Advisors Excel D

Changes to your Benefit Descriptions

To: Subscribers of Blue Cross and Blue Shield of Kansas (BCBSKS) benefit descriptions

Effective on your plan's anniversary date, your Blue Cross and Blue Shield of Kansas benefit description has undergone some changes and clarifications including the items listed below.

Autism Spectrum Disorder: To best support individuals diagnosed with Autism Spectrum Disorder, we have removed the age limit for ABA therapy coverage. Now, any individual with coverage through your plan who is diagnosed and is referred to ABA therapy as part of their treatment plan will be covered, whereas before only individuals under the age of 18 were eligible for ABA treatment coverage.

Grandfathered plan status
BCBSKS believes your plan is a "grandfathered health plan." As part of the Affordable Care Act (ACA), we are required to inform you of your plan's status. Essentially, any plan in force prior to March 23, 2010, is considered grandfathered. A grandfathered plan helps to preserve certain basic health coverage already in effect when the law was enacted.

If you have any questions, please contact our customer service center at the telephone number on the back of your BCBSKS identification card. Thank you for your attention to this important information.

We value you as a member of Blue Cross and Blue Shield of Kansas.

Sincerely,

Holly S. Graves

Holly S. Graves
Vice President, Operations and CMS Programs
Blue Cross and Blue Shield of Kansas

Form CCL-15 1/23

ISSUED TO:
GROUP ID: INSURED ID:

Administered by Blue Cross and Blue Shield of Kansas, Inc.

BENEFIT DESCRIPTION

Blue Cross and Blue Shield of Kansas, Inc., has been retained to administer claims under this Program. Blue Cross and Blue Shield of Kansas, Inc. is not the insurer under this Program. Blue Cross and Blue Shield of Kansas, Inc. provides administrative claims payment services and does not assume any financial risk or obligation with respect to claims, except to the extent benefits are paid under the stop loss provision of this coverage. For answers to questions regarding claims payments, eligibility for benefits, and other information about this Program, contact Blue Cross and Blue Shield of Kansas, Inc., 1133 SW Topeka Boulevard, Topeka, Kansas 66629.

GROUP NAME:

GROUP NUMBER:

SUBSCRIBER:

SUBSCRIBER IDENTIFICATION NUMBER:

You have specific consumer rights regarding internal appeals. Our complete appeals procedure process is available in Spanish. To request a Spanish version of the appeals process, please call our Customer Service number on the back of your member identification card.

Usted tiene derechos específicos como consumidor con relación a las apelaciones internas. Nuestro proceso completo para el procedimiento de apelaciones está disponible en español. Para solicitar una versión en español del proceso de apelaciones, llame a nuestro número de Servicio al cliente que se encuentra en la parte posterior de su tarjeta de identificación del afiliado.

Form APFL-131e 1/18

Women's Health Care and Cancer Rights Act (WHCRA) Notice

In accordance with the requirements of WHCRA and K.S.A. 40-2,166, Blue Cross and Blue Shield of Kansas is notifying You of the following coverage mandated by state and federal law. When the need for such benefits is determined by the Subscriber and the Subscriber's attending physician, benefits include the following:

- Reconstruction of the breast on which a mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatments for physical complications of all stages of mastectomy, including lymphedemas.

Normal Deductible, Coinsurance, and/or Copayment amounts applicable to Your health coverage are also applicable to these benefits.

Grandfather Status

BCBSKS believes Your plan is a "grandfathered health plan" under the Affordable Care Act (ACA). Essentially, any plan in force prior to March 23, 2010, is considered grandfathered. As permitted by the ACA, a grandfathered plan can preserve certain basic health coverage that was already in effect when the law was enacted. This also means Your grandfathered health plan may not include certain consumer protections of the ACA that apply to other plans.

For questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan You may contact Customer Service at the telephone number listed on Your Identification Card. For plans subject to ERISA, You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or dol.gov/ebsa/healthreform.

Supplemental Endorsement Issued by Blue Cross and Blue Shield of Kansas, Inc.

Blue Cross and Blue Shield of Kansas offers savings and well-being programs collectively called HealthyOptions. These programs are not insurance and are offered at no additional cost. You may refer to Your BlueAccess account for additional details.

Blue Cross and Blue Shield of Kansas offers additional discounts through a Prescription Drug savings program. These programs are not insurance and are being offered at no additional cost.

These programs are made possible through arrangements with various providers and vendors. Changes in these arrangements and/or their discontinuance may occur in the future at the discretion of the Administrator.

Form APFL-137e 1/23

Privacy of financial and health information is of concern to all of us, and in response to these concerns, the federal government has required states to adopt laws that require insurance companies to explain their privacy practices. These laws are commonly known as HIPAA (privacy) and Gramm-Leach-Bliley (financial). Our Notice of Privacy Practices for health and financial information is available on our website at bcbsks.com/help/legal_privacy.

Our privacy practices for "non-public personal financial information" are also set out below. We want to assure You that we take Your privacy concerns seriously and join with Your lawmakers in believing this disclosure of such practices is a good idea.

OUR PRIVACY PRACTICES REGARDING FINANCIAL INFORMATION

Blue Cross and Blue Shield of Kansas has the following practices regarding nonpublic personally identifiable financial information with respect to our customers.

The nonpublic personal financial information we collect consists of information You provide in applications or enrollment forms (such as name, address, social security number, telephone number), or changes in that information You submit to us, and whether You hold other health coverage.

We collect such information from the following sources:

- Information we receive from You on applications or other forms;
- Information about Your transactions with us and our affiliate;
- Information we receive from others, if You hold duplicate coverage subject to coordination with coverages we issue or administer.

We do not disclose such information about our customers or former customers to anyone except:

- We disclose such information as permitted by law. Examples of disclosures we make which are permitted by law include disclosures of the fact of enrollment (a type of personally identifiable financial information) collected by one affiliate to the other, disclosures to persons providing services to us necessary to adjudicate claims, and disclosures to health care providers allowing such providers to determine Your eligibility for coverage.
- We may disclose Your name, address and telephone number which we receive from You on Your applications or other forms to companies that perform customer satisfaction or other surveys on our behalf. Such companies have agreed not to redisclose such information to others.

We restrict access to nonpublic personal financial information about You to those employees who need to know that information to provide products or services to You. We maintain physical, electronic, and procedural safeguards to guard Your personal financial information.

DEFINITIONS

This section lists definitions of terms that may be used throughout this document. Inclusion of a definition does not imply coverage. To determine if a specific service is covered under Your benefits, refer to the Covered Services and General Exclusions sections.

A. Definitions

1. **Accidental Injury:** an unintended injury to Your body caused through external means. "Accidental Injury" does not include: injuries that occur before the date from which You have had continuous coverage with the Administrator; disease or infection (except for infection that occurred from an accidental cut or wound); hernia; injuries to the teeth caused by biting or chewing.
2. **Administrator:** Blue Cross and Blue Shield of Kansas. Note: Blue Cross and Blue Shield of Kansas is not the Plan Administrator.
3. **Alternate Recipient:** any child of a Subscriber who is recognized under a Qualified Medical Child Support Order as having a right to enrollment under this Benefit Description.
4. **Benefit Description:** a document describing the benefits and provisions issued to each Subscriber.
5. **Brand:** a Prescription Drug that is or has been marketed under patent protection.
6. **Benefit Period:** the length of time during which a benefit is paid.
7. **Blue Cross and Blue Shield Plan:** the Administrator and any other corporation approved or licensed by the Blue Cross Blue Shield Association to use the registered service marks and names.
8. **Coinsurance:** the percentage of the allowable charge You pay for covered services per Benefit Period.
9. **Compound Drug:** prescription medication that is manufactured by a Pharmacy when no suitable commercial alternative is available, and for which the sole purpose is to prepare a Medically Necessary dosage form.
10. **Contracting Provider:** an Eligible Provider who has entered into a Contracting Provider Agreement with the Administrator.
11. **Convalescent Care, Custodial/Maintenance Care or Rest Cures:** treatment or services, regardless of by whom recommended or where provided, in which the service could be rendered safely and reasonably by self, family, or other caregivers who are not Eligible Providers. The purpose of the services are designed mainly to help the patient with daily living activities, to maintain their present physical and mental condition, or provide a structured or safe environment.
12. **Copayment:** a fixed amount of the allowable charge You pay for:
    a. a covered service per instance of that service.
    b. a covered Prescription Drug each time Your Prescription Order is filled or refilled.
13. **Cost Sharing:** Your out-of-pocket costs related to covered services which include, but are not limited to, Deductibles, Coinsurance and/or Copayments, or similar charges.
14. **Credible Evidence:** scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations or consensus among experts.
15. **Deductible:** a fixed amount of the allowable charge You pay for covered services per Benefit Period.
16. **Designated Telemedicine Provider:** the Eligible Provider contracting with the Telemedicine entity designated by the Administrator.
17. **Diabetic Supplies:** supplies used exclusively with diabetic management, including but not limited to syringes, needles, lancet devices and lancets, test strips and control solutions, continuous glucose monitors and supplies, and calibration strips.
18. **Eligible Provider:** any of the following providers when services provided are within the scope of the Facilities (IDTFs) are not considered Eligible Providers unless they meet the applicable criteria as set out in the definitions below.
    a. **Ambulance Service:** any form of transportation specially designed, equipped, and intended to be used for the purpose of transporting ill or injured persons and is operated according to state and local laws which control the issuing of valid licenses or permits for the operation of an Ambulance Service.
    b. **Ambulatory Surgical Center:** a facility that meets all of the following criteria:
        (1) is licensed by the proper licensing agency as an Ambulatory Surgical Center
        (2) is not a part of a Hospital

(3) provides hospital-type services for Outpatient surgery

c. **Eligible Providers for Telemedicine:**

(1) Advanced Practice Registered Nurse (APRN)/Advanced Registered Nurse Practitioner (ARNP) or Physician Assistant (PA) under the direct supervision of a licensed physician

(2) Audiologist (AUD)

(3) Doctor of Medicine (MD) or Doctor of Osteopathy (DO)

(4) Providers licensed, registered, certified, or otherwise authorized to practice by a behavioral sciences regulatory board

(5) Speech-Language Pathologist (SLP)

d. **Free-Standing Birthing Center:** a facility, operated by a licensed physician, that performs uncomplicated normal/routine (i.e., non-Cesarean) deliveries of newborns.

e. **Free-Standing Cardiac Catheterization Laboratory:**

(1) A facility approved by Medicare to perform diagnostic cardiac catheterization procedures

(2) Performs only diagnostic cardiac catheterization procedures

(3) Does so in a non-Hospital outpatient setting

f. **Free-Standing Dialysis Center:** a facility approved by Medicare to perform dialysis and related services.

g. **Free-Standing Imaging Center:** a facility operated by a licensed physician and approved by Medicare to perform specialized diagnostic and radiologic tests.

h. **Free-Standing Sleep Center/Laboratory:** a facility that only performs sleep studies.

i. **Home Health Agency:** a public agency or private organization which is primarily engaged in providing Skilled Nursing Care services and other therapeutic services in the patient's place of residence that is licensed pursuant to the pertinent state and local authority and is certified by Medicare. The Medicare certification requirement does not apply to pediatric home health agencies.

j. **Hospital:** any of the following types of institutions:

(1) The acute care, psychiatric, rehabilitation and long-term acute care sections of a licensed general hospital

(2) Other facilities licensed by their state of operation as a hospital that provide acute care services

(3) Licensed privately operated psychiatric hospitals

(4) Health care institutions operated by the State of Kansas or the United States government

Hospital does not include any of the following, even if licensed as a hospital:

(1) Ambulatory Surgical Centers

(2) Clinics

(3) Practitioner's offices

(4) Facilities that are primarily for the care of convalescents

(5) Health resorts

(6) Nursing homes

(7) Private homes

(8) Residential or transitional living centers

(9) Residential treatment centers or similar facilities

(10) Rest homes

(11) Skilled Nursing Facilities

k. **Independent Diagnostic Testing Facility (IDTF):** eligible only for ambulatory event monitors, mobile cardiac outpatient telemetry and nerve conduction studies.

l. **Independent Laboratory:** a medical laboratory that is CLIA-certified Medicare to perform diagnostic and/or clinical tests and is independent of an Institutional Provider or a Professional Provider's office.

m. **Institutional Provider:** a Hospital, Medical Care Facility, or Ambulatory Surgical Center.

n. **Medical Care Facility:** a facility that is not a Hospital (see definition) but that is: an alcoholic treatment facility; a drug abuse treatment facility; or a community mental health center. To qualify as a Medical Care Facility, the facility must also be licensed by the State of Kansas to provide diagnosis and/or treatment of a Mental Illness or Substance Use Disorder.

o. **Professional Provider (Practitioner):** any of the following health practitioners licensed or certified to provide health services in the state of Kansas, or equivalent practitioners licensed or certified in the state in which covered services are received:

(1) Advanced Registered Nurse Practitioner (ARNP)/Advanced Practice Registered Nurse (APRN)

(2) Any of the following when authorized to engage in private, independent practice under the laws of the state in which covered services are received:

(a) Licensed Clinical Marriage and Family Therapist (LCMFT)

(b) Licensed Clinical Professional Counselor (LCPC)

(c) Licensed Clinical Psychotherapist (LCP)

(d) Licensed Marriage and Family Therapist (LMFT)

(e) Licensed Professional Counselor (LPC)

(f) Licensed Specialist Clinical Social Worker (LSCSW)

(3) Athletic Trainer (AT)

(4) Audiologist (AUD)

(5) Autism Specialist or Intensive Individual Service Provider as defined by the Kansas Department for Aging and Disability Services

(6) Certified Diabetes Educator (CDE)

(7) Certified Nurse-Midwife

(8) Certified Registered Nurse Anesthetists (CRNA)

(9) Doctor of Chiropractic (DC)

(10) Doctor of Dental Surgery (DDS)

(11) Doctor of Medicine (MD)

(12) Doctor of Optometry (OD)

(13) Doctor of Osteopathy (DO)

(14) Doctor of Podiatric Medicine (DPM)

(15) Licensed Acupuncturist (LAC)

(16) Licensed Addiction Counselor (LAC)

(17) Licensed Bachelor's Social Worker (LBSW)

(18) Licensed Dental Hygienist (LDH)

(19) Licensed Dietitian (LD)

(20) Licensed Master's Level Addiction Counselor (LMAC)

(21) Licensed Master's Level Psychologist (LMLP)

(22) Licensed Master's Social Worker (LMSW)

(23) Licensed Mental Health Technician (LMHT)

(24) Licensed Naturopathic Doctor (LND)

(25) Licensed Physical Therapist (LPT)

(26) Licensed Practical Nurse (LPN)

(27) Licensed Radiological Technologist (LRTC)

(28) Licensed Respiratory Therapist (LRT)

(29) Occupational Therapist (OT)

(30) Oral Surgeon

(31) Physician Assistant (PA)

(32) Psychologist licensed to practice under the laws of the state in which covered services are received

(33) Registered Nurse (RN)

(34) Registered Pharmacist (RPH)

(35) Speech-Language Pathologist (SLP)

p. **Residential Treatment Center:** a facility which provides 24-hour care for Mental Illness or Substance Use Disorders and is licensed to provide Covered Services by the state in which it is located.

q. **Other Eligible Providers** (as limited herein)**:**

(1) Adjunct Providers: only the following providers that perform Covered Services under the direction of a Professional Provider.

(a) Certified Occupational Therapy Assistant

(b) Certified Physical (Therapy) Therapist Assistant

(2) Orthopedic/Prosthetic Device Supplier

(3) Home Medical Equipment Supplier

(4) Infusion Therapy Providers licensed to provide infusion therapy in the state in which services are received, e.g., infusion suites, home infusion therapy providers.

(5) Specialty Pharmacy for dispensing Specialty Prescription Drugs eligible for coverage under the Comprehensive Program.

(6) Hospice: a Medicare Certified organization or agency providing comprehensive, continuous Outpatient and home-like Inpatient care for terminally ill patients and their families and is licensed to practice under the laws of the state in which covered services are received.

(7) Ancillary Provider: a Home Medical Equipment Supplier, an Independent Laboratory, an Air Ambulance, or a Specialty Pharmacy located outside the Kansas Plan Area.

(8) Methadone Clinic: a clinic that is certified by SAMHSA (Substance Abuse and Mental Health Services Administration), licensed by the state in which they operate, accredited by a SAMHSA-approved accrediting body such as CARF International, Council on Accreditation, or The Joint Commission, and registered with the DEA (Drug Enforcement Agency) to provide methadone treatment as part of an opioid treatment program.

19. **Experimental or Investigational:** refers to the status of a drug, device, medical treatment or procedure:

a. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished and the drug or device is not Research-Urgent as defined in these Definitions; or

b. if Credible Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined in these Definitions; or

c. if Credible Evidence shows that the consensus among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined in these Definitions; or

d. if there is no Credible Evidence available that would support the use of the drug, device, medical treatment or procedure compared to the standard means of treatment or diagnosis.

20. **Formulary:** a list of both Brand and Generic Prescription Drugs reviewed and updated by a Pharmacy and Therapeutics Committee. The Formulary is subject to periodic review and modification. The Formulary name is located on the back of Your Identification Card.

The Formulary applies only to Prescription Drugs covered under this Program. The Formulary does not apply to Inpatient medications or to medications administered by a Professional Provider. The level of benefits You receive under this Program will be affected by a Prescription Drug's Generic/Brand status on the Formulary.

21. **Generic:** a Prescription Drug that: a) is equivalent to a Brand Drug; b) is available after the patent on that Brand Drug has expired and c) is available from more than one source. Equivalent means therapeutic equivalent as determined by the U.S. Food and Drug Administration.
22. **Identification Card:** a card issued to identify You as a Subscriber of the Program.
23. **Inpatient:** a setting where services are provided when You have been admitted to a Hospital or Medical Care Facility.
24. **Intensive Care Unit:** a specialized room or area or section in a Hospital which includes:
    a. Beds in a distinctly identifiable unit that are used only for critically ill or injured patients
    b. A separate nursing staff, with a qualified Registered Nurse in 24-hour attendance while the unit is occupied ("Qualified" means the nurse has had special training in intensive care nursing.)
    c. Special supplies and equipment needed to care for critically ill or injured patients.
25. **Kansas Plan Area:** the State of Kansas except Johnson and Wyandotte Counties.
26. **Mail Order Pharmacy:** an establishment that is registered or licensed in the state in which it is domiciled, from which Prescription Drugs are dispensed by a Pharmacist, which has entered into a written agreement to provide Prescription Drugs to Subscribers of the Administrator who are eligible under this Program, and which has been separately identified to Subscribers in a directory or through some other means. The Mail Order Pharmacy, after receiving and processing Your Prescription Order, will deliver the Prescription Drugs through a parcel delivery service company.
27. **Medical Emergency:** a sudden and, at the time, unexpected onset of a health condition that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect to require immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. Medical Emergency does not include the onset of a health condition while an Inpatient. A health condition is no longer considered a Medical Emergency once stabilization (i.e., no material deterioration of the health condition is likely to result from a transfer or during a transfer) has occurred.
28. **Medically Necessary:** a service or supply that is:
    a. performed, referred, and/or prescribed by a duly licensed provider; and
    b. provided in the most appropriate setting and consistent with the diagnosis and treatment of the Subscriber's condition; and
    c. in accordance with the current generally accepted standards of medical practice in the United States based on credible scientific evidence; and
    d. not primarily for the convenience of the patient, physician or other health care provider; and
    e. not more costly than an alternative service or supply or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the Subscriber's illness, injury or disease.
29. **Medicare:** Title XVIII of the Social Security Act as amended now and in the future, any rules and regulations authorized by any agency authorized to administer that Act.
30. **Mental Illness or Substance Use Disorder:** a disorder specified in the Diagnostic and Statistical Manual of the American Psychiatric Association IV (1994). This does not include any condition or problem that is designated in the DSM IV (1994) as a focus of clinical attention.
31. **Non-Contracting Provider:** an Eligible Provider who has not entered into a Contracting Provider Agreement with the Administrator.
32. **Open Enrollment:** the period of time during which eligible persons who have not previously enrolled with the Administrator within the time periods specified, following their first opportunity or an event, as defined by state or federal law, that qualifies them for coverage, may do so. This time period is the 30 days preceding the anniversary month of the underwriter of this program. If agreed upon by the underwriter of this program and the Administrator, different, additional or longer Open Enrollment Periods may be established.
33. **Out-of-Pocket Maximum:** the total amount of applicable Cost Sharing under the Comprehensive Program, Prescription Drug Program and/or Mail Order Prescription Drug Program for which You are responsible per Benefit Period. If You are enrolled in a Dental Care Program, the applicable dental Cost Sharing amounts do not apply to this Out-of-Pocket Maximum. The Out-of-Pocket Maximum never includes Your premium, balance-billed charges, or health care Your health insurance or plan doesn't cover.

34. **Outpatient:** a setting where provided services are other than as an Inpatient in a Hospital or Medical Care Facility. These settings include but are not limited to the Outpatient department of a Hospital, an Ambulatory Surgical Center, a clinic or a Professional Provider's office.
35. **Palliative Care:** treatment directed at controlling pain, relieving other physical and emotional symptoms and focusing on the special needs of the patient with life-limiting illnesses as well as their families, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.
36. **Plan Administrator:** the entity legally responsible for the administration of Your group health plan as established under Your employer's plan document.
37. **Pharmacist:** a person registered or licensed under that individual's State laws to dispense Prescription Drugs and/or administer vaccines and immunizations.
38. **Pharmacy:** an establishment, registered or licensed, where Prescription Drugs are dispensed by a Pharmacist. Pharmacies are further classified as:
    a. **Contracting Pharmacy or Network Pharmacy:** a Pharmacy which has entered into a written network participation agreement with the Administrator and/or a Pharmacy Benefit Manager.
        (1) **Contracting Extended Supply Network (ESN) Pharmacy:** a Pharmacy which has entered into a written agreement with the Administrator and/or a Pharmacy Benefit Manager (PBM) to provide 90 day supplies of covered Prescription Drug products.
        (2) **Vaccine Network Pharmacy:** a Pharmacy which has entered into a written network participation agreement with the Administrator and/or a Pharmacy Benefit Manager specifically to administer vaccines and immunizations.
    b. **Non-Contracting Pharmacy:** a Pharmacy which has not entered into a written network participation agreement with the Administrator or Pharmacy Benefit Manager.
    c. **Specialty Pharmacy:** a Pharmacy that dispenses Specialty Prescription Drugs.
        (1) **Contracting Specialty Pharmacy or Network Specialty Pharmacy:** a Pharmacy which has entered into a written network participation agreement with the Administrator and/or a Pharmacy Benefit Manager to provide Specialty Prescription Drugs.
        (2) **Designated Specialty Pharmacy:** the Specialty Pharmacy designated by the Administrator from which You may receive benefits for Specialty Prescription Drugs.
39. **Pharmacy Benefit Manager (PBM):** an entity with which the Administrator contracts for the provision of administrative, utilization review and network services for the covered drug and supplies under this Program.
40. **Pharmacy and Therapeutics (P & T) Committee:** an independent committee, including but not limited to practicing physicians in various medical specialties and Pharmacists. This committee reviews scientific literature and reports, consults with other health care professionals, and uses their expertise to determine which medications should be added to or deleted from the Formulary. This committee evaluates drugs for safety, efficacy (ability in treating a disease or symptoms), and cost effectiveness.
41. **Prescription Drug:** a drug approved for general use in the United States by the U.S. Food and Drug Administration, assigned a National Drug Code (NDC) number and dispensed in compliance with federal or state laws pursuant to a Prescription Order or refill, and approved by Pharmacy Benefit Manager and/or Pharmacy and Therapeutics Committee. The P & T Committee has up to 180 days to determine a Prescription Drug status on the Formulary.
42. **Prescription Order:** the request Your Practitioner may legally issue for a Prescription Drug.
43. **Prior Authorization:** the process of determining whether certain Prescription Drugs are Medically Necessary based on criteria established by the Administrator.
44. **Program:** this healthcare plan as described in this Benefit Description.
45. **Rehabilitation Services:** therapies that, when provided in an Inpatient or Outpatient setting, are designed to restore physical functions following an Accidental Injury or an illness.
46. **Research-Urgent:** a drug, device, medical treatment or procedure that is otherwise excluded by Your Benefit Description as Experimental or Investigational (see Definitions and General Exclusions) but meet all the following criteria:
    a. It is therapeutic (not diagnostic or supportive) treatment used to directly improve health outcomes for a condition that is either life threatening or severely and chronically disabling and that has a poor prognosis with the most effective conventional treatment.

(1) For purposes of Research-Urgent Benefits a condition is considered life threatening if it has a substantial probability of causing premature death and all other conventional treatments have failed.

(2) For purposes of Research-Urgent Benefits a condition is considered severely and chronically disabling if the individual with the condition is unable to perform even the functions that are required for daily life and if the severe disability is not expected to improve with the most effective conventional treatment.

b. There is Credible Evidence that the treatment may provide a clinically significant and substantial improvement in net health outcome compared to the most effective conventional treatment, or where conventional treatment has failed or is not medically appropriate.

c. Regardless of funding source, the drug, device, medical treatment or procedure is available to the Subscriber seeking it and will be provided within a well designed clinical trial conducted by the National Institute of Health, Inc. or by an institution or entity which the protocol for the drug, device, medical treatment or procedure has been approved by an Institutional Review Board that is in compliance with the ethical principles in: (a) The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research or the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, or (b) other appropriate ethical standards recognized by federal departments and agencies that have adopted the Federal Policy for the Protection of Human Subjects.

47. **Skilled Nursing Care:** direct observation, direct care, management, education or treatment performed by a Registered Nurse, Licensed Practical Nurse or licensed vocational nurse.

48. **Skilled Nursing Facility:** a facility certified by Medicare as a Skilled Nursing Facility.

49. **Sound Natural Tooth:** a tooth that is whole or properly restored; is without advanced periodontal disease and is not in need of the treatment provided for any reason other than an Accidental Injury.

50. **Specialty Prescription Drug:** Prescription Drugs or classes of Prescription Drugs that are designated by the Administrator as Specialty Prescription Drugs. These include, but are not limited to, drugs that are self-administered by injection, inhaled or taken orally; drugs that may require special handling and storage; drugs that may require strict compliance and patient support; and drugs that may be available through limited distribution arrangement. The list of Specialty Prescription Drugs is on the Formulary. To find this list, go to bcbsks.com and log in to Your BlueAccess account. You may also contact Customer Service at the telephone number listed on Your Identification Card.

51. **Subscriber:** the person named on the Identification Card.

Subscriber also means the following persons that have been duly enrolled in the Administrator's records according to the specifications set forth in the Enrollment and Effective Dates Section:

a. The spouse of the Subscriber; and

b. Each dependent of the Subscriber or the Subscriber's spouse, by birth, adoption, legal guardianship, or court-ordered custody, who is:

(1) Under 26, or

(2) Age 26 or over and meets all of the following criteria:

(a) unmarried and incapable of self-support due to a severe disability resulting from a physical condition or a Mental Illness or Substance Use Disorder prior to the dependent's 26th birthday.

(b) covered as a dependent under a policy or certificate issued by the Administrator or other creditable coverage (as defined under HIPAA) upon reaching age 26. There must be no more than a 60-day gap in dependent coverage prior to application for disabled dependent coverage.

c. Domestic Partnership

Definitions:

Domestic partners are two persons, each aged 18 or older, who have chosen to live together in a committed relationship and who have agreed to be jointly responsible for living expenses incurred during the domestic partnership.

(1) Live Together. "Live together" means that two people share the same living quarters. Each partner must have the legal right, documented in writing, to possess the living quarters.

(2) Living Expenses. "Responsible for living expenses" means that the partners are jointly responsible for the common welfare and financial obligations of each other which are incurred during the domestic partnership.

Eligibility and Enrollment Criteria:

In order to be eligible for domestic partner coverage, the following criteria must be met:

(1) The benefit must be one for which the employee's spouse would be eligible, if the employee were married.

(2) The employee and the non-employee must be domestic partners according to the definition in above.

(3) Both members of the domestic partnership must have reached the age of 18 and be mentally competent to consent to contract.

(4) The employee and non-employee must be each other's sole domestic partner.

(5) Neither member of the domestic partnership may be married.

(6) Neither member of the domestic partnership may have had another domestic partner within the previous six months, unless that domestic partnership terminated by death.

(7) Neither of the partners is related to the other by blood as would prevent them from marrying under law (i.e., parent, child, sibling, half-sibling, grandparent, grandchild, niece, nephew, aunt, uncle).

(8) The domestic partners must share the same principal place of residence and intend to do so indefinitely. They must disclose the address of that residence.

(9) The domestic partners must agree that they both are jointly responsible for the common welfare and financial obligations of each other which are incurred during the domestic partnership.

(10) The domestic partners must intend that the circumstances which render them eligible for enrollment will remain so indefinitely.

(11) The domestic partners must acknowledge that they understand and agree that the employee domestic partner may make health plan and other benefit elections on behalf of the non-employee domestic partner.

(12) The domestic partners must acknowledge that the Company may require supportive documentation satisfactory to the Company concerning any and all eligibility criteria. Such documentation may include but not be limited to: a deed showing joint ownership of property, a lease stating both partners names as lessees, a joint bank account, or other similar documentation.

(13) The employee must acknowledge that he or she understands that under applicable federal and state tax law, Company-provided benefits coverage of the non-employee domestic partner could result in imputed taxable income to the employee, subject to income tax withholding and applicable payroll taxes.

(14) The domestic partners must agree to notify the Human Resources Department in writing within 30 days if there is any change of circumstances. The non-employee domestic partner must agree that the employee domestic partner may terminate the domestic partner benefits unilaterally, at any time, irrespective of the view of the non-employee. If the employee executes such an option, that employee shall notify the non-employee domestic partner as soon as possible that his or her benefits have been terminated and it shall be the sole responsibility of that employee to make such notification.

(15) The domestic partners must acknowledge that they understand that, if either has made a false statement regarding his or her qualification as a domestic partner or has failed to comply with the terms of the affidavit, the Company shall have the absolute right to terminate any and all of the domestic partner's benefits in accordance with the eligibility procedures specified in the health benefits plan. Additionally, if the Company suffers any loss thereby, the Company may bring a civil action against either or both of the domestic partners to recover its losses, including reasonable attorney's fees and court costs.

(16) The domestic partners must acknowledge that the Administrator of any benefit plan at issue will be the sole and final judge of whether a domestic partner is qualified for benefits.

Subscriber does not refer to persons who have been voluntarily disenrolled by the person named on the Identification Card.

52. **Telemedicine (telehealth):** the delivery of healthcare services or consultations while the Subscriber is at an originating site and the healthcare provider is at a distant site. Telemedicine may be provided by means of real-time two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support healthcare delivery, that facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a Subscriber's healthcare. Telemedicine does not include communications between

healthcare providers that consist solely of telephone voice-only conversations, emails, or facsimile transmissions, or communications between a physician and a Subscriber that consists solely of emails or facsimile transmissions.

53. **You or Your:** refer to definition of the Subscriber.

ENROLLMENT AND EFFECTIVE DATES

In order to enroll or make a change due to any of the events listed below, a qualified individual or Subscriber must notify the Administrator within 60 days of a triggering event. This may require the submission of a change form. The addition of new Subscribers due to one of these triggering events may require a change in coverage type and/or additional premiums.

For those who do not make application within the time periods set forth above, but who are enrolling in conjunction with an event, as defined by state or federal law, that qualifies them for coverage, such coverage will be effective on the first of the month following the event that qualifies them for coverage as long as the application is received by the Administrator within 60 days of the event except when the event is birth, adoption, placement for adoption, or discharge from the military in which case the effective date will be the date of the event.

A. Special Enrollment

An eligible employee, spouse, or dependent may enroll as a result of one of the following triggering events:

1. Triggering Events effective on the first of the month following the event
   a. Involuntary loss of other medical coverage in which:
      -- The other coverage was the basis for You, Your spouse, and/or dependent(s) declining coverage hereunder; AND
      -- The loss of other coverage occurred solely due to one of the following designated triggering events: loss of eligibility for such coverage or exhaustion of COBRA coverage. Note: Special Enrollment Rights are not recognized if coverage and/or eligibility was lost due to any of the following: failure on the part of the employee, spouse, or dependent, as applicable, to pay contributions/premiums on a timely basis, submission of fraudulent claims, or intentional misrepresentation of material information.
   b. Complete cessation of employer contributions toward non-continuation group coverage
   c. Adding a dependent or becoming a dependent through marriage. Applicable to the employee, spouse, and any newly-acquired dependent(s) only.
   d. Adding or retaining a dependent with a disability:
      (1) You must request from and submit to the Administrator a special application within 60 days of the latter of the following:
         (a) the dependent's 26th birthday (but no earlier than 60 days prior); or
         (b) the first opportunity for the dependent to enroll for coverage hereunder or accrual of a special enrollment right pursuant to HIPAA. The Administrator will then determine the dependent's eligibility.
      (2) The Administrator will request written proof from time to time related to this dependent's incapacity and dependence. This dependent's coverage will end when the dependent is no longer disabled or requires dependency from the Subscriber.
   e. Becoming eligible for a state premium assistance program under Medicaid or a state Children's Health Insurance Program (CHIP). Applicable to the employee and dependent(s) only.
2. Triggering Events effective the date of the event
   a. Adding a dependent through birth, adoption or placement for adoption: for the employee, spouse, and any newly-acquired dependent(s) only.
      (1) Subscriber only coverage: If the current coverage provides benefits for only one parent of the newborn child, coverage must be changed to a type which provides benefits for dependent children within 60 days of a triggering event, in order for the newborn child's coverage to continue beyond the initial 48 or 96 hour period.

      Covered services received by the child within the initial 48 or 96 hour period will be treated as though they were services received by the parent Subscriber.
      (2) Two or more Subscribers coverage: A newborn, an adopted child (regardless of age) or a child placed in the Subscriber's home by a child placement agency, as defined by state law for the purpose of adoption, is covered as follows, if the type of coverage is for two or more Subscribers:
         (a) Coverage is effective and provided without charge for 31 days beginning on the date of birth for:
            i. natural newborns
            ii. newborns for which the petition for adoption has been filed within 31 days following birth

Exception: If the petition of adoption is filed after 31 days of birth, coverage will be effective the date the petition for adoption was filed and provided without charge for 31 days.

iii. newborns placed in the Subscriber's home within 31 days following birth

Exception: If a child is placed after 31 days of birth, coverage will be effective the date of placement and provided without charge for 31 days.

B. Dependent coverage pursuant to a Qualified Medical Child Support Order

Coverage will be effective on the first day of the month following the date on which the Administrator qualifies the order. Medical Child Support Orders must be qualified by the underwriter of this program and the Administrator pursuant to specifications of federal and state law. The procedure for qualification is to timely submit the Medical Child Support Order to the underwriter of this program for initial qualification or rejection. The underwriter of this program will forward the order to the Administrator for qualification or rejection with notice to the parties to the order. If the order is qualified, an Identification Card, Benefit Description and claim form will be issued to the Alternate Recipient.

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COMPREHENSIVE PROGRAM

No Surprises Act:

a. **Continuity of Care:** In the event You are receiving continuity of care as described in the No Surprises Act, Your benefits will be the same as if the services were provided by a Contracting Provider for a period of 90 days or Your episode of care ends, whichever comes first.

b. **Cost Sharing:** Cost Sharing for out of network emergency services, air ambulance services, or services provided by an out of network provider at an in-network facility is set based on State and Federal regulations. Cost Sharing for these services will change year to year. For the most up to date information, please visit bcbsks.com/latest-news/no-surprises-act.

A. Benefits

1. **Benefit Period:** The 12 month period beginning on June 1, 2023.

2. **Deductible:** $3,000 for any one Subscriber, not to exceed $6,000 for all Subscribers on a family membership. This is not a separate Deductible from the Prescription Drug Program Deductible.

   Each Subscriber is only responsible for the $3,000 Deductible. The $6,000 Deductible can be met by eligible costs incurred by any combination of Subscribers enrolled under the same family plan.

3. **Coinsurance:** After Your Deductible has been met, Your benefits will be covered at 100% of the allowable charge.

4. **Preventive Health Benefits:** Each Subscriber is eligible to receive the following preventive services paid at 100% of the allowable charge when received from a Contracting Provider for preventive (i.e., not diagnostic or treatment) purposes. Preventive Health Services received from a Non-Contracting Provider will be subject to the Cost Sharing requirements (including copayments, coinsurance and deductible), applicable hereunder, in a manner consistent with 42 U.S.C. 300gg-13 for:

   a. evidence-based items or services that have in effect, a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;

   b. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

   c. with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

   d. with respect to women, such additional preventive care and screenings not described in item (a) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph (including breast cancer screening and mammography screenings).

   A list of the preventive services covered under this section is available on our website at bcbsks.com, or will be mailed to You upon request. You may request the list by calling the Customer Service number on Your Identification Card.

   Note: Benefits for any Prescription Drug under this Preventive Health Benefits section will be provided only to the extent they are available under Your Prescription Drug coverage with the Administrator, if applicable.

5. **Childhood Immunizations:** Benefit payments will be made at 100% of the allowable charge for a covered newborn from birth to 72 months of age for the following immunizations: at least five doses of vaccine against diphtheria, pertussis, tetanus; at least four doses of vaccine against polio and Haemophilus B (Hib) and three doses of vaccine against Hepatitis B; two doses of vaccine against measles, mumps and rubella; one dose of vaccine against varicella; and such other vaccines and dosages as may be prescribed by the secretary of health and environment.

6. **Any reduction made in allowable charges** due to the provider being non-contracting cannot be used to meet any Deductible, Coinsurance, Copayments and/or the Out-of-Pocket Maximum if applicable.

7. **Mental Illness or Substance Use Disorders:** Benefits for Inpatient and Outpatient Mental Illness or Substance Use Disorder services that are Medically Necessary will be provided at the same payment level that is applicable to the service if it had been provided for a condition other than Mental Illness or Substance Use Disorder, unless otherwise indicated. No annual dollar limits will apply.

8. **Diabetic Education**

   Benefits for a covered diabetic education service will be subject to the same payment provisions as an office visit.

9. **Speech Therapy:** Benefits are subject to the Deductible and/or Coinsurance provisions.

10. **Telemedicine:** Telemedicine is subject to the same provisions within the Benefits section for equivalent non-Telemedicine services.
11. **Bariatric Surgery:** Bariatric surgery will be subject to the Deductible and/or Coinsurance provisions. See the Bariatric Surgery Rider for more information.
12. **Obesity Services:** Obesity services will be subject to the applicable Cost Sharing provisions as equivalent non-obesity services. Covered services include nutritional counseling, office visits, and laboratory and radiology services for the purposes of treating obesity (BMI of 30 or higher).
13. **Wigs or Hair Prostheses:** Wigs or Hair Prostheses are covered for any diagnosis subject to Deductible and/or Coinsurance to a maximum benefit of $750 per Subscriber per Benefit Period.
14. **Reproductive Health (Infertility) Services):** Coverage related to conception through artificial means are subject to Deductible and/or Coinsurance and a lifetime max of $10,000 per Insured.

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B. General

1. All coverage under this section is subject to the service having been ordered by a Professional Provider with the legal authority to order such service, furnished or performed and billed for by an Eligible Provider with the legal authority to provide such service, and is Medically Necessary.
2. You have the right to select Your own provider. However, the Administrator does not guarantee the availability of any service and benefits shall be provided according to the cost-containment policies and procedures applicable to Contracting Providers, regardless whether Your Provider is actually a Contracting Provider.
3. "Except as limited" is a phrase You will see before explanations of services. It is a reminder that the terms of this Benefit Description -- especially exclusions -- may restrict Your benefits.
4. Prior Authorization is required for some Prescription Drugs covered under this Comprehensive Program. A list of those drugs is available at bcbsks.com or by contacting customer service. To obtain Prior Authorization Your physician must provide appropriate records to the Administrator prior to providing services and the Administrator will authorize coverage if the medical necessity is supported. Failure to obtain Prior Authorization will not result in a denial of benefits if medical necessity is supported when the claim is adjudicated.
5. Prompt Filing of Claims. Notice of Your claim must be given to the Administrator within 90 days after You receive services.

   You are responsible for making sure Your Institutional Provider or Professional Provider knows You are eligible for Covered Services and submits a claim for You.

   If Your provider does not submit a claim for You, You must do so Yourself. If You need help submitting a claim, call or write the home office.

   If it is not reasonably possible for You to submit a claim within 90 days after You receive services, You or someone authorized by You must submit the claim as soon as reasonably possible. No claim will be paid if not received by the Administrator within one (1) year and 90 days after You receive services.
6. Site of Care Program: infused or injected drugs subject to this program, must receive Prior Authorization and are covered only when provided by one of the following:

   a. Infusion Therapy Providers when such drugs are administered in the home or office setting.

   b. A Hospital specifically designated by the Administrator to administer such drugs.

   Drugs subject to this program, designated Hospitals and exception criteria are listed at bcbsks.com.
7. Certain High Cost Drugs and Therapies: certain drugs or therapies, as determined by the Administrator, may be subject to specific benefit, administration and billing requirements. Drugs and therapies subject to this program and the criteria are listed at bcbsks.com/costlydrugs.

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C. Covered Services

Unless otherwise specified, all covered services shall be subject to the applicable Cost Sharing provisions as described in the Benefits section(s).

1. **Inpatient Admission Services** -- Except as limited, the following are covered:

   a. Room accommodation, dietary and general nursing service, nursery care.

      Limitation: If You occupy a private room, only the average semi-private room rate (based on the provider's rates for rooms with two or more beds) is covered.

b. Intensive Care Unit facilities and services.

   Limitation: If You occupy an Intensive Care Unit room when it is not Medically Necessary but it is Medically Necessary for You to be in the Hospital, only the Hospital's average semi-private room rate (based on rates for rooms with two or more beds) is covered on such days.

c. Operating room services.

d. Delivery room service.

e. Surgical preparatory and recovery room services.

f. Clinical laboratory and pathology services.

g. Diagnostic radiology services and imaging studies.

h. Radiation therapy.

i. Drugs approved for use in the United States by the U.S. Food and Drug Administration, except drugs approved for experimental use and drugs for take-home use.

j. Surgical dressings, splints, and casts.

k. Chemotherapy, other than High-Dose Chemotherapy, for malignant conditions. (See the Special Situations section for High-Dose Chemotherapy with Hematopoietic Support benefits.)

l. Prostheses that require surgical insertion into the body and are furnished and billed by the Hospital or Ambulatory Surgical Center. This does not include artificial eyes, ears, and limbs.

m. Setups for intravenous solutions.

n. Setups for blood transfusions (including Blood plasma).

o. Oxygen and use of equipment for its administration.

p. Radioactive isotopes.

q. Electroencephalograms (EEGs) and electrocardiograms (EKGs).

r. Inhalation therapy/breathing treatment.

s. Physical or occupational therapy.

t. Anesthesia, including general anesthesia and facility charges for dental care provided to the following covered persons:

   (1) A child five (5) years of age and under

   (2) A person who is severely disabled

   (3) A person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided

u. Hemodialysis.

v. Services for a Mental Illness or Substance Use Disorder.

w. Inpatient services in a Hospital are covered for at least 48 hours following a vaginal delivery and at least 96 hours following delivery by a cesarean section for the newborn child of an Subscriber and the mother (if a Subscriber) of such newborn.

   The Administrator has the right to determine the medical necessity of any length of stay beyond the 48-96 hours described above.

Prior Authorization Requirement

Inpatient admissions require Prior Authorization by the Administrator unless the admission is for a Medical Emergency, a life-threatening condition, for obstetrical care or occurs outside the 50 United States.

You or Your Practitioner will need to notify the Administrator to obtain the Prior Authorization. Notice should be given to the Administrator at least 72 hours in advance of the planned admission and should include: The patient's name, date of birth, identification number, telephone number, address, Hospital name, planned date of admission, reason for admission, admitting physician's name. The notification may be telephoned to the Administrator at the telephone number on the Subscriber's Identification Card.

The Administrator has the right to request and obtain whatever medical information it considers necessary to determine whether admission as an Inpatient is Medically Necessary. If it is, the Administrator will notify You, the Hospital and the admitting physician of approval. If inpatient admission is not deemed Medically Necessary You will be notified, as will be the Hospital and admitting physician.

Prior Authorization of an admission or any service is related solely to the medical necessity of the service and is not a determination of the eligibility of the service under other provisions of this Benefit Description.

If You fail to obtain a necessary Prior Authorization, the Administrator will review that admission for medical necessity. No coverage will be provided under this Program for services determined to be medically unnecessary. Only that portion of the inpatient claim that would normally be payable if services were received as an outpatient will be covered.

2. **Hospital Services for an Outpatient.**

   Except as limited, Covered Services by a Hospital for an Outpatient will include all services listed in C.1.c through v when the service is received in the Outpatient department of the Hospital. Infused and injected drugs may be subject to the Site of Care program discussed above, in section B.

3. **Ambulatory Surgical Center Services.**

   Except as limited, the services listed in C.1.c through u are covered when billed by an Ambulatory Surgical Center.

4. **Professional Provider Services.**

   a. Except as limited, the following are covered:

      (1) Surgery and anesthesia services to include coverage for the administration of general anesthesia for dental care provided to the following covered persons:

         (a) A child five (5) years of age and under

         (b) A person who is severely disabled

         (c) A person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided

      (2) Treatment of fractures and dislocations

      (3) Biopsies and aspirations

      (4) Endoscopic (scope) procedures

      (5) Maternity services

      (6) Inpatient medical (non-surgical) services (See 4.b for details of this benefit)

      (7) Diagnostic radiology services and imaging studies

      (8) Diagnostic laboratory services

      (9) Radiation therapy

      (10) Chemotherapy, other than High-Dose Chemotherapy, for malignant conditions (See 4.c for details of the standard chemotherapy benefit and the Special Situations section for High-Dose Chemotherapy with Hematopoietic Support benefits)

      (11) Diagnostic radio isotope studies

      (12) Electroencephalograms (EEGs) and electrocardiograms (EKGs)

      (13) Rehabilitation services (See 4.e for details of this benefit)

      (14) Home and office visits

      (15) Immunizations, injections and infusions subject to any Prior Authorization requirements of this Benefit Description that are otherwise applicable to these services. Infused and injected drugs may be subject to the Site of Care program discussed above, in section B.

      (16) Allergy testing

      (17) Transfusions (but not the cost of the blood itself)

      (18) Oral surgery and certain other dental services (See 4.d for details of this benefit)

      (19) Pap Smears

      (20) Prescription contraceptive devices including placement and fitting of the device itself

      (21) Surgical procedures for the implantation of Bone Anchored Hearing Aids (BAHA)

      (22) Services for a Mental Illness or Substance Use Disorder

(23) Coverage for Prostate Cancer Screening for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older. The screening may consist of a Prostate Specific Antigen (PSA) test and/or a digital rectal examination.

(24) Coverage for services related to diagnosis, treatment and management of osteoporosis for individuals with a condition or medical history for which bone mass measurement is medically necessary for such an individual. Coverage is subject to the same Deductible, Coinsurance and other limitations as apply to other covered services.

(25) Diagnosis and treatment of cause of infertility

b. Inpatient medical (non-surgical) services include:

(1) Visits by the attending Practitioner.

Limitations:

(a) During a stay for surgery, Medical (Non-Surgical) Services given by a Practitioner other than the surgeon will not be covered unless they are Medically Necessary.

(b) If non-surgical treatment is given by two (2) or more Practitioners at the same time, only one (1) Practitioner will be paid for services.

(2) Consultations.

(a) The first visit of a Practitioner to give professional advice about Your condition is covered if the visit is requested by the attending Practitioner and Your condition requires special skill or knowledge. This consultation benefit is normally limited to one (1) during each Hospital stay. However, additional consultations may be approved with individual consideration of Your condition.

(b) Consultations required by Hospital rules and regulations are not covered.

(3) Well Baby Care.

(a) This covered service is for care of a well newborn during the mother's stay. It includes the normal Inpatient medical care for a newborn. The child must meet the applicable Deductible then this service is payable at the applicable Coinsurance amount.

c. Chemotherapy for malignant conditions.

(1) Chemotherapy administration services.

(2) Chemotherapy drugs that are injected or given intravenously or taken by mouth and under the direct supervision of Your Practitioner. Prescription Drugs for chemotherapy are covered under the health benefits section of this coverage only if You are not enrolled in Prescription Drug coverage.

(3) Home and office visits for treatment of an adverse reaction to chemotherapy.

(4) Any other services related to chemotherapy that are specifically stated as covered.

d. Oral Surgical Services and Services for Accidental Injuries to Sound Natural Teeth, limited to:

(1) Surgical procedures of the jaw and gums;

(2) Removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

(3) Removal of exostoses (bony growths) of the jaw and hard palate;

(4) Treatment of fractures and dislocations of the jaw and facial bones;

(5) Surgical removal of impacted teeth;

(6) Treatment (including replacement) for damage to or loss of Sound Natural Teeth caused by an Accidental Injury.

(7) Intra-oral dental imaging services in connection with covered oral surgery if treatment begins within 30 days.

(8) General anesthesia.

(9) Cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants and the associated fixed and/or removable prosthetic appliance when provided because of an Accidental Injury.

(10) Cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants and the associated fixed and/or removable prosthetic appliances following surgical resection of either benign or malignant lesions (NOT including inflammatory lesions).

Exclusions: The extraction of teeth (except impacted teeth); fillings; prophylaxis (cleaning); scaling, scraping and/or root planing; dentures; straightening of teeth; and other dental services not listed as covered.

e. Covered Rehabilitation Services. Except as limited, the following Rehabilitation Services are covered on both an Inpatient and Outpatient basis:

(1) Physical medicine, includes physical and occupational therapy and modalities/therapeutic procedures.

(2) Speech therapy.

(3) Respiratory therapy.

(4) Neuropsychological testing.

(5) Cardiac Rehabilitation program or provider approved by the Administrator.

(6) Pulmonary Rehabilitation program or provider approved by the Administrator.

(7) Manipulations.

Limitations:

(1) Services are covered only if they are expected to result in significant improvement in the Subscriber's condition. The Administrator, with appropriate medical consultation, will determine whether significant improvement has occurred.

(2) Cardiac and pulmonary rehabilitation programs are covered services only when provided by a provider whose program has been approved by the Administrator. You can obtain a list of approved programs, by calling the Customer Service number on Your Identification Card.

Exclusions:

(1) Vocational rehabilitation. Vocational rehabilitation is a process to restore or develop the working ability of the physically, emotionally or mentally disabled patients to the extent that they may become gainfully employed. This may include services provided to determine eligibility or provide treatment for vocational rehabilitation, to include but not limited to counseling, work trials and driving lessons.

(2) Therapies designed to evaluate and assist an individual in developing a program to complete the individual's work and prevent physical damage or reinjury.

(3) Cognitive therapy. Cognitive therapy is a service provided to retain or enhance information processing due to brain damage or brain dysfunction which alters the way in which a person perceives or responds. These therapies include, but are not limited to treatment of memory loss, problem solving difficulties, short attention span, or inability to scan visually. Cognitive therapy services may also be known as multi-sensory programs, educational therapies, perceptual therapies, sensory integration, auditory integrative training, augmentative/alternative communication, discrete training trials, developmental therapy or similar therapies. For the purposes of this Benefit Description, cognitive therapy services do not include neuropsychological testing.

f. Services for Autism Spectrum Disorder

(1) Definitions:

(a) Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior;

(b) Autism Spectrum Disorder (ASD) means a neurobiological disorder which includes autistic disorder, Asperger's disorder, pervasive developmental disorder not otherwise specified, Rett's disorder, and childhood disintegrative disorder when diagnosed by a licensed physician, licensed psychologist, or licensed specialist clinical social worker.

(2) Covered Services:

(a) ASD services include:

(i) diagnostic evaluations performed by a licensed physician, licensed psychologist or licensed specialist clinical social worker;

(ii) treatment, including ABA therapy, limited to care, services, and related equipment prescribed or ordered by a licensed physician, licensed psychologist or licensed specialist clinical social worker;

(b) Only those services actually provided on an hourly basis or fractional portion thereof by certified ABA providers are covered.

(c) ABA therapy services require Prior Authorization by the Administrator. You or Your Practitioner will need to notify the Administrator to obtain Prior Authorization. Notice should be given to the Administrator at least 72 hours in advance of the planned ABA therapy services and should include: the patient's name, date of birth, identification number, telephone number, address, the name of the prescribing physician, psychologist or licensed clinical specialist social worker and the date the patient was first diagnosed with autism spectrum disorder.

The Administrator has the right to request and obtain whatever medical information it considers necessary to determine whether the ABA therapy services are Medically Necessary. If it is, the Administrator will notify You and the treating provider of approval. If ABA treatment is not deemed Medically Necessary You and the treating provider will be notified.

If You fail to obtain a necessary Prior Authorization, the Administrator will review the ABA services for medical necessity. No coverage will be provided under this Program for services determined to be medically unnecessary.

(3) Exclusions:

(a) Full or partial day care or habilitation services, community support services, services at intermediate care facilities, school-based rehabilitative services, or overnight, boarding and extended stay services at facilities for autism patients; or

(b) Services that are otherwise provided, authorized or required to be provided by public or private schools receiving any state or federal funding for such services.

g. Orthopedic, orthotic and prosthetic devices and appliances, including orthopedic braces, artificial eyes and auditory osseointegrated devices other than myoelectric/microprocessor-controlled prosthetic limbs.

Limitations:

(1) Benefits are not provided for eyeglasses and contact lenses.

Exceptions:

(a) For Subscribers over 12 years of age, benefits are available for the initial eyeglasses or contacts, to include lens add-ons, within one year following surgery for age related, congenital or traumatic cataracts resulting from aphakia, or pseudophakia.

(b) For Subscribers under 12 years of age, benefits are available for the initial eyeglasses or contacts, to include lens add-ons, within one year following surgery for age related, congenital or traumatic cataracts resulting from aphakia or pseudophakia. A second pair of eyeglasses or contacts are available when there is a minimum change of .25 diopter.

(2) Benefits are not provided for hearing aids or dental appliances including plates, bridges, prostheses or braces.

(3) Benefits are not provided for items of wearing apparel except coverage is available for two post-mastectomy bras per Subscriber per Benefit Period. A post-mastectomy bra is a bra that is specifically designed and intended to support single or bilateral breast prostheses.

(4) Benefits are limited to the allowable amount for a basic/standard appliance which provides the essential function(s) required for the treatment or amelioration of the medical condition.

(5) Charges for deluxe or electrically/electronically operated appliances or devices (or any components of such appliances or devices) are not covered beyond the allowable amount for basic/standard appliances. Deluxe describes medical devices or appliances that have enhancements that allow for additional convenience or use beyond that provided by a basic/standard device or appliance.

(6) Benefits are not provided for custom or over the counter orthotic appliances or devices (including shoe inserts.)

(7) Benefits are not provided for repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect, or to replace lost or stolen items.

h. Myoelectric/microprocessor-controlled prosthetic components and limbs are covered when provided by a certified Orthopedic/Prosthetic Device Supplier and to the extent medically necessary to replace or improve functioning of a body part as determined through medical records and documentation by

the treating physician for the resumption of daily activities based on the Subscriber's functional classification level as defined by Medicare for the following limbs: hand, wrist, elbow, foot, ankle, knee. In addition, this benefit includes coverage associated with the use, maintenance, sizing and repair of prosthetic devices. These device components are covered at an allowable charge greater than for basic/standard devices.

Limitations:

(1) Benefits are not provided for repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect, or to replace lost or stolen items.

(2) Benefits are not provided for implantable prosthetic components and limbs, exoskeleton prosthetic devices or cosmetic components and coverings for prosthetic devices.

i. Medical Equipment and Supplies.

(1) Equipment for use in Your home is covered if:

(a) Prescribed by a Practitioner for use in the home

(b) Not provided by a Hospital

(c) Serves a medical purpose

(d) Not an item that would ordinarily be of use to a person in the absence of a medical need. This includes items such as hemodialysis equipment, wheelchairs and hospital-type beds.

(2) Medical Supplies: Coverage is also available for certain supplies as designated by the Administrator. You can obtain a list of covered supplies by contacting Customer Service at the number listed on Your Identification Card.

Limitations:

(1) Items for comfort or convenience are not covered. Included within the definition of convenience items are:

(a) Pieces of equipment used to provide exercise to functioning and non-functioning portions of the body when leased, purchased, or rented for use outside a recognized institutional facility.

(b) Those pieces of equipment designed to provide the walking capability for individuals with non-functioning legs.

(2) The Administrator has the right to decide whether to provide for the rental or purchase of a covered item, to apply rental payments to purchase, and to stop covering rental when the item is no longer Medically Necessary.

(3) Benefits are limited to the allowable amount for a basic/standard item which provides the essential function(s) required for the treatment or amelioration of the medical condition.

(4) Charges for deluxe or electrically/electronically operated medical equipment (or any components of such equipment) are not covered beyond the allowable amount for basic/standard items. Deluxe describes medical equipment that has enhancements that allow for additional convenience or use beyond that provided by basic/standard equipment. For example, if an electric wheelchair is obtained, the benefit will not exceed the amount for a hand-operated wheelchair.

j. Allergy Antigens.

k. Services associated with intravenous drug treatment, intralesional drug treatment, intratympanic drug treatment, and hemodialysis, including Prescription Drugs, supplies, equipment and nursing services by Eligible Providers. Infused and injected drugs may be subject to the Site of Care program discussed above, in section B.

(1) Benefits for certain Prescription Drugs or devices found on the Outpatient Medical Drug Exclusion list are only covered when provided through the Prescription Drug Program and are not covered under the Comprehensive Program unless provided during a Medical Emergency (i.e. not routine/recurring Prescription Drug administration) in a Hospital emergency room. The Outpatient Medical Drug Exclusion list can be found at bcbsks.com/drugexclusions.

l. Diabetic Management.

(1) Equipment used exclusively with diabetes management.

Limitations:

(a) Benefits are limited to the allowable amount for a basic/standard item; charges for deluxe items are not covered.

(2) Coverage for Diabetic Supplies is provided under the Comprehensive Program only if the Subscriber does not have Prescription Drug coverage for such supplies.

(3) Insulin pump and insulin pump supplies used exclusively with diabetic management.

(4) Outpatient self-management training and education, including medical nutrition therapy, for insulin dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes when provided by a certified, registered or licensed health care professional with expertise in diabetes and the diabetic (1) is treated at a program approved by the American Diabetes Association or Association of Diabetes Care & Education Specialists (ADCES); (2) is treated by a person certified by the national certification board of diabetes educators; or (3) is, as to nutritional education, treated by a licensed dietitian pursuant to a treatment plan authorized by such healthcare professional.

m. Genetic Molecular Testing only in the following situations.

(1) When there are signs and/or symptoms of an inherited disease in the affected individual, there has been a physical examination, pre-test counseling, and other diagnostic studies, and the determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed.

(2) BRCA 1 and/or BRCA 2 testing according to the criteria established by the Administrator. Prior Authorization is required.

As used herein, "Genetic Molecular Testing", means analysis of nucleic acids used to diagnose a genetic disease, including but not limited to sequencing, methylation studies and linkage analysis.

n. Telemedicine

o. Palliative Care

p. Sleep studies, to include unattended sleep studies

5. **Reproductive Health (Infertility) Services:** Except as limited, the following are covered:

a. Artificial insemination including in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and similar procedures. This includes, but is not limited to, sperm and egg collection, preparation, transfer and implantation.

Exclusion:

(1) Prolonged sperm/egg freezing and storage

6. **Emergency Services:** Services necessary to provide a Subscriber with evaluation and stabilizing treatment when provided for a Medical Emergency.

7. **Ambulance Services:** Except as limited, Medically Necessary Ambulance Services are covered:

a. To the place of treatment following an Accidental Injury or during Medical Emergency

b. To a Hospital for care as an Inpatient

c. From a Hospital where You have been an Inpatient

d. For transfer of an Inpatient to another Hospital for care as an Inpatient

e. Within a 500-mile radius of the place where You are picked up, by the least expensive means or transport that meets the medical need

8. **Skilled Nursing Care**

All Skilled Nursing Care services, except home infusion and related services, require Prior Authorization by the Administrator in order to be eligible for benefits. If prior approval is not obtained, the Administrator has the right to request medical records to review to determine whether services are eligible under this Benefit Description.

a. Covered services that require that the patient be homebound:

A Subscriber will be considered to be homebound if the Subscriber has a condition due to illness or injury for which leaving the home is medically contraindicated. The Administrator has the right to determine whether the patient is homebound.

(1) Skilled Nursing Care visits include services provided by a Home Health Agency.

(2) Skilled Nursing Care services are covered when provided by a state licensed nursing agency or state licensed nurse on an hourly basis.

b. Covered services that do not require that the patient be homebound:

(1) Home care education associated with diabetes, colostomy care, wound care, IV therapy or any other condition or treatment which the Administrator has determined is appropriate for home care education, when provided by a Home Health Agency. Benefits for educational services will be limited to no more than three home care education visits per Benefit Period for which home care education is appropriate.

(2) Home infusion and related services. These services can be provided by either a Home Health Agency, state licensed nursing agency or state licensed nurse.

c. Skilled Nursing Care services do not include:

(1) Services provided by a member of the Subscriber's immediate family.

(2) Services provided by a person who normally lives in the Subscriber's home.

(3) Custodial/Maintenance Care. The Administrator has the right to determine which services are Custodial/Maintenance Care.

D. Special Situations

Unless otherwise specified, all covered services shall be subject to the applicable Cost Sharing provisions as described in the Benefits section(s).

1. **Case Management**

Case Management is a process conducted by the Administrator which:

a. Identifies cases involving a Subscriber which presents either the potential for catastrophic claims or a utilization pattern that exceeds the norms and demonstrates or has the potential for atypical utilization of services;

b. Assesses such cases for the appropriateness of the level of patient care and the setting in which it is received;

c. Reviews services requested by the provider for potential alternative use of benefits or coordination of existing benefits; and

d. Evaluates and monitors the requested services for cost efficient use of benefits.

e. Assists Subscribers with coordination of medical and/or Pharmacy providers when a Subscriber is required to participate in mandatory Case Management.

The services may include both covered services and non-covered services with the exception of specifically stated exclusions. Total benefits paid for such services shall not exceed the total benefits to which the Subscriber would otherwise be entitled under the terms of this Benefit Description.

If the Administrator elects to provide benefits for a Subscriber in one case, it shall not obligate the Administrator to provide the same or similar benefits for the same or another Subscriber in the same or another case.

Participation in Case Management is voluntary unless otherwise outlined within this Benefit Description.

2. **Research-Urgent Benefits.** Drugs, devices, medical treatments or procedures that are otherwise excluded as Experimental or Investigational but meet the criteria for Research-Urgent benefits as provided in the Definitions section. No benefits shall be available under this section for any Research-Urgent drug, device, medical treatment or procedure (or related services) that are provided free of charge to trial participants or for any Research-Urgent drug, device, medical treatment or procedure that are excluded by another provision of this Benefit Description.

3. **Penile Prosthesis for Physiological Impotence**

Benefits are provided for a penile prosthesis required for physiological (not psychological) impotence, subject to advance approval by the Administrator only in the following situations: trauma, radical pelvic surgery, diabetes, Peyronie's Disease, vascular or neurological diseases when individual situation warrants coverage in the Administrator's opinion.

To request advance approval, a written report prepared by Your Practitioner must be submitted to the Administrator. The Administrator has the right to request and obtain medical information it considers needed to determine whether benefits should be approved or not.

Benefits are not provided for services of sleep laboratories for nocturnal penile tumescence testing.

4. **Home Social Work Visits**

Covered home social work visits include services provided in the Subscriber's home by a licensed social worker that is an Eligible Provider.

A Subscriber must be homebound for services to be eligible. A Subscriber will be considered to be homebound if the Subscriber has a condition due to illness or injury for which leaving the home is medically contraindicated. The Administrator has the right to determine whether the patient is homebound.

All home social work visits require Prior Authorization by the Administrator in order to be eligible for benefits. If prior approval is not obtained, the Administrator has the right to request medical records to review to determine whether services are eligible under this Benefit Description.

5. **Hospice Care**

Definitions

a. **Hospice Care Plan:** a coordinated plan of care which provides Palliative Care for the Hospice Patient. This plan is designed to provide care to meet the special needs during the final stages of a terminal illness.

b. **Hospice Patient's Family:** the Hospice Patient's immediate family, including a spouse, brother, sister, child or parent. Other relations and individuals with significant personal ties to the Hospice Patient may be designated as members of the Hospice Patient's Family by mutual agreement among the Hospice Patient, the relation or individual and the Hospice Team.

c. **Hospice Patient:** a patient diagnosed or referred by a physician, to a Hospice and who alone, or in conjunction with designated family members, has requested and received admission into a hospice program. Written certification by the patient's Practitioner that the Hospice Patient has a life expectancy of 6 months or less is required.

d. **Hospice Team or Interdisciplinary Group:** the attending physician and the following hospice personnel: physician, registered or licensed practical nurses, licensed social workers, pastoral or other counselors. Providers of special services, such as mental health, Pharmacy, home health aides, trained volunteers and any other appropriate allied health services shall also be included on the Interdisciplinary Group as the needs of the patient dictate.

Election of Hospice Benefits

In order for You to receive Hospice benefits for the covered services listed below, the Administrator must receive a copy of a hospice election form and the informed consent form from a Medicare certified Hospice. If these forms are not received, benefits of this Hospice Care provision will not be available and services You receive will be processed according to the benefits and limitations of this Benefit Description other than those listed in this Hospice Care provision.

All Hospice Care services require Prior Authorization by the Administrator in order to be eligible for benefits. If prior approval is not obtained, the Administrator has the right to request medical records for review to determine whether services are eligible under this Benefit Description.

Eligibility of Services

a. Once Hospice benefits are elected, coverage for the terminal illness and related conditions is limited to the coverage listed in this Hospice Care provision unless specified otherwise.

b. Coverage under this Hospice Care provision is available only for Palliative Care. If the Administrator determines the care provided is not Palliative Care, benefits of this Hospice Care provision cease to be available.

c. When covered services are not available from a Hospice provider (for example individual psychotherapy services) and the Subscriber is referred to another provider of service, benefits are not available under this Hospice Care provision, except as provided under the description of Covered Services.

In situations b. and c. listed above when services are not eligible for benefits under the Hospice Care provision the services will be processed according to the benefits and limitations of this Benefit Description other than those listed in this Hospice Care provision.

Covered Services

Covered Hospice Care includes the following services provided by a Medicare certified Hospice (or an Institutional or Professional Provider under the direction of a Medicare certified Hospice and not charging for services separately from the Hospice). Covered services also include the following when provided for routine home care according to the Hospice Care Plan:

a. Nursing care.

b. Home health aide services.

c. Social work services.

d. Pastoral services.

e. Volunteer support.

f. Bereavement services.

g. Counseling services.

h. Dietary and nutritional counseling/services.

i. All drugs, medical supplies, and equipment related to the terminal illness.

j. Speech therapy.

k. Occupational therapy.

l. Physical therapy.

m. Lab fees.

n. Home medical equipment.

o. Educational services.

p. Other services and supplies provided through the Medicare certified Hospice (excluding Inpatient Hospital care and Inpatient or Outpatient physician's visits) recommended by a Practitioner.

6. **Human Organ or Human Tissue Transplants**

   Benefits are provided (subject to the Prior Authorization provision set forth below) for the following human organ transplants:

   a. Cornea

   b. Heart

   c. Heart-lung

   d. Kidney

   e. Kidney-liver

   f. Liver

   g. Lung (whole or lobar, single or double)

   h. Multivisceral transplants

   i. Pancreas

   j. Pancreas-kidney

   k. Small intestine

   There is no coverage hereunder for any transplant not specifically listed as covered or for supplies or services provided directly for or relative to human organ transplants not specifically listed as covered. No benefits will be provided for multiple organ transplant combinations not listed even when one or more of the organs involved is listed as a covered transplant.

   Benefits for a human organ transplant will be available for a live donor (whether or not a Subscriber), if the recipient is a Subscriber, unless the donor has other coverage.

   NOTE: See Prior Authorization Requirement below.

7. **High-Dose Chemotherapy with Hematopoietic Support (commonly referred to as bone marrow transplant and/or peripheral stem cell transplant):** Benefits are available only when precertified and the treatment particular for the Subscriber's condition is not Experimental or Investigational.

   Benefits will be available for the costs associated with the donor search and acquisition of bone marrow or peripheral stem cells when a related donor is not available.

   NOTE: Prior Authorization Requirement for Human Organ or Human Tissue Transplants and High-Dose Chemotherapy with Hematopoietic Support

   Human organ and human tissue transplants (except cornea and kidney transplants), and high-dose chemotherapy with hematopoietic support, require advance written authorization from the Administrator.

You or Your Practitioner must give written notice to the Administrator at the time as You become a candidate for a human organ transplant or re-transplant or for the high-dose chemotherapy with hematopoietic support.

The Administrator has the right to require, request and obtain information from Your Practitioners and other health care providers involved in the performance of the transplant or re-transplant or the high-dose chemotherapy procedure with hematopoietic support, and to determine whether or not to authorize benefits based on such information.

The Administrator's determination of whether or not to authorize benefits will be based on factors such as (but not limited to):

a. Provider and facility qualifications

b. Comparative costs of the proposed providers and facility

Notwithstanding any contradictory provisions in this document addressing allowable amounts, the Administrator reserves the right to limit benefits to the lowest allowable amount including organ or tissue acquisition cost which would be accepted by another facility that contracts with the Administrator to provide these services. Any balance will be the obligation of the Subscriber.

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8. **Temporomandibular Joint Dysfunction Syndrome**

a. **Definitions:** For the purposes of this Benefit Description, the following terms have these meanings:

(1) **Temporomandibular Joint Dysfunction Syndrome (TMJ):** a condition involving misalignment or imbalance in the relationship of the person's lower jaw (mandible) to the upper jaw (maxilla), with related spasm of the muscles of mastication (chewing). In this Benefit Description the terms Craniomandibular Cervical Pain (CRMP), Craniomandibular Facial Pain (CMFP) or Myofascial Pain Dysfunction Syndrome (MFPD) shall have the same meaning and benefits as Temporomandibular Joint Dysfunction Syndrome.

(2) **"Treatment Plan":** Your dentist's written report of recommended treatment.

b. **Benefits for Temporomandibular Joint (TMJ) Dysfunction Syndrome**

To the extent this Benefit Description provides benefits for office visits, diagnostic dental imaging services, etc. for medical conditions, the following services are also covered under the medical (not dental) coverage of this Benefit Description, applying appropriate Deductibles, Coinsurances, Copayments, and shared payments:

(1) Only one of the following are eligible for benefits and will be subject to the home or office visit payment provision:

(a) A clinical evaluation, to include examination, history, ordering of necessary diagnostic procedures (such as radiographs, study models if necessary, muscle testing), evaluation of results and consultation with the patient.

(b) A total diagnostic evaluation including, but not limited to, history, examination, radiographs, study models and a patient consultation.

(2) Diagnostic services, including but not limited to:

(a) Panoramic radiographs

(b) Cephalometric radiographs with tracing

(c) Temporomandibular joint tomography

(d) Temporomandibular joint arthrography

(e) Skull series; computerized tomography of temporomandibular joint

(f) Manual muscle testing procedures

And one of the following:

(g) Electromyography of cranial supplied nerves

(h) Electronic computerized neuromuscular testing

(i) Oscilloscopic neuromuscular testing

The maximum benefit payment (after application of any payment provisions) will be the Administrator's allowable amount for conventional electromyography, or neuromuscular-type test.

(3) Non-surgical initial treatment procedures (reversible Phase I) limited to:

(a) Orthopedic repositioning appliances (maxillary or mandibular).

(b) Orthopedic (orthotic) splints (such as nite-guards, biteblocks, bite openers, bite plates, muscle de-programmer).

(c) Physical therapy procedures (limited to transcutaneous electrical nerve stimulators, Galvanic stimulation, ultrasound, diathermy).

(d) Trigger point injections.

These services are subject to the provisions of the Subscriber's medical benefits program.

Exclusions: Benefits do not include:

(a) Equilibration of occlusion

(b) Massage, either manual or by machine

(c) Coronoplasty

(d) Acupuncture or dry needling

(e) Occlusal adjustment

(f) Cold packs

(g) Slides and/or photographs

(h) Range of motion treatments

(i) Non-Prescription Drugs

(j) Diet survey

(k) Vitamins

(l) Nutrition counseling

(m) Nutrition supplements

(n) office visits

(o) Stretching and other exercises

(p) Hot packs

(q) Coolant sprays

(r) Moist heat therapy

(s) Orthodontic treatment, including both fixed and removable appliances used for the purpose of moving teeth

(t) Rental or purchase of transcutaneous electrical nerve stimulators

(u) Periapical, bitewing and full-mouth radiographs

(4) Surgical procedures, subject to the appropriate Deductible, Coinsurance, Copayment, and shared payments of this Benefit Description, must be prior authorized by the Administrator based on a Treatment Plan. Requests for authorization will be reviewed based on: diagnosis (the condition must be treatable by surgery); the patient's age; presence of debilitating pain; efficacy of conservative treatment; diagnostic records and description of the proposed surgical procedure.

(5) Final stabilization non-surgical (Irreversible Phase II) treatment

Benefits for Phase II services, such as appliances, crowns and replacement of missing teeth, may be covered under Your Dental Care Program. If You do not have a Dental Care Program, there are no benefits for these services.

PRESCRIPTION DRUG PROGRAM

A. General

1. Benefits of the Prescription Drug Program apply to Subscribers enrolled for such coverage under the Benefit Description.
2. **Administrator Not Liable.** The Administrator will not be liable for any acts or wrongs of any party related to the sales, compounding, dispensing, manufacturing, or use of any Prescription Drug or insulin. This includes any claim, injury, demand, or judgment based on tort or other grounds (including warranty of merchantability).
3. **Your Pharmacy.** You have the right to select Your own Pharmacy. However, the Administrator does not guarantee the availability of any drug or supply and does not itself furnish Prescription Drugs. Also, coverage may be limited or unavailable for certain Pharmacies or Specialty Pharmacies as provided below.
4. **Prompt Filing of Claims.** Notice of Your claim should be given to the Administrator within 90 days after You receive services.

   You are responsible for making sure Your Pharmacy knows You are eligible for Covered Services and submits a claim for You.

   If Your Pharmacy does not submit a claim for You, You must do so Yourself within 90 days.

   If it is not reasonably possible for You to submit a claim within 90 days after You receive services, You or someone authorized by You must submit the claim as soon as reasonably possible. No claim will be paid if not received by the Administrator within one (1) year and 90 days after You receive services.
5. **Certain High Cost Drugs and Therapies:** Certain drugs or therapies, as determined by the Administrator, may be subject to specific benefit, administration and billing requirements. Drugs and therapies subject to this program and the criteria are listed at bcbsks.com/costlydrugs.

B. Cost Sharing

Manufacturer (or other third party) rebates, discounts, coupons, or other similar financial assistance programs (whether direct or indirect) cannot be used to satisfy a Subscriber's out-of-pocket Cost Sharing responsibilities; therefore, such amounts will not accumulate towards any Deductible, Coinsurance, Copayment, or Out-of-Pocket Maximums hereunder.

1. **Deductible**

   The Deductible amounts are: $3,000 for any one Subscriber, not to exceed $6,000 for all Subscribers on a family membership. This is not a separate Deductible from the Comprehensive Program Deductible.

   Each Subscriber is only responsible for the $3,000 Deductible. The $6,000 Deductible can be met by eligible costs incurred by any combination of Subscribers enrolled under the same family plan.
2. **Designated Specialty Pharmacy Mandatory:** If a Specialty Prescription Drug is obtained from a Pharmacy other than the Administrator's Designated Specialty Pharmacy, the drug will not be covered.
3. **Flu Vaccines and ACA Preventive Vaccines**

   a. Flu and ACA preventive vaccines administered by a Contracting Pharmacy that is also a Vaccine Network Pharmacy are covered at 100% of the allowable charge. Any administration fees charged by the Pharmacy are covered at 100% of the allowable charge.

   b. Flu and ACA preventive vaccines administered by a Contracting Pharmacy that is not a Vaccine Network Pharmacy are subject to the applicable Pharmacy benefit Cost Sharing provisions. Any administration fees charged by the Pharmacy are not covered.

   c. Flu and ACA preventive vaccines administered by a Non-Contracting Pharmacy that is not a Vaccine Network Pharmacy are not covered at the point of sale.
4. **Non-ACA Preventive Vaccines**

   a. Non-ACA preventive vaccines administered by a Contracting Pharmacy that is also a Vaccine Network Pharmacy are subject to the applicable Pharmacy benefit Cost Sharing provisions. Any administration fees charged by the Pharmacy are subject to the applicable Cost Sharing provisions.

   b. Non-ACA preventive vaccines administered by a Contracting Pharmacy that is not a Vaccine Network Pharmacy are subject to the applicable Pharmacy benefit Cost Sharing provisions. Any administration fees charged by the Pharmacy are not covered.

   c. Non-ACA preventive vaccines administered by a Non-Contracting Pharmacy that is not a Vaccine Network Pharmacy are not covered at the point of sale.

5. **ACA Preventive Drug List**

   a. Prescription Drugs other than vaccines obtained at a Contracting Pharmacy and included on the ACA Preventive Drug List are covered at 100% of the allowable charge, subject to the USPSTF recommendations.

   b. Prescription Drugs included on the ACA Preventive Drug List and provided by Non-Contracting Pharmacy are not covered at the point of sale.

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C. Covered Services

Prescription Drugs are covered when ordered by Your Practitioner and dispensed by a Pharmacy based on a Prescription Order. This includes the filling of the initial Prescription Order and/or refills/reissues of that Prescription Order, except as limited. To determine if Your Prescription Drug is covered on the Formulary, go to bcbsks.com and log in to Your BlueAccess account. You may also contact Customer Service at the telephone number listed on Your Identification Card. Prescription Drugs may be added or deleted from the Formulary on a quarterly basis.

1. Limitations to Your Prescription Order:

   a. The benefit for Prescription Drugs pursuant to a Prescription Order shall be limited to a supply sufficient for up to 34 consecutive days of therapy based on criteria established by the Administrator.

   b. Prescription Drugs for certain chronic conditions as designated by the Administrator may be dispensed in supplies up to a 100-unit dosage, not to exceed a supply sufficient for 100 consecutive days of therapy, if such is greater than a 34 consecutive day supply.

   c. Coverage for Specialty Prescription Drugs will be limited to a supply sufficient for up to 34 consecutive days of therapy.

   d. Refills and reissues will be allowed after 75% of the Prescription Order for non-controlled Prescription Drugs has been exhausted.

   e. Refills and reissues will be allowed after 85% of the Prescription Order for controlled Prescription Drugs has been exhausted.

   f. Prior Authorization is required in order for some Prescription Drugs to be covered under this Program. Prescription Drugs requiring Prior Authorization are listed on the Formulary.

   g. A Pharmacy is not required to fill a Prescription Order which in the Pharmacist's judgment should not be filled.

   h. Authorization for an early refill or reissue to accommodate a vacation supply may be obtained by contacting the Administrator, but not more often than two times per Subscriber during any 12-month period.

2. Growth hormone therapy is covered only for the Administrator's preferred growth hormone agent(s) and only under one or more of the following circumstances:

   If under age 18 and diagnosed with:

   a. Both laboratory proven growth hormone deficiency or insufficiency and significant growth retardation; or

   b. Substantiated Turner's Syndrome, Prader-Willi Syndrome, or Noonan's Syndrome with significant growth retardation; or

   c. Chronic renal insufficiency and end stage renal disease with significant growth retardation prior to successful transplantation; or

   d. Panhypopituitarism; or

   e. Neonatal hypoglycemia related to growth hormone deficiency.

   If age 18 and over with:

   a. Evidence of pituitary or hypothalamic disease or injury and laboratory proven growth hormone deficiency; or

   b. A history of prior growth hormone therapy for growth hormone deficiency or insufficiency in childhood and laboratory confirmation of continued growth hormone deficiency.

   Children, Adolescents and Adults:

   a. AIDS wasting syndrome

   b. Short bowel syndrome

c. Severe burn patients

3. Diabetic Supplies and Insulin.
4. After the Deductible is met, oral anticancer medication used to kill or slow the growth of cancerous cells is covered at 100% of the allowable charge.
5. Psychotherapeutic drugs used for the treatment of Mental Illness and Substance Use Disorders under terms and conditions not less favorable than coverage provided for other Prescription Drugs.
6. Generic oral contraceptives will be covered at 100%.
7. Off-label Prescription Drugs used for the treatment of cancer.
8. Benefits for certain Prescription Drugs or devices found on the Outpatient Medical Drug Exclusion list are only covered when provided through this Prescription Drug Program and are not covered under the Comprehensive Program unless provided during a Medical Emergency (i.e. not routine/recurring Prescription Drug administration) in a Hospital emergency room. The Outpatient Medical Drug Exclusion list can be found at bcbsks.com/drugexclusions.

D. Amount and Payment of Benefits

Subject to the payment provision(s) of this Prescription Drug Program, benefits are based on the following allowable charges:

1. **Contracting Pharmacies** -- The allowable charge for a covered Prescription Drug is established under the applicable network participation agreement. The allowable charge, minus the applicable Cost Sharing provision(s), is paid directly to the Pharmacy.

   NOTE: If You obtain a Prescription Drug from a Contracting Pharmacy and do not, at that time, notify the Pharmacy You are eligible for Prescription Drug benefits through this Program, the applicable Cost Sharing provisions will apply and You will also be responsible for any difference between the actual charge and the allowable charge.

2. **Non-Contracting Pharmacies** -- The allowable charge is the lesser of the Pharmacy's actual charge for the covered Prescription Drug or the allowable charge had the order been filled by a Contracting Pharmacy. You are responsible for the applicable Cost Sharing provision(s) and any difference between the actual charge and the allowable charge.

   Benefits will be paid to the Subscriber. Such benefits are personal to that Subscriber and cannot be assigned to any other person or entity.

E. Exclusions

Benefits are not provided for:

1. Prescription Drugs for which normally (in professional practice) there is no charge.
2. Prescription Drugs for other than human use.
3. Orthopedic or prosthetic appliances and devices.
4. Prescription Drugs purchased from an institutional Pharmacy for use while the Subscriber is an Inpatient in that institution.
5. Charges for delivering any drugs.
6. Any drug prescribed or dispensed in a manner that does not agree with generally accepted medical or pharmaceutical practices.
7. Drugs, supplies, and equipment used in intravenous, intralesional, intratympanic, and hemodialysis treatment, unless otherwise specifically indicated as a covered service.
8. Benefits are not available to the extent a Prescription Drug has been covered under another contract, certificate, or rider issued by the Administrator.
9. Any food item, including breast milk, formulas and other nutritional products.
10. Total parenteral nutrition.
11. Drugs available over-the-counter in the equivalent dose which do not require a Prescription Order under federal or state law except those covered under the Preventive Health Benefits section.
12. Charges for services that are not listed as covered services.
13. Services for injuries or diseases related to Your employment to the extent You are covered or are required to be covered by a worker's compensation law. If You enter into a settlement giving up Your right to recover past or future medical benefits under a worker's compensation law, the Administrator will not pay past or future medical benefits that are the subject of or related to that settlement.

In addition, if You are covered by a worker's compensation program which limits benefits when other than specified providers are used, and You receive services from a provider not specified by the program, the Administrator will not pay balances of charges from such non-specified providers after Your benefits under the program are exhausted.

14. Services in which duplicate benefits are available under federal, state, local laws, regulations or programs. Examples of such programs are: Medicare; TRICARE; services in any veteran's facility when the services are eligible for coverage by the government. This Benefit Description will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid.

    This exclusion applies whether or not You choose to waive Your rights to these services except for those services that would be eligible for benefits under Medicare Part D Prescription Drug coverage. Such benefits shall only be excluded if You are enrolled in Part D.

15. Any service provided through a school district pursuant to an Individual Education Plan (IEP) as required under any federal or state law.

    This exclusion applies whether or not You choose to waive Your rights to these services.

16. Health services associated with accidental bodily injuries arising from a motor vehicle accident to the extent such services are payable under medical expense payment provision of any automobile insurance policy.

17. Services not prescribed by a Practitioner or continued after a Practitioner has advised that further care is not necessary.

18. Services that are not Medically Necessary, as defined in this Benefit Description.

19. Prescription Drugs utilized primarily for stimulation of hair growth. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth.

20. Charges for completion of insurance claim forms.

21. Any drug, device or medical treatment or procedure and related services that are, as of the date of service, Experimental or Investigational as defined in the Definitions section. This exclusion does not apply to routine patient care services (as defined in Kansas Administrative Regulation 40-4-43) provided in an approved cancer clinical trial for which benefits would otherwise be available for the same services when not provided in connection with such clinical trial.

22. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression.

23. Any drug or supply associated with the medical management and treatment of obesity. This includes, but is not limited to, nutrients and Prescription Drugs prescribed for purposes other than the treatment of obesity.

24. Appetite suppressants.

25. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would not have been provided and which is provided on whether an Inpatient or Outpatient basis by any Eligible Provider.

26. Growth hormone therapy or other drugs used to treat growth failure except in those situations specifically set out as eligible for benefits.

27. Certain Prescription Drugs that have therapeutically equivalent or interchangeable drugs that are available over the counter (OTC) and may be obtained without a Prescription Order. This would include drug products from the same therapeutic class containing different chemical entities, but which would provide similar effects or the same pharmacological action when administered in therapeutically equivalent doses. These drugs are listed on the Formulary.

28. To determine if Your specific prescription is excluded, go to bcbsks.com and log in to Your BlueAccess account. You may also contact Customer Service at the telephone number listed on Your Identification Card.

29. Prescription Drugs prescribed by You.

30. Travel vaccines.

31. Tuberculosis vaccines.

32. Anthrax vaccines.

ALLOWABLE CHARGES

This section will tell You what the allowable charge for a service is. It may or may not be the same as the actual charge. Inclusion of a service or provider type in the Allowable Charges section below does not imply coverage for such service. See Covered Services to determine the extent of Your coverage.

As used herein, actual charge means the total amount billed by a provider to all parties for a particular service.

A. Contracting Providers of or on behalf of the Administrator for other than Ancillary Providers or Prescription Drugs

The Contracting Provider Agreement between the provider and the Administrator sets out the method the Administrator will use to determine allowable charges for covered services. Contracting Providers have agreed to accept the Administrator's determination of Your benefits as payment in full for covered services, except that You are responsible for payment of: Deductible, Coinsurance, Copayment amounts, shared payment amounts, non-covered services, private room charges in excess of the allowable amount stated in this Benefit Description, and amounts in excess of any other benefit limitations of this Benefit Description.

B. Contracting Providers of the Administrator for limited services for other than Ancillary Providers or Prescription Drugs

In certain situations, Institutional Providers may be Contracting Providers for only a limited set of services, e.g., chemical dependency treatment or Outpatient treatment of Medical Emergencies and Accidental Injuries. In such cases, such an Institutional Provider will be treated as a Contracting Provider for the purpose of acceptance of allowable charges established by the Administrator as payment in full, and direct payment of benefits. For services other than the limited set of services identified above, these Institutional Providers will be considered Non-Contracting.

C. Prescription Drugs

The allowable charge is the amount that contracting providers of the Administrator's Pharmacy Benefit Manager have agreed to as payment in full for covered Prescription Drugs and/or supplies except that You are responsible for payment of any Deductible, Coinsurance or Copayment amounts.

D. Non-Contracting Providers

If You receive services from a provider who has not contracted with the Administrator or another Blue Cross and Blue Shield Plan (for services provided outside the Kansas Plan Area), the allowable charges (before application of any Deductible, Coinsurance, Copayment, shared payment or benefit limits called for by this Benefit Description) will be determined as follows and You are responsible for any difference between the allowable charge and the actual charge. As used in this section, "Contracting" means contracting with the Administrator.

When a covered service that is required for a Medical Emergency is provided by a Non-Contracting Provider, the allowable charge will be the actual charge for the service up to the maximum amount allowable for the same service provided by providers that are Contracting Institutional Providers of the Administrator that are the same kinds of providers or Contracting Professional Providers of the Administrator with the same licensure or certification.

"Same service" as used in this section D shall be determined on the basis of the intended result of the service and not the technical methodology used by the provider to perform that service.

All reimbursement identified in this section D is paid according to the cost-containment policies and procedures applicable to Contracting Providers. The allowable charge for a Non-Contracting Provider is subject to change based on regulatory or statutory requirements under federal or state law. If You receive services from a Non-Contracting Provider, You will be responsible for payment for services for which payment is not made by the Administrator due to a cost-containment policy or procedure applicable to a Contracting Provider of the same licensure providing the same service. Such cost-containment policies include, but are not limited to, determinations by the Administrator that the services provided are of such a nature that they should be considered one service with a single payment, or that the billing for service inappropriately categorized the nature of the services performed, in the opinion of the Administrator, and payments should be made for a different type or different intensity of service.

1. **General Acute Care and Special Hospitals**

   a. **Inpatient Services**

      (1) **General Acute Care (Full-Service) Hospitals** -- The allowable charge for Inpatient services will be the lesser of:

         (a) the actual charge; or

         (b) 80% of the prior calendar year's average allowed charge per day (sum of allowed charges divided by sum of Inpatient days) for Contracting facilities in the same Peer Group (as designated below); or

(c) 80% of the prior calendar year's average allowed charge per day for all Contracting General Acute Care Hospitals in Kansas.

For purposes of this provision, "General Acute Care Hospitals" are defined as those Hospitals providing 24-hour emergency care, as well as a wide range of other medical services.

For purposes of this provision, "Peer Group Designations" are as follows:

Peer Group Designations

1 = Hospitals with less than 50 beds

2 = Hospitals with 51-99 beds

3 = Hospitals with more than 100 beds (excluding Topeka and Wichita)

4 = Topeka Hospitals

5 = Wichita Hospitals

(2) **Special Hospitals** -- The allowable charge for Inpatient services will be the lesser of:

(a) the actual charge; or

(b) 80% of the prior calendar year's average allowed charge per day (sum of allowed charges divided by sum of Inpatient days) for all Contracting Special Hospitals of the Administrator.

For purposes of this provision, "Special Hospitals" are defined as those Hospitals which are primarily or exclusively engaged in the care and treatment of patients with specified medical conditions, including cardiac, orthopedic, or surgical patients.

b. **Outpatient Services** -- The Outpatient services allowable charge will be the lesser of:

(1) the actual charge; or

(2) 80% of the current year's lowest maximum amount allowable used for all Contracting Institutional Providers.

If a maximum amount allowable has not been set for services provided on an Outpatient basis, the allowable charge will be 80% of the actual charge. If no Contracting Provider provides the same service, the Administrator will determine an amount to be allowed for the procedure at its discretion.

2. **All Other Hospitals and Ambulatory Surgical Centers**

The allowable charge will be the lesser of:

a. the actual charge; or

b. 80% of the maximum amount allowable for a Contracting Provider for the same service.

If no Contracting Provider provides the same service, the Administrator will determine an amount to be allowed for the procedure at its discretion.

3. **Medical Care Facilities** -- The allowable charge is the actual charge for covered services up to 80% of the maximum amount allowable for a Medical Care Facility that is a Contracting Provider.

4. **Ambulance Service** -- The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable for the ambulance service had it been provided by a Contracting Provider of ambulance service under similar circumstances.

5. **Doctors of Medicine, Doctors of Osteopathy, Dentists, Optometrist, Chiropractors, Podiatrists or Certified Psychologists** -- The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable for the same procedure by providers that are Contracting Providers of the Administrator with the same licensure or certification. If no Contracting Providers provide the same service, the Administrator will determine an amount to be allowed for the procedure.

6. **Skilled Nursing Care, Home Social Work Visits, Hospice Care, Medical Supplies, Orthopedic Appliances, Prostheses, Ancillary Providers and Other Services that may be covered by this Benefit Description** -- The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable for the same service by providers that are Contracting Providers of the Administrator with the same licensure or certification.

7. **Dentists**

a. **Dental Services provided within the Kansas Plan Area:**

The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable for the same procedure by dentists that are Contracting Providers of the

Administrator with the same licensure or certification. If no Contracting Providers provide the same service, the Administrator will determine an amount to be allowed for the procedure at its discretion.

b. **Dental Services provided outside the Kansas Plan Area:**

The allowable charge is the smaller of: the actual charge for the service or the maximum allowable charge for the service as determined by the Administrator.

E. Out-of-Area Services

1. **In areas where the Administrator offers contracting provider status directly to a class or classes of providers (such as Hospitals and/or physicians),**

a. When a provider in such class contracts with the Administrator the provisions in section A apply.

b. When a provider in such class does not contract with the Administrator the provisions in section D apply.

2. **For out-of-area arrangements other than those set forth in item E.1:**

The Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You access healthcare services outside of our Kansas Plan Area, the claim for those services may be processed through one of these Inter-Plan Arrangements, which include the BlueCard Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside our Kansas Plan Area, You will obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, You may obtain care from non-participating healthcare providers. Our payment practices in both instances are described or referenced below.

a. **BlueCard Program (not applicable to Ancillary Providers and Dental Services not associated with Accidental Injuries)**

Under the BlueCard Program, when You access covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever You access covered healthcare services outside our Kansas Plan Area and the claim is processed through the BlueCard Program, the amount You pay for covered healthcare services is calculated based on the lower of:

(1) The billed covered charges for Your covered services; or

(2) The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with Your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we use for Your claim because they will not be applied retroactively to claims already paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to Subscriber accounts. If applicable, the Administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

If You receive covered healthcare services under a Value-Based Program inside a Host Blue's service area, You will not bear any portion of the provider incentives, risk sharing, and/or care coordination fees of such arrangement (other than through Your premium contributions), except when a Host Blue passes these fees to us through average pricing, or actual pricing. Value-Based Program means an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality factors and is reflected in provider payment.

b. **Non-Participating Healthcare Providers Outside the Blue Cross and Blue Shield of Kansas Plan Area - See section D, Non-Contracting Providers, above.**

c. **Blue Cross Blue Shield Global® Core Program**

General Information

If You are outside the United States, You may be able to take advantage of the Blue Cross Blue Shield Global® Core Program when accessing covered healthcare services. The Blue Cross Blue Shield Global® Core Program is not served by a Host Blue. As such, when You receive care from providers outside the BlueCard service area, You will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If You need medical assistance services (including locating a Practitioner or Hospital) outside the BlueCard service area, You should call the Blue Cross Blue Shield Global® Core Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if You contact the Blue Cross Blue Shield Global® Core Service Center for assistance, hospitals will not require You to pay for covered inpatient services, except for Your Deductibles, Coinsurance, etc. In such cases, the hospital will submit Your claims to the Blue Cross Blue Shield Global® Core Service Center to begin claims processing. However, if You paid in full at the time of service, You must submit a claim to receive reimbursement for covered healthcare services. You must contact us to obtain precertification for non-emergency inpatient services.

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require You to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.

Submitting a Blue Cross Blue Shield Global® Core Claim

When You pay for covered healthcare services outside the BlueCard service area, You must submit a claim to obtain reimbursement. For institutional and professional claims, You should complete a Blue Cross Blue Shield Global® Core International claim form and send the claim form with the provider's itemized bill(s) to the Blue Cross Blue Shield Global® Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of Your claim. The claim form is available from us, the Blue Cross Blue Shield Global® Core Service Center or online at bcbsglobalcore.com. If You need assistance with Your claim submission, You should call the Blue Cross Blue Shield Global® Core Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

F. Ancillary Providers

The contracting status of Ancillary Providers is determined as follows:

1. Independent Laboratory - Determined by the contracting status of the Independent Laboratory with the Blue Cross and/or Blue Shield Licensee in whose Kansas Plan Area the specimen was drawn. Where the specimen was drawn will be determined by the physical location of the referring provider at the time of service.
2. Home Medical Equipment Supplier - Determined by the contracting status of the Home Medical Equipment Supplier with the Blue Cross and/or Blue Shield Licensee in whose Kansas Plan Area the equipment was shipped to or purchased at a retail store.
3. Specialty Pharmacy - Determined by the contracting status of the Specialty Pharmacy with the Blue Cross and/or Blue Shield Licensee will be determined by the physical location of the ordering physician at the time of service.
4. Air Ambulance - Determined by the contracting status of the Air Ambulance with the Blue Cross and/or Blue Shield Licensee based on the ZIP code of the location where the member is picked up.

Contracting Ancillary Providers - The allowable charge is the amount the Ancillary Provider has agreed upon with the applicable Blue Cross and/or Blue Shield Licensee as payment in full for covered services, except You are responsible for payment of any Deductible, Coinsurance or Copayment amounts.

Non-Contracting Ancillary Providers - See section D above.

GENERAL EXCLUSIONS

The following General Exclusions apply to all Your coverages described in this Benefit Description. Additional limitations and exclusions that apply to specific benefits may be found within the description of such benefits.

A. Benefits will not be provided for:

1. Services that are not listed as covered services.
2. Services for injuries or diseases related to Your employment to the extent You are covered or are required to be covered by a worker's compensation law. If You enter into a settlement giving up Your right to recover past or future medical benefits under a worker's compensation law, the Program will not pay past or future medical benefits that are the subject of or related to that settlement.

   In addition, if You are covered by a worker's compensation program which limits benefits when other than specified providers are used, and You receive services from a non-specified provider not specified by the program, the Program will not pay balances of charges from such non-specified providers after Your benefits under the Program are exhausted.
3. Services in which duplicate benefits are available under federal, state, or local laws, regulations or programs. Examples of such programs are: Medicare; TRICARE; services in any veteran's facility when the services are eligible for coverage by the government. This Benefit Description will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid.

   This exclusion applies whether or not You choose to waive Your rights to these services except for those services that would be eligible for benefits under Medicare Part D Prescription Drug coverage. Such benefits shall only be excluded if You are enrolled in Part D. Waiving Your rights to these services shall include failure to purchase coverage under any such government programs, including Medicare Parts A and B, when You are eligible to purchase such coverage.
4. Any service provided through a school district pursuant to an Individual Education Plan (IEP) as required under any federal or state law.

   This exclusion applies whether or not You choose to waive Your rights to these services.
5. Services not prescribed by a Practitioner or continued after a Practitioner has advised that further care is not necessary.
6. Services that are not Medically Necessary, as defined in Your Benefit Description.
7. Services that are determined not to be Medically Necessary through the Hospital's utilization review process. In the absence of a Hospital utilization review process, the Administrator has the right to determine when services are medically unnecessary.
8. Services provided by Institutional and Professional Providers for unnecessary Inpatient admissions when services and evaluations that could satisfactorily be provided on an Outpatient basis.
9. Any drug, device or medical treatment or procedure and related services that are, as of the date of service, Experimental or Investigational as defined in the Definitions section. This exclusion does not apply to routine patient care services (as defined in Kansas Administrative Regulation 40-4-43) provided in an approved cancer clinical trial for which benefits would otherwise be available for the same services when not provided in connection with such clinical trial.
10. Procedures and diagnostic tests that are considered to be obsolete by the Administrator's professional medical-advisory committee.
11. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression.
12. Services that are already covered under another provision of this Benefit Description.
13. Blood or payment to blood donors.
14. Any service or supply associated with the medical management and treatment of obesity that is not listed as a covered service, including but not limited to Prescription Drugs. Obesity services covered as Preventive Health Benefits, office visits, nutritional counseling, laboratory or radiology services and weight loss surgery are not part of this exclusion.
15. Inpatient Skilled Care, Intermediate Care, Convalescent Care, Custodial/Maintenance Care or Rest Cures.
16. All services associated with transplant procedures except those specifically set out as benefits.
17. Services associated with any mass screening type of physical or health examination except for pap smears and mammograms performed at a mobile facility certified by the Centers for Medicare and

Medicaid Services. Examples of mass screenings are mobile vans, school testing programs, surveillance testing and testing for purposes of employment.

18. Autogenic biofeedback services and materials except for urinary incontinence in adults 18 years old and older.
19. Acupuncture or dry needling.
20. Reversal of sterilization procedures.
21. Charges for autopsies, unless the autopsy is requested by the Administrator.
22. Travel or transportation expenses other than covered Ambulance Services. Some travel expenses related to covered services may be reimbursed as determined by the Administrator.
23. Charges for completion of insurance claim forms.
24. Laboratory services performed by an independent laboratory that is not approved by Medicare.
25. Prescription Drugs utilized primarily for stimulation of hair growth. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth.
26. Cosmetic surgery or reconstructive surgery except when the surgical procedure is one of the following:
    a. Cosmetic or reconstructive repair of an Accidental Injury.
    b. Reconstructive breast surgery in connection with a Medically Necessary mastectomy that resulted from a medical illness or injury. This includes reconstructive surgery on a breast on which a mastectomy was not performed in order to produce a symmetrical appearance.
    c. Repair of congenital abnormalities and hereditary complications or conditions, limited to:
        (1) Cleft lip or palate.
        (2) Birthmarks on head or neck.
        (3) Webbed fingers or toes.
        (4) Supernumerary fingers or toes.
    d. Reconstructive services performed on structures of the body to improve/restore impairments of bodily function resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.
    e. Reconstructive surgery for sex reassignment surgery including mastectomy, gonadectomy, and/or genital reconstructive surgery.

    For purposes of this provision, the term "cosmetic" means procedures and related services performed to reshape structures of the body in order to alter the individual's appearance.
27. Refractive procedures including: radial keratotomies, corneal relaxation, keratophakia, keratomileusis, or any other procedure used to reshape the corneal curvature except for Medically Necessary procedures associated with severe anisometropia.
28. All services associated with Temporomandibular Joint Dysfunction Syndrome except those services specifically set out as benefits.
29. Health services associated with accidental bodily injuries arising from a motor vehicle accident to the extent such services are payable under medical expense payment provision of any automobile insurance policy. The excluded expenses cannot be used for any purpose under this Benefit Description.
30. Automatic external defibrillators.
31. Institutional Provider services for personal items such as television, radio, telephone, comfort kits, materials used in occupational therapy, air conditioning provided on an optional basis or internet access.
32. Professional Provider services or charges for:
    a. Services where the Provider would normally make no charge.
    b. Travel expenses, mileage, time spent traveling, telephone calls, charges for services provided over the telephone, services provided through e-mail or electronic communications, unless otherwise indicated as a covered service.
    c. Services by an immediate relative or member of Your household. "Immediate relative" means the spouse, children, parents, brother, sister, or legal guardian of the person who received the service. "Member of Your household" means anyone who lives in the same household and who was claimed by You as a tax deduction for the year during which the service was provided.

d. Repair or replacement of dental plates and all dental care other than that listed as a covered service.

e. Hearing aids, servicing of visual corrective devices, or consultations related to such services; orthoptic and visual training; drugs for vision correction to prevent the use of reading glasses, eyeglasses or contact lenses.

f. Services performed or ordered by You.

33. Any services associated with dental implants, surgical treatment or diagnostic services except as otherwise stated in this Benefit Description.

34. Educational benefits except for those pertaining to diabetic education, colostomy care, wound care, IV therapy, or any other condition or treatment which the Administrator has determined is appropriate for home care education.

35. Dental appliances or restorations necessary to increase vertical dimensions or restore the occlusion.

36. Any food item including breast milk, formulas and other nutritional products.

37. Appetite suppressants.

38. Drugs which are available in an equivalent dose over-the-counter and which do not require a Prescription Order by federal or state law.

39. Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders IV(1994) which are not attributable to a mental disorder and are a focus of clinical attention, e.g., marriage counseling. This exclusion applies to all benefits provided by this Benefit Description; it is not limited to those benefits listed for Mental Illness or Substance Use Disorders.

40. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would not have been provided and which is provided on either an Inpatient or Outpatient basis by any Eligible Provider.

41. Diagnostic tests and evaluations are ordered, requested or performed solely for the purpose of resolving issues in the context of legal proceedings including those concerning custody, visitation, termination of parental rights, civil damages or criminal actions.

42. Services, appliances or restorations for altering vertical dimension for restoring occlusion, for replacing tooth structure lost by attrition or abrasion, bruxism, erosion or abfractions; for aesthetic purposes; splinting or equilibration.

43. Temporary or Provisional dental services and procedures, including, but not limited to, Provisional crowns, Provisional splinting, interim complete or partial dentures. "Provisional" means a service or procedure that is provided for temporary purposes or is used over a limited period; a temporary or interim solution; usually refers to a prosthesis or individual tooth restoration.

44. Dental services and prosthodontic devices that are duplicated in whole or in part, due to the Subscriber failing to complete the initial treatment plan.

45. Pharmacological agent(s) inserted into a periodontal pocket to suppress pathogenic microbiota.

46. Any devices used for enhancing or enabling communication except for an electrolarynx.

47. Non-medical services (including but not limited to legal services, social rehabilitation, educational services, vocational rehabilitation, job placement services).

48. Services of volunteers.

49. Any assessment to attend an alcohol and drug safety action program by a diversion agreement or by court order.

50. Prostheses that require surgical insertion into the body and are billed by an entity or person that is not the Hospital or Ambulatory Surgical Center where the surgery was performed.

51. Services related to sexual function unless specifically listed under the Covered Services section.

52. Services for or related to elective abortions.

    For purposes of this provision, "elective" means as follows: for any reason other than to prevent the death of the mother upon whom such services are performed, except that it includes those services based on a claim or diagnosis that the mother shall or may engage in conduct likely to result in her death.

    For the purpose of this provision, "abortion" means as follows: the use or prescription of any instrument, medicine, drug, or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or

health of a child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma, or physical assault on the pregnant woman or her unborn child and which causes the premature termination of the pregnancy.

APPEAL PROCEDURES

This section outlines the procedures for and the time periods applicable to Claim and Appeal determination decisions for Adverse Decisions. It is the policy of the plan to afford Subscribers a full and fair review of Claim decisions and Appeal decisions as described in this Benefit Description.

However, a Subscriber's rights accrued hereunder or under applicable state or federal law (including but not limited to ERISA) are not assignable to any person or entity. Authorized Representatives may be designated as provided in section A below.

A. Definitions

For the purpose of this Appeal Procedures section, the following terms and their definitions apply:

1. **Adverse Decision:** for the purposes of these Appeal procedures (and ERISA, as applicable), means a denial in whole or in part of a Pre-Service Claim or a Post-Service Claim and for which You are financially responsible or, for a Pre-Service Claim, for which You would be financially responsible, if You obtained the service. Adverse Decision also means any retroactive cancellation of coverage other than for non-payment of premium.
2. **Appeal:** a written request, except in the case of Urgent Care in which case the request may be submitted orally or in writing, for review of an Adverse Decision that is submitted to the Administrator by a Subscriber or the Subscriber's Authorized Representative.
3. **Authorized Representative:** for non-urgent care, a person designated by You in writing as authorized to represent them for Appeals as permitted under ERISA. This may only be achieved through use of a form provided by the Administrator by contacting Customer Service at the telephone number on the back of Your Identification Card. Any attempt to designate via any other form shall be deemed void and ineffective on its face. For Urgent Care, such written authorization is not required if the Appeal is made on Your behalf by a health care provider with knowledge of Your medical condition.
4. **Claim for Benefits or Claim:** a request for treatment benefit or payment benefits made by a Subscriber in accordance with the Administrator's procedure for filing Claims. A Claim includes both Pre-Service Claims and Post-Service Claims. A Claim must have sufficient information upon which to base a decision regarding benefits according to all of the provisions of the Benefit Description.
5. **Emergency Medical Condition:** (a) a medical condition in which the timeframe for completing an Urgent Care Appeal would seriously jeopardize the Subscriber's life or health or jeopardize the Subscriber's ability to regain maximum function and the Subscriber has filed a request for an Urgent Care Appeal; or (b) a medical condition for which the Subscriber has received emergency services but has not been discharged from the facility providing those services.
6. **ERISA:** the Employee Retirement Income Security Act of 1974. ERISA is a federal law that applies to employer sponsored health benefit plans if the employer is not a government entity or a church organization.
7. **Pre-Service Claim:** a request for a Claims decision when Prior Authorization of the services is required by the Administrator. Requests for advance information on the Administrator's possible coverage of items or services or advance approval of covered items or services do not constitute Pre-Service Claims.
8. **Pre-Service Request:** a request for advance information on the Administrator's possible coverage of items or services or advance approval of covered items or services that do not constitute Pre-Service Claims. Subsequent inquiries regarding the same service or item shall not be considered a Pre-Service Request unless additional substantive clinical information is provided.
9. **Post-Service Claim:** a request for a Claims decision for services that have been provided.
10. **Urgent Care:** care for a condition that delay in receiving such care could seriously jeopardize the life or health of the Subscriber or the ability of the Subscriber to regain maximum function or, in the opinion of a physician knowledgeable of the Subscriber's condition, would subject the Subscriber to severe pain that could not be adequately managed without care or treatment. In determining whether a Claim involves Urgent Care, the Administrator must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of the Subscriber's medical condition determines that a Claim involves Urgent Care, the Claim must be treated as an Urgent Care Claim.

B. Initial Claim Decisions

The time periods in which the Administrator must make initial Claim decisions (the first determination of benefits available for an Urgent Care Claim, a Pre-Service Claim or a Post-Service Claim) are as follows:

Action	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Initial Benefit Decision (from the date the Claim is	72 hours	15 days	30 days

received by the Administrator)

Extension (from the date the Claim is received by the Administrator)	None - Notice requesting additional information due - 24 hours*	30 days*	45 days*

* The time periods listed are those required. A Subscriber may voluntarily agree to provide the Administrator additional time within which to make a decision.

Time for Subscriber to Provide more information (from receipt of notice)	48 hours	45 days	45 days

C. Appeal of Initial Adverse Decisions (first level Appeal)

A Subscriber or the Subscriber's Authorized Representative has the right to obtain, without charge, copies of documents relating to the Adverse Decision and has the right to appeal an Adverse Decision from an initial Claim decision. This is a first level Appeal.

1. The time periods that apply to Appeal decisions are as follows:

Action	**Urgent Care Claim**	**Pre-Service Claim**	**Post-Service Claim Retroactive Cancellation**
Time to File Appeal (from the date of receipt of the Adverse Decision)	180 days	180 days	180 days
Initial Appeal Decision (from the date the Appeal is received by the Administrator)	72 hours	15 days	30 days
Extension (from the date the Appeal is received by the Administrator)	None*	None*	None*

* The time periods listed are those required. A Subscriber may voluntarily agree to provide the Administrator additional time within which to make a decision.

2. A first level Appeal will be coordinated by a representative of the Administrator's Customer Service.

D. ERISA Right to a Judicial Review

You have the right to bring suit (including under ERISA Section 502(a) if applicable) in state or federal court (as appropriate) only after You have exhausted the first level Appeal of an Adverse Decision. In all events, such suit or proceeding must be commenced no later than five (5) years after the date from the time written proof of loss is required to be given.

Form APCG-213e 1/18

GENERAL INFORMATION

A. Subscriber/Provider Relationship. The choice of a provider is solely that of the Subscriber.

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

C. Your Authorization. By accepting coverage under this Benefit Description, You permit the Administrator to request any information related to a claim for services that You received and authorize that any information may be given to the Administrator regarding medical services You have received. This applies to all types of claims, including claims related to Medicare.

If the Administrator asks for information and does not receive it, payment for covered services cannot be made. The claim will be processed for payment only when the requested information has been received and reviewed.

D. Payment of Claims. For covered services received from the following providers:

1. **Contracting Provider of the Administrator or another entity on behalf of the Administrator:** Your benefits will be paid directly to the Contracting Provider.
2. **Contracting Provider of the Administrator for limited services:**
   a. When You receive services for which the provider is contracting Your benefits will be paid directly to the Contracting Provider.
   b. When You receive services for which the provider is not contracting Your benefits will be paid directly to You. Such benefits are personal to You and cannot be assigned to any other person or entity.
3. **Non-Contracting Provider in the Kansas Plan Area:** Your benefits will be paid directly to You. Such benefits are personal to You and cannot be assigned to any other person or entity.
4. **Covered Provider in a class of providers that are not offered Contracting Provider status:**

   Your benefits will be paid directly to You, with such benefits being personal to You and not assignable to any other person or entity.
5. **Covered Provider Outside the Kansas Plan Area:**
   a. Located in an area where the Administrator offers Contracting Provider status, directly or through arrangements with another entity, to the provider from whom service was received:
      (1) If the provider is a Contracting Provider, Your benefits will be paid to the provider.
      (2) If the provider is a Non-Contracting Provider, Your benefits will be paid directly to You, with such benefits being personal to You and not assignable to any other person or entity.
   b. Located in an area where the Administrator does not offer Contracting Provider status, either directly or through arrangements with another entity, to the provider from whom service was received:
      (1) In instances where the Subscriber receives service from a provider that is contracting with the Blue Cross and/or Blue Shield Plan servicing the area in which the provider is located, payment will be made directly to the provider.
      (2) In instances where the Subscriber receives service from a provider that is not contracting with the Blue Cross and/or Blue Shield Plan servicing the area in which the provider is located, Your benefits will be paid directly to You, with such benefits being personal to You and not assignable to any other person or entity.
   c. Notwithstanding the above provisions, Your benefits may be paid directly to the provider instead of You when:
      (1) the Host Blue plan in the area in which the provider is located, in carrying out their duties under the BlueCard program, reasonably believes they are obligated to pay the provider pursuant to the laws of their state; or
      (2) the benefits are processed via the Blue Cross Blue Shield Global® Core Program.
6. **Any benefits unpaid at Your death may be paid to Your estate.**

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

E. Statements Made by the Subscriber. Coverage for a Subscriber may be rescinded or terminated due to fraudulent material misstatements made in the application for it. Coverage may also be terminated without notice if the Subscriber or a covered dependent submits a claim which is found to have been fraudulent in any criminal or civil proceeding.

F. Claims Recoveries.

There may be circumstances in which the Administrator recovers amounts paid as claims expense from the provider of service, from the Subscriber or from a third party. Such circumstances include rebates paid to the Administrator by pharmaceutical manufacturers based upon amounts of claims paid by the Administrator for certain specified pharmaceuticals, amounts recovered by the Administrator from health care providers or pharmaceutical manufacturers through certain legal actions instituted by the Administrator relating to the claims expense of more than one Subscriber, recoveries by the Administrator of overpayments made to health care providers or to Subscribers, and recoveries from other parties with whom the Administrator contracts or otherwise relies upon for payment or pricing of claims. The following rules govern the Administrator's actions with respect to such recoveries:

1. In the event such recoveries relate to claims paid more than a year and 90 days before the recovery, no adjustment will be made to any Deductible and/or Coinsurance paid by a Subscriber and the underwriter of this program (subject to the limitations otherwise set forth below) shall be entitled to retain such recoveries for its own use. If the recovery relates to a claim paid within a year and 90 days and is not otherwise addressed herein, Deductible and/or Coinsurance amounts for a Subscriber will be adjusted for the applicable Benefit Period if affected by the recovery.
2. If such recovery amounts to less than $500 attributable in any Benefit Period (the period of time in which the Deductible and/or Coinsurance is calculated) for any Subscriber, no adjustments in Deductible and/or Coinsurance will be made, and the underwriter of this program (subject to the limitations otherwise set forth herein) shall be entitled to retain such recoveries for its own use.
3. If a Subscriber is no longer covered by this program at the time any such recovery is made, the underwriter of this program (subject to limitations otherwise set forth herein) shall be entitled to retain such recovery for its own use.
4. If the underwriter of this program no longer contracts with Blue Cross and Blue Shield at the time the recovery occurs, recoveries otherwise owing to the underwriter of this program pursuant to these rules will be paid to the underwriter of this program if fewer than five years have elapsed from the date of such recovery. Nothing, however, obligates the Administrator to continue to pursue subrogation or other recoveries after termination of the Agreement, and such active subrogation files as the Administrator maintains shall be returned to the underwriter of this program upon such termination.
5. The Administrator has no obligation to pursue recovery from health care providers or manufacturers of health care products or services on behalf of the underwriter of this program for causes of action arising out of violations of antitrust law, fraud, claims relating to fraud (including claims under the Racketeering Influenced and Corrupt Organizations Act), and its administration of subrogation provisions (if any) under the underwriter of this program's benefit plan shall be limited in such circumstances solely to cases in which Subscribers have individually initiated a claim or cause of action. Notwithstanding the foregoing, if (a) the Administrator asserts a claim or cause of action against a party (other than the underwriter of this program itself) arising out of antitrust violations or fraud by health care providers or manufacturers of health care products or services relating to claims paid by the Administrator under insured contracts and (b) claims payment made by the Administrator on behalf of the underwriter of this program and Subscribers would have been equally affected under the circumstances of such claim or cause of action, then the underwriter of this program assigns to the Administrator its rights under such claim or cause of action. If recoveries by the Administrator in such a claim or cause of action are less than actual injury asserted by the Administrator for itself and on behalf of the underwriter of this program and other similarly situated underwriters of programs, then the Administrator shall pay to the underwriter of this program a prorated amount based upon claims costs under this program compared to claims costs of the Administrator under its insured programs. No adjustments of Deductible and/or Coinsurance will be made for Subscribers in such circumstances. This assignment of a cause of action shall survive termination of this program.
6. The total amount of any recoveries which are available for adjustments to claims of or payments to the underwriter of this program or for adjustments to Cost Sharing of Subscribers of the program of the underwriter of this program in the form of Deductible and/or Coinsurance will be reduced by the cost to the Administrator to procure that recovery, including amounts paid in attorney fees, amounts paid to collection agencies or other entities obtaining recoveries on a contingency basis, and other costs.

G. For additional information regarding the benefits covered hereunder or to obtain a copy of the list of Contracting Providers that when used will assure that You are receiving the highest possible level of benefits available under this Benefit Description, call the Customer Service phone number on Your Identification Card. Information You request about benefits and lists of Contracting Providers will be furnished without charge.

H. Proof of Coverage. You have the right to request and obtain proof of coverage from the Administrator while You are a Subscriber and up to 24 months following the date on which Your coverage cancelled. To request proof of coverage, contact the Customer Service phone number on Your Identification Card.

I. Underwriter of this Program's Responsibilities Concerning Enrollment: It is the responsibility of the underwriter of this program/employer group's Plan Administrator to submit to the Administrator for enrollment only those employees and dependents who meet the eligibility criteria of the underwriter of this program and the Administrator, and to ensure and verify the continued eligibility status of covered employees and dependents. The Administrator has the right to recover from Subscribers and/or providers any benefit payments paid on behalf of ineligible persons.

J. Incentives to You: Sometimes the Administrator may offer incentives to encourage You to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is Yours alone but we recommend that You discuss participation in such programs with Your Physician. These incentives are not benefits and do not alter or affect Your benefits.

K. Potentially Inappropriate Use of Covered Services and Prescription Drugs by Subscribers: If the Administrator determines that a Subscriber's pattern of use for covered services or Prescription Drugs is not consistent with generally accepted standards of medical practice, the Administrator may require the Subscriber to participate in mandatory Case Management. If the Subscriber does not then actively participate in Case Management or demonstrate appropriate behavior during Case Management, the Administrator has the right to restrict access to and therefore deny the applicable medical and/or Pharmacy benefits. If restrictive action is taken, the Subscriber will be notified in writing of such restrictions at least 30 days in advance.

L. Choice of Law: The terms of this Benefit Description shall be construed solely pursuant to the laws of the state of Kansas to the extent not pre-empted by federal law.

Form APGI-541 1/19

COORDINATION OF BENEFITS WITH OTHER COVERAGE

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.

A. Definitions

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

   a. Plan includes:

      (1) group insurance and subscriber contracts

      (2) nongroup insurance contracts effective on or after January 1, 2014

      (3) health maintenance organizations (HMO) contracts

      (4) closed panel or other forms of group or group-type coverage (whether insured or uninsured)

      (5) medical care components of long-term care contracts, such as Skilled Nursing Care

      (6) Medicare or any other federal governmental plan, as permitted by law

   b. Plan does not include:

      (1) hospital indemnity coverage or other fixed indemnity coverage

      (2) accident only coverage

      (3) specified disease or specified accident coverage

      (4) benefits for non-medical components of long-term care policies

      (5) Medicare supplement policies

      (6) Medicaid policies

      (7) coverage under other federal governmental plans, unless permitted by law

   Each contract or certificate for coverage under a or b above 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.

2. This plans 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.

3. 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.

4. 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:

   a. 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.

   b. 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.

c. 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.

5. 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.

6. 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.

B. 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:

1. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other plan.

2. a. Except as provided in Paragraph (b), 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.

   b. 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.

3. 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.

4. Each plan determines its order of benefits using the first of the following rules that apply:

   a. 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.

   b. 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:

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

         (a) The plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

         (b) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

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

         (a) 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;

         (b) If a court decree states that both parents are responsible for the dependent child's heath care expenses or health care coverage, the provisions of item (1) above shall determine the order of benefits;

(c) 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 item (1) above shall determine the order of benefits; or

(d) 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:

(i) The plan covering the custodial parent;

(ii) The plan covering the spouse of the custodial parent;

(iii) The plan covering the noncustodial parent; and then

(iv) The plan covering the spouse of the noncustodial parent.

(3) For a dependent child covered under more than one plan of individuals who are the parents of the child, the provisions of item (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

c. 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 B.4.a can determine the order of benefits.

d. COBRA Coverage. If a person whose coverage is provided pursuant to COBRA, or under a right of continuation provided by 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 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 B.4.a can determine the order of benefits.

e. 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.

f. 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.

C. Effect on the Benefits of this Plan

1. 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 amount it would have credited to its Deductible in the absence of other health care coverage.

2. 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.

D. 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. The Administrator 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. The Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the Administrator any facts it needs to apply those rules and determine benefits payable.

E. Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, the Administrator 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. The Administrator 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.

F. Right of Recovery

If the amount of the payments made by the Administrator 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.

Form APND-156 1/20

TERMINATION OF ELIGIBILITY

A. The eligibility of an individual Subscriber will terminate in the following situations

1. When the Administrator is notified that a Subscriber is no longer eligible for this Program.
2. Termination of marriage. The coverage of the spouse of the person named on the Identification Card ends on the last day of the month in which the divorce decree is entered by the court. If timely notification (within 60 days) of the divorce is not provided to the Administrator, cancellation will be effective the first of the month following the late notification.
3. Dependents who no longer qualify under the general definition of "Subscriber".
4. The sub-section "Statements Made by the Subscriber" in the "General Information" section explains the circumstances under which Your coverage can be cancelled or rescinded because of fraud or intentional misrepresentation.

B. Benefits When the Eligibility Terminates

1. Extension of benefits: Your coverage under this Benefit Description ends on the date of cancellation, except for continuity of care.
2. Continuity of care when the Plan Administrator terminates coverage with the Administrator: Coverage ends on the date of termination, except for a Subscriber who is a continuing care patient as defined within the Consolidated Appropriations Act of 2021. This extension of coverage is available without payment of premium and will be considered continuation coverage for coordination of benefits purposes.

   This extension of benefits will be terminated upon the earlier of:

   a. the completion of a 90-day period following termination of coverage; or

   b. the Subscriber is no longer a continuing care patient with the Eligible Provider.

CONTINUATION AND CONVERSION RIGHTS

A. COBRA Continuation Coverage - Federal Law

This law applies to employers whose payroll included 20 or more employees during the previous calendar year and such employer's group health plans, not to insurance contractors or third party administrators. That is, if Your employer changes from the Administrator to another insurance carrier or third party administrator (in the case of a self-funded arrangement), the right to continuation under federal law remains with the employer through the new carrier or to claims adjudication under the new administrator.

CONTINUOUS COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because You have recently become covered under a group health plan (the Program). This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Program. If You have recently become covered under the group health plan of the underwriter of this Program or have changed to a type of coverage that includes coverage for Your spouse and/or dependent child(ren), this is the initial notice of COBRA continuation coverage rights. Otherwise, this section is included as part of Your Benefit Description for informational purposes. This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Program. **This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You when You would otherwise lose Your group health coverage. It can become available to You and to other members of Your family who are covered under the Program when they would otherwise lose their group health coverage. For additional information about Your rights and obligations under the Program and under federal law, You should review the Program's Summary Plan Description or contact the Plan Administrator.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Program coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". A qualified beneficiary is someone who will lose coverage under the Program because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Program, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You are an employee, You will become a qualified beneficiary if You will lose Your coverage under the Program because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee, You will become a qualified beneficiary if You will lose Your coverage under the Program because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from Your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Program because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child".

If the group health plan offered by Your employer includes coverage for retired employees, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the entity identified on the face page of this Benefit Description, and that bankruptcy results in the loss of coverage of any retired employee covered under the Program, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Program.

When is COBRA Coverage Available?

The Administrator will offer COBRA continuation coverage to qualified beneficiaries only after Your employer's Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, for group health plans that include coverage for retired employees commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify Your employer's Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), You must notify Your employer's Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to Your employer's Plan Administrator.

How is COBRA Coverage Provided?

Once Your employer's Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), Your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuous coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If You or anyone in Your family covered under the Program is determined by the Social Security Administration to be disabled and You notify Your employer's Plan Administrator in a timely fashion, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Program as a dependent child, but only if the event would have caused the spouse or Dependent to lose coverage under the Program had the first qualifying event not occurred.

If You Have Questions

Questions concerning Your Program or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa.

(Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

Keep Your Administrator Informed of Address Changes

In order to protect Your family's rights, You should keep Your employer's Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to Your employer's Plan Administrator.

Program Contact Information

The Administrator has agreed with the employer to undertake only limited duties with respect to COBRA as set forth below.

1. Payment of Dues
   a. Upon receipt of the COBRA Declaration Form, the Administrator will send the employee or dependent who qualifies for COBRA continuation of benefits a notice of the amount of dues needed for the continued benefits.
      (1) Initial dues - A period of 45 days (from the date of election/declaration) is allowed in which to pay the initial required dues. The first dues payment will be for a period commencing with the date following the date coverage would otherwise cancel. No gap in coverage will be permitted. The dues may be higher than for active employees, as permitted by law.
      (2) Subsequent dues - Subsequent dues payments will be allowed a 30-day grace period after the due date. The Administrator will bill the Subscriber directly and payment will be made directly to the Administrator.
   b. Nonpayment of dues occurs when dues are not paid by the due dates as provided in 1.a. above.
2. Enrollment and Benefit Changes
   a. If the group changes benefits, the COBRA Subscriber's benefits will also change to match the group's new benefit package.
   b. The COBRA Subscriber has the same right to change benefit programs as the active group employees during the employer's Open Enrollment period.
   c. If the employer changes insurers during the period of Continued Group Benefits, the COBRA Subscribers for that group will be cancelled as to coverage under this Benefit Description and become the responsibility of the new insurer.
   d. The Administrator shall not be obligated to provide COBRA coverage to You if the Underwriter of this Program or Plan Administrator fails to timely notify You of Your rights under COBRA or You fail to timely elect COBRA coverage. If the Administrator allows enrollment in COBRA coverage under these circumstances, such coverage shall begin the month following the late notification and may only be elected up to the maximum coverage period measured from the month following the qualifying event.

B. USERRA Continuation Coverage - Federal Law

USERRA applies to ALL employer groups even if COBRA does not apply to the employer.

The right to USERRA continuation coverage was created by a federal law, the Uniformed Services Employment and Re-employment Rights Act of 1994 and amendments (USERRA).

Continuation and Reinstatement of Coverage on Account of Qualified Uniformed Service. Apart from the rights to continued coverage described in the preceding information, if applicable, You may be entitled to continue certain aspects of Your coverage (on a self-pay basis) during a period of Qualified Uniformed Service. You also may have certain reinstatement rights following a period of Qualified Uniformed Service. The specific rules are as follows:

1. **Persons Eligible for Continued Coverage.** An employee who is absent from the employment of his or her employer on account of a period of Qualified Uniformed Service may continue employee and dependent medical coverage on a self-pay basis for the 24 month period beginning on the date on which the employee is first absent from employment by reason of Qualified Uniformed Service. Coverage will cancel on the day after the date on which the employee fails to apply for or return to a position of employment, if the failure to apply or return cancels the employee's right to reemployment rights under applicable federal law regarding uniformed service.

2. **Cost of Continued Coverage.** The monthly charge for continued coverage will be determined by the Administrator, and will be the same for all similarly situated individuals electing the same type of coverage under this provision. If any single period of Qualified Uniformed Service is for a period of less than 31 days, the only amount required to be paid by the employee is the amount, if any, the employee would pay if he or she had not entered Qualified Uniformed Service. In other cases, the employee's charge will reflect both the employee's portion and the employer's portion, determined in the same manner as COBRA charges.

3. **Benefits Subject to Continuation.** Any election made by an employee applies to the employee and the employee's dependents who otherwise would lose coverage under this Benefit Description. No separate election may be made by any dependent. The medical coverage that employees are allowed to continue on behalf of themselves and their dependents will be the same as that provided to employees and their dependents under the Program. Except in connection with circumstances that permit other employees to make changes, an employee may continue only the type of coverage that he or she was receiving on the day before the employee first was absent from employment.

4. **Election of Continued Coverage.** An employee eligible to continue coverage under this provision will be sent an application for continued coverage within 30 days after the Administrator receives notice, satisfactory to the Administrator, that the employee will be, or is, absent from employment for a period of Qualified Uniformed Service. If an employee wishes to have coverage continued, he or she must complete the application and return it to the Administrator within 60 days from the later of the date the application is sent or the date coverage otherwise would cancel.

5. **Payment for Continued Coverage.** The continuation of coverage is conditioned on an employee's payment of the monthly charges for the coverage, determined from the date coverage otherwise would cancel, even if the employee waits 60 days from that date to return the application. If an employee elects continued coverage, payment must be made, relating back to the date that coverage otherwise would cancel, within 45 days after the date the employee elects to continue coverage. After that, payments must be made by the first day of each month for which coverage is to be provided, subject to a 30-day grace period.

6. **Interaction with COBRA** (if applicable)**:**

   Generally, rights to USERRA and COBRA continuation coverage run concurrently from the commencement of Qualified Uniformed Service. Accordingly, employees and/or their dependents may have continuation rights that extend beyond 24 months.

7. **Reemployment Rights**

   If Your coverage has been cancelled as a result of the service member's failure to elect continuation coverage, or the service member's length of service, at the time of the service member's reemployment no exclusions or waiting period may be imposed where one would not have been imposed if the coverage of the service member had not been cancelled as a result of service in the uniformed services. This provision does not apply to any condition (illness or injury) determined by the Secretary of Veteran's Affairs to have been incurred or aggravated during service, however, the service member and any dependents must be reinstated as to all other medical conditions covered by this Benefit Description.

SUBROGATION AND RIGHT OF RECOVERY PROVISIONS

A. Definitions

1. **Subrogation**
   Immediately upon paying or providing any benefit under this plan, the plan shall be subrogated to (stand in the place of) all rights of recovery a **Covered Person** has against any **Responsible Party** with respect to any payment made by the **Responsible Party** to a **Covered Person** due to a **Covered Person's** injury, illness or condition to the full extent of benefits provided or to be provided by the plan.

2. **Reimbursement**
   In addition, if a Covered Person receives any payment from any **Responsible Party** or **Insurance Coverage** as a result of an injury, illness or condition, has the right to recover from, and be reimbursed by, the **Covered Person** for all amounts this plan has paid and will pay as a result of that injury, illness or condition, from such payment, up to and including the full amount the **Covered Person** receives from any **Responsible Party**.

3. **Constructive Trust**
   By accepting benefits (whether the payment of such benefits is made to the **Covered Person** or made on behalf of the **Covered Person** to any provider) from the plan, the **Covered Person** agrees that if he/she receives any payment from any **Responsible Party** as a result of an injury, illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the **Covered Person's** fiduciary duty to .

4. **Lien Rights**
   Further, the plan will automatically have a lien to the extent of benefits paid by for the treatment of the illness, injury or condition for which **Responsible Party** is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise, including from any **Insurance Coverage**, related to treatment for any illness, injury or condition for which paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by including, but not limited to, the **Covered Person**; the Covered Pers on's repres entative or agent; **Responsible Party**; **Responsible Party's** insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan or .

5. **First-Priority Claim**
   By accepting benefits (whether the payment of such benefits is made to the **Covered Person** or made on behalf of the **Covered Person** to any provider) from the plan, the **Covered Person** acknowledges that this plan's recovery rights are a first priority claim against all **Responsible Parties** and are to be paid to the plan before any other claim for the **Covered Person's** damages. This plan shall be entitled to full reimbursement on a first-dollar basis from any **Responsible Party's** payments, even if such payment to the plan will result in a recovery to the **Covered Person** which is insufficient to make the **Covered Person** whole or to compensate the **Covered Person** in part or in whole for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the **Covered Person** to pursue the **Covered Person's** damage claim.

6. **Applicability to All Settlements and Judgments**
   The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any **Responsible Party** and regardless of whether the settlement or judgment received by the **Covered Person** identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

7. **Cooperation**
   The **Covered Person** shall fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the **Covered Person** to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the **Covered Person's** intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the **Covered Person**. The **Covered Person** and his/her agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the **Covered Person** or the institution of court proceedings against the **Covered Person**.

The **Covered Person** shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

The **Covered Person** acknowledges that has the right to conduct an investigation regarding the injury, illness or condition to identify any **Responsible Party**. reserves the right to notify **Responsible Party** and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

8. **Interpretation**

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

9. **Jurisdiction**

By accepting benefits (whether the payment of such benefits is made to the **Covered Person** or made on behalf of the **Covered Person** to any provider) from the plan, the **Covered Person** agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the **Covered Person** hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

Form APSB-100 1/18

ISSUED TO:
GROUP ID: INSURED ID:

BLUE CHOICE RIDER

PART 1. GENERAL

This is a Rider to Your Benefit Description. It becomes effective on the date shown in the records of the Administrator.

The conditions described in Your Benefit Description also control this Rider except where this Rider specifically states there is a change.

PART 2. ENROLLMENT IN BLUE CHOICE

The underwriter of this program and the Subscriber agree to the following related to the offering of Blue Choice and the Subscriber's enrollment therein:

A. Blue Choice Providers

"Blue Choice Provider" means an Institutional Provider or Professional Provider of health care services that has entered into an agreement with the Administrator under which it is classified as a Blue Choice Provider.

"Blue Plan Preferred Provider" means an Eligible Provider that has entered into an agreement with another Blue Cross and/or Blue Shield Plan (other than the Administrator) under which additional Deductibles and/or Coinsurances for use of a non-preferred provider do not apply to such Eligible Provider.

The Administrator will provide the underwriter of this program with listings of the Blue Choice Providers in the Kansas Plan Area. You may call the number listed on Your Identification Card if You wish to determine if a provider outside the Kansas Plan Area is a Blue Plan Preferred Provider.

B. Use Blue Choice or Blue Plan Preferred Providers

To receive the maximum level of benefits from Your Blue Choice coverage, You must use Blue Choice or Blue Plan Preferred Providers. Section C describes the lesser benefits when non-Blue Choice Providers or non-Blue Plan Preferred Providers are used.

C. Additional Coinsurance

You will be responsible for an additional 20% of the allowable charge up to a maximum additional coinsurance of $2,000 per Subscriber per Benefit Period or $4,000 for all Subscribers on family coverage per Benefit Period that would otherwise be allowable if You fail to use a Blue Choice Provider or a Blue Plan Preferred Provider. This additional coinsurance does not accumulate toward the satisfaction of any other Deductible, Coinsurance or shared payment called for by Your Benefit Description, and those other Deductibles, Coinsurances or shared payment amounts called for by Your Benefit Description continue to apply.

The additional coinsurance is not applied when service is required for a Medical Emergency or a life, limb, or function-threatening Accidental Injury.

The Administrator has no obligation to advise You of the applicability of additional Coinsurances for use of a non-Blue Choice Provider or a non-Blue Plan Preferred Provider during the course of pre-authorization or otherwise. You are responsible for choosing Your providers of health care services.

Form APRI-417 1/17

RIDER

PART 1. GENERAL

This is a Rider to a Benefit Description issued by the Administrator and becomes effective on the date shown in the records of the Administrator.

The conditions described in the Benefit Description also control this Rider except where this Rider specifically states there is a change.

PART 2. PURPOSE AND EFFECTS OF THIS RIDER

This Rider applies only to employees, spouses of employees and dependents of employees who by federal law are entitled to retain the employer's coverage as primary to Medicare. The effects of this Rider for those employees, spouses, and dependents are:

A. The exclusion in the Benefit Description relating to services covered by Medicare not being duplicated by the Benefit Description is hereby removed.

B. The services or benefits provided by the Benefit Description to which this Rider is issued for attachment will be provided without regard to whether Medicare coverage is available or not.

C. The non-duplication of benefits sections of the Benefit Description and any other sections of the Benefit Description are also amended to the extent necessary to permit benefits of this Benefit Description to be treated as primary and Medicare benefits as secondary.

The effects of this Rider (as set out in A, B, and C above) cease to apply at such time as the person is not subject to such Federal law or ceases to be eligible for the employer group health plan.

Form APRI-423 1/19

BARIATRIC SURGERY RIDER

PART 1. GENERAL

This is a Rider to Your Benefit Description. It becomes effective on the date shown in the records of the Administrator.

The conditions described in Your Benefit Description also control this Rider except where this Rider specifically states there is a change.

This Rider provides the terms of coverage provided for treatment of bariatric services available to Subscribers over the age of eighteen (18). Unless otherwise specified, all other provisions of the plan, as described in this Benefit Description, apply to benefits outlined in this Bariatric Rider, including Deductibles, Coinsurance, Copayments, Out-of-Pocket Maximums, Network Provider arrangements and Prior Authorization.

PART 2. DEFINITIONS

A. BMI: Body Mass Index.

B. Co-morbid conditions: for the purposes of the bariatric surgery benefit, the following chronic health conditions:

1. Cardiomyopathy
2. Type 2 Diabetes
3. Coronary Heart Disease
4. Hypertension
5. Gastroesophageal reflux disease (GERD)
6. Clinically significant obstructive sleep apnea

C. Multi-disciplinary surgical preparatory regimen: within six (6) months prior to surgery, You must participate in an organized multi-disciplinary surgical preparatory regimen of at least ninety (90) days duration that meets all of the following criteria:

1. Includes participation in a behavior modification program supervised by qualified professionals.
2. Includes participation in a reduced calorie diet program in consultation with a dietician.
3. Includes participation in an exercise regimen (unless contraindicated in medical records) supervised by a physical therapist to improve pulmonary reserve prior to surgery.
4. Medical records must document Your participation in the multi-disciplinary surgical preparatory regimen at each visit. The physician supervised program must include regular face to face interactions between You and the physician to discuss and evaluate Your progress and results and which shall be documented in Your medical record.

D. Physician supervised nutrition and exercise program: a physician supervised program that includes consultation with a dietician on a low-calorie diet, increased physical activity and behavior modification of at least six (6) months in length. The medical records of the physician supervising the weight loss program shall provide simultaneous documentation of the physician's assessment of the patient's progress throughout the course of the weight loss program. The physician supervised program must include substantial face to face interactions with the physician for a cumulative total of six (6) months (180 days) or longer in duration and occur within two (2) years prior to the surgery.

PART 3. COVERAGE

All covered services provided under this Rider are subject to the applicable Deductible, Coinsurance, Copayment and Out-of-Pocket Maximums as outlined in the Benefit Description to which this Rider is attached.

You must meet all of the criteria set forth under the terms of the plan, and as outlined in this Benefit Description, to be eligible for coverage of bariatric surgery for the treatment of obesity. To qualify for bariatric surgery, You must be able to understand, fully participate and comply with the lifelong behavior and diet changes required for successful sustainable weight loss following surgery. All bariatric surgeries must receive prior authorization by the Administrator.

To be eligible to begin the qualification process You must be an adult age 18 or over, a non tobacco user and have a documented medical history of two years or more of a Body Mass Index (BMI):

1. Equal to 35 and less than 40 with two or more co-morbid conditions
2. 40 or over with one or more co-morbid conditions

Your primary care provider must provide a letter of medical clearance for You to be evaluated for bariatric surgery. You must have attempted weight loss in the past without successful long term weight reductions.

You must have a pre-operative psychological evaluation by a psychologist, psychiatrist or an Advanced Practice Registered Nurse (APRN) certified in psychiatry or with 10 years direct behavioral health experience to ensure that You are able to comply with the pre- and post-operative regimen and that there are no barriers that might prevent You from making the lifestyle changes required for successful long term weight loss.

You must also participate in one of the following: either a physician supervised nutrition and exercise program or the multi-disciplinary surgical preparatory regimen. During this pre-operative period, You will begin working with a care manager of the Administrator. You will be required to complete at least 6 discussions with the Administrator care manager within 8 months following Your surgery. The Administrator care manager will provide support to You post operatively on the diet, exercise, health and lifestyle changes necessary for successful long term weight loss.

You must complete all of the preparatory requirements to be eligible for coverage of bariatric surgery. The following bariatric surgical services may be eligible for coverage:

1. Open or Laparoscopic Roux-en-Y (RYGB)
2. Open or Laparoscopic Biliopancreatic Diversion (BPD) with or without duodenal switch (DS)
3. Laparoscopic Sleeve Gastrectomy
4. Laparoscopic Adjustable Silicone Gastric Banding (LASGB) - Adjustments of the silicone gastric banding are covered to control the rate of weight loss.

Other surgery procedures not specifically stated as covered in this Rider are excluded from coverage. Coverage is provided for post-operative physician assessments at 48 hours, 30 days, six (6) months, one (1) year, eighteen (18) months and two (2) years. Additional follow-up services may be eligible as long as the services are Medically Necessary and recommended by the physician of record.

These procedures are only covered when performed at facilities that are: (1) certified by the American College of Surgeons as a Level 1 Bariatric Surgery Center (program standards and requirements in effect on February 15, 2006); or (2) certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (program standards and requirements in effect on February 15, 2006). A list of approved facilities and their approval dates are listed and maintained at: http://www.mbsaqip.org/?page_id=56. You will also need to review the Network of the Administrator to make sure that the Service Provider You select is a Network Provider. Services covered under this rider are not covered with an out of network provider.

PART 4. SURGICAL REVISIONS

Surgical revision of a bariatric surgery must receive prior approval from the Administrator. Surgical revision is covered to correct complications such as stricture, obstruction, erosion or band slippage. To be eligible for surgical revision, the initial surgery must meet the Medically Necessary criteria, and at least one of the following Medical Necessity criteria:

1. Conversion to a Laparoscopic Sleeve Gastrectomy, RYGB or BPD/DS may be considered Medically Necessary for Subscribers who have not had adequate success (defined as loss of more than fifty (50) percent of excess body weight) two (2) years following the primary bariatric surgery procedure and the Subscriber has been compliant with the prescribed diet and exercise program.
2. Revision is required due to dilation of the gastric pouch or dilation of the gastrojejunostomy anastomosis if the Subscriber has been compliant with the prescribed diet and exercise program and the primary surgery was successful in inducing weight loss prior to the dilation.
3. Replacement of an adjustable band due to complications (Example: port leakage, slippage) that cannot be corrected with band manipulation or adjustments.

PART 5. LIMITATIONS AND EXCLUSIONS

Coverage for bariatric surgery, unless otherwise provided for in this Rider, is limited to one surgical procedure per lifetime regardless of whether or not the procedure was paid for by this plan.

Bariatric Surgical services not specifically listed as covered are excluded.

Bariatric surgery is not covered for the treatment of:

1. Infertility
2. Idiopathic intracranial hypertension