured's card, all rights of the Insured(s) may be cancelled effective immediately upon written notice.
3. If an Insured fails to disclose information requested by the Company or intentionally misrepresents information provided to the Company, then the rights of such Insured under this Certificate may be Rescinded with a 30 days minimum written notice. Premiums received on behalf of such cancelled Insured shall be refunded less nonrecoverable claims paid and the Company shall have no further liability or responsibility under this Certificate.
4. When an Insured is determined to be ineligible for coverage provided by this Contract Holder. All rights of the Insured may be cancelled effective immediately upon written notice and coverage may be retroactively cancelled effective the first day of the month following the date on which the Insured became ineligible for coverage. At the effective date of such cancellation, premiums received on behalf of such cancelled Insured applicable to periods after the effective date of cancellation shall be refunded and the Company shall have no further liability or responsibility under this Certificate.

C. Rescission by the Company

The Company may Rescind this contract for the following reasons only:

1. The Insured performs an act, practice, or omission that constitutes fraud as determined by a court of law.
2. The insured makes an intentional misrepresentation of material fact.

Rescission for the foregoing reasons will treat the contract as void from the time of the Insured's enrollment. The Company will void all benefits paid up to a year before the date the written notice of Rescission was sent. The Company will also refund all premiums paid up to a year before the date the written notice of Rescission was sent.

D. Reinstatement: If an Insured's coverage is cancelled for non-payment of premiums by the Contract Holder (see A.1 above), the Company has the right to decide whether or not to reinstate the Group Contract. If coverage is reinstated, there will be no gap in coverage.

E. Grace Period: When a grace period for payment of premiums is applicable, benefits are provided during the grace period only if premiums are received by the end of the stated grace period.

SECTION 9. GENERAL INFORMATION

A. The Company has the Right to Determine if Services are Medically Necessary: If Medicare determines that a service or admission was not Medically Necessary, the Company will also consider the service or admission to not be Medically Necessary. The Company has the right to determine medical necessity for emergency care in a foreign country and the additional 365 days of inpatient care once the Medicare's lifetime reserve days are exhausted.

B. The Company's Responsibility is Limited: Institutional Provider services are subject to the rules and regulations of the provider including rules about admissions, discharge and availability of services. The Company does not guarantee that admission or any specific type of room or kind of service will be available.

The Company is obligated to provide benefits for the services of Your Eligible Provider only to the extent provided in this Certificate. The Company does not guarantee the availability of a provider.

The Company shall not be liable for any acts or admissions of any provider of service. This includes negligence, misconduct, malpractice, refusal to provide a service or breach of contract.

C. Your Identification Card: When You receive services, show Your current Identification Card when obtaining services from an Eligible Provider at the provider's office.

D. Your Authorization: By accepting coverage under this Certificate, You:

1. Permit the Company to request any information related to a claim for services that You received; and
2. Authorize that any information may be given to the Company regarding medical services You have received.

If the Company asks for information and does not receive it, payment for benefits cannot be made. The claim will be processed for payment only when the requested information has been received and reviewed. This applies to all types of claims, including claims related to Medicare.

E. Notice of Claim: You are responsible for submitting written notice of claim within 20 days after a covered loss begins or as soon as reasonably possible. If Your provider submits written notice on Your behalf within the time period specified above, such notice will satisfy the requirements of this provision. The notice can be given to the Company at 1133 SW Topeka Boulevard, Topeka, Kansas 66629. Notice should include Your name and identification number as stated on Your Identification Card.

F. Claim Forms: The Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice the claimant shall be deemed to have complied with the claim filing requirements of this Certificate.

G. Proof of Loss (Prompt Filing of Claims): Written proof of loss must be furnished to the Company at 1133 SW Topeka Boulevard, Topeka, Kansas 66629, in case of claim for loss for which this Certificate provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the Company is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

H. Time of Payment of Claims: Benefits payable under this Certificate will be paid immediately upon receipt of proper written proof of loss.

I. Payment of Claims: In most cases benefits will be paid to the provider who Medicare pays. In situations where the Company is unable to identify the provider, or when Medicare does not provide a benefit provided by Your Certificate, benefits will be paid to You. Any benefits unpaid at Your death may be paid to Your estate.

If benefits are payable to Your estate, the Company may pay up to $1,000 to anyone related to You by blood or marriage, whom the Company considers to be entitled to the benefits. The Company will be discharged to the extent of any such payment made in good faith.

J. Physical Examination: The Company, at its expense, has the right to have You examined as often as reasonably necessary while a claim is pending.

K. Legal Actions: No legal action may be brought to recover on this Certificate within 60 days after written proof of loss has been given as required by this Certificate. No such action may be brought after 5 years from the time written proof of loss is required to be given.

L. Certificate of Creditable Coverage: You have the right to request and obtain a Certificate of Creditable Coverage from the Company while You are an Insured and up to 24 months following the date on which Your coverage cancelled. To request a Certificate of Creditable Coverage, You may contact the customer service center phone number on Your Identification Card.

M. Errors Related to Your Coverage:

If the Company's records of Your coverage are in error due to a Company error or delay, the record will be corrected after discovery of the error. If Your premiums are affected, the Company may need to make a retroactive change in Your premiums. The Company will make appropriate changes in Your coverage and/or premiums to ensure You have the coverage You are entitled to under this Certificate.

The Company has the right to correct benefit payments which are made in error. Providers and/or You have the responsibility to return any overpayments to the Company. The Company has the responsibility to make additional payments if an underpayment is made.

N. Notice

1. **From the Company to the Contract Holder:** A notice sent to the Contract Holder by the Company is considered given when mailed to the address as it appears on the records of the Company.
2. **From the Company to You:** A notice sent to You by the Company is considered given when mailed to the address as it appears on the records of the Company.
3. **From the Contract Holder or an Insured to the Company:** Notice to the Company is considered given when received by the Company at 1133 SW Topeka Boulevard, Topeka, Kansas 66629. Any such notice should include the Insured's name and the identification number.

O. Changes in this Contract: Benefits and premiums may be changed after approval by the Board of Directors of the Company and filing with the Kansas Insurance Commissioner.

No agent or representative of the Company other than its Board of Directors is authorized to change this Contract or waive any of its provisions.

P. Notification of Change: The Contract Holder and Insured(s) will be given notice of any approved benefit change by a new Group Contract, rider, amendment, or other means as permitted by law. If substantive changes to the Certificate issued thereunder are made, new Certificates or riders or amendments will also be issued.

Q. Acceptance of Change: If premium payment is made to the Company after the effective date of any change to this Group Certificate, such payment shall be deemed consent to that change.

R. Information to be Provided by the Parties to this Contract: Each month while this Contract is in force, the Contract Holder shall provide the Company such information as may

be reasonably required to enroll Insureds, process terminations of individual coverage, and determine the premiums of this Contract.

The Company will provide the Contract Holder with information concerning enrollment of Insureds and other matters as may reasonably be required

S. Membership, Voting, Annual Meeting and Participation: The policyholder (the person or entity to which the insurance Contract has been issued) is a member of the Company and is entitled to vote in person or by proxy at meetings of policyholders. The annual meeting of policyholders is held on the second Thursday in May of each year at 8:30 a.m. at the corporation's principal place of business at 1133 SW Topeka Boulevard, Topeka, Kansas 66629, or at such other place as the Chairman of the Board of Directors might designate in a notice of meeting given to policyholders. Printed notice in this Contract shall be sufficient as to notification. If any dividends are distributed, the policyholder will share in them according to law and under conditions set by the Board of Directors.

T. The Contract Holder on behalf of itself and its participants hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Contract Holder and the Company, which is an independent corporation operating under an agreement with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting the Company to use the Blue Cross and/or Blue Shield Service Marks in the State of Kansas and that the Company is not contracting as the agent of the Association. The Contract Holder on behalf of itself and its participants further acknowledges that it has not entered into this Contract based upon representations by any person other than the Company and that no person, entity, or organization other than the Company shall be held accountable or liable to the Contract Holder for any of the Company's obligations to the Contract Holder created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of the Company other than those obligations created under other provisions of this agreement.

U. The Contract Holder agrees to be responsible for any access fees or amounts of discounts from provider charges retained by another Blue Cross and Blue Shield Company. These fees, if charged, are based on the discount the other Blue Cross and Blue Shield Company has obtained from its contracting providers. Access fees may only be charged if the other Blue Cross and Blue Shield Company's agreement prohibits billing Insureds for amounts in excess of the negotiated fees. In addition to the access fee that may be charged by the other Blue Cross and Blue Shield Company, the Company may charge the Contract Holder a fee of up to 10% of the discount obtained through use of the other Blue Cross and Blue Shield Company's provider network. This administrative fee is designed to partially offset the costs charged to the Company for administrative activities associated with making discounts available to the Contract Holder which arise out of other Blue Cross and Blue Shield Company's provider arrangements. Both the access fee and the administrative fee will be applied to the Contract Holder's claims expense. They will not be applied to the charge used for calculations of deductible and copayments owing by an Insured, however.

V. For additional information regarding the benefits covered under this Contract, You may call the customer service center phone number on Your Identification Card. Information You request about benefits will be furnished without charge.

W. Suspension of Coverage: Benefits and premiums under the Certificate will be suspended, at Your request, for the period (not to exceed twenty-four (24) months) in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act (Medicaid), but only if You notify the Company within ninety (90) days after the date You become entitled to such assistance. Upon receipt of timely notice, the Company will return to the Contract Holder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

If such suspension occurs and if You lose entitlement to such medical assistance, Your coverage under this Certificate will be automatically reinstituted, effective as of the date of termination of such entitlement, if You provide notice of loss of such entitlement within ninety

(90) days after the date of such loss and premium attributable to the period is paid, effective as of the date of termination of such entitlement.

Benefits and premiums under the Certificate will be suspended (for any period that may be provided by federal regulation) at Your request if You are entitled to benefits under Section 226 (b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if You lose coverage under the group health plan, the Contract will be automatically reinstituted (effective as of the date of loss of coverage) if You provide notice of loss of coverage within ninety (90) days after the date of loss.

X. Contract Holder's Responsibilities Concerning Enrollment: It is the responsibility of the Contract Holder/employer group's Plan Administrator to submit to the Company for enrollment only those employees who meet the eligibility criteria of the Contract Holder and the Company, and to ensure and verify the continued eligibility status of covered employees. The Company has the right to recover from Insureds and/or providers any benefit payments paid on behalf of ineligible persons.