Group Insurance Benefits

Tiger Waterfront Products, LLC

Group Dental Insurance

Class 01

KANSAS CITY LIFE
INSURANCE COMPANY

Notice of Protection Provided By Missouri Life and Health Insurance Guaranty Association

This notice provides a *brief summary* of the Missouri Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Missouri law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Missouri law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are as follows:

- Life Insurance
    - $300,000 in death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values
- Health Insurance
    - $500,000 for health benefit plans
    - $300,000 in disability insurance benefits
    - $300,000 in long-term care insurance benefits
    - $100,000 in other types of health insurance benefits
- Annuities
    - $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is as follows:

- $300,000 in aggregate for all types of coverage listed above, with the exception of health benefit plans
- $500,000 in aggregate for health benefit plans
- $5,000,000 to one policy owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons

"Health benefit plan" is defined in section 376.718, RSMo.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Missouri law.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the basic life insurance policy or annuity contract to which it relates.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mo-iga.org, or contact:

Missouri Life and Health Insurance
Guaranty Association
630 Bolivar Street, Suite 204
Jefferson City, MO 65101
Ph: 573-634-8455
Fax: 573-634-8488

Missouri Department of Commerce and Insurance
301 West High Street, Room 530
Jefferson City, MO 65101
Ph: 573-522-6115

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

Internal Grievance Procedures for Group Dental and Vision Care Plans

Kansas City Life Insurance Company
3520 Broadway, P.O. Box 219425, Kansas City, MO 64121-9425

Person responsible for administering grievance system:
Manager, Group Claims Department

Person responsible for receiving complaints:
Manager – Dental/Vision Claims, Group Claims Department
3520 Broadway, P.O. Box 219425, Kansas City, MO 64121-9425
1-800-874-5254

Kansas City Life Insurance Company has established procedures to allow you to file grievances with the Company and to seek a review of the Company's decision with respect to grievances. This document describes the grievance procedures that are available to you. This document forms a part of the policy or certificate to which it is attached.

You have the right to contact the Missouri Department of Commerce and Insurance for assistance at any time.

Missouri Department of Commerce and Insurance
Consumer Affairs Division
P.O. Box 690
Jefferson City, Missouri 65102-0690
The Insurance Consumer Hotline is: 1-800-726-7390

A Covered Person/Insured Individual, that person's authorized representative, or a provider acting on that person's behalf may file a grievance with Kansas City Life on a group dental plan or group vision care plan. "Grievance" means a written complaint submitted by or on behalf of a Covered Person/Insured Individual regarding (1) the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (2) claims payment, handling, or reimbursement for health care services; or (3) matters pertaining to the contractual relationship between a Covered Person/Insured Individual and Kansas City Life.

First-Level Grievance Review
Within ten working days of receipt of a grievance, Kansas City Life will mail a written acknowledgment to the Covered Person/Insured Individual or that person's authorized representative confirming receipt of the grievance. If a grievance is filed by an authorized representative or a provider acting on the Covered Person/Insured Individual's behalf, Kansas City Life will process the grievance without written authorization unless the acknowledgement of receipt specifically states that a written authorization is required and an authorization form is provided with the acknowledgement. The acknowledgment will include a notice that health care information may be disclosed to the authorized representative only if permitted by law. The acknowledgment will also state that unless otherwise permitted by applicable law, including HIPPA, an informed consent form is required. A consent form will be provided with the acknowledgment.

Kansas City Life will make a full investigation of the grievance within twenty working days after receipt of the grievance, unless the investigation cannot be completed within this time. If the investigation cannot be completed within twenty working days after receipt of the grievance, the Covered Person/Insured Individual will be notified in writing on or before the twentieth working day and the investigation will be completed within thirty working days thereafter. The notice will set forth the specific reasons for which additional time is needed for the investigation.

Within five working days after the investigation is completed, someone not involved in the circumstance giving rise to the grievance or its investigation will decide upon the appropriate resolution of the grievance and notify the Covered Person/Insured Individual in writing of Kansas City Life's decision regarding the grievance and of the right to file an appeal for a second-level review.

Within fifteen working days after the investigation is completed, Kansas City Life will notify the person who submitted the grievance of Kansas City Life's resolution of the grievance, if the person who submitted the grievance is other than the Covered Person/Insured Individual who has already received notice.

Second-Level Grievance Review
Upon receipt of a request for second-level review, Kansas City Life will submit the grievance to a grievance advisory panel consisting of other Covered Persons/Insured Individuals and representatives of Kansas City Life that were

not involved in the circumstance giving rise to the grievance or in any subsequent investigation or determination of the grievance.

Review by the grievance advisory panel will follow the same time frames as a first-level review, except in the case of a grievance involving a situation where the time frame of the standard grievance procedures would seriously jeopardize the life or health of a Covered Person/Insured Individual or would jeopardize that person's ability to regain maximum function. Any decision of the grievance advisory panel will include notice of the Covered Person/Insured Individual's rights, or Kansas City Life's rights, or the plan sponsor's rights to file an appeal of the grievance advisory panel's decision with the Director of the Missouri Department of Commerce and Insurance. The notice of decision will include the toll-free telephone number and address of the Director's office.

Where the grievance involves an adverse determination and the grievance advisory panel makes a preliminary decision that the determination should be upheld, Kansas City Life will submit the grievance for review to two independent clinical peers in the same or similar specialty as would typically manage the case being reviewed who were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance. If both independent reviews concur with the grievance advisory panel's preliminary decision, the panel's decision will stand. If both independent reviewers disagree with the grievance advisory panel's preliminary decision, the adverse determination will be overturned. If one of the two independent reviewers disagrees with the grievance advisory panel's preliminary decision, the panel will reconvene and make a final decision in its discretion.

Expedited Review

If the time frame of the standard grievance procedures would seriously jeopardize the life or health of a Covered Person/Insured Individual or would jeopardize that person's ability to regain maximum function, an expedited review may be requested. A request for an expedited review may be submitted orally or in writing, however, the request shall not be considered a grievance unless the request is submitted in writing. Expedited review procedures will be available to a Covered Person/Insured Individual, that person's authorized representative, or a provider acting on that person's behalf.

Kansas City Life will notify a Covered Person/Insured Individual within 72 hours after receiving a request for an expedited review of Kansas City Life's determination and will provide written confirmation of the decision covering an expedited review within three working days of providing notification of the determination.

Utilization Review Procedures for Group Dental Care Plans

Kansas City Life Insurance Company
3520 Broadway, P.O. Box 219425, Kansas City, MO 64121-9425

Kansas City Life Insurance Company has established procedures to allow you to seek a review of the Company's decision with respect to claims. This document describes the utilization review process that is available to you. This document forms a part of the policy or certificate to which it is attached.

Requests for utilization review can be made by calling 800-875-5254, ext. 6045.

Adverse determination means a determination by the Company or its utilization review entity that a health care service furnished or proposed to be furnished to an enrollee has been reviewed and, based upon the information provided, does not meet the Company's or utilization review entity's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, or are experimental or investigational, and the payment for the requested service is therefore denied, reduced, or terminated.

Concurrent review means utilization review conducted during a patient's course of treatment.

Enrollee means a policyholder or other covered individual under a policy or certificate issued by the Company.

Retrospective review means utilization review of medical necessity that is conducted after services have been provided to a patient but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prior authorization review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. Utilization review shall not include elective requests for clarification of coverage.

Proposed Procedures or Services

If review is requested for proposed procedures or services, an initial determination will be made within 36 hours, which will include one working day, of obtaining all necessary information regarding a proposed procedure or service. Review of proposed procedures or services is not required.

In the case of a determination to certify a procedure or service, the provider rendering the service will be notified by telephone or electronically within 24 hours of the making of the certification. Written or electronic confirmation of a telephone or electronic notification will be made to the enrollee and to the provider within two working days of the making of the certification.

In the case of an adverse determination, the provider rendering the service will be notified by telephone or electronically within 24 hours of the making of the adverse determination. Written or electronic confirmation of a telephone or electronic notification will be made to the enrollee and to the provider within one working day of the making of the adverse determination.

Concurrent Reviews

Concurrent review determinations will be made within one working day of obtaining all necessary information.

In the case of a determination to certify additional services, the provider rendering the service will be notified by telephone or electronically within one working day of the making of the certification. Written or electronic confirmation of the certification will be made to the enrollee and to the provider within one working day after telephone or electronic notification. The written notification will include the next review date, the service(s) approved, and the date of initiation of services.

In the case of an adverse determination, the provider rendering the service will be notified by telephone or electronically within 24 hours of the making of the adverse determination. Written or electronic notification will be made to the enrollee and to the provider within one working day of the telephone or electronic notification. The service shall be continued without liability to the enrollee until the enrollee has been notified of the determination.

Retrospective Reviews

For retrospective review determinations, a determination will be made within 30 working days of receiving all necessary information. Notice in writing of the determination will be provided to an enrollee within 10 working days of the making of the determination. A written notification of an adverse determination will include the principal reason or reasons for the determination, including the clinical rationale, and the instructions for initiating an appeal or reconsideration of the determination. The clinical rationale for an adverse determination, including the clinical review criteria used to make that determination, will be provided in writing to the provider and to any party who received notice of the adverse determination.

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

Guide to Certificate Provisions

Schedule of Benefits

POLICYHOLDER
Tiger Waterfront Products, LLC

GROUP NUMBER
28058

EMPLOYER
Tiger Waterfront Products, LLC

Classes of Eligible Individuals

Class 01: All full-time active Employees working 30.0 hours or more per week who are legal residents or citizens of the U.S., excluding temporary and seasonal employees.

Probationary Waiting Period

Current Individuals: As noted in Your Policyholder's Group Dental Insurance Policy

New Individuals: As noted in Your Policyholder's Group Dental Insurance Policy

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.

Schedule of Benefits

	Participating Provider	Non-Participating Provider
Calendar Year Deductible		
Individual Type 1 (Preventive)	$0	$0
Individual Types 2 & 3 (Basic & Major)	$50	$50
Individual Type 4 (Orthodontia) for Children under age 19	$0	$0
Family Deductible Maximum	3 x Individual	3 x Individual
Coinsurance	**MAC***	**UCR****
Type 1 (Preventive)	100%	100%
Type 2 (Basic)	80%	80%
Type 3 (Major)	50%	50%
Type 4 (Orthodontia) for Children under age 19	50%	50%
Maximums		
Types 1, 2, 3 Calendar Year Maximum	$5,000	$5,000
Type 4 Lifetime Maximum for Children under age 19	$2,500	$2,500
Benefit Waiting Periods		
Type 1 (Preventive)	0 months	0 months
Type 2 (Basic)	0 months	0 months
Type 3 (Major)	0 months	0 months
Type 4 (Orthodontia) for Children under age 19	0 months	0 months

Provisions for Current Insured Individuals are provided. Previous carrier - Humana

*MAC – Maximum Allowable Charge

**UCR – Usual, Customary, and Reasonable Charge

Definition of Certain Terms

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

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

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

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

Current Insured Individual
Any Insured Individual 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 30.0 hours each week for the Policyholder.

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

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

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

Maximum Allowable Charge (MAC)
The fee for a service as negotiated with a contracted Participating Provider.

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

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

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

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

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

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

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

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

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

General Provisions

Entire Contract
The contract between the parties consists of:

1) the policy;
2) the application of the Policyholder, a copy of which is attached to and made a part of the Policy when issued;
3) this certificate;
4) any endorsements, amendments, or riders; and
5) the applications, if any, of each insured person.

All statements made by the Policyholder and persons insured under the Policy shall be deemed representations and not warranties and are true and complete to the best of the knowledge and belief of the person(s) making them. No statement will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his or her beneficiary. A copy of any employee's medical applications (if any) will be given to the employee.

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.

If the first of the policy month effective date does not apply (Contributory):
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 date you are first eligible, if you submit the enrollment card on or before the date you are first eligible; or

2) 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 next date that you are a member of an eligible class.

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

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

When am I eligible for insurance for my dependents?
You are eligible for insurance for your dependents on the later of:

1) the date you are eligible to be insured; or

2) the date you acquire an eligible dependent.

The date acquired for eligible dependents is as follows:

1) a spouse is deemed acquired on the date of marriage;

2) a natural child is deemed acquired on the date of birth;

3) an adopted child is deemed acquired on the date of placement for the purpose of adoption and continues to be eligible unless the placement is disrupted prior to legal adoption and the child is removed from placement;

4) a stepchild is deemed acquired on the date of marriage to the natural parent; and

5) a grandchild or other child is deemed acquired on the first date he or she meets the definition of "child" as shown below.

Who are eligible dependents?
Eligible dependents are:

1) your spouse; and/or

2) each unmarried child who is:

    a) under 26 years of age (until the end of the month in which the child turns age 26);

    b) age 26 or over if the child:

        i) is incapable of earning a living due to mental or physical handicap on the day before reaching the age limit;

        ii) depends on you for more than half of his or her support on that day; and

        iii) remains incapacitated and dependent as described. You must submit proof of incapacity and dependency to Kansas City Life within 31 days after the child reaches the age limit. Kansas City Life can require proof of continued incapacity and dependency but not more than once each year after the two-year period following the child reaching that age limit.

Child includes only:

1) your natural child or adopted child; and/or

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

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

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

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

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

If the first of the policy month effective date does not apply (Contributory):
The dependent's insurance begins for each dependent then eligible on the later of:

1) the date your insurance begins; or

2) the date:

   a) 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) 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. Kansas City Life will provide You with all forms and instructions necessary to enroll the newly born child and will allow You an additional 10 days from the date the forms and instructions are provided in which to enroll the newly born child.

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 end of the period for which you last made any required payment toward the cost of insurance;

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

Benefits Payable

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

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

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

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

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

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

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

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

What is the difference between a Participating and Non-Participating Provider?
Participating Providers have agreed to a negotiated fee schedule that is generally less than the Usual, Customary, and Reasonable charges of other providers in any given region. With select plans, in addition to

potentially lower total charges, deductibles, and coinsurance percentages for Participating Providers may differ from those for Non-Participating Providers.

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

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

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

	Participating Provider	Non-Participating Provider
Initial Charge	$700	$700
Allowable Charge	$500 (Negotiated Fee)	$650 (UCR Limit)
Deductible	$50	$50
Coinsurance Percentage	60%	50%
Amount Paid by Kansas City Life	$270 ($500 - $50 Deductible) x 60%	$300 ($650 - $50 Deductible) x 50%
Amount Paid by the Insured (Out-of-pocket)	$230 ($500 Allowable Charge - $270 paid by Kansas City Life)	$400 ($700 Initial Charge - $300 paid by Kansas City Life)

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

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

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

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

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

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

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

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

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

1) the statement "Provision for Current Insured Individuals is provided" is included on the Schedule of Benefits page;

2) a previous plan is shown on the Schedule of Benefits page; and

3) you and your dependents are Current Insured Individuals.

Will I receive credit towards the Length of Time Covered if I had coverage under the previous plan?
If the Policy replaces comparable previous coverage, Current Insured Individuals will receive credit for the length of time they were covered under the previous plan. Credit for Length of Time Covered under the previous plan will be allowed if:

1) the statement "Provision for Current Insured Individuals is provided" is included on the Schedule of Benefits page;

2) a previous plan is shown on the Schedule of Benefits page; and

3) you and your dependents are Current Insured Individuals.

Are there limitations on expenses covered if the Policy replaces existing coverage?
Any benefits paid under the previous plan with respect to replaced coverage will be applied to and deducted from the maximum benefit payable.

Are there limitations on expenses covered if the previous plan extends benefits?
Kansas City Life will not pay benefits for any dental expenses for which benefits are paid or payable under any provision of the previous plan.

What are the provisions for extension of benefits?
The coverage under the Policy for covered dental expenses for you and your covered dependents will be extended after the date the coverage for such person terminates only if:

1) a covered dental expense for such services was incurred while covered; and

2) such services are completed within 31 days after coverage terminates.

A covered dental expense will be deemed incurred as follows:

1) for crowns, dentures, or bridgework – on the date the impression is taken;

2) for root canal therapy – on the date the pulp chamber is opened; or

3) for all other dental expenses – on the date the service is rendered or the supply is furnished.

Limitations and Exclusions

What are the limitations and exclusions?
Kansas City Life will not pay for (and covered dental expenses do not include) charges:

1) for any care, services, supplies, or treatment rendered on an experimental, investigational, or research basis not recognized as a generally accepted dental practice by the dental profession or The American Dental Association;

2) for services that, to any extent, are payable under any other group insurance or service plan (that provides coverage for medical charges) for which the Policyholder makes payroll deductions or pays all or part of the cost;

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

4) made by any facility owned or operated by the United States or any of its agencies unless you are legally required to pay in the absence of insurance;

5) made by any government entity unless you are required to pay; or by any public entity from which coverage could have been obtained by application or enrollment even if application or enrollment was not actually made;

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

7) for services provided by a member of your immediate family (including spouse, siblings, parents, children, or grandparents either by blood, marriage, or legal adoption) or a member of your household;

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

9) for procedures started before the benefit waiting period has been met (other than orthodontia), which include but are not limited to:

a) crowns, inlays, onlays, bridges, and prosthetic appliances (which are considered started when the initial impression is taken);

b) root canals (which are considered started when the pulp chamber is opened);

c) treatment or supplies that are for congenital or developmental malformations existing on your effective date;

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

11) that are more than the usual, customary, and reasonable (UCR) charge;

12) for treatment or services that are not medically necessary, not appropriate, or that are primarily for cosmetic reasons (unless noted in Type V Services (Cosmetic));

13) for any duplicate device or appliance;

14) for duplication or repetition of non-surgical periodontal procedures (excluding periodontal maintenance) within any 12 consecutive month period and duplication or repetition of any surgical periodontal procedure within any 24 consecutive month period;

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

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

17) for bite registrations (study models);

18) for treatment of temporomandibular disorders;

19) 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;

20) for prosthetic appliances or fixed bridges to replace missing teeth that were not extracted while this coverage was in force unless necessitated by the loss of one or more natural teeth while covered under this plan. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth. Benefits will be pro-rated;

21) 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.)

22) 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;

23) 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;

24) for replacement of a lost or stolen appliance;

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

26) for the following periodontal procedures: crown lengthening, provisional splinting, apically positioned flaps, local delivery of chemotherapeutic agents;

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

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

29) for cephalometric x-rays;

30) for analgesia;

31) for sedative fillings and temporary or provisional restorations;

32) for photographs;

33) for broken appointments;

34) for the completion of insurance forms;

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

Covered Dental Services

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

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

Type I Services (Preventive/Diagnostic)

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

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

X-rays including:

1) one full mouth series of at least 14 films or Panoramic film, including bitewings, if needed (limited to once in any 60 consecutive months period);

2) periapical x-rays, if needed to diagnose a specific dental condition (limited to a maximum of 12 in any 12 consecutive months);

3) other x-rays will be considered covered (or excluded) at the level of the specific dental condition being treated.

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

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

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

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.

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.

Occlusal Adjustment and Guard
Limited occlusal adjustment - limited to a total of two visits, covered only when done within a 6 consecutive month period after covered scaling and root planing or osseous surgery. Must have radiographic evidence of vertical defect or widened periodontal ligament space. Occlusal guards, covered only when done within a 6 consecutive month period after osseous surgery, and limited to one per lifetime.

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.

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.

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 natural teeth);

4) denture repair;

5) denture rebase (limited to once in any 60 consecutive month period);

6) denture reline (limited to once in any 24 consecutive month period);

7) denture adjustment (following 6 months of initial setting).

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.

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.

Type IV Services (Orthodontia)

Benefits for orthodontic services will be limited to dependent children under the age of 19 and will terminate on the day the Insured Individual reaches the age of 19.

This type includes comprehensive full banded orthodontic treatment and fixed or cemented appliances for tooth guidance or to control harmful habits. No coverage is provided for repair or replacement of orthodontic devices. The orthodontia total case fee will include diagnostic records, exams, x-rays, extractions as required for orthodontic treatment, installation of appliances, and monthly adjustments.

Method of Payment
First, Kansas City Life will allow the lesser of (1) 25% of the provider's total case fee, or (2) the provider's initial fee, whichever is less. The remaining balance is divided by the number of months in the treatment plan and the resulting amount is allowed each month that the coverage remains in force until either the entire case fee

has been allowed or the maximum benefit has been paid. Coinsurance will be applied to both the initial fee and monthly payments. It does not matter what services are rendered during any given month.

If you stop treatment for any reason, benefits will terminate on that day. If you resume treatment, any remaining benefits will be paid subject to the original lifetime maximum.

Example of method of payment:

		Paid Year to Date
Provider's estimated cost for treatment (2-year plan)	$2,800	
Maximum orthodontics benefit*	$1,000	
Provider's initial fee	$400	
Kansas City Life's first payment (coinsurance applied)	$200	$200

The remainder of $2,400 divided by 24 months (2-year treatment plan) = $100.00

		Paid Year to Date
Amount payable 1st month (coinsurance applied)	$50	$250
Amount payable 2nd month	$50	$300
Amount payable 16th month	$50	$1,000

*The maximum benefit may vary with the plan selected. The schedule of benefits shows the maximum lifetime benefit (if any).

When the provider's initial fee equals or exceeds the maximum orthodontia benefit, the initial fee will be payable in five monthly installments provided coverage remains in force during that period.

Orthodontia Coverage for Treatment in Progress
If orthodontic treatment begins before an individual is eligible for orthodontic services, Kansas City Life will first determine the *greater* of 25% of the total case fee or the initial fee and exclude it from coverage. The remaining balance will be divided by the number of months in the treatment plan starting with the month in which an appliance is first placed. Subject to applicable coinsurance and plan maximums, coverage will begin the first month the Insured Individual becomes eligible for orthodontia and will cover only the months remaining in the treatment plan, regardless of the number of months since the initial appliance placement. As determined by the above method of payment, at no time will Kansas City Life provide coverage for charges that would have been scheduled for payment prior to an Insured Individual becoming eligible for orthodontia benefits.

Coordination of Benefits

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

2) If a person is covered by two 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 two 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. Kansas City Life or the Policyholder will send you a claim form within 15 days of notifying us that you have a claim.

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. If you do not receive a claim form within 15 days of notifying us of your loss then you shall be deemed to have complied with the requirements of the certificate as to submitting proof of loss by submitting, within 90 days, written proof of loss covering the occurrence, character, and extent of the loss for which claim is made. 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 it was not reasonably possible to furnish proof of loss within such time and 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.

The Following Important Notice is Provided by Your Employer for Your Information Only.

Conforming Instrument
For the purpose of meeting certain requirements of the Employee Retirement Income Security Act of 1974, the following information and the attached Claim Procedures and Statement of ERISA Rights are provided for use with your booklet-certificate to form the Summary Plan Description.

The benefits described in your booklet are provided under a group plan by the Insurance Company and are subject to the terms and conditions of that plan.

A copy of this plan is available for your review during normal working hours in the office of the Plan Administrator.

1. Plan Name

Group Plan for employees of Tiger Waterfront Products, LLC

2. Plan Number

3. Employer/Plan Sponsor

Tiger Waterfront Products, LLC
35 Cooperative Way
Wright City, MO 63390

4. Employer Identification Number

800012049

5. Type of Plan

Welfare Benefit Plan providing Group Dental benefits.

6. Plan Administrator

Jessica Kunde
HR Manager
35 Cooperative Way
Wright City, MO 63390

7. Agent for Service of Legal Process

For the Plan:

Christina Davis
CEO
35 Cooperative Way
Wright City, MO 63390

For the Policy:

Kansas City Life Insurance Company
P.O. Box 219425
Kansas City, MO 64121-9425

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

8. Sources of Contributions -- The Employer pays the premium for the insurance, but may allocate part of the cost to the employee. The Employer determines the portion of the cost to be paid by the employee.

9. Type of Administration -- The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

10. The Plan and its records are kept on a Policy Year basis.

11. Labor Organizations

None

12. Names and Addresses of Trustees

Tiger Waterfront Products, LLC
35 Cooperative Way
Wright City, MO 63390

13. Plan Amendment Procedure

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

Statement of ERISA Rights

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1) Receive Information About Your Plan and Benefits:

   a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

   c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

2) Continue Group Health Plan Coverage:

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuous coverage rights.

3) Prudent Actions by Plan Fiduciaries:

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

4) Enforce Your Rights:

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

5) Assistance with Your Questions:

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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

Kansas City Life will handle claims as follows:

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 Grange Life Insurance Company, 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, P.O. Box 219425, Kansas City, MO 64121-9425, phone 1-800-874-5254 ext. 6046.