KANSAS CITY LIFE
INSURANCE COMPANY

GROUP DENTAL COVERAGE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL DENTAL EXPENSES

OUTLINE OF COVERAGE

1. **Read Your Certificate Carefully** — This outline of coverage provides a very brief description of the important features of your certificate. This is not the insurance contract and only the actual certificate provisions will control. The certificate itself sets forth in detail the rights and obligations of both you and Kansas City Life. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

2. **IMPORTANT:** If you opt to receive dental services that are not covered services under this policy, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call client services at 800-821-6164, Ext. 6045 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

   In the event of termination of a Participating Provider's contract, continuity of care is provided for 90 days, or a longer period if necessary to ensure a safe transfer to another provider. This applies when an insured is undergoing a course of treatment from a terminated provider for an acute condition, or for a serious chronic condition, or for a pregnancy, which either has reached the second or third trimester, or is a high risk. An insured may request continuity of care by contacting Kansas City Life.

3. **Classes of Eligible Individuals include:**

   Class 01: All full-time active employees working 30 hours or more per week who are legal residents or citizens of the U.S and eligible retirees., excluding temporary and seasonal employees.

4. **Kansas City Life will pay the percentage payable as shown on the Plan Description of your Certificate 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.

Plan Description

	Participating Provider	Non-Participating Provider
Calendar Year Deductible		
Individual Type 1 (Preventive)	None	None
Individual Type 2 & 3 (Basic & Major)	$50	$50
Family Deductible Maximum	3 x Individual	3 x Individual
Coinsurance	**MAC***	**MAC***
Type 1 (Preventive)	100%	100%
Type 2 (Basic)	80%	80%
Type 3 (Major)	50%	50%
Maximums		
Types 1, 2, 3 Calendar year Maximum	$1,500	$1,500
Benefit Waiting Periods		
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 – Delta Dental

*MAC – Maximum Allowable Charge

5. Definition of Maximum Allowable Charge

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

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

1) 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;

2) due to injury, sickness, or disease that is covered under any Workers' Compensation Law, occupational disease law or similar laws;

3) 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;

4) 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;

5) for which you do not legally have to pay or that would not be made if you were not insured under the Policy;

6) 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;

7) which are incurred before insurance begins or after it ends;

8) 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;

9) for any dental procedure performed outside of the United States and its Territories;

11) for any duplicate device or appliance;

12) 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;

13) for instruction or supplies for plaque control, oral hygiene, nutritional counseling, or behavioral management;

14) for the use of materials (other than fluorides and sealants applied by your provider) to prevent tooth decay;

15) for bite registrations (study models);

16) for treatment of temporomandibular disorders;

17) 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;

18) 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 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;

19) 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.)

20) 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;

21) 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;

22) for replacement of a lost or stolen appliance;

23) for intravenous sedation in conjunction with routine dental procedures;

24) for the following periodontal procedures: occlusal analysis, adjustments, or guards, crown lengthening, provisional splinting, apically positioned flaps, local delivery of chemotherapeutic agents;

25) for adjustments and/or repairs to dentures or bridgework within the first 12 months;

26) for bacteriologic studies, caries susceptibility tests, or pulp vitality tests;

27) for cephalometric x-rays;

28) for analgesia;

29) for sedative fillings and temporary or provisional restorations;

30) for photographs;

31) for broken appointments;

32) for the completion of insurance forms;

33) for procedures or services not specifically addressed under the list of Covered Dental Services.

7. Premium rates are subject to change according to the terms of the policy.

Premium rates may be changed any time:

1) this policy is amended to change the eligibility and/or benefits; or

2) a subsidiary, division, or affiliate is added to or deleted from this policy.

Kansas City Life may determine that a premium rate change is necessary for reasons other than in 1) or 2) above. However, such a rate change will not be made during the first 24months or occur more often than once in any 6-month period.

Kansas City Life will provide written notification of any increases in premium rates to the Policyholder at least 31 days prior to the effective date of the increase unless the Policyholder and Kansas City Life both agree otherwise.

8. The Insured Individual's Insurance will terminate as follows:

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;

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 on which you or your dependent enters the Armed Forces, other than for reserve duty of 30 days or less.

9. The Insured Individual's Insurance will continue as follows:

If this policy requires an Insured Individual to be actively-at-work, and an Insured Individual is absent from work because of injury, sickness, approved leave of absence, or temporary lay-off or is placed on part-time employment, the Policyholder, acting on a basis that does not discriminate for or against any person, may consider the Insured Individual still employed until the Policyholder notifies Kansas City Life differently or stops paying premiums for the Insured Individual. However, in any event, insurance cannot be continued in this way for longer than the maximum continuation period stated below.

For Absence Due To:	**Maximum Continuation Period**
Temporary lay-off	3 Months
Approved leave of absence	3 Months
Part-time employment	3 Months
Injury or sickness	1 Year from the date injury or sickness begins

10. The procedure for filing a claim is as follows:

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.

KANSAS CITY LIFE
INSURANCE COMPANY

Important Notice

We are here to serve you...

As our policyholder, your satisfaction is very important to us. Should any questions arise regarding your insurance, please contact your agent. If you have additional questions, you may contact:

Group Department
Kansas City Life Insurance Company
3520 Broadway
P.O. Box 219425
Kansas City, MO 64121-9425
Telephone: 816-753-7000

If you are not satisfied...

If you are unable to obtain satisfaction from the agent or the company, you may write or call:

Consumer Services Bureau
California Department of Insurance
300 South Spring Street
Los Angeles, California 90013
Consumer Hotline: 1-800-927-HELP
(1-800-927-4357)
Out-of-area callers: 1-213-897-8921

Group Insurance Benefits

Lake Tahoe Unified School District

Group Dental Insurance

Class 01

KANSAS CITY LIFE
INSURANCE COMPANY

Notice of Protection Provided by

California Life and Health Insurance Guarantee Association

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities, and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions, and limits provided by the Association. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association and the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees, or assignees, whether or not they live in California.

Amounts of Coverage

The basic coverage protections provided by the Association are as follows.

Life Insurance, Annuities, and Structured Settlement Annuities

For life insurance policies, annuities, and structured settlement annuities, the Association will provide the following:

Life Insurance

80% of death benefits but not to exceed $300,000

80% of cash surrender or withdrawal values but not to exceed $100,000

Annuities and Structured Settlement Annuities

80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for all life insurance, annuities, and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

Health Insurance

The maximum amount of protection provided by the Association to an individual, as of March 31, 2022, is $637,989. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1067.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association
2377 Gold Meadow Way, Suite 100

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street

Gold River, California 95670

(916) 631-1581

Los Angeles, CA 90013

(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce, or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

KANSAS CITY LIFE
INSURANCE COMPANY

Important Notice

We are here to serve you...

As our policyholder, your satisfaction is very important to us. Should any questions arise regarding your insurance, please contact your agent. If you have additional questions, you may contact:

Group Department
Kansas City Life Insurance Company
3520 Broadway
P.O. Box 219425
Kansas City, MO 64121-9425
Telephone: 816-753-7000

If you are not satisfied...

If you are unable to obtain satisfaction from the agent or the company, you may write or call:

Consumer Services Bureau
California Department of Insurance
300 South Spring Street
Los Angeles, California 90013
Consumer Hotline: 1-800-927-HELP
(1-800-927-4357)

CJ144-CA

Out-of-area callers: 1-213-897-8921
Hearing-impaired callers: 1-800-482-4833 (4TDD)

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.

A. Craig Mason Jr.

Secretary

Walter E Bixby

President, CEO, and Vice Chairman

This dental coverage does not include "essential" pediatric dental health benefits as required by the Affordable Care Act.

IMPORTANT: If you opt to receive dental services that are not covered services under this policy, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call client services at 800-821-6164, Ext. 6045 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

Guide to Certificate Provisions

Schedule of Benefits

POLICYHOLDER
Lake Tahoe Unified School District

GROUP NUMBER
GT-27206

EMPLOYER
Lake Tahoe Unified School District

Classes of Eligible Individuals

Class 01: All full-time active employees working30 hours or more per week who are legal residents or citizens of the U.S., includes eligible retirees, 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

	Participating Provider	Non-Participating Provider
Calendar Year Deductible		
Individual Type 1 (Preventive)	None	None
Individual Type 2 & 3 (Basic & Major)	$50	$50
Family Deductible Maximum	3 x Individual	3 x Individual
Coinsurance	**MAC***	**MAC***
Type 1 (Preventive)	100%	100%
Type 2 (Basic)	80%	80%
Type 3 (Major)	50%	50%
Maximums		
Types 1, 2, 3 Calendar year Maximum	$1,500	$1,500
Benefit Waiting Periods		
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 – Delta Dental

*MAC – Maximum Allowable 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 in excess of the Maximum Allowable Charge (MAC) as shown in the Schedule of Benefits. Covered dental services also include the MAC charges for a less expensive mode of treatment.

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/dependent 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.

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 or registered domestic partner; and/or
2) each unmarried child who is:
    a) under 26 years of age;
    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;
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 on 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 your 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 – 3 months.
- for injury or sickness – 1 year from the date injury or sickness begins.

Entire Contract; Changes

This policy (the application of the employer, if any, and the individual applications, if any, of the employees) constitute(s) the entire contract between the parties, and any statement made by the employer or by any employee shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall avoid the insurance or reduce the benefits under this policy or be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the employer, except a fraudulent misstatement, be used at all to void this policy after it has been in force for three years from the date of its issue, nor shall any such statement of any employee eligible for coverage under the policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or disability (as defined in the policy) commencing after the insurance coverage with respect to which claim is made has been in effect for three years from the date it became effective.

No change in this policy shall be valid unless approved by an executive officer of Kansas City Life and unless such approval be endorsed herein or attached hereto. No agent has authority to change this policy or waive any of its provisions.

Time Limit on Certain Defenses

No claim for loss incurred or disability (as defined in the policy) commencing after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

Grace Period

A grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which grace period the policy shall continue in force, but the employer shall be liable to Kansas City Life for the payment of the premium accruing for the period the policy continues in force.

Notice of Claim

Written notice of claim must be given to Kansas City Life within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to Kansas City Life at P.O. Box 9040, Austin, TX 78766-9040, or to any authorized agent of Kansas City Life, with information sufficient to identify the insured employee, shall be deemed notice to Us.

Claim Forms

Kansas City Life, upon receipt of a written 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 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to Kansas City Life, in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable, and in case of claim for any other loss, within 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 of the employee, later than one year from the time proof is otherwise required.

Time of Payment of Claim
Indemnities payable under this policy for any loss other than loss for which this policy provides periodic payments will be paid (to the insured employee) as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which this policy provides periodic payment will be paid (to the insured employee) and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

Payment of Claims
Subject to any written direction of the insured employee in an application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical service may, at Kansas City Life's option, and unless the insured employee requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the hospital or person rendering such services, but it is not required that the service be rendered by a particular hospital or person.

Physical Examinations and Autopsy
Kansas City Life, at its own expense, shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the Pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

Legal Actions
No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

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.

In the event of termination of a Participating Provider's contract, continuity of care is provided for 90 days, or a longer period if necessary to ensure a safe transfer to another provider. This applies when an insured is undergoing a course of treatment from a terminated provider for an acute condition, or for a serious chronic condition, or for a pregnancy which either has reached the second or third trimester or is a high risk. An insured may request continuity of care by contacting Kansas City Life.

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. If x-rays are not provided, benefits will be made for procedures that result in professionally adequate restoration, replacement, or treatment.

Covered Charges will include only charges for procedures listed in this certificate.

How can I determine in advance what benefits are payable?
Pre-treatment estimate 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.

Pre-treatment estimate should not be requested unless total charges for a proposed treatment plan exceed $400. Ask your provider to submit a pre-treatment estimate 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 on 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)	$500 (Negotiated Fee)
Deductible	$50	$50
Coinsurance Percentage	60%	50%
Amount Paid by Kansas City Life	$270 ($500 - $50 Deductible) x 60%	$225 ($500 - $50 Deductible) x 50%
Amount Paid by the Insured (Out-of-pocket)	$230 ($500 Allowable Charge - $270 paid by Kansas City Life)	$475 ($700 Initial Charge - $225 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 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;
2) due to injury, sickness, or disease that is covered under any Workers' Compensation Law, occupational disease law or similar laws;
3) 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;
4) 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;
5) for which you do not legally have to pay or that would not be made if you were not insured under the Policy;
6) 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;
7) which are incurred before insurance begins or after it ends;
8) 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;
9) for any dental procedure performed outside of the United States and its Territories;
10) for any duplicate device or appliance;
11) 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;

12) for instruction or supplies for plaque control, oral hygiene, nutritional counseling, or behavioral management;
13) for the use of materials (other than fluorides and sealants applied by your provider) to prevent tooth decay;
14) for bite registrations (study models);
15) for treatment of temporomandibular disorders;
16) 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;
17) 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 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;
18) 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.)
19) 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;
20) 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;
21) for replacement of a lost or stolen appliance;
22) for intravenous sedation in conjunction with routine dental procedures;
23) for the following periodontal procedures: occlusal analysis, adjustments, or guards, crown lengthening, provisional splinting, apically positioned flaps, local delivery of chemotherapeutic agents;
24) for adjustments and/or repairs to dentures or bridgework within the first 12 months;
25) for bacteriologic studies, caries susceptibility tests or pulp vitality tests;
26) for cephalometric x-rays;
27) analgesia;
28) for sedative fillings and temporary or provisional restorations;
29) for photographs;
30) for broken appointments;
31) for the completion of insurance forms;
32) for procedures or services not specifically addressed under the list of Covered Dental Services.

Covered Dental Services

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.

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 2 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.

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.

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.

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 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, Implant and Supported Prosthetics 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) implant and supported prosthetics;

6) posts (covered only where there is root canal treatment and there is insufficient tooth structure to support a preparation);

7) 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.

California Continuation Benefits Replacement Act (Cal-COBRA)

NOTICE: These provisions are only applicable to certain plans as defined under the Act. Not all employers or groups are subject to this law. For further details to determine if this continuation coverage is available, please contact the person who handles the Policyholder's insurance matters.

The California Continuation Benefits Replacement Act (Cal-COBRA) signed into law effective January 1, 1998 requires that any employer meeting the definition under the Act allow a qualified beneficiary to continue group health coverage, including dental and vision care coverages after it would otherwise end, as a result of a qualifying event. Continuation coverage will be provided under the plan with the same terms and conditions that apply to similarly situated individuals.

A. Definitions

Employer means any employer that:

1) meets the definition of "small employer" as set forth in California;

2) employed 2-19 eligible employees on at least 50 percent of its working days during the preceding calendar year or, if the employer was not in business during any part of the preceding calendar year, employed 2 to 19 eligible employees on at least 50 percent of its working days during the preceding calendar quarter; and

3) is not subject to Section 4980B of the United States Internal Revenue Code (Federal COBRA) or Chapter 18 of the Employee Retirement Income Security Act.

Qualified Beneficiary means any individual who, on the day before the qualifying event, is an insured under a group benefit plan. An individual will not be considered to be a qualified beneficiary if:

1) The individual is entitled or becomes entitled to Medicare benefits. Entitlement to Medicare Part A only constitutes entitlement to benefits under Medicare.

2) The individual is covered or becomes covered under another group benefit plan which does not impose any exclusion or limitation with respect to any preexisting condition.

3) The individual is covered, becomes covered or is eligible for coverage under Federal COBRA, Chapter 18 of the Employee Retirement Income Security Act, or Chapter 6A of the Public Health Service Act.

4) The qualified beneficiary fails to meet the notification requirements as stated within the Enrollment provision below.

5) The qualified beneficiary fails to submit the correct premium amount for continuation of coverage or fails to satisfy other terms and conditions of the plan contract.

Qualifying Event means any of the following events that, but for the election of continuation of coverage under this provision, would result in a loss of coverage for the qualified beneficiary under the group benefit plan.

1) The death of the covered employee.

2) The termination of employment or reduction of hours of the covered employee's employment, except that termination for gross misconduct does not constitute a qualifying event.

3) The divorce or legal separation of the covered employee from the covered employee's spouse.

4) The loss of dependent status by a dependent enrolled in the group benefit plan.

5) With respect to a covered dependent only, the covered employee's entitlement of benefits under Medicare (Title XVIII of the United States Social Security Act).

B. Enrollment

Notice Requirements

The qualified beneficiary must request the continuation of coverage in writing and deliver such notice, by first-class mail or other reliable means of delivery, to the health services plan (or to the employer if the employer has contracted with the insurer to perform the administrative services under Cal-COBRA) within the 60-day period following the later of:

1) the date that the enrollee's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event;

2) the date the enrollee was sent notice of the ability to continue coverage.

Premium Payments

The first premium payment must be delivered by first class mail, certified mail or other reliable means of delivery, including personal delivery, express mail, or private courier company to the health services plan (or the employer if the employer has contracted with the plan to perform the administrative services under Cal-COBRA) in accordance with the following terms and conditions:

1) the first premium must be delivered within 45 days of the date of the qualified beneficiary provided written notice to the health services plan; and

2) the first premium payment must equal an amount sufficient to pay any required premiums and all premiums due.

Failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage.

Monthly Cost

The premium will be due monthly and will not be more than 110% of the applicable rate charged for a similarly situated individual under the group benefit plan.

C. Continuation Period

Continuation coverage shall terminate for those qualified beneficiaries at the first to occur of the following:

1) For those who are eligible for continuation coverage as a result of a termination of employment or reduction in work hours, the date 36 months following the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a qualifying event.
2) For those who are eligible for continuation coverage as a result of:
    a. the death of an employee,
    b. a loss of dependent status,
    c. divorce or legal separation, or
    d. the employee's eligibility for Medicare (for dependent coverage), the date 36 months following the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a qualifying event.
3) For those qualified beneficiaries who are eligible for continuation coverage and are determined to be disabled by the Social Security Administration at any time during the first 60 days of continuation coverage, and the spouse or dependent who has elected coverage, the date 36 months following the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a qualifying event. The qualified beneficiary must notify the insurer, or the employer or administrator that contracts to perform administrative services, of the social security determination within 60 days of the date of the determination letter and prior to the end of the original 36-month continuation coverage period in order to be eligible for coverage based on these criteria.
4) For those who fail to make premium payments, at the end of the period for which premium payments were made.
5) In the case of a qualified beneficiary who is initially eligible for and elects continuation coverage as a result of termination of employment or reduction of hours, as defined within paragraph (2) of "Qualifying Event", but who has another qualifying event as described in paragraphs (1), (3), (4) or (5) of "Qualifying Event", within 36 months of the date of the first qualifying event, and the qualified beneficiary has notified the plan, or the employer or administrator under contract to provide the administrative services, of the second qualifying event within 60 days of the date of the second qualifying event, the date 36 months after the date of the first qualifying event.
6) The employer, or any successor employer ceases to provide any group benefit plan to his or her employees. See Additional Provisions below.
7) The qualified beneficiary moves out of the insurer's service area or the qualified beneficiary commits fraud or deception in the use of the insurer's services.

An individual who becomes a qualified beneficiary shall continue to receive coverage until continuation coverage is terminated at the qualified beneficiary's election or the period of time provided for continuation coverage as defined in Section C. Continuation Period, whichever comes first, even if the employer that sponsored the group benefit plan subsequently becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

D. Additional Provisions

Change in Group Benefit Plans

If the continuation coverage would terminate prior to the end of the period the qualified beneficiary would have remained covered as a result of a termination of an agreement between the group benefit plan and

the employer, and a new group benefit plan is available for active employees, then the qualified beneficiary may continue coverage based on the following terms and conditions:

1) the coverage will continue for the balance of the period that the qualified beneficiary would have remained covered under the prior plan;
2) notice must be provided to the new group benefit plan within 30 days after receiving notice of the termination of the prior plan;
3) any requirements for enrollment in, and payment to, the new group benefit plan must be met.

Coverage will terminate if the qualified beneficiary fails to comply with (2) or (3) above.

Newborn or Adopted Children

Any child who is born to or is placed for adoption with a former employee who is a qualified beneficiary during the period of continuation coverage, shall be considered a qualified beneficiary and entitled to receive coverage benefits as well for the remainder of the period that the former employee is covered under the plan. Notice must be provided within 30 days of the child's birth or placement of adoption.

For purposes of this section:

"COBRA" means Section 4980B of Title 26 of the United States Code, Section 1161 et seq. of Title 29 of the United States Code, and Section 300bb of Title 42 of the United States Code, as added by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) and as amended.

"Cal-COBRA" means the continuation coverage that must be offered pursuant to Article 1.7 (commencing with Section 10128.50) of Chapter 1 of Part 2 of Division 2 of the Insurance Code.

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 the maximum amount required by the policy 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** will pay the lesser of either the amount it would have paid in the absence of any other dental benefit coverage, or the insured's total out-of-pocket cost payable under the **Primary plan.** The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do 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 must pay the maximum amount required by the policy without regard to the possibility that another **Plan** may cover some expenses. When **This plan** is secondary, it will pay the lesser of either the amount it would have paid in the absence of any other dental benefit coverage, or the insured's total out-of-pocket cost payable under the **Primary plan** and may reduce the benefits it pays so that payments from all **Plans** 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 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 not 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 in equity 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.

Claim Procedures for Dental Insurance Plans

How to File a Claim

To file a claim for benefits for yourself or your insured dependents, you must complete a claim form. You can get a claim form from the Policyholder or from Kansas City Life.

Send the completed claim form and bills to Kansas City Life. You may assign you dental care benefits. Unless you assign your benefits to a health care provider, payment will be made to you.

Claim Procedures

a) For Post-Service claims, a decision will be made on your claim within 30 days after receipt. The time for decision may be extended for an additional 15 day period provided that, prior to any extension period, Kansas City Life notifies you in writing that an extension is necessary due to matters beyond the control of the plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, you will have 45 days from receipt of the notice to provide the specified information.

b) For Pre-Service claims, a decision will be made on your claim within 15 days after receipt. The time for decision may be extended for an additional 15 day period provided that, prior to any extension period, Kansas City Life notifies you in writing that an extension is necessary due to matters beyond the control of the plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, you will have 45 days from receipt of the notice to provide the specified information.

c) For Urgent Care claims, a decision will be made on your claim within 72 hours after receipt, unless you fail to submit information necessary to decide your claim. If this is the case, Kansas City Life will notify you no later than 24 hours after receipt of the claim of the specific information needed. You will then have 48 hours to provide the specified information.

If your claim for benefits is wholly or partially denied, any notice of adverse benefit determination will:

a) state the specific reason(s) for determination;

b) reference specific plan provision(s) on which the determination is based:

c) describe additional material or information necessary to complete the claim and why such information is necessary;

d) describe plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court; and

e) disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination or provide that such information will be provided free of charge upon request.

Appealing Denial of Claims

You are entitled to full and fair review of the denial of a claim which has been wholly or partially denied. The procedure for review is as follows:

a) We must receive your written request within 180 business days of the notice of denial.

b) You may review pertinent documents and submit issues and comments in writing.

c) For Post-Service claims, a decision will be made on your request for review within 60 days after receipt unless special circumstances require an extension of time for processing.

d) For Pre-Service claims, a decision will be made on your request within 30 days after receipt unless special circumstances require an extension of time for processing.

e) For Urgent Care claims, a decision will be made within 72 hours after receipt.

f) The review will be conducted by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate.

g) The written decision will include specific references to the plan provisions on which the decision is based and will include any other information required by applicable law.

h) The above appeal procedure will pre-empt any state requirements on internal appeals except to the extent that both federal and state requirements can be met.

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.