B E N E F I T D E S C R I P T I O N

State Employee Health Plan

This booklet describes the health benefits that the Kansas State Employees Health Care Commission provides to Members and their Dependents.

These benefits are funded by:

The Kansas State Employees Health Care Commission

Third Party Administrator (TPA): Blue Cross Blue Shield of Kansas has been retained to administer claims under this Plan. The TPA provides Administrative Services Only pursuant to this Benefit Description, including claims processing and administration of appeals and grievances. For answers to questions regarding eligibility for benefits, payment of claims, and other information about this Plan contact:

Blue Cross Blue Shield of Kansas
1133 SW Topeka Blvd
Topeka, KS 66629

By Phone 785-291- 4185 or
Toll Free at 1-800-332-0307
www.bcbsks.com/state

Blue Cross Blue Shield of Kansas is not the insurer under this Program and does not assume any financial risk or obligation with respect to claims.

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Introduction

This document is a description of the State Employee Health Plan (the “Plan”) for the exclusive benefit of, and to provide health benefits to its members and their dependents. No oral interpretations will override the terms of this Plan.

Benefit Description. This document constitutes the Benefit Description and is intended to summarize the features of Your health care plan in clear, understandable, and normal usage language. The terms under which the State Employee Health Plan (hereinafter the Plan) administers benefits are contained in this booklet. Carefully read this document to understand Your rights and obligations under the Plan.

When Your claims for any services covered under the Plan are processed, You will receive an Explanation of Benefits (EOB) to help explain how Your claim was paid.

You Must Notify Your Human Resources Department When One Of The Following Events Occurs:

- Birth of child (within 31 days)
- Marriage (within 31 days)
- Divorce (within 31 days)
- Adoption of child (within 31 days)
- Your Covered dependent child gets married (within 31 days)

Section I - Coverage

Part 1: General Provisions

RESPONSIBILITIES OF THE THIRD PARTY ADMINISTRATOR

Third Party Administrator (hereinafter the TPA) Responsibilities for administering the Plan is limited. The TPA does not guarantee that a specific type of room or kind of service will be available to You. However, the TPA is obligated to provide benefits for services provided under the terms of the Plan, as specified within the Benefit Description, when available.

Only Medically Necessary services are covered under the Plan. The fact that a Physician or other Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an injury or illness, substance use disorder, or a mental illness does not mean that the procedure or treatment is covered. The Plan shall have the right, subject to Your rights described in this Benefit Description, to interpret the benefits of the Plan subject to other terms, conditions, limitations, and exclusions set forth in the Plan, and described in this Benefit Description, in making factual determinations related to the Plan, benefits under the Plan, its Members, and in construing any disputed or ambiguous terms. In accordance with all applicable law, the Plan reserves the right at any time, to change, amend, interpret, modify, withdraw, or add benefits to this Plan.

NOTE: Your doctor is the most qualified person to balance quality and safety considerations in choosing the most appropriate treatment for you. The patient and the physician, not the health plan or the employer determine the course of treatment. The health plan is responsible only for determining what is eligible for reimbursement. The final decision on what is the appropriate therapy for you rests with you and your physician.

CASE MANAGEMENT/COST EFFECTIVE CARE

The TPA will provide Case Management if necessary. Case Management will identify Members, who are at risk, have specific Chronic Condition(s). Case Management can provide interventions approved by the case manager to maintain or improve the Member's health status and avoid complications from the chronic disease.

The interventions may include both Covered and Non Covered Services with the exception of specifically stated exclusions. The fact that the Case Management/Cost Effective Care interventions may authorize otherwise Non Covered services in any particular case shall not in any way be deemed to require it to do so in other similar cases.

If written approval for coverage of such services is granted, payment for such services or supplies provided under the terms of the Plan shall be subject to the same standards and requirements of Covered Services under the terms and provisions of the Plan as described in this Benefit Description.

You are not required to accept an alternate treatment plan recommended by the case manager neither is the plan required to provide alternative treatment option(s) at your request.

If the TPA elects to provide benefits for Members in a particular case after reviewing all the surrounding facts and circumstances, such action shall not obligate the TPA to provide the same or similar benefits for the same or another Member in another case. Such determinations will be made on a case-by-case basis and will be determined by the TPA based on all the facts and circumstances.

HOW TO CONTACT THE TPA

Throughout this Benefit Description, You will find that the TPA encourages You to contact the TPA for further information. Whenever You have a question or concern regarding Covered Services or any required procedure, please contact the TPA at the telephone number or website on the back of Your ID card. The customer service representatives, working for the TPA, will be able to assist in answering your questions and provide education for how your benefits work. You can call with questions on a specific claim, denial of a prior authorization or to find out where you are at on satisfying your deductible/out of pocket maximum.

SERVICES FROM NON NETWORK PROVIDERS

If you receive Covered Services from a Non Network Provider, the Member will be responsible for the Non Network Provider's actual billed charges less the amount approved as the Allowed Amount by the TPA. These charges must be paid by the Member in addition to any applicable deductibles, co-payments, or coinsurance.

TRANSFER OF CARE

If you are admitted for emergency care to a Facility that does not contract with the TPA, You and/or the TPA may request that you be transferred to a Network Provider for continuation of care when it is not medically contraindicated. You will have the option to elect to continue Your care with the Non Network Provider, understanding that claims for such care and/or services will be paid at the Non Network level.

Section I - Coverage

Part 2: Prior Authorization

PRIOR AUTHORIZATION PROCESS

Medical

For services that require prior authorization under the terms of the Plan, You are responsible for requesting such Prior Authorization if required for certain health care services as determined by TPA. Coverage of services that require prior authorization is subject to eligibility and benefits requirements that are in effect at the time services are provided. The TPA has the right to request, and obtain, all medical information it considers necessary to determine whether the service is Medically Necessary.

Notice should be given to the TPA at least 72 hours in advance of any planned admission and such notice should include: the patient's name, date of birth, identification number, telephone number, address, Hospital name, planned date of admission, reason for admission, and admitting physician's name. The notification including the required information can be provided to the TPA by telephone at the number on the Identification Card. Service Providers may contact the TPA to obtain Prior Authorization. You, the Hospital, and the admitting Physician will be notified of the decision made by the TPA.

If You fail to obtain the necessary Prior Authorization for an inpatient stay, the TPA will review that admission for Medical Necessity. No benefits will be covered for services determined by the TPA not to be Medically Necessary. In such cases, only the portion of the Inpatient claim that would normally be payable if services were received on an Outpatient basis will be covered.

Prior Authorization for Prosthetics, Durable Medical Equipment (DME) and Intravenous treatment will require more than 72 hours, but not more than 15 days.

Prior Authorization for Autism Services requires a comprehensive assessment and a treatment plan submitted for prior approval at least 21 days in advance of the start of treatment. Please refer to the Autism Rider for specific qualifications and periodic evaluations.

The following services require prior authorization:

- All Medical, Behavioral and Substance Abuse Inpatient Admissions
- Autism Services – see Section II Part 6
- Bariatric Surgery – see Section II Part 8
- Cochlear Implants
- Durable Medical Equipment and/or repairs greater than $750
- Home Health treatment plan
- Hospice – 6 month limit on inpatient
- Intravenous and injectable Medication (given in home; if given in the Service Provider's office and exceeds $1,000 excluding cancer treatment.)
- All new Prosthetics and prosthetic repairs that exceeds $1,000
- Repair or Replacement of Orthotic and/or Orthopedic Devices that exceeds $750

Unless otherwise specified, notice should be given to the TPA at least 15 days in **advance** of any planned admission or course of treatment as listed above and should include: the patient's name, date of birth, identification number, telephone number, address, Hospital

name, planned date of admission, reason for admission, and admitting physician's name. The notification and required information can be provided by telephone to the TPA at the number on the Identification Card.

BEHAVIORAL HEALTH PRIOR AUTHORIZATION

The Member is responsible for contacting TPA for Prior Authorization of inpatient behavioral health and substance use disorder. Prior Authorization may be obtained by calling: 1-800-952-5906 twenty-four hours a day, 7 days a week.

Section I – Coverage

Part 3: Schedule of Benefits

State(s) of Issue: Kansas		
Plan: 2022 State Employee Health Plan - Plan C		
	When Receiving Services from Network Providers	**When Receiving Services from Non Network Providers**
Annual Plan Deductible Deductible for all "non-single" policies (employee/spouse; employee/children; employee/family) will be $2,800 for an individual within the family. The overall family deductible for these policies will remain at $5,500.	$2,750 Single / $5,500 Family	$2,750 Single / $5,500 Family
Coinsurance For All Eligible Expenses (unless otherwise noted)	10% Coinsurance	50% Coinsurance
Combined Medical and Pharmacy Annual Out of Pocket Maximum Includes Deductible, Copays and Coinsurance for services covered under the Plan	$4,500 Single / $9,000 Family	$4,500 Single / $9,000 Family

Covered Services	**Cost to Members When Receiving Services from Network Providers**	**Cost to Members When Receiving Services from Non Network Providers**
PREVENTIVE CARE **As determined by the Affordable Care Act.** • https://www.healthcare.gov/coverage/preventive-care-benefits/ • https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/, • http://www.cdc.gov/vaccines/schedules/hcp/index.html, and • http://www.hrsa.gov/womensguidelines/. Deductible and Coinsurance does not apply to preventive care services when using a Network Provider.		
Age Appropriate Physical Exam and Routine Health Screening	**Limited to one visit or service per year unless otherwise noted**	

Covered Services	Cost to Members When Receiving Services from Network Providers	Cost to Members When Receiving Services from Non Network Providers
Well Baby Exams (includes multiple office visits as specified in benefit description along with the immunization schedule) Includes newborn screenings for: • Congenital hypothyroidism • Sickle cell disease • Gonococcal ophthalmia neonatorum including topical medication for prevention • Phenylketonuria (PKU) Includes Well Baby screenings for: • Physical exams and measurements • Oral health risk assessments	Covered in Full	Deductible plus 50% Coinsurance
Well Child Annual Exam Includes screenings for: • Adolescent Depression • HIV • Obesity At the time of exam, counseling for: • Healthy diet • Obesity/Weight management • Sexually Transmitted Infections (STI's) • Chemoprevention for dental caries • Iron Deficiency	Covered in Full	Deductible plus 50% Coinsurance
Well Man Annual Exam Includes screenings for: • Prostate exam • Sexually Transmitted Infections (STI's) • HIV • High blood pressure • Cholesterol • Diabetes • Depression • Colorectal Cancer	Covered in Full	Deductible plus 50% Coinsurance

Covered Services	Cost to Members When Receiving Services from Network Providers	Cost to Members When Receiving Services from Non Network Providers
Well Man Annual Exam continued At the time of exam, counseling for: • Alcohol usage • Aspirin usage • Healthy diet • Obesity/Weight Management • Tobacco usage • STI's	Covered in Full	Deductible plus 50% Coinsurance
Well Woman Annual Exam Includes screenings for: • Sexually Transmitted Infections (STI's) • HIV • Cervical cancer • High blood pressure • Cholesterol • Diabetes • Depression • Osteoporosis • Colorectal Cancer At the time of, counseling for: • Alcohol usage • Aspirin usage • Breast Cancer Risks/BRCA screening and testing • Contraceptive education • Domestic and Interpersonal Violence screening • Healthy diet • Obesity/Weight management • Tobacco usage • STI's Folic Acid intake	Covered in Full	Deductible plus 50% Coinsurance

Covered Services	Cost to Members When Receiving Services from Network Providers	Cost to Members When Receiving Services from Non Network Providers
Prenatal Services Initial screenings for: • Hepatitis B • Bacteriuria • RH Incompatibility At the time of exam counseling for: • Folic acid supplements • Tobacco usage • Alcohol usage Screenings during pregnancy for: • Iron Deficiency Anemia • Sexually Transmitted Infections (STI's) • Gestational Diabetes testing after 24 weeks Counseling for: • Breastfeeding support • Breastfeeding supplies/rental	Covered in Full	Deductible plus 50% Coinsurance
Age Appropriate Bone Density Screening	Covered in Full	Deductible plus 50% Coinsurance
Colonoscopy Screenings • Including polyp removal	Covered in Full	Deductible plus 50% Coinsurance
Contraception/Sterilization Includes: • Implantable/Injectable contraceptives • Sterilization procedure (tubal ligation) • Educational\counseling	Covered in Full Covered in Full Covered in Full	Deductible plus 50% Coinsurance Deductible plus 50% Coinsurance Deductible plus 50% Coinsurance
Immunizations: • Under Age 18 • Over Age 18	Covered in Full Covered in Full	Covered in Full to Age 6, Otherwise Deductible plus 50% Coinsurance Deductible plus 50% Coinsurance

Covered Services	Cost to Members When Receiving Services from Network Providers	Cost to Members When Receiving Services from Non Network Providers
Mammography (not limited to one)	Covered in Full	Deductible plus 50% Coinsurance
Routine Hearing Exam – Preventive (once per calendar year)	Covered in Full	Deductible plus 50% Coinsurance
Vision Exam- first eye exam per year covered at 100% regardless of diagnosis	Covered in Full	Deductible plus 50% Coinsurance
Ultrasonography for Aortic Aneurysm • Men Age 65 to 75 • History of Tobacco use • Once per Lifetime	Covered in Full	Deductible plus 50% Coinsurance
MEDICAL TREATMENT		
Inpatient Services Services must be pre-approved by TPA.	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
Outpatient Services	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
Office Visits		
• Primary Care Provider Office Visits	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
• Specialist Office Visits	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
• Telehealth Consultation	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
• Urgent Care Center	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
Allergy Testing	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
Allergy Shot & Antigen Administration Desensitization/Treatment	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance

Covered Services	Cost to Members When Receiving Services from Network Providers	Cost to Members When Receiving Services from Non Network Providers
Ambulance/Emergency Transportation Ground or Air limited to domestic use	Deductible plus 10% Coinsurance	Network Deductible* plus 10% Coinsurance
Autism Services	See Separate Rider	See Separate Rider
Dietician Consultation	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
Durable Medical Equipment (DME) Any charges exceeding $750 require pre-approval by the TPA	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
Durable Medical Equipment (DME) Repairs Any charges exceeding $750 require pre-approval by the TPA	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
Emergency Room Services	Deductible plus 10% Coinsurance	Network Deductible* plus 10% Coinsurance
Formula & Low Protein Modified Foods for PKU Limited to $5,000 per calendar year	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
Home Health Care Services must be pre-approved by the TPA	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
Hospice Care Services must be pre-approved by the TPA Inpatient Hospice care limited to 180 units (days).	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance

Covered Services	Cost to Members When Receiving Services from Network Providers	Cost to Members When Receiving Services from Non Network Providers
Major Diagnostic Testing (Includes but is not limited to PET Scans, CT Scans, Nuclear Cardiology Studies, MRI Computerized Topography/Angiography)	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
Spinal Manipulation Therapies Limited to 30 visits per year	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
Mental Health and Substance Use Disorder • Inpatient Services • Outpatient Services • Office Visits • Group Therapy Sessions	Same as Medical	Same as Medical
Outpatient Laboratory Services		
• Preferred Laboratory Providers Discounted contracted rate while satisfying deductible. Once deductible is satisfied lab services will be paid at 100%.	Deductible plus 0% Coinsurance	Not Applicable
• Other Laboratory Providers	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
Outpatient Surgery Surgery/Anesthesia/Assistant Surgeon	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
Rehabilitation Services		
• Inpatient Hospital Services	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
• Outpatient Facility Services	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance
• Office Services	Deductible plus 10% Coinsurance	Deductible plus 50% Coinsurance

Network and Non Network out of pocket accumulate separately.

*** Must be a Medical Emergency**

Section I - Coverage

Part 4: Definitions

Administrative Service Contract: The written agreement entered into by the Kansas State Employee Health Care Commission (hereinafter the Group) and the TPA for the provision of Medical and Hospital claims administration and adjudication.

Activities of Daily Living: Activities usually done during a normal day including, but not limited to, bathing, dressing, eating, maintaining continence, toileting, transferring from bed to chair, taking medications and mobility.

Acute: An Illness or Injury that is both severe and of recent onset.

Adverse Benefit Determination or Adverse Benefit Decision: A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit claimed under the Plan. The term shall include the denial of services for a benefit claimed under the Plan that resulting from the application of any utilization review resulting in a failure to cover an item or service, in whole or in part, for which benefits are otherwise provided because it is determined to be Experimental, Investigational, or not Medically Necessary. An adverse benefit decision also includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at that time).

Age Appropriate: Suitable treatment for a particular age or age group.

Alcohol, Chemical, Drug or Substance Use Disorder: The psychological or physiological dependence upon and/or misuse of alcohol, chemical(s), drug(s), or substance(s), characterized by withdrawal and impairment of ability to function or both.

Allowed Amount(s)/Allowed Charge: The maximum monetary payment for health care services rendered to You and authorized by the TPA.

Alternate Recipient: means any child of a Member who is recognized by the plan, as an Eligible Dependent, under a Qualified Medical Child Support Order, which is made pursuant to Kansas domestic relations law or section 1908(A) of the Social Security Act and any amendments therein as having a right to enrollment in the Plan and is on file with the Group.

Amendment: Any attached written description of additional or alternative provisions to the insurance Agreement underlying the Plan and/or set forth in this Benefit Description. Amendments are effective only when authorized in writing by the Plan, and are subject to all conditions, limitations, and exclusions of the existing insurance Agreement except for those which are specifically amended.

Appeal: An Appeal is a written request, except in the case of Urgent Care in which case the request may be submitted orally or in writing, by You or Your Authorized Representative for reconsideration of an Adverse Benefit Determination on a request for service or a benefit You believe You are entitled to receive under the terms of the Plan.

Audit: Any audit in the form of government, internal or external audit.

Authorization/Prior Authorization: The TPA has given approval for Services to be performed. Authorization does not guarantee payment. The process includes determination of eligibility, Covered Services, and medical necessity, as well as implications about the use of Network and Non Network providers.

Authorized Representative: An Authorized Representative is an individual authorized in writing by You or by state law to act on Your behalf in requesting a health care service, obtaining claim payment or during the Appeal process. A Provider may act on Your behalf with Your expressed consent, or without Your expressed consent when it involves an Urgent Care claim or Appeal. An Authorized Representative does not constitute designation of a personal representative for Health Insurance Portability and Accountability Act (HIPAA) privacy purposes.

Benefit Description: This booklet and any Amendments attached hereto.

Calendar Year: The time period that begins at 12:01 January 1 and ends at midnight on December 31 annually.

Case Management: A process conducted by the TPA where they have identified a member with chronic condition(s) that would benefit from the services of a case manager, within the TPA, to help assess and intervene, if needed, to ensure that the appropriate level of care is being received by the patient. Participation in Case Management is voluntary.

Claim for Benefits or Claim(s): A request for payment for a service made by You or Your Provider in accordance with TPA's procedure for filing Claims. A Claim must have sufficient information upon which to base a decision regarding coverage according to all of the provisions of the Plan, as described in this Benefit Description. All claims must be submitted in English.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1986 and its administrative regulations. This federal law requires employers with group health plans to offer participants and beneficiaries the opportunity to purchase the continuation of health care coverage for a limited period of time after the occurrence of a qualifying event, which is usually the termination of employment. The law applies to both public and private employers with twenty (20) or more employees.

Coinsurance: A portion of the Allowed Amount that is payable by You and usually is based on a percentage of the Allowed Amount for Covered Services under the terms of the Plan, as set forth in this Benefit Description.

Confinement and Confined: An uninterrupted stay following formal admission to a Hospital.

Congenital Anomaly: A physical developmental defect that is present from birth.

Convalescent Care, Custodial/Maintenance Care or Rest Cures: Treatment or services, rendered safely and reasonably by self, family members or other caregivers who are not Health Professionals. The services are designed primarily for the purpose of helping the Member with Activities of Daily Living, meeting personal needs, maintaining their present physical and/or mental condition, and providing a structured or safe environment. This term includes such care that is provided to a Member who has reached

his or her maximum level of recovery. This term also includes services to a Member who is institutionalized and who cannot reasonably be expected to live outside of an institution. Examples of Custodial Care include, but are not limited to, respite care and/or home care which is or could be provided by family members or private duty caregivers.

Copayment or Copay: Means a fixed monetary amount that is paid by You each time a specific Covered Service is received (excluding preventive services).

Cosmetic: Procedures and related services performed to reshape structures of the body in order to alter the individual's appearance, to alter the aging process or when performed primarily for psychological purposes and determined not to be Medically Necessary.

Closed Panel Plan: A Medical Carrier or plan that provides health benefits to subscribers primarily in the form of services, through a panel of providers, that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers.

Covered Services: The services or supplies provided to You for which the Plan will make payment according to the terms of the Plan, and as described in this Benefit Description.

Credible Evidence: Means published reports and articles in authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying and/or substantially the same drug, device, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying and/or substantially the same drug, device, medical treatment, or procedure.

Custodial Care, Maintenance, Domiciliary, or Convalescent Care: This includes care that assists Members in the Activities of Daily Living like walking, getting in and out of the bed, bathing, dressing, feeding, and using the toilet; preparation of special diets and supervision of medication that is usually self-administered regardless of who orders the services.

Customer Service: A group of TPA employees who can assist you with understanding your benefits and how Your claims were processed.

Deductible: The amount of Allowable Charges for Covered Services that must be paid by a Member before payments are made by the Plan with respect to benefits covered for a Service that is permitted under the Plan. Amounts applied toward the Deductible are accumulated until a specified dollar maximum has been reached during a Calendar Year after which no additional Deductible amount is required to be paid by the Member for the remainder of the Calendar Year covered by the applicable period.

Durable Medical Equipment (DME): Medical equipment covered under the terms of the Plan, and as set forth in this Benefit Description, which can withstand repeated use and is not disposable; is used to serve a medical purpose; is generally not useful to a person in the absence of an Illness or Injury; and is appropriate for use in the home. Medically Necessary, non-disposable accessories that are commonly associated with the use of a covered piece of DME will be considered DME.

Eligible Dependent: A covered spouse or eligible child of a Member, up to the end of the month in which the child turns 26 years.

Emergency Medical Condition/ Medical Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part. Examples of Emergency Medical Conditions include (but are not limited to) heart attacks, cerebrovascular accidents (i.e., strokes), poisoning, convulsions, and severe bleeding.

Experimental or Investigational: Means a drug, device, medical treatment, or procedure that meets any of the following:

- The drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (herein after FDA) and approval for marketing has not been given at the time the drug or device is furnished. The informed consent document utilized with the drug, device, medical treatment, or procedure indicates that such drug, device, medical treatment, or procedure is experimental / investigational.
- Credible evidence shows that the drug, device, medical treatment, or procedure is the subject of on-going phase I or phase II clinical trials, is in the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.
- Creditable evidence shows that the prevailing opinion 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 a standard means of treatment or diagnosis.

Expedited Appeal: Means an Appeal that may be requested either orally or in writing to be expedited if the Member feels their condition requires Urgent Care.

FDA: Means the Federal Food and Drug Administration.

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

Grandchild(ren): A newborn of a dependent child that does not meet the requirements to be added as an eligible dependent as outlined in the SEHP Employee Guidebook will only be covered from the date of birth up to 5 days while an inpatient in the hospital.

Group: The State of Kansas.

High-Dose Chemotherapy: is defined as the dose of chemotherapy which exceeds standard doses of chemotherapy to the extent that virtually all patients who receive High-Dose Chemotherapy sustain destruction of the bone marrow to the point that bone marrow or peripheral stem cells must be implanted or infused to keep the patient alive. Thus, the role of autologous bone marrow transplantation or peripheral stem cell support is not as a treatment, but to restore the bone marrow destroyed by the High-Dose Chemotherapy.

HIPAA: means the Health Insurance Portability and Accountability Act of 1996 and its administrative regulations.

Hospice Care Plan or Hospice Care Program: means a coordinated plan of care which provides Palliative Care for the Hospice Patient. This plan will be designed to provide care to meet the patient's special needs during the final stages of a terminal illness.

Hospice Patient: means a patient diagnosed as terminally ill by an attending Physician or referred and accepted into a hospice program.

Hospital Services: means those services which are provided to registered Inpatients or Outpatients by an acute care general Hospital.

Infertility: Any medical condition causing the inability or diminished ability to reproduce.

Infertility Services: Treatment or services (including confinement) related to the restoration of fertility or the promotion of conception.

Injury: Means a bodily damage, other than Illness, including all related conditions and recurrent symptoms.

Inpatient: Means settings in which services are provided to a person who has been admitted to a Hospital.

Inpatient Facility Based Rehabilitation: Means rehabilitation services that are payable for inpatients residing in Hospitals at an acute level of care, subject to the Medical Necessity provisions of the health plan. Only facilities with acute care licenses (Hospitals) that provide short and long term rehabilitation services for medical or mental covered services.

Inquiry: Any question from You or Your Authorized Representative that is not a Pre-Service Appeal, a Post-Service Appeal or an Urgent Care Appeal, or a Complaint.

Legal Finding: The legal finding that is the result from a court case.

Manipulative Services: Rehabilitative Services provided by a licensed provider, including but not limited to subluxation and manipulation.

Maternity Services: Includes prenatal and postnatal care, childbirth, and any complications associated with pregnancy.

Manipulation: Means the skillful or dexterous treatment or procedure involving the use of the hands. In physical therapy, manipulation is the forceful passive movement of a joint beyond its active limit of motion.

Medical Director: The Physician specified by the TPA, or his or her designee, who is responsible for medical oversight programs, including but not limited to Authorization/Prior Authorization programs.

Medically Necessary/Medical Necessity: Means a service required to diagnose or to treat an Illness or Injury. To be Medically Necessary, the service must: be performed or prescribed by a Health Professional; be consistent with the diagnosis and treatment of your condition; be in accordance with standards of good medical practice; not be for the convenience of the patient or his Professional Provider; and be performed in the most appropriate setting or manner appropriate to treat the Member's medical condition. Benefits will be provided only for Medically Necessary services. To determine if services are Medically Necessary, the TPA may require information related to (but not limited to) medical records, medical history, the service performed, the admission, and continued care.

Medical Services: Means those services of Eligible Providers, including medical, surgical, diagnostic, therapeutic and preventive services. Eligibility for payment of medical services is outlined in this Benefit Description.

Medicare: Means the Health Insurance for the Aged Act (Title XVIII of the Social Security Act Amendments of 1965, as amended now and in the future). The term Medicare includes any rules and regulations authorized by that Act and any law designed specifically to replace that Act. Part A, Part B and Part D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Member: is any employee or former employee who is enrolled in the Plan for medical coverage.

Members: is the Member and his or her covered Eligible Dependents. A Member who is covered under the terms of the Plan, as set forth in this Benefit Description.

Member(s) Effective Date: is the date when Coverage will take effect, in accordance with the Kansas Administrative Regulations 108-1-1 for State employees and 108-1-3 and 108-1-4 for Non State employees. Proper documentation is required when enrolling Eligible Dependents. If you have any questions or need assistance completing your enrollment form, please consult your Human Resource Representative.

Mental Illness or Mental Health: Those conditions classified as "mental disorders" as specified within the diagnostic and statistical manual of mental disorders, fourth edition, text revision (DSM-IV), of the American psychiatric association.

Modalities: means a method of application or the employment of any therapeutic agent, limited usually to physical agents.

Non-Covered Service(s): mean health care services that are exclusions or limitations of benefits as identified in the Benefit Description and Schedule of Benefits.

Obesity: Body Mass Index (BMI) greater than or equal to 30.

Open Enrollment Period: means a period, defined by the Group, during which the Member may enroll in the Plan and/or make changes to existing enrollment of benefits.

Orthognathic Surgery: is a corrective facial surgery on the bones of the jaw where deformities of the jaw exist.

Orthotic Appliances: Orthotics are externally placed appliances that correct or support a defect of a body form or function. For example: a leg brace.

Out of Pocket: means the member's financial responsibility for covered services.

Out of Pocket Maximum: means the dollar limit of a member's financial responsibility (e.g., deductible, coinsurance, and copayments) for covered services during a plan year.

Outpatient: Means a setting in which services are provided 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, a Physician's office, or an Independent Diagnostic Testing Facility.

Outpatient Facility Based Rehabilitation: Means rehabilitation services provided for Outpatient treatment provided in an Acute Hospital or clinic setting (including services from a registered Physical Therapist or Occupational Therapist in this setting). Clinic for the purposes of this provision shall mean: an institution connected with a hospital or medical school where diagnosis and treatment are made available to Outpatients.

Outpatient Office Based Rehabilitation: means all rehabilitation services provided in an Eligible Service Provider's office.

Palliative Care: means treatment directed at controlling pain, relieving other physical and emotional symptoms, and focusing on preventing the suffering of patients.

Peer-Reviewed Medical Literature: A scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in two major American medical journals. Peer-Reviewed Medical Literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company, a device manufacturing company, or health vendor.

Plan: The Health Plan offered by the State of Kansas.

Prosthetic Device: An artificial substitute or replacement of a part of the body. It may be an internal replacement such as an artificial joint or an external replacement such as an artificial limb.

Proof of Loss: means documentary evidence required by the TPA to prove the existence of a valid claim for financial loss.

Provider:

- **Eligible Provider** To be eligible for reimbursement under terms of this Plan a provider must be practicing within the scope of his/her license, providing covered services to members and must be of a type recognized by the TPA as eligible for reimbursement and listed as institutional or professional service providers. The TPA makes no guarantee that service providers recognized in other states or jurisdictions will be eligible for reimbursement under the terms of the Plan in effect at the time the services are provided.

- **Institutional Service Providers** may include, but are not limited to:
  - Alcohol or Drug Treatment Facilities,
  - Ambulatory Surgical Centers,
  - Birthing Centers,
  - Dialysis Centers/Facilities,
  - Home Health Agencies,
  - Hospices,
  - Hospitals,
  - Hospital Sleep Laboratories,
  - Medical Care Facilities and

- Rehabilitation Centers/Facilities, **Network Provider** means a Professional or Institutional provider that has entered into a written agreement with the TPA's PPO Network or designated affiliates to provide health services to Members.

- **Non Network Provider** means a Professional or Institutional provider who has not entered into a PPO contract with the TPA or designated affiliates to provide health care services to Members.

- **Preferred Provider Organization (PPO)** is an arrangement whereby the TPA contracts with a network of medical care providers who furnish medical services.

- **Primary Care Provider** originates in a primary health care setting that is family-centered and compassionate. Professional Providers within the following areas of specialty are considered Primary Care Providers ("PCP"):
  - General practice,
  - Family practice,
  - Internal medicine,
  - Pediatrics,
  - Geriatrics,
  - Physician Assistants

  Note: Physician extenders (physician assistants and advance practice registered nurse) are treated as PCPs if it is primary care (Ex. general practice, family practice, internal medicine, pediatrics, geriatrics). If the Physician Extender is conducting medicine under an area of specialty the Specialist Copay will apply.

- **Professional Providers** may include, but are not limited to:
  - Advance Practice Registered Nurse (APRN)
  - Ambulance
  - Audiologist
  - Chiropractor (DC)
  - Dentist (DDS)
  - Doctor of Medical Dentistry (DMD)
  - Doctor of Medicine (MD)
  - Doctor of Osteopathy (DO)
  - Home Health Agency
  - Licensed Specialist Clinical Social Worker (LSCSW)

- Occupational Therapist (OT)
- Ophthalmologist (MD)
- Optometrist (OD)
- Osteopath (DO)
- Physician's Assistant (PA)
- Podiatrist (DPM)
- Psychologist (PhD)
- Speech-language Pathologist (MD)
- Speech Therapist (ST)
- Registered Pharmacist
- Registered Physical Therapist (RPT)
- Free Standing Sleep Centers/Laboratories
- Dietician
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Nurse Midwife (CNM)
- Certified Occupational Therapy Assistant (COTA)
- Certified Physical Therapy Assistant (CPTA)
- Licensed Clinical Marriage and Family Therapists (LCMFT)
- Licensed Clinical Professional Counselor (LCPC)
- Licensed Clinical Psychotherapist (LCP)

- **Specialty Care Physician/Specialist** A Physician who is not a Primary Care Provider and provides medical services to Members concentrated in a specific medical area of expertise.

Reconstructive Surgery: is Surgery which is incidental to an Injury, Illness, or Congenital Anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. The definition of Reconstructive Surgery includes the following: reconstructive surgery following a mastectomy, including reconstructive surgery on the opposite breast to restore symmetry and Prosthetic Devices/implants or reduction mammoplasty; and reconstructive surgery for a covered newborn member.

Rehabilitation Services: means therapies that, when provided in an Inpatient or Outpatient setting is designed to restore physical functions following an Accidental Injury or an Illness including physical therapy, speech therapy and occupational therapy.

Rescission: is a retroactive cancellation of coverage. In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage except when premiums and contributions are not timely paid (in full), or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact. A failure to timely pay premiums includes a failure to pay premiums for continuation coverage under COBRA.

Schedule of Benefits: means the document that summarizes benefits and includes, but is not limited to, cost sharing amounts and limitations.

Semi-private Accommodations: a room with two (2) or more beds in a Hospital. The difference in cost between Semi-private Accommodations and private accommodations is covered only when private accommodations are Medically Necessary.

Telemedicine: means the use of telecommunications technology to provide, enhance, or expedite health care services, as by accessing off-site databases, linking clinics or physicians' offices to central hospitals, or transmitting x-rays or other diagnostic images for examination at another site.

Telemedicine Consultation: a two-way real time interactive communication between the patient and the physician or practitioner located at a different location. This electronic communication uses interactive telecommunications equipment that includes audio and video.

Terminal Illness: means an illness of a Member, which has been diagnosed by a physician and for which the Member has a prognosis of six months or less to live.

Third Party Administrator (TPA): is a company who processes claims pursuant to a service contract and who may also provide one (1) or more administrative services. The party financially responsible for the payment of benefits under the terms of the Plan. Reimbursement by the Group will be provided to the TPA after payment to the provider/facility has been made.

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

You or Your: A Member covered under this Benefits Description.

Section 1 - Coverage

Part 5: Covered Services

Subject to all terms, conditions and definitions in this Benefit Description, Members are entitled to receive the Covered Services provided under the terms of the Plan, and as set forth in this section. (See the Prior Authorization List for services requiring Prior Authorization included in a previous section.)

Ambulance Services: Coverage is provided for domestic licensed air or ground ambulance following a Medical emergency when transport by other means is not medically appropriate. Ambulance Services are also covered when it is medically necessary to transfer You from one Hospital to another Hospital for care as an Inpatient or for transport to the nearest appropriate place of treatment. Ambulance services are limited to the Allowable charges for the least expensive ambulance type appropriate when transport by other means is not medically appropriate and limited to the nearest appropriate place of treatment. In no instance, shall air or ground Ambulance Services be provided for greater than 500 miles in one direction.

Allergy Services: Coverage is provided for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections. In the case of allergy antigens, the antigen itself is covered whether injected by a Provider or provided to You for self-administration.

Blood And Blood Products Processing: Coverage is provided for administration, storage, and processing of blood and blood products in connection with services covered under the terms of the Plan, and as set forth in this Benefit Description.

Breast Reconstruction: Coverage is provided for Breast Reconstructive Surgery and prosthesis following a Medically Necessary mastectomy. As required by the Women's Health and Cancer Rights Act (WHCRA), if You elect breast reconstruction after a covered mastectomy, benefits will be provided for augmentation, reduction of the affected breast, nipple reconstruction, and augmentation or reduction on the opposite breast to restore symmetry, prosthesis, and treatment of physical complications at all stages of the mastectomy, including lymphedema. Benefits are limited to 2 external prostheses per breast, per member, per calendar year.

Chemotherapy (chemical treatment): For malignant conditions. Your Doctor's charges for services administering chemotherapy. The chemotherapy drugs that are injected, given intravenously, or taken by mouth during the course of a professional treatment administered by your doctor (excluding those services eligible for coverage under a Prescription Drug Plan).

Child Health Services: Coverage is provided for the periodic review of a Dependent child's physical and emotional status by a Physician or pursuant to a Physician's supervision.

A review shall include a history, complete physical examination, development assessment, anticipatory guidance, appropriate immunizations, and laboratory tests consistent with prevailing standards.

Periodic reviews are covered, at a minimum, from the date of birth, two months, four months, six months, nine months, twelve months, eighteen months, two years, and annually thereafter.

Clinical Trials: Effective for plan years beginning on or after January 1, 2014, charges incurred due to participation in either a Phase I, II, III, or IV Approved Clinical Trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, provided the charges are those that are:

1. Ancillary to participation in the Approved Clinical Trial and would otherwise be covered under this Plan if the individual were not participating in the Approved Clinical Trial; and

2. Not attributable to any device, item, service, or drug that is being studied as part of the Approved Clinical Trial or is directly supplied, provided, or dispensed by the provider of the Approved Clinical Trial.

A Participant or Dependent is eligible for payment of charges related to participation in an Approved Clinical Trial if he or she:

1. Satisfies the protocol prescribed by the Approved Clinical Trial provider; and

2. Either:

    a. The individual's network participating provider determines that the individual's participation in the Approved Clinical Trial would be medically appropriate; or

    b. The individual provides the Plan with medical and scientific information establishing that participation in the Approved Clinical Trial would be medically appropriate.

For the purposes of this provision, an Approved Clinical Trial means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The Approved Clinical Trial's study or investigation must be (1) approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention (CDC), (c) the Agency for Health Care Research and Quality (AHCRQ), (d) the Centers for Medicare and Medicaid Services (CMS), (e) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the

Department of Defense (DOD), or the Department of Veterans Affairs (VA); (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

Excluded Expenses include:

- Expenses incurred due to participation in an Approved Clinical Trial that are: (1) the investigational items, devices, services, or drugs being studied as part of the Approved Clinical Trial; (2) items, devices, services, and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services, or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

- Expenses incurred at a non-network provider if a network participating provider will accept the patient in an Approved Clinical Trial. If there is no such participating provider and the Approved Clinical Trial is only offered outside the patient's state of residence, this Plan will pay for covered expenses provided at a non-network provider.

Colorectal Cancer Screening: Coverage is provided for a colorectal cancer exam and related laboratory testing pursuant to the current American Cancer Society and U.S. Preventative Services Taskforce guidelines.

Dental Services, Oral Surgery And Other Related Services: The Plan will pay for the following limited dental services:

Administration of general anesthetic and Facility charges determined by the Plan to be Medically Necessary for dental care, and provided to the following persons:

- Dependent children seven (7) years of age or under; or
- A Member who is severely disabled; or
- A Member who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.
- Benefits for oral surgical procedures of the jaw or gums will be covered for:
    - Removal of tumors or cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;
    - Removal of symptomatic exostoses (bony growths) of the jaw and hard or soft palate;

- Treatment of fractures and dislocations of the jaw and facial bones;
- Laceration of mouth, tongue, or gums;
- Intraoral x-rays in connection with covered oral surgery;
- General anesthetic for covered oral surgery; and
- Biopsies and associated lab work in connection with covered oral surgery.

Note: All Claims for treatment of accidental trauma to natural teeth should be processed according to the terms under the dental plan coverage. Services covered by the dental plan coverage are not eligible for additional payment by the medical plan coverage.

- The dental plan coverage will cover 1 hour of sedation if billed by a dentist.
- The dental plan will not cover the facility charges or separate anesthesiologist charges if billed.

Dermatological Services: Coverage is provided for the necessary removal of a skin lesion that interferes with normal body functions or is suspected to be malignant.

Diabetic Services: Coverage is provided for the diagnosis and treatment of diabetes. Inclusion of outpatient self-management training and education for diabetes will be covered if treated through an approved program, and such treatment is rendered by a person certified by the National Certification Board of Diabetes Educators.

Glucometers, insulin pumps, and insulin pump related supplies used for the self-management of diabetes are covered when deemed Medically Necessary and purchased from a Network Service Provider. Note: Other supplies used for the self-management of diabetes including, insulin, syringes, alcohol swabs, glucose test strips (blood and urine), ketone testing strips and tablets, lancets and lancet devices are covered under the terms of the prescription benefit plan.

Durable Medical Equipment (DME) is all of the following:

- Ordered by a Physician and consistent with the patient's diagnosis.
- Medically Necessary as determined by the TPA.
- Manufactured and used to serve a medical purpose with respect to treatment of an illness, injury or accompanying symptoms and is appropriate for home use.
- Generally, not useful to a person in the absence of an illness, injury or accompanying symptoms.
- Can withstand repeated use.
- Not disposable.

Coverage is limited to the standard item of equipment that adequately meets the medical need. If more than one piece of DME can meet Your functional needs, benefits are available under the Plan, but is limited to the basic piece of equipment. Prior authorization is required for the purchase of DME that exceeds $750.

Coverage will be provided for basic (standard) equipment, devices, or supplies. If you elect to purchase DME with enhancements or components to enhance performance, for the comfort or convenience of the patient and determined by the TPA not to be Medically

Necessary You are responsible for paying the additional cost of such items or components. The Plan provides coverage for the amount that would have been allowed for a basic (standard) piece of equipment. Coverage for wheelchairs will be determined by the TPA based on the applicable medical criteria and guidelines. The determination of rental or purchase of DME will be based on the review of the diagnosis, severity of illness, and prognosis. Average usable life of a wheelchair is considered to be approximately five (5) years. Coverage for replacement will be considered when:

- The cost of the repair exceeds of the replacement cost;
- Other extenuating medical circumstances occur which require special consideration; OR
- The current wheelchair no longer meets the patient's needs.

If an upgrade in equipment is requested, the patient's functional status (diagnosis, prognosis, and severity of condition) must be reviewed for special consideration, in accordance with the justification for Medical Necessity.

For DME that becomes non-functional, the determination of whether to repair or replace the piece of DME owned by the member will be made by the TPA. Repair of DME in excess of $750 requires Prior Authorization of the TPA. Coverage of DME includes batteries and repairs that are required to keep the device operational.

The TPA has the right to decide whether to provide for the rental or purchase of DME and whether to stop covering rental of an item when the item is no longer Medically Necessary. Total rental costs must not be more than the purchase price and will be applied to the purchase price. It will be up to the TPA to determine rental or purchase.

Exclusions (even if the above criteria are met) - The following services are not covered under the terms of the Plan:

- Repairs, adjustments, or replacements necessitated by misuse or abuse are not covered.
- Duplication, spare or alternate use equipment is not covered. Example: If coverage has been provided for a wheelchair, requests for a second chair of the same type are considered duplicates and are not covered.
- Comfort, convenience or enhanced components equipment or features are not covered.
- Additional components to enhance performance are not covered.
- Devices or equipment used for environmental accommodations such as, but not limited to, chair lifts, stair lifts, home elevators, standing frames, and ramps are not covered.
- Exercise or hygiene equipment is not covered.
- Replacement of lost equipment is not covered.

Coverage will be provided for enteral nutrition (tube feedings) if:

- The medical records indicate your medical condition is expected to last longer than three (3) months; or
- The medical condition prevents food from reaching the intestines; or

- The condition requires tube feedings to provide sufficient nutrients to maintain weight and strength. To be covered, adequate nutrients must not be possible by dietary adjustment and/or oral supplements.

Limitation: Enteral pumps and supplies will be covered only when one of the above criteria is met.

Exclusions (even if the above criteria are met) - The following services are not covered under the terms of the Plan:

- Enteral products that can be administered orally.
- Products that can be purchased over-the-counter, which do not require a prescription by federal or state law, including, but not limited to, formula, Ensure®, Pediasure®, and Nutren®. Over-the-counter drugs will not be reimbursable even if supported by a prescription by the provider.

Disposable Medical Supplies: associated with certain Durable Medical Equipment coverage for disposable medical supplies is limited to the following:

- Ostomy supplies (appliance pouches, skin care agents, support belts);
- Open wound supplies (gauze pads, wound packing strips, ABD pads);
- Venous access catheter supplies (alcohol pads, benzoin, OP site);
- Urinary supplies limited to catheters, bags, and related supplies;
- Tracheostomy supplies;
- Inhaler supplies (aero chamber masks, spacers, and peak flow meters);
- Compression gloves and sleeves;
- Compression stockings; and
- Mastectomy supplies.
    - Following a mastectomy, coverage will be provided for either two (2) bras or two (2) camisoles or a combination of one (1) each, per Member, per Calendar Year.

Eating Disorders: See Mental Health Services Benefit under covered services section.

Emergency Services: the Plan would provide coverage for Emergency Services if the symptoms presented by you and recorded by the attending Physician indicate that an Emergency Medical Condition exists, or for Emergency Services necessary to provide you with a medical examination and stabilizing treatment and regardless of whether the provider is a Network Provider or a Non Network Provider. However, payment will be limited to the allowable charge for a Network provider. **Examples of Emergency Medical Conditions** include but are not limited to, heart attacks, cerebrovascular accidents, poisoning, convulsions, and severe bleeding. Examples of care that do not qualify as Emergency Medical Conditions are rashes, coughs, colds, sore throats, ear infections, and nausea.

- Emergency Room copayment is waived if admitted into any hospital within 24 hours.

Genetic Testing: Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following are met:

You display clinical features or are at direct risk of inheriting the mutation in question (pre-symptomatic); and the result of the test will directly impact the treatment being delivered to you; and if, after a comprehensive medical history, physical examination, pedigree analysis, genetic counseling and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.

Genetic Testing is also covered during obstetrical care of You or your covered spouse if Medically Necessary to determine if You are a carrier of an inheritable disease such as cystic fibrosis.

Exclusions- The following services are not covered under the terms of the Plan:

- No coverage of genetic testing if the testing is performed primarily for the medical management of family members who are not covered under this Plan. The Genetic testing costs may be covered only if such testing would directly impact the Medically Necessary treatment of the members.
- Home genetic testing kits/services are not covered.
- Genetic testing determined by the TPA or its designee to be not Medically Necessary or determined to be experimental or investigational.

Gynecological Examinations: Coverage is provided for examinations, including services, supplies and related tests by an obstetrician, gynecologist or obstetrician/gynecologist, or Primary Care Provider.

Health Education: Health education services and education in the appropriate use of the medical services are provided when organized or conducted by a Network Primary Care Provider in the Provider's office. Health education services include instructions on achieving and maintaining physical and mental health and preventing illness and injury.

Hearing Screenings: One routine preventive exam is covered at 100% with a Network Provider once per calendar year per member, to determine hearing loss. Test and exam must have the same date of service to apply preventive benefits. If additional examinations or tests are medically necessary benefits will apply.

High Cost Drugs and Therapies: Certain drugs or therapies as determined by the TPA may be subject to specific administration and billing requirements. Drugs and therapies subject to this program and the criteria ae listed at https://www.bcbsks.com/prescription-drugs/very-high-cost-drugs-and-therapies

Home Health Care Services: Coverage is provided when all of the following requirements are met:

- You are homebound due to a disabling condition, are unable to receive medical care on an ambulatory Outpatient basis, and do not require confinement in a Hospital;

- The service is ordered by a Physician;
- Services required are of a type which can be performed only by a licensed nurse, physical therapist, speech therapist, respiratory therapist, or occupational therapist;
- Part-time intermittent services are required;
- A treatment plan has been established and periodically reviewed by the ordering Physician;
- The services are Authorized by the TPA; and
- The agency rendering services is a Network Provider licensed by the State of location.
- Covered services include:
- Nursing care provided in your home by:
  - A registered nurse
  - A licensed practical nurse
  - A licensed vocational nurse.
- Physical, occupational or speech therapy provided in your home by:
  - A licensed physical therapist
  - A Certified Physical Therapy Assistant (CPTA)
  - A licensed occupational therapist
  - A Certified Occupational Therapy Assistant (COTA)
  - A licensed speech therapist.
- Medically Necessary services provided in the Member's home by a licensed social worker.

The TPA has the right to determine which services are Convalescent Care, Custodial/Maintenance Care or Rest Cures.

Exclusions- The following services are not covered under the terms of the Plan:

- Services provided by a member of your immediate family;
- Services provided by a person who normally lives in your home; or
- Services which are Convalescent Care, Custodial/Maintenance Care or Rest Cures.

Hospice: Coverage is provided for hospice care rendered by a certified hospice program for treatment of a terminally ill Member. Care through a hospice program includes supportive care involving the evaluation of the emotional, social, and environmental circumstances related to or resulting from the Illness, and guidance and assistance during the Illness for the purpose of preparing you and your family for a terminal Illness.

Covered Hospice Care includes services provided by a Medicare certified Hospice or other facility or Provider under the direction of a Medicare certified Hospice and not charging for services separately from the charges made by the Hospice. Covered services include the following when provided for routine home care according to the Hospice Care Plan and provided by the Hospice for the terminal illness:

- Nursing care
- Home health aide services

- Social work services
- Pastoral services
- Volunteer support
- Bereavement services
- Counseling services
- Dietary and nutritional counseling/services
- All drugs, medical supplies, and equipment related to the terminal illness (excluding those services eligible for coverage under a Prescription Drug Expense Program)
- Speech therapy
- Occupational therapy
- Physical therapy
- Lab fees
- Medical equipment
- Educational services

Limitation: Inpatient Hospice Care is limited to up to 180 units (days) per lifetime.

Immunizations: See Preventive Services.

Inpatient Hospital Care: Coverage includes semi-private accommodations, associated professional and ancillary services.

Covered Services by a Hospital for an Inpatient may include the following:

- Room accommodation, dietary and general nursing service, nursery care.
- Intensive Care Unit facilities and services.
- Operating room service.
- Delivery room service. (Including the obstetrical and delivery expenses of the birth mother of a child adopted and added to coverage within 90 days of birth of such child.)
- Surgical preparatory room service and anesthesia recovery room service.
- Clinical laboratory and pathological examinations.
- Diagnostic radiology services and radiation therapy.
- Drugs approved for use in the United States by the FDA except drugs approved for experimental use and drugs for take-home use, except for cancer treatment which is covered as described in the Clinical Trial section.

- Surgical dressings, splints, and casts. Special appliances are excluded.
- Chemotherapy other than High-Dose Chemotherapy, for malignant conditions. (See High-Dose Chemotherapy with Hematopoietic Support benefits.)
- Prostheses that require surgical insertion into the body and are furnished by the Hospital. This does not include artificial eyes, ears, and limbs.
- Setups for intravenous solutions.
- Setups for blood transfusions. (Blood plasma and packed platelets are included but blood and payments to donors of blood are not.)
- Oxygen and use of equipment for its administration.
- Radioactive isotopes.
- Electroencephalograms (EEG's) and electrocardiograms (EKG's).

- Inhalation therapy.
- Physical or occupational therapy.
- Anesthesia.
- Hemodialysis. (Kidney transplants and hemodialysis care eligible for coverage by Medicare are excluded.)

Note: If You fail to obtain the necessary Prior Authorization, the TPA will review the admission for Medical Necessity. No coverage will be provided for services determined by the TPA not to be Medically Necessary. Only that portion of the Inpatient claim that would normally be payable if services were received as an Outpatient will be covered.

Exclusions- The following services are not covered under the terms of the Plan: Hospital also includes Surgical Centers and Birthing Centers licensed by the state in which it operates. Hospital does not include services provided in facilities operating as residential treatment centers.

Intravenous and Injectable Medications: FDA-approved intravenous (IV) and Injectable medications, which have a National Drug Code, will be covered when deemed Medically Necessary and ordered by a Physician. Services associated with Intravenous Drug Treatment, including the drugs themselves, administration sets and equipment and total parenteral nutrition, require Prior Authorization. Failure to obtain Prior Authorization will not result in a denial of benefits if services are determined to be Medically Necessary when the claim is adjudicated.

Exclusion- The following services are not covered under the terms of the Plan: Injectable medications covered under the SEHP prescription drug plan.

Laboratory Services: Diagnostic laboratory and pathological services (including biopsies, pap smears and other services) are covered when performed by an independent laboratory that is approved by Medicare.

Services performed and billed by a Preferred Lab Vendor will apply to deductible and then will be covered at 100%. All other laboratory services are subject to deductible and coinsurance.

Manipulative Therapies: Spinal manipulation services rendered in the office setting on an outpatient basis are covered as Medically Necessary and significant improvement is shown. These services are subject to a maximum benefit of thirty (30) visits per calendar year. The TPA may conduct periodic evaluations, as required, to assure continued Medical Necessity.

Maternity Care: Maternity care includes medical, surgical and Hospital care during pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy. Maternity care also includes obstetrical and delivery expenses for the birth mother of a child adopted by the Member within ninety (90) days of the birth of such child. After delivery, You and your newborn child are allowed at least a forty-eight (48) hour Hospital stay for a vaginal birth and a ninety-six (96) hour Hospital stay for birth by a cesarean section. Stays beyond the

48 / 96 hour require an attending provider to complete a certificate of medical necessity. If the period is shorter than stated above, such period must be agreed upon between You and Your Service Provider. Your attendance at a childbirth preparation class at a Network Hospital or from Network OB/GYN or a Registered Nurse Educator will be reimbursed by the Plan at 50% of the cost not to exceed a maximum benefit of $30.00 per pregnancy per family. A TPA paper claim form, proof of payment, and proof of class completion must be submitted to the TPA. A maximum of $30.00 per family will be paid by the TPA per pregnancy.

Exclusions- The following services are not covered under the terms of the Plan:

- Surrogate Pregnancy/Delivery
- Scheduled delivery in the home setting.
- Amniocentesis, ultrasound, or any other procedures requested solely for sex determination of a fetus, unless Medically Necessary to determine the existence of a sex-linked genetic disorder.

Medical Services: Medical, surgical, anesthesia, diagnostic, therapeutic and preventive services are provided. Medical services include:

- Home and Office visits,
- Consultations and medical services, including telemedicine, as medically necessary and appropriate,
- Medical eye examinations,
- Consultations and medical services received as a Hospital Inpatient/Outpatient
- Surgery and anesthesia services; treatment of fractures and dislocations; biopsies and aspirations; endoscopic (scope) procedures; sterilization procedures.
- Medical (non-surgical) services for patients in a Hospital (including those services provided for a condition included in the definition of Mental Illness)
- Visits by the attending Doctor.

Limitations:

- During a hospital stay, if treatment is provided by two (2) or more service providers for the same diagnosis only one (1) provider will be paid unless medical necessity is documented.
- For consultations, the first visit of a Doctor to give professional advice about Your condition is covered if the visit is requested by the attending Doctor and Your condition requires special skill or knowledge.

Exclusion- The following services are not covered under the terms of the Plan: Consultations normally limited to one (1) during each Hospital stay. However, additional consultations may be approved with individual consideration of Your condition.

Mental Health Services Benefits: The Plan provides Mental Health services the same as for medical services. Inpatient care must be pre-approved as is the case with medical

inpatient services. Both inpatient and outpatient care are subject to medical necessity and appropriateness guidelines. Partial day mental health services would be processed as outpatient. The TPA contracts with an outside vendor to coordinate and determine Medical Necessity of the diagnosis and treatment of all Mental Illnesses and psychiatric conditions. If You have any questions about Your Mental Health Coverage, the appropriate way to access Coverage, or how to prior authorize care for Mental Health, you must contact the TPA. The vendor's name and telephone number are listed on the back of Your ID card.

Newborn Care: The Covered Services for eligible newborn children shall consist of:

- Coverage for Injury or Illness,
- Reconstructive Surgery for the treatment of medically diagnosed congenital anomalies,
- Testing for metabolic or genetic diseases,
- Newborn hearing screening examinations, and
- Well Baby Care.

Nutritional Counseling: Coverage is provided for nutritional counseling sessions if Medical Necessary and provided by your primary care provider or Licensed Dietician. Note: If nutritional counseling is being performed for a primary diagnosis of weight loss, BMI will need to be 25+ to be considered for medical necessity.

Obesity Services: Coverage is provided for nutritional counseling, physician office visits and appropriate lab work when for the purposes of treating obesity (BMI 30 or higher). See Bariatric Rider for other covered services.

Oral Surgery: See Dental/Service / Oral Surgery and other Related Services.

Orthognathic Surgery: Orthognathic surgery will be covered as medically necessary and appropriate for enrolled members through the age of twenty-six (26) for conditions manifested in childhood and adolescence and necessary to properly align the jaw and bite.

> **Limitation:** Orthognathic surgery will not be covered for cosmetic purposes (for appearances only). Surgery will not be provided when the necessary corrections could be accomplished through orthodontic or other dental services.

Orthotic Devices (Orthopedic Devices): Coverage is provided for the purchase of Orthotic Appliances when deemed Medically Necessary. Charges for electronic or performance enhancing devices or items are not covered, beyond the extent normally allowed for basic (standard) appliances.

Coverage will be provided for one permanent Orthotic or Orthopedic Device per Member, per extremity, per lifetime unless the Device becomes non-functional and non-repairable due to normal usage, change in condition, or routine wear and tear. Orthotics or

Orthopedic Devices will be replaced for documented growth in an Eligible Dependent child that results in required replacement.

Coverage is provided for Orthotic Appliances, splints, and braces, including necessary adjustments to shoes to accommodate braces. Shoes and shoe inserts will be covered if the Member has peripheral neuropathy, or the insert is needed for a shoe that is part of a brace. Coverage of shoes is limited to one pair per calendar year.

The determination of whether to repair or replace an Orthotic or Orthopedic Device will be made by the TPA based on all the facts and circumstances. Repairs of Orthotic or Orthopedic Devices that exceed $750 require Prior Authorization from the TPA.

Osteoporosis: Coverage is provided for services related to diagnosis, including central bone density test; Medically Necessary treatment; and appropriate management of osteoporosis.

Outpatient Diagnostic Services: Coverage is provided as Medically Necessary and appropriate in the Outpatient Department of a Hospital, a Physician's Office, an Independent Diagnostic Testing Facility, or other services provided in an Outpatient setting.

Outpatient Surgery: Coverage is provided for services and supplies for Outpatient surgery provided under the direction of a Provider at a Hospital or approved alternative facility or the service provider's office where surgery is completed.

Preventive Services: The **preventive services payable by this Plan are designed to comply with ACA regulations**. Covered preventive items and services include the recommendations with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF), guidelines for women issued by the Health Resources and Services Administration (HRSA), the services listed in the Bright Futures Initiative (issued by the American Academy of Pediatrics with support from HRSA), and immunizations recommended by the Centers for Disease Control & Prevention (CDC). The following websites (periodically updated) list the types of payable preventive services (such as **CDC-recommended immunizations** and screening services for children and adults, screening mammograms, etc.):

- https://www.healthcare.gov/coverage/my-preventive-care-benefits
- https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/,
- http://www.cdc.gov/vaccines/schedules/hcp/index.html, and
- http://www.hrsa.gov/womensguidelines/.

Preventive services are payable without regard to gender assigned at birth, or current gender status.

Preventive services are payable without cost sharing when obtained from Network providers. If there is no Network provider who can provide the preventive service, the Plan will authorize coverage by an out-of-network provider without cost sharing.

The government agencies and organization listed above periodically revise their lists of recommended preventive services. This Plan will cover new or revised items and services beginning with the plan year that begins one year after new or revised recommendations are issued by the relevant agency or organization.

For a complete list of Preventive Services visit HealthCare.gov. The following represents a summary of the major Preventive Services. Preventive services when received from a Network Provider are covered in full. Claims submitted with a diagnosis of anything other than preventive services are subject to the appropriate copay, deductible, and coinsurance. Preventive Services will include:

Prenatal Services:

Initial screenings for:

Hepatitis B

Bacteriuria

RH Incompatibility

At the time of an exam counseling for:

Folic Acid Supplements

Tobacco usage

Alcohol usage

Breastfeeding support as well as breastfeeding supplies/rental.

Screenings during pregnancy for:

Gestational Diabetes Mellitus testing after 24 weeks

Iron Deficiency Anemia

Sexually Transmitted Infections (STI's)

Depression screening for pregnant and postpartum women

Well Baby/Child Care: from birth (as age appropriate), periodic health evaluations, ear examinations to determine the need for hearing correction, and pediatric immunizations in accordance with accepted medical practice.

Newborn Screenings:

Congenital hypothyroidism

Sickle cell disease

Gonococcal ophthalmia neonatorum

Phenylketonuria (PKU)

Hearing Check

Well Child Annual Exam

Includes screenings for:

Adolescent Depression

HIV

Obesity

At the time of an annual exam counseling for:

Healthy Diet

Obesity/Weight management

Sexually Transmitted Infections (STI's)

Chemoprevention for dental caries

Iron Deficiency

Well Woman Care: including the following routine services, is covered as long as provided by a network OB/GYN or the Network Provider at 100% and must be billed as preventive.

Well Woman Annual Exam

Includes screening for:

Sexually Transmitted Infections (STI's)

HIV

Cervical Cancer

High blood pressure

Cholesterol

Diabetes

Depression

Osteoporosis

Colorectal Cancer

At the time of an annual exam counseling for:

Alcohol usage

Aspirin usage

Breast Cancer Risks/BRCA screening and testing

Contraceptive education

Domestic and Interpersonal Violence screening

Healthy diet

Obesity/Weight management

Tobacco usage

STI's

Folic Acid intake

Well Man Care: will be covered as long as the services are obtained from a Network Urologist or Network Provider once per Calendar Year at 100% and must be billed as preventative. Please note that only one office visit would be paid as preventive. If you elect to have two separate exams for your Well Man Exam, only one will be covered in full.

Well Man Annual Exam

Includes screenings for:

Prostate exam

Sexually Transmitted Infections (STI's)

HIV

High blood pressure

Cholesterol

Diabetes

Depression

Colorectal Cancer

At the time of an annual exam counseling for:

Alcohol usage

Aspirin usage

Healthy diet

Obesity/Weight management

Tobacco usage

STI's

Other Preventive Care Services:

Coverage will be provided for the following services once annually at 100% limited to one visit per year unless otherwise noted. All recommended services must be discussed at the annual well man, well woman or well child visit.

Immunizations in accordance with accepted medical practice,

Shingles (Herpes Zoster) Vaccination (Age 50 and older),

Routine Laboratory to include:

General health lab panel and/or lipid panel,

Complete blood count (CBC),

Thyroid stimulating hormone (TSH),

Basic or Comprehensive metabolic panel,

Cholesterol (HDL/LDL) and/or triglyceride,

Fecal occult blood,

Creatinine,

Urinalysis (UA),

HIV testing,

Prostate-specific antigen (PSA) blood test,

Sexually Transmitted Infections (STI's)

High Blood Pressure screening,

Diabetes screening,

Depression screening,

Digital rectal exam,

Bone density screening,

Hearing exam,

Vision exam for the first eye exam per year covered at 100% regardless of diagnosis.

Implantable/Injectable contraceptives,

Sterilization procedure (tubal ligation).

Ultrasonography for Aortic Aneurysm for Males 65-75 with documented history of tobacco use. Limited to one per lifetime.

Hepatitis C screening for at risk members born between 1945-1965

Lung Cancer screening for members age 55-80 smoking or members who quit smoking in last 15 years.

Members should check with the TPA regarding Network availability issues.

Colonoscopy for colorectal cancer screening, including the anesthesia that would be needed for a colonoscopy.

Polyp removal during a colonoscopy

The following services are not limited to one screening per calendar year regardless of age and diagnosis:

Mammogram including digital.

Pap Smears

Pap smears and Mammograms will be covered at 100% only if received by a Network provider. Coverage for Non Network providers for Pap Smears and Mammograms are limited to services related to a diagnosis and are subject to deductible and coinsurance.

Prosthetic Devices: Coverage is provided for Medically Necessary Prosthetic appliances or devices including, but not limited to, purchase of artificial limbs, breasts, and artificial eyes. Coverage is limited to the basic (standard) appliance or device which will restore the body part or function. Assistive electronic components for Prosthetic devices will be considered eligible for coverage when medically necessary.

These services must be Prior Authorized in advance by the TPA. For Prosthetic Device placements requiring a temporary and then a permanent placement, only one (1) temporary device will be covered. Coverage will be provided for one permanent Prosthetic Device per Member, per extremity, per lifetime unless the Prosthetic Device becomes non-functional and/or non-repairable due to normal usage and change in condition or routine wear and tear. Prosthetics will be replaced for documented growth in an eligible Dependent child. The determination of whether to repair or replace a Prosthetic Device will be made by the TPA. Repairs of Prosthetic Devices that exceed $1,000 require Prior Authorization of the TPA. Polishing and resurfacing of eye prosthetics are covered. Stump stockings and harnesses are covered when they are essential to the effective use of an artificial limb. Coverage is provided for external Prosthetic Devices prior to breast reconstruction due to a mastectomy. Benefits are limited to two (2) prostheses per breast per member per calendar year.

Penile Prosthesis: Penile Prostheses are covered for physiological impotence only. Subject to advance approval by the TPA, the benefits under the terms of the Plan, and as described in this Benefit Description are provided for a penile prosthesis or other approved alternative therapies required for treatment of physiological (not psychological) impotence only in the following situations: trauma, radical pelvic surgery, diabetes, Peyronie's Disease, vascular or neurological diseases when the individual situation warrants coverage in the TPA's opinion.

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

Limitation: The covered services are eligible for physiological, not psychological impotence.

Exclusions- The following services are not covered under the terms of the Plan:

- Services of sleep laboratories for nocturnal penile tumescence testing,
- Services eligible for coverage under a Prescription Drug Plan or prescription over the counter medications.

Radiology (Diagnostic): Diagnostic radiology services in support of diagnosis or in order to maintain good health are provided.

Limitations:

- Therapeutic Radiological Services (such as radiation therapy or gamma/cyber knife) are limited to certain procedures and diagnoses.

Reconstructive Surgery: For purposes of this provision, reconstructive surgery means reconstructive and related services that are performed on structures of the body to improve/restore impairments of bodily function resulting from disease, trauma, congenital anomalies, or previous therapeutic processes.

Benefits are available for:

- Reconstructive repair of an Accidental Injury.
- 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 to produce a symmetrical appearance.
- Repair of congenital anomalies

Rehabilitation Services: Unless specified otherwise in this Benefit Description, the following rehabilitation services are those designed to help restore physical functions following injuries, surgery, or acute medical conditions:

- Physical therapy;
- Occupational therapy;
- Speech therapy;
- Respiratory therapy;
- Neuropsychological testing;
- Cardiac rehabilitation; and
- Pulmonary rehabilitation.

Note: Cardiac and pulmonary rehabilitation programs are covered services only when provided by an Eligible Provider and is considered medically necessary by the TPA.

Limitations:

- Rehabilitation Services are covered only if they are expected to result in significant improvement in the Member's condition. The TPA will determine whether significant improvement has or is likely to occur based upon the medical information received from Your Provider.
- Second Opinions: The TPA has the right to require the Member to obtain a second opinion from a Professional Provider of the TPA's choice regarding the appropriateness of the Rehabilitation Services being provided. The Plan will be entirely responsible for paying the costs associated with such a second opinion

Exclusions- The following services are not covered under the terms of the Plan:

- Long-term rehabilitation
- Vocational rehabilitation including, but not limited to, employment counseling and training
- Convalescent Care, Custodial/Maintenance Care or Rest Cures as determined by the TPA. Including therapies designed to evaluate and assist an individual in developing a program to complete their work and prevent physical damage or re-injury.
- Cognitive therapy unless otherwise specified as covered under the Autism Rider incorporated in this Benefit Description. Cognitive therapy is a service provided to retrain 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, behavioral training, educational testing and therapy, dyslexia testing and treatment, learning disabilities and inability to scan visually. Cognitive 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 and athletic evaluation and training. For the purposes of benefits under the Plan, as described in this Benefit Description, cognitive services have no correlation to neuropsychological testing.
- Treatment for disorders relating to delays in learning, motor skills and communication, including any therapy for developmental delay not related to Autism services.

Reproductive Health Services: Covered Services include office visits, medical evaluation, and counseling;

- Testing required to establish the etiology of female infertility, which is limited to hysterosalpingogram, diagnostic laparoscopy, and endometrial biopsy;
- Testing required to establish the etiology of male infertility, which is limited to sperm counts and or semen analysis, scrotal or prostate ultrasound, prostate biopsy, and cystoscopy;
- Surgical correction of physiological abnormalities causing infertility;
- Three (3) attempts for artificial insemination, per Member, per Calendar Year; however, laboratory, x-ray, and other testing associated with artificial insemination are not covered.

For maternity care coverage, refer to the Maternity Care section of this Benefits Description and Schedule of Benefits.

Exclusions- The following services are not covered under the terms of the Plan:

- Fees associated with donors;
- Collection or storage of sperm;

- Those services related to conception through artificial means including, but not limited to, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and similar procedures;
- Injectable drugs for stimulation of ovaries or treatment of infertility and associated office visits, injections, laboratory, and
- Other testing, including those provided in any Physician's office setting;
- Embryo transplants;
- Reversal of voluntarily induced sterilization;
- Expenses related to any aspect of surrogate pregnancy and/or motherhood;
- Any experimental procedure; and
- Office visits, laboratory, x-ray, and other testing associated with any Non Covered Service under the Plan.

Abortion-related services will be covered as follows:

- Procedure is necessary to preserve the life of the mother.
- Medical complications that have risen from an abortion will be covered

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

Sex Reassignment Surgery: Reconstructive surgery for sex reassignment surgery including mastectomy, gonadectomy, and/or genital reconstructive surgery.

Sleep Studies: The Plan provides coverage for attended and unattended sleep studies for the diagnosis and treatment of sleep related disorders, such as sleep apnea.

Substance Use Disorder: The Plan provides treatment for Alcohol, Chemical, Drug and Substance Use Disorder services the same as for medical services. Inpatient care for such services must be pre-approved as is the case with medical inpatient services. Both inpatient and outpatient care are subject to medical necessity and appropriateness guidelines. Partial hospitalization and intensive outpatient for Substance Use Disorder are covered as outpatient. The TPA contracts with an outside vendor to coordinate and determine Medical Necessity of the diagnosis and treatment of all Substance Use Disorder services. If You have any questions about Your Substance Use Disorder Coverage, the appropriate way to access Coverage, or how to prior authorize care for Substance Use Disorder, you must contact the contracted vendor. The vendor's name and telephone number are listed on the back of Your ID card.

Tobacco Cessation: coverage for the discussion of tobacco use and a treatment plan for tobacco cessation.

For those who use tobacco products, and are over the age of eighteen (18) years old the Plan will offer these tools by the appropriate vendor(s):

- A cessation attempt can include coverage for a 12 week online workshop available through the HealthQuest portal with our wellness vendor.

- Prescription coverage and guidelines for Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) available through the pharmacy plan vendor when such products are prescribed by a health care provider.

Transplants: Coverage for human organ transplants will include organ procurement, compatibility testing, and organ transportation. Organ procurement costs also include donor transportation, hospitalization, and surgery where a live donor is involved.

An office visit for a dental examination and x-rays required as part of the transplant will be covered. Any additional dental treatment/services required prior to a transplant will not be covered.

- Prior Authorization Requirement for Human Organ or Human Tissue Transplants. Benefits for transplants (except benefits for cornea transplants) require prior authorization. You or Your Provider must give written notice to the TPA at such time as You become a candidate for a human organ transplant or re-transplant. The TPA has the right to require, request and obtain all necessary information from Your Doctor and other Eligible Providers who will be involved in the performance of the transplant or re-transplant, and to then determine whether or not to authorize benefits. The TPA will direct the Member to a high quality cost effective service provider within the TPA's network, when available. Notwithstanding any other provisions in this document addressing Allowable Charges to the contrary, the TPA reserves the right to limit its allowance to the lowest allowable amount, including organ or tissue acquisition cost which would be accepted by another facility that has agreed to contract with the TPA to provide these services. Any balance will be the obligation of the Member.

Limitation:

- The benefits of this section are available only when the condition for which the treatment is being proposed would not render the treatment non-covered through application of the Experimental or Investigational definition.

Exclusion- The following services are not covered under the terms of the Plan: No benefits will be available when the Member is a donor.

Urgent Care Services: are covered as listed in the benefit schedule and subject to the network status of the provider.

Vision Services: Coverage is provided for medical conditions of the eyes. The first eye exam billed to the TPA will be paid at 100%, regardless of diagnosis. Any subsequent eye exams will apply the appropriate copay. Additional vision services will be paid at the appropriate copay, deductible, and coinsurance, if deemed medically necessary. Please also see the Exclusions Section regarding vision care that is specifically denied under the Plan.

Vision Therapy: Vision therapy is subject to the Deductible and/or Coinsurance provisions. The maximum limit for vision therapy per Subscriber is 30 visits per Benefit Period. Once the 30 visit maximum is met for vision therapy, services not associated with Mental Illness or Substance Use Disorders are non-covered. Once the 30 visit maximum is met for vision therapy, services associated with Mental Illness or Substance Use Disorders will continue to be subject to the cost sharing for this service.

Weight Management: See Obesity Services

Section 1 - Coverage

Part 6: General Exclusions

The following items are excluded from Coverage:

Abortions: except in those situations as provided under the terms of the Plan, and as described in the Covered Services section of this Benefit Description.

Autopsies: Charges for autopsies

Blood, Blood Products, Blood Storage: Coverage is not provided for:

- Whole blood
- Payments to donors for blood
- Payment to a blood collection site
- Blood storage-Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgical procedure.
- Fetal cord blood harvesting and storage.
- Charges for storage of your own blood

Alternative Therapies: Unless otherwise specified, those services and associated expenses related, but not limited, to:

- Acupressure
- Acupuncture: Those acupuncture services and associated expenses that include, but are not limited to, the treatment of certain painful conditions or for anesthesia purposes are not covered.
- Allergy Services: Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system clearing.
- Aquatic Therapy
- Art Therapy
- Autogenic biofeedback services and materials except for urinary incontinence in adults 18 years old or older.
- Biofeedback
- Chelation therapy, except for acute arsenic, gold, mercury, or lead poisoning.
- Cognitive Skills Therapy to improve attention, memory or problem solving, including compensatory training behavior modification
- Cranio-Sacral Therapy
- Dance or Dance Therapy
- Educational therapies
- Guided Imagery
- Holistic medicine and providers
- Homeopathic medicine and providers
- Hydro-Massage
- Hypnotherapy and hypnosis
- Massage Therapy
- Naturopathic medicine and providers

- Music Therapy
- Recreational Therapy
- Reflexology
- Sensory Integrative Techniques
- Sleep Therapies and any related treatment
- Therapeutic Touch
- Wilderness Therapy

Charges for completion of forms: Any charges for services or completion of forms completed by provider, staff, or another billing entity.

Concierge Medicine: Those fees and associated expenses related to obtaining access to a specific physician or practice are not covered.

Cosmetics, and health and beauty aids.

Cosmetic Services and Surgery and any associated expenses: Cosmetic services and surgery and any associated expenses, including expenses associated with complications arising out of Cosmetic Services, are not covered under the terms of the Plan. (See definitions section.)

- Reduction or Augmentation Mammoplasty

Custodial Care, Maintenance, Domiciliary Care, or Convalescent Care: Custodial care, maintenance, domiciliary care, private duty nursing, respite care or rest care are not covered.

Dental Services: Treatment of teeth or supporting structures except as specified in the Dental Services and the Transplant within the Covered Service Section provided under the terms of the Plan.

Durable Medical Equipment (DME) and Supplies: DME and Supplies unless otherwise stated in this Benefit Description. Electronically controlled cooling compression therapy devices (such as polar ice packs, Ice Man Cool Therapy, or Cryo-cuff); home traction units (unless approved by Case Management); Repair, adjustments or replacements necessitated by loss, misuse or abuse of items owned by the Member; Automatic external defibrillators (unless approved by case management); or any types of services, supplies (including consumable and disposable supplies) unless covered under the Plan, and stated otherwise in the Covered Services section or treatment not specifically provide herein.

Educational/School Related Benefits: for any service that Federal or state laws required be made available through a child's school district pursuant to an Individual Education Plan (IEP).

- This exclusion applies whether or not you choose to waive your rights to these services.
- Treatment for disorders relating to delays in learning, motor skills and communication, including any therapy for developmental delay.
- Vocational therapy.

Elective or Voluntary Enhancement Procedures: Elective or voluntary enhancement procedures, services and medications including, but not limited to:

- Hair growth or Hair removal
- Sexual performance
- Athletic performance
- Cosmetic services
- Removal of Acne Scarring
- Anti-aging
- Mental performance
- Salabrasion
- Chemosurgery
- Laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos, or actinic changes. In addition, service performed for the treatment of acne scarring, even when the medical or surgical treatment has been provided by the Plan.
- Reversal of Sterilization Services - Those services and associated expenses related to reversal of voluntary sterilization. (Services related to voluntary sterilization procedures are covered)
- Braces and supports needed for athletic participation or employment
- Sports Related Services - Those services or devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation including braces and Orthotics
- Speech therapy or voice training when prescribed for stuttering or hoarseness

Evaluations and Diagnostic tests: ordered or requested in connection with criminal actions, divorce, child custody, or child visitation proceedings.

Examinations: Those physical, psychiatric, or psychological examinations or testing, vaccinations, immunizations, or treatments when such services are for purposes of obtaining, maintaining or otherwise relating to:

- Career or employment;
- Travel;
- Insurance;
- Marriage or adoption;
- Services relating to judicial or administrative proceedings;
- Orders which are conducted for purposes of medical research; or
- Obtaining or maintaining a license of any type.

Experimental or Investigational Treatments: Experimental or investigational treatments, procedures, or devices and related services unless otherwise covered under the terms of the Plan, and as described in this Benefit Description.

Federal, State or Local Laws: The cost of services covered under Federal, state, or local laws, regulations, or programs. Examples are Medicare and care for disabilities

connected to military service for which you are legally entitled to services, and for which facilities are reasonably available to the Member. This exclusion does not apply to Medicaid.

This exclusion applies even if you fail to qualify for Medicare benefits solely by reason of not having purchased Medicare Coverage; in such case, you shall be responsible for the reasonable value of services provided under the terms of the Plan, and as described in this Benefit Description which otherwise would have been covered under Medicare.

With respect to Medicare, the foregoing exclusion shall not apply if the Member is otherwise eligible for Medicare but has elected coverage under the terms of the Plan, and as described in this Benefit Description as primary coverage pursuant to the provisions of law.

This exclusion applies whether or not you choose to waive your rights to these services.

Food or Nutritional Supplements or Dietary Aids: The cost of food or over the counter nutritional supplements or over-the-counter formula and supplies are not covered.

Genetic Molecular Testing: Unless otherwise specified genetic molecular testing is not covered except 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.

Hair Analysis: Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning.

Hearing Aids and Services: Those services and associated expenses for hearing aids, bone-anchored hearing aid (BAHA) devices, digital and programmable hearing devices, the examination for prescribing and fitting hearing aids, hearing therapy and any related diagnostic hearing tests.

Health Clubs: Enrollment fees for, or services provided by, a health, athletic, weight loss or similar club.

Household Goods: Purchase or rental of supplies for common household use, such as, but not limited to; exercise equipment; air purifiers; central or unit air conditioners; water purifiers; allergenic pillows or mattresses or waterbeds. Purchase or rental of escalators or elevators; saunas or swimming pools or any types of services, supplies (including consumable and disposable supplies) unless otherwise provided under the terms of the Plan and stated in the Covered Health Services section or treatment provided for under the Plan, and as described in this Benefit Description.

Incorrectly Billed Services or Medical Errors: Any portion of a Claim that is determined to be incorrectly or inappropriately billed or for the treatment of medical errors by a

Physician, Health Professional, Facility or Hospital. This includes, but is not limited to, unbundling of procedural services, office visits that take place within a global period, inappropriate modifier use. Treatment for, or complications from medical procedures resulting from medical errors in treatment. Any service(s) rendered and/or billed by a Service Provider through misrepresentation of material fact or fraud.

Ineligible Service Providers: Services received from providers not defined as eligible for coverage. (See Network Provider for a listing of eligible providers).

Injuries incurred while the Member is in the commission or attempted commission of a felony.

Laboratory services performed by an independent laboratory that is not approved by Medicare.

Maintenance therapy: Once the maximum therapeutic benefit has been achieved for a given condition, ongoing Maintenance Therapy is not covered. Services or supplies provided directly for, or relative to, the maintenance of addiction.

Medically-aided insemination procedures: except as specifically listed as covered services including:

- In vivo fertilization
- In vitro fertilization
- Any other medically-aided insemination procedure
- Infertility treatment or drugs

Membership Costs: of fees associated with health clubs, exercise programs, weight loss programs, and tobacco use cessation programs.

Mass Screening: Services provided directly for or relative to 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.

Motor Vehicle Accidents: The costs of health services resulting from accidental bodily injuries arising from or out of a motor vehicle accident to the extent such services are payable under any medical expense provisions or to be covered by motor vehicle financial responsibility laws, regulations, or programs of any automobile insurance policy. If you enter into a settlement giving up Your right to recover past or future medical benefits provided in connection with the accidental bodily injury, the TPA will not pay past or future medical benefits that are the subject of, or related to, that settlement.

Newborn:

Employee/Spouse, Employee/Children, Employee/Family or Single coverage administratively provides benefits for newborn child for first 31 days (beginning as of the date of birth). The newborn child will have a separate deductible and coinsurance, (these amounts will not accumulate towards the parent's/parent deductible and coinsurance). However, NO benefits will be available beyond that time unless the status of the coverage is changed to include the newborn. All mid-year membership change requests for SEHP members must be submitted through their member portal with the appropriate documentation.

Non Compliance: Charges resulting from Your failure to appropriately cancel a scheduled appointment. Those services otherwise covered under the agreement related to a specific condition when a Member has refused to comply with or has terminated the scheduled service or treatment against the advice of a Network Provider or the Mental Health/Substance Use Disorder Service Provider.

Non Covered Services: Any service or supply that is not listed as a Covered Service or that is directly or indirectly a result of receiving a Non Covered Service. Medical Complications arising directly or indirectly from a Non Covered Service. Services not provided by an Eligible Provider or services continued after an Eligible Provider has advised that further care is not necessary. Any reduction made in a charge for a Covered Service due to the Service Provider being Non Network and not covered.

Not Medically Necessary: Any service or supply that is not Medically Necessary; amounts in excess of the Allowed Amount(s) for the care, service or supply rendered; Services that are considered to be obsolete by a professional medical-advisory committee; Services or items for the convenience of the Member or Provider including, but not limited to, home laboratory testing and duplication of Durable Medical Equipment. Hospital, doctor, or other health services when the patient is unnecessarily admitted to the hospital for services and evaluations that could satisfactorily be done on an Outpatient basis. The services that would be covered as an Outpatient will be covered. Unproven or obsolete treatments, procedures or devices and related services unless otherwise provided under the terms of the Plan, and as described in this Benefit Description.

Note: If You fail to obtain the necessary Prior Authorization, the TPA will review that admission for Medical Necessity. No coverage will be provided for services determined by the TPA not to be Medically Necessary. Only that portion of the Inpatient claim that would normally be payable if services were received as an Outpatient will be covered.

Orthognathic Surgery: or other procedures unless otherwise listed as covered in this Benefit Description.

Orthotics: Orthotic Appliances unless otherwise listed as covered, the following items and services are not covered by the Plan:

- Repairs or Replacement necessitated by loss, misuse or abuse of items owned by the Member;
- Foot or shoe inserts, arch supports, heel lifts, heel of sole wedges, heel pads or insoles whether custom-made or prefabricated;
- Special orthopedic shoes,
- Cost for additional components to enhance function or convenience are not covered.

Pain Management: Costs associated with commercial pain management programs.

Personal or Comfort Items: Private inpatient room, unless Medically Necessary or if a Semi-private room is unavailable. Personal or comfort items (such as television, radio, telephone, barber or beauty service, guest meals, admission kits and materials used in occupational therapy).

Plan Termination: Those services otherwise covered under the terms of the Plan, but rendered after the date Coverage under the Plan, and as described in this Benefit Description, terminates, including services for medical conditions arising prior to the date individual Coverage under the Plan and as stated in this Benefit Description terminates, and Eligible Expenses - Any other Eligible Expenses that exceed the maximum allowance or benefit limit.

Prescription Drugs: All prescription drugs, non-prescription drugs, and Investigational and Experimental drugs except as described as covered under the Plan, and as described in this Benefit Description, and prescribed medications incidental to Outpatient care and insulin. Prescription drugs utilized primarily for stimulation of hair growth/hair loss or other cosmetic purposes. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth/hair loss. Compound medications which are injected or completely used up at the time and place of service and which do not contain an active ingredient with a valid NDC number. Human growth hormone therapy or other drugs to treat growth failure. Chemotherapeutic agent(s) inserted into a periodontal pocket.

Prosthetic Devices Repairs or Replacement: Repair or replacement costs for any otherwise covered device necessitated by loss, misuse or abuse of items owned by the Member.

Providers: Not listed as eligible service providers are excluded. (See Network Provider).

Private Duty Nursing: Private duty nursing services, nursing care on a full-time basis in Your home, or home health aides.

Residential Care: Refers to care given to adults or children outside of the patient's home and can be 24 hour care or partial care depending on the person's needs. Residential Care is not a covered benefit.

Repair, Adjustments or Replacements Necessitated by Misuse or Abuse: of Durable Medical Equipment, Prosthetics or Orthotics are not covered. Replacement of lost equipment is not covered.

Reimbursement of Claim: Payment of claim under one carrier will not be reimbursable under another carrier for the same service except for secondary insurance. Example: Medical reimbursement for a drug(s) will not be eligible for reimbursement under your Pharmacy reimbursement on the same drug to provide more payment by the carrier for that same service.

Routine Foot Care: including the paring and removal of corns and calluses or trimming of nails unless Medically Necessary for the treatment of a person who, due to a demonstrated medical condition, is unable to perform such activity, and except as specifically provided for a diabetic Member.

Services by an Immediate Relative or Member of Your Household: "Immediate relative" means the husband or wife, 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 or who was claimed as a tax deduction for the year during which the service was provided.

Services, equipment or supplies which are not FDA approved for the purpose, treatment, or time period prescribed. For services, equipment or supplies under the jurisdiction of the FDA, care must be provided in accordance with recommended treatment and use guidelines. Use of services, equipment, and supplies for purposes, treatment, or time periods outside of these guidelines are not eligible for coverage under the Plan. Unproven or obsolete treatments, procedures or devices and related services, unless otherwise covered under the terms of the Plan, and as described in this Benefit Description, are not covered.

Services or items for the convenience of the Member or Provider: including, but not limited to, home laboratory testing and duplication of covered Durable Medical Equipment or appliances, are not covered. Exercise or hygiene equipment is not covered. Components to enhance performance, increase comfort, convenience, or optional features or components are not covered.

Services or supplies provided at no cost to the Member or for which the Member would not be obligated to pay in absence of health care coverage. For example: Services provided by volunteers.

Service(s) rendered where the Member(s) receives monetary or in-kind enticement, incentive, rebate, or kickback of any kind from a Provider(s) or agent(s) of a Provider(s).

Services when the Member is not present: including but not limited to, case management team conferences, telephone calls, electronic communication and consultations with family members, miscellaneous service charges, telephone consultations with the member, charges for failure to keep a scheduled appointment or any late payment charge and charges to complete insurance claim forms.

Services provided by ineligible providers or beyond the scope of the Provider's license. This includes services rendered outside the scope of a Network or Non Network Provider's License.

Services or supplies provided or obtained relative to an excluded service. Any service or supply which would not have been needed, provided, or obtained had an excluded service not been performed is not covered. The excluded service or supplies may have been paid for by the Member, or by another health plan. However, if the service is not a covered service under the terms of the Plan, and as described in this benefit description, any services including complications and revisions that occur are also excluded from coverage under the Plan.

Sexual Dysfunction: Any device, implant, or self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy. Treatment for physiological impotence will be limited to an implant of a penile prosthesis and other accepted medical treatment as prior authorized.

Sex Determination: Procedures requested solely for sex determination of a fetus, unless Medically Necessary to determine the existence of a sex-linked genetic disorder.

Speech therapy: or voice training when prescribed for stuttering, hoarseness or delays in learning, motor skills, communication, or developmental delay.

Surrogate Mother: Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception, pregnancy of, and delivery by a Member acting as a surrogate mother.

Tobacco Cessation: supplies and prescription products for tobacco cessation programs and treatment of nicotine addiction.

Temporomandibular Joint Dysfunction (TMJ): Medical, surgical, or dental treatment or services related to the treatment of temporomandibular joint (jaw hinge) disease (TMJ), Myofascial Pain Dysfunction Syndrome (MPDS), and temporomandibular dysfunctional (TMD) or Chemotherapeutic agent(s) inserted into a periodontal pocket.

Transportation: Transportation other than covered Ambulance Services or those services listed as covered in connection with Human Organ and Human Tissue Transplant Services.

Travel Expenses: Travel or transportation expenses even though prescribed; mileage; time spent traveling; telephone calls; charges for services provided over the telephone; and services provided through e-mail or electronic communications. For the purpose of this provision, electronic communications means communication other than telemedicine.

Vision Care: Vision aids are not covered unless otherwise specified in the Covered Services section under the Plan. Vision Care services such as:

- Servicing of corrective lenses;
- LASIK eye surgery;
- Visual analysis testing and therapy;
- Muscular imbalance training of the eye;
- Eye exercises;
- Surgical treatment for the correction of a refractive error, unless Medically Necessary; and
- Refractive lensectomy with intraocular lens implant.

War (Acts of): Services for diseases or injuries caused by, or arising out of, acts of war, insurrection, rebellion, armed invasion, or aggression.

Wearing Apparel: Items of wearing apparel except as described under the Durable Medical Equipment/Disposable Medical Supply, Prosthetic or Orthotic Devices or Reconstructive Surgery/Treatment benefits covered under the Plan, and as described in this Benefit Description. Wigs, hairpieces and hair prostheses and hair styling, including those ordered by a provider, are not covered unless covered under the terms of the Plan in the case of cancer treatment. Unless provided for under the terms of the Plan, and as described in this Benefit Description, shoe inserts, arch supports, special orthopedic shoes, heel lifts, heel or sole wedges, heel pads, or insoles whether custom-made or prefabricated, and protective head gear are not covered.

Work-Related Services: No coverage for worker's compensation or other work-related incidents.

- There is no coverage for services for injuries or diseases related to the Member's job to the extent the Member is covered, or is required to be covered, by worker's compensation law. If the Member enters into a settlement giving up their right to recover past or future medical benefits under worker's compensation law, the TPA will not pay past or future medical benefits that are the subject of, or related to, that settlement. In addition, if the Member is covered by a workers compensation program which limits benefits if other than specified providers of health services are used, and the Member receives services from a provider not specified by the workers compensation program, TPA will not pay balances after the Member's benefits under the program are exhausted.
- The cost of biologicals that are immunizations or medications to protect against occupational hazards and risks.
- Vocational Rehabilitation services to restore or develop the working ability of 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, including but not limited to, work trials and driving lessons.
- Therapies designed to evaluate and assist an individual in developing a program to complete their work and prevent physical damage or re-injury.

Section II – Administrative Provisions

Part 1: Eligibility, Enrollment, Effective Dates of Coverage

ELIGIBILITY

- Member
  - To be eligible to enroll as a Member, an individual must:
    - Meet and continue to meet all eligibility requirements within the Employee Guidebook or Administration Manual for participation in the Plan.
- Eligible Dependent
  - To be eligible to enroll as a Dependent, an individual must:
    - Meet and continue to meet all eligibility requirements within the Employee Guidebook or Administration Manual for participation in the Plan.

ENROLLMENT Adding Newly Eligible Dependents to an Existing Membership

- When a new Dependent is to be added to Coverage, the Member named on the Identification Card must provide the Group, within the Membership Administration Portal, the Eligible Dependent's name, date of birth, gender and relationship to the Member and the Dependent's social security number.
- Notification must be made in accordance with the enrollment requirements established by the Group.
- It is required that each Member within 31 days of the qualifying event provide the required documentation (birth certificate, marriage licenses, social security cards etc.) to the Group, within the Membership Administration Portal. The Group will verify the dependent to be eligible. Approval must be given by the Group prior to claims being paid.
- Claims for Eligible Dependents not included in the records will be denied until it has been established that the person is an Eligible Dependent.
- 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 an Order is deemed qualified by the Group.
  - Medical Child Support Orders must comply with the specifications of Federal and State law to be a qualified Order under the Plan.
  - The procedure for determining qualification of an Order requires timely submission of the Medical Child Support Order for initial acceptance or rejection of the Order.
  - The Administrator will forward the Order to the TPA for issuance of an Identification Card, Benefit Description, and claim form to the Alternate Recipient.

EFFECTIVE DATE OF COVERAGE

Coverage of a Member or an Eligible Dependent shall become effective at 12:01 a.m. on the first day of meeting the eligibility requirements, subject to applicable payment. If a Member or an Eligible Dependent is confined in a Hospital on the effective date of coverage, TPA will cover the Hospital confinement (beginning on the effective date of this coverage); benefits may be subject to the Non-Duplication of Benefits provisions under the terms of the Plan, and as specified in this Benefit Description. The Member or Dependent must notify TPA of the Hospital confinement within forty-eight (48) hours of the effective date of coverage, or as soon thereafter as reasonably possible.

Section II – Administrative Provisions
Part 2: Termination, Extension of Benefits

TERMINATION OF COVERAGE

Situations When Coverage is Terminated

The eligibility of an individual Member will terminate in the following situations:

- When the TPA is notified that a Member is no longer eligible for benefits under the Plan.
- Termination of Marriage. The coverage of the husband or wife of the person named on the Identification Card ends on the last day of the month in which the divorce or legal separation was granted by court action. In such cases, the Member whose coverage is terminating will be eligible for Continuation of Coverage under COBRA.
- Eligible Dependent who no longer meets the requirements of an Eligible Dependent. In such cases, the Member whose coverage is terminating will be eligible for Continuation of Coverage under COBRA.
- If a Member fails to disclose information requested by TPA or is abusive toward providers or TPA personnel in applying for or seeking any benefits under this Benefit Description, then the rights of such Member under this Benefit description may be prospectively terminated upon written notice. At the effective date of such termination, prepayments received on account of such terminated Member applicable to periods after the effective date of termination shall be refunded and the TPA shall have no further liability or responsibility under this Benefit Description.

Fraud or Intentional Misrepresentation: You and Your Eligible Dependent's coverage may be terminated, and other appropriate action taken as determined by the Plan Sponsor if You or Your Eligible Dependents participate in any act, practice or omission that constitutes fraud or intentional misrepresentation of material fact in applying for or seeking benefits under the Plan. This includes, but is not limited to:

- Allowing unauthorized persons use of Your Plan identification card(s) to obtain health care services, supplies or medications that are not prescribed or ordered for You or a covered family member, or health services which You are not otherwise entitled to receive.
- Permitting the unauthorized use of Your Plan identification card(s) to obtain health care services or supplies for someone not covered under Your Plan membership. In this instance, Coverage of the Member and/or Eligible Dependent(s) may be terminated by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor may be taken.

- Using another Plan Member's identification card(s) to obtain health care services, medication or supplies for You or another third party who is not specifically covered under Your Membership in the Plan may result in the termination of Your coverage and that of Your Eligible Dependents by the TPA and any other action determined appropriate by the Plan or TPA.

In any instance of fraud or intentional misrepresentation of material fact, with proper 30-day advance written notice, coverage for You and/or any covered Eligible Dependent(s) may be retroactively cancelled effective the first day of the month following the date on which the Member became ineligible for coverage.

BENEFITS WHEN YOUR ELIGIBILITY TERMINATES

Coverage under the terms of the Plan, and as described in this Benefit Description ends on the date the Member no longer meets the definition for eligibility, except for a Member who is receiving Inpatient Hospital services when that Member's coverage terminates. In such case, benefits may be extended for that Member without premium payment for a period not more than 31 days following the date of termination of coverage.

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

- The completion of a 31-day period following termination of coverage,
- The date Hospital confinement ends, or
- The date replacement coverage takes effect.

Benefits are subject to the Deductibles, Coinsurance, Copayments and Out of Pocket maximums applicable to terms of coverage applicable for the Member's coverage.

CERTIFICATE OF CREDITABLE COVERAGE

You have the right to request and obtain a Certificate of Creditable Coverage from the TPA while You are a Member and up to 24 months following the date on which Your coverage was cancelled. To request a Certificate of Creditable Coverage, contact the customer service center phone number on your Identification Card.

CONTINUATION OF COVERAGE

FAMILY MEDICAL LEAVE allows you to take up to 12-calendar weeks of unpaid leave during any 12-calendar-month period due to:

- The birth, adoption, or placement with you for adoption of a child;
- Your need to care for a seriously ill Spouse, parent, or child;
- Your serious illness, and
- A qualifying exigency, or urgent need for leave because your Spouse, son, daughter, or parent is on active duty in the armed services in support of a military operation.

In addition, you may be able to take up to 26-calendar weeks of unpaid leave during any 12-month period to care for a service member. The service member must be:

- your Spouse, son, daughter, parent, or next of kin;
- undergoing medical treatment, recuperation, or therapy for a serious illness or injury incurred in the line of duty while in the armed forces; and
- an outpatient or on the temporary disability retired list of the armed services.

Your eligibility for FMLA leave and benefits will be determined by the Plan Administrator. If you have a question regarding eligibility for FMLA leave, please contact your human resource office.

COBRA is a federal law which permits persons to continue coverage under an employer group health plan for specified periods. This law is referred to as COBRA which stands for "The Consolidated Omnibus Budget Reconciliation Act of 1986" and any amendments thereto. That law applies to employers of 20 or more employees and such employer's group health plans, not to insurance contractors. That is, if Your employer changes from the TPA to another insurance carrier or TPA (in the case of a self-funded arrangement), the right to continuation of coverage under federal law is a right which transfers to the new carrier or to claims adjudication under the new administrator.

This Section shall apply to the group and its Members only if the group is subject to the requirements of Title X of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and any amendments thereto.

For more detailed information concerning COBRA, the Member should contact their Human Resource Representative.

Military Service The Plan will provide benefits to you and your Covered Dependents during your military service in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Please contact your human resource department before you enter military service to receive details about how, and to what extent, you and your Dependents' coverage can be maintained.

Service in the uniformed service means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes:

- Active duty,
- Active duty for training,
- Initial active duty for training,
- Inactive-duty training,
- Full-time National Guard duty,
- A period for which you are absent from a position of employment for an examination to determine your fitness for duty.

If you serve in the uniformed services for less than 31-calendar days, your health coverage will continue. If your service continues for more than 31-calendar days, you may elect to continue coverage under the Plan by making monthly self-payments for up to 24-calendar months. Continuation coverage under USERRA will be administered in the same manner as COBRA continuation coverage and will run concurrently with COBRA continuation coverage.

Your coverage will continue until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- Twenty-four (24) consecutive calendar months after your coverage would have otherwise ended.

However, your coverage will end at midnight on the earliest of the day:

- Your coverage would otherwise end as described herein;
- The Kansas State Employees Health Care Commission no longer provides any health Plan coverage to any Employee; or
- Your self-payment is due and unpaid.

Your coverage ends on the first day of the month following the date you enter uniformed services and elect not to continue coverage. Your Eligible Dependents may continue coverage under the Plan by electing and making self-payments for COBRA continuation coverage.

You need to notify your human resource in writing when you enter the military and when you returning to employment. Reemployment includes the right to elect reinstatement in the existing health coverage provided by the State Employee Health Plan. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service. Contact your human resource department for more information about reemployment following discharge from military service.

Section II – Administrative Provisions

Part 3: Internal Appeal and External Review

Internal Claims and Appeal Procedures

This section describes the procedures followed by the Plan in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for health benefits.

The Plan's internal claims and appeal procedures are designed to provide the Member and their Eligible Dependent with a full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to all other similarly situated individuals covered by the Plan. The Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate or is Experimental or Investigational).

The internal claims process pertains to determinations made by the Plan about whether a request for benefits (known as an initial "claim") is payable. If the Plan denies a Member's or Eligible Dependent's initial claim for benefits (known as an "adverse benefit determination"), he or she has the right to appeal the denied claim under the Plan's internal appeals process.

A Member or Eligible Dependent may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted.

General Information Days Defined

For the purpose of the initial claims and appeal processes, "days" refers to calendar days, not business days.

Discretionary Authority
In carrying out their respective responsibilities under the Plan, Plan fiduciaries are individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

Adverse Benefit Determination

An adverse benefit determination, for the purpose of the internal claims and appeal process, means:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit;

- A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or

- A rescission of coverage, whether or not there is an adverse effect on any benefit.

Health Care Professional

A health care professional, for the purposes of the claims and appeals provisions, means a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

Definition of a Claim

A claim is a request for a Plan benefit made by a Member or his or her Eligible Dependent (also referred to as "claimant") or his or her authorized representative in accordance with the Plan's reasonable claims procedures. **Types of Claims**

There are four categories of health claims as described below:

- **Pre-Service Claims** - A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained. (Note: A Pre-Service Request is a request for advance information from the TPA of possible coverage of items or services or advance approval of covered items or services and does not constitute a Pre-Service Claim. Subsequent inquiries regarding the same service or item shall not be considered a Pre-Service Request unless additional substantive clinical information is provided. A Pre-Service request is not eligible for a first level appeal, however, may be eligible for an External Review pursuant to Kansas State law.)

- **Urgent Care Claims** – An Urgent Care Claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of the claimant's attending health care provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health.

- **Concurrent Claims** - A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.

- **Post-Service Claims** - A Post-Service Claim is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Claim Elements

An initial claim must include the following elements to trigger the Plan's internal claims process:

- Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);
- Be received by the Plan;
- Name a specific individual participant and his/her Social Security Number;
- Name a specific claimant and his/her date of birth;
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is not a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than claimant or his or her authorized representative;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, the claimant may file a claim with the Plan;

If the claimant submits a claim that is not complete or lacks required supporting documents, the Plan will notify the claimant about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim, or which relate to proposed or anticipated treatment or services that do not require prior approval.

Initial Claim Decision Timeframes

Claim Filing Deadline

Claims should be filed within 90 days after You receive services. Failure to file claims within the time required will not invalidate or reduce any claim if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than one (1) year and 90 days from the date the charges were incurred.

The time period for making a decision on an initial claim request starts as soon as the claim is received by the Plan, provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by the claimant, a claimant's authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be the claimant's authorized representative.

Decision Timeframes

The Plan will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give the claimant a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, the claimant will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which notice of adverse benefit determination on review is required to be provided) to give the claimant a reasonable opportunity to respond prior to that date.

- **Pre-Service Claims -** Claims for Pre-Service (that are not for Urgent Care) will be decided no later than fifteen (15) days after receipt by the Plan. The claimant will be notified in writing (or electronically, as applicable) within the initial fifteen (15) day period whether the claim was approved or denied (in whole or in part).

  The time for deciding the claim may be extended by up to fifteen (15) days due to circumstances beyond the Plan's control (e.g., inability of a medical reviewer to meet a deadline); provided the claimant is given written (or electronic, if an applicable) notification before the expiration of the initial fifteen (15) day determination period.

  If the claimant improperly files a Pre-Service Claim, the Plan will notify him or her in writing (or electronically, as applicable) as soon as possible, but in no event later than five (5) days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, the claimant must re-file a claim to begin the Pre-Service Claim determination process.

  If a claim cannot be processed due to insufficient information, the Plan will notify the claimant in writing (or electronically, as applicable) about what specific information is needed before the expiration of the initial fifteen (15) day determination period. Thereafter, the claimant will have 45 days following his or her receipt of the notice to supply the additional information. If the claimant does not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which the claimant is permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of 45 days or the date the Plan receives the claimant's response to the request for information. The Plan then has fifteen (15) days to make a decision and notify the claimant in writing (or electronically, as applicable).

- **Urgent Care Claims -** In the case of an Urgent Care Claim, if a health care professional with knowledge of the claimant's medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be the claimant's authorized representative bypassing the need for completion of the Plan's written authorized representative form.

  The Plan will decide claims for Urgent Care as soon as possible, but in no event later than 72 hours after receipt of the claim. The Plan will orally communicate its decision telephonically to the claimant and his or her health care professional. The determination will also be confirmed in writing (or electronically, as applicable) no later than three (3) days after the oral notification.

If the claimant improperly files an Urgent Care Claim, the Plan will notify him or her and his or her health care professional as soon as possible, but in no event later than 24 hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, the claimant must re-file a claim to begin the Urgent Care Claim determination process.

If a claim cannot be processed due to insufficient information, the Plan will provide the claimant and his or her health care professional with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, the claimant will have not less than 48 hours following receipt of the notice to supply the additional information. If the claimant does not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination). Written (or electronic, as applicable) notice of the decision will be provided to the claimant and his or her health care professional no later than 48 hours after the Plan receives the specific information or the end or the period given for the claimant to provide this information, whichever is earlier.

- **Concurrent Claims -** If a decision is made to reduce or terminate an approved course of treatment, the claimant will be provided with a written (or electronic, as applicable) notification of the termination or reduction sufficiently in advance of the reduction or termination to allow him or her to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.

  A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the Urgent Care Claim section.

  A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section.

  If the Concurrent Care Claim is approved, the claimant will be notified orally followed by written (or electronic, as applicable) notice provided no later than three (3) calendar days after the oral notice.

  If the Concurrent Care Claim is denied, in whole or in part, the claimant will be notified orally with written (or electronic, as appropriate) notice.

- **Post-Service Claims -** Claims for Post-Service treatments or services will be decided no later than 30 days after receipt by the Plan. The claimant will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if the claim is denied (in whole or in part).

  The time for deciding the claim may be extended by fifteen (15) days due to circumstances beyond the Plan's control (e.g., inability of a medical reviewer to meet a deadline); provided the claimant is given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period.

  If a claim cannot be processed due to insufficient information, the Plan will notify the claimant in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 30-day determination period. Thereafter, the claimant will have 45 days after his or her receipt of the notice to supply the additional information. If the claimant does not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which the claimant is permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision

deadline is suspended until the earlier of 45 days or until the date the Plan receives the claimant's written response to the request for information. The Plan then has fifteen (15) days to make a decision and notify the claimant in writing (or electronically, as applicable).

Initial Determinations of Benefit Claims

Notice of Adverse Benefit Determination

If the Plan denies the claimant's initial claim, in whole or in part, he or she will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to the claimant in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination must:

- Identify the claim involved – including the date of service, health care provider and claim amount if applicable);
- Give the specific reason(s) for the denial (including a statement that the claimant has the right to request the applicable diagnosis and treatment codes and their corresponding meanings; however, such a request is not considered to be a request for an internal appeal or external review for health benefit claims);
- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard.
- Reference the specific Plan provision(s) on which the denial is based;
- Describe any additional material or information needed to perfect the claim and an explanation of why such added information is necessary;
- The opportunity, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to an initial claim for benefits;
- Provide an explanation of the Plan's internal appeal and external review claims processes along with time limits and information about how to initiate an appeal and an external review;
- If the denial was based on an internal rule, guideline, protocol, standard, or similar criteria, a statement will be provided that a copy of such rule, guideline, protocol, or similar criteria that was relied upon will provided to the claimant free-of-charge upon request;
- If the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to the claimant free-of-charge upon request;
- For Urgent Care health benefit claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification; and

- Provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist the claimant with the Plan's internal claims and appeal processes as well as with the external review process.

Notice of Approval of Pre-Service and Urgent Care Claims

If a Pre-Service claim is approved, the claimant will receive written (or electronic, as applicable) notice within fifteen (15) days of the Plan's receipt of the claim. Notice of Approval of an Urgent Care Claim will be provided in writing (or electronically, as applicable) to the claimant and his or her health care professional within the applicable timeframe after the Plan's receipt of the claim.

Internal Appeal Request Deadline

If an initial health care claim is denied (in whole or in part) and the claimant disagrees with the Plan's decision, the claimant and his or her authorized representative may request an internal appeal. The claimant has 180 calendar days following receipt of a notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period. Under limited circumstances, explained below in the section on External Review, the claimant may bypass the Plan's internal claims and/or appeal processes and file a request for an external review.

Internal Appeals Process

APPEAL PROCEDURES

To file an internal appeal, the claimant must submit a written statement to the Plan at the following address:

Blue Cross Blue Shield of Kansas
1133 SW Topeka Blvd
Topeka, KS 66629
By Phone 785-291-4185 or
Toll Free at 1-800-332-0307
www.bcbsks.com/state

Appeal requests involving Urgent Care Claims may be made orally by calling the TPA at the telephone number listed above.

A claimant's request for an internal appeal must include the specific reason(s) why he or she believes the initial claim denial was improper. The claimant may submit any document that he or she feels is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

As a part of its internal appeals process, the Plan will provide the claimant with:

- The opportunity, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's initial claim for benefits;

- The opportunity to submit to the Plan written comments, documents, records, and other information relating to the claimant's initial claim for benefits;

- The Plan will automatically provide the claimant with a reasonable opportunity to respond to new information by presenting written evidence and testimony;

- A full and fair review by the Plan that takes into account all comments, documents, records, and other information submitted by the claimant, without regard to whether such information was submitted or considered in the initial claim determination;

- The Plan will automatically provide the claimant, free-of-charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied initial claim. The Plan will automatically provide the claimant with any new or additional evidence or rationale as soon as possible once it becomes available to the Plan and sufficiently in advance of the date on which notice of an adverse determination on appeal is scheduled to be provided to the claimant. New or additional evidence or rationale will be provided to the claimant so that he or she has a reasonable opportunity, sufficiently in advance of the date on which a notice of an adverse benefit determination upon appeal is required to be provided, to respond to the Plan regarding such evidence. If the new or additional evidence or rationale is received by the Plan so late that it would be impossible to provide it to the claimant in time for him or her to have a reasonable opportunity to respond, then the period for providing a notice of a final adverse benefit determination will be delayed (tolled) until the claimant has had a reasonable opportunity to respond. After the claimant responds (or does not respond after having a reasonable opportunity to do so), the Plan (acting in a reasonable and prompt manner) will notify the claimant of its benefit determination upon appeal as soon as it can provide a notice of determination, taking into account any medical exigencies.

- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- Continued coverage during the pendency of the appeal process; and

- In deciding an appeal of any adverse benefit determination regarding a health benefit claim that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary, or appropriate, the fiduciary or fiduciaries will:

    - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment; and

    - Is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and

- The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Appeal Determination Timeframes

- **Pre-Service Claims -** A determination will be made and a written (or electronic, as applicable) notice regarding the appeal will be sent to the claimant within 30 days from the date his or her written request for an appeal is received by the Plan. No extension of the Plan's internal appeal review timeframe is permitted.

- **Urgent Care Claims -** This is an expedited internal appeals process under which a written notice regarding a decision on the approval or denial of the expedited internal appeal will be sent to the claimant (and his or her health care professional) no later than within 72 hours of the Plan's receipt of the claimant's (oral or written) request for appeal. If claimant's situation involves an urgent medical condition, which the timeframe for completing an expedited internal appeal would seriously jeopardize his or her ability to regain maximum function, and the claim involves a medical judgment or a rescission of coverage, the claimant may seek an expedited external review at the same time that he or she requests an expedited internal appeal (the claimant must seek both).

- **Concurrent Claims –** The claimant may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the Plan. A determination will be made on the internal appeal and the claimant will be notified as soon as possible before the benefit is reduced or treatment is terminated.

Post-Service Claims – A written (or electronic, as applicable) notice regarding the Plan's determination on the internal appeal will be sent to the claimant within 60 days from the date his or her written request for an appeal is received by the Plan. No extension of the Plan's internal appeal review timeframe is permitted.

Notice of Adverse Benefit Determination Upon Appeal

A written (or electronic, as applicable) notice of the appeal determination must be provided to the claimant that includes:

- The specific reason(s) for the adverse benefit determination upon appeal, including (i) the denial code (if any) applicable to a health benefit claim and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;

- Reference to the specific Plan provision(s) on which the denial is based;

- A statement that the claimant is entitled to receive upon request, free access to and copies of documents relevant to the claim;

- An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review regarding the denied internal appeal of a health benefit claim;

- If the denial of the claim was based on an internal rule, guideline, protocol, standard, or similar criterion a statement must be provided that such rule, guideline, protocol, or criteria will be provided free of charge, upon request;

- If the denial of the claim was based on a medical judgement (Medical Necessity, Experimental or Investigational), a statement must be provided that an explanation regarding the scientific or clinical judgement for the denial will be provided free of charge, upon request; and

- Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist the claimant with internal claims and appeals and external review processes.

This concludes the appeal process under this Plan.

Authorized Representative

The Plan recognizes an authorized representative as any person at least 18 years old whom the claimant has designated in writing as the person who can act on his or her behalf to file an initial claim and appeal an adverse benefit determination under the Plan. An authorized representative under the Plan also includes a health care professional. The claimant does not need to designate in writing that the health care professional is his or her authorized representative if that health care professional is part of the claim appeal. A health care provider with knowledge of the claimant's medical condition may act as his or her authorized representative in connection with an Urgent Care Claim without filing a written statement with the Plan.

The Plan requires the claimant to provide a written statement declaring his or her designation of an authorized representative [(except for a health care professional who does not require a written statement in order to appeal a claim for a claimant)] along with the representative's name, address, phone number, and email address. To designate an authorized representative, the claimant must submit a completed authorized representative form (available from the TPA).

If the claimant is unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (e.g., notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is the claimant's legal spouse, parent, grandparent, or child over the age of 18).

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative rather than to the claimant. The Plan will honor the designated authorized representative [for one (1) year before requiring a new authorization/until the designation is revoked], or as mandated by a court order. The claimant may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the TPA.

The Plan reserves the right to withhold information from a person who claims to be the claimant's authorized representative if there is suspicion about the qualifications of that individual.

Limitation On When A Lawsuit May Be Started

A claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's internal claims and appeal procedures described in this section) for every issue deemed relevant by the claimant, or until [60/90] days have elapsed since the claimant filed a request for appeal review if he or she has not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. In addition, with respect to health care claims, the claimant is not required to exhaust external review before seeking judicial remedy.

No lawsuit may be started more than [three years] after the end of the year in which services were provided.

Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators, medical professionals, and vocational experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination, or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

External Review Of Claims

If a Member's or Eligible Dependent's initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and the Member or Eligible Dependent is dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, he or she may (under certain circumstances) be able to seek external review of the claim by an external review process administered by the Kansas Insurance Department (KID). This process includes review of your claim by an Independent Review Organization ("IRO"). The Kansas State external review process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

Claims Eligible For The External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational.

- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

The KID, through its Commissioner, will determine whether a denial is approved for external review

Claims Not Eligible For The External Review Process

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment.
- A determination that a Member or Eligible Dependent are not eligible for coverage under the terms of the Plan.
- Claims that are untimely, meaning the Member or his or her Eligible Dependent did not request review within the 120-day deadline for requesting external review.
- Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).

In general, a Member or Eligible Dependent may only seek external review after he or she receives a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny the Member's or Eligible Dependent's initial claim in whole or part and the Member or Eligible Dependent has exhausted the Plan's internal claims and appeals process.

Under limited circumstances, a Member or Eligible Dependent may be able to seek external review before the internal claims and appeals process has been completed:

- If the Plan waives the requirement that he or she complete its internal claims and appeals process first.
- In an urgent care situation (see "Expedited External Review Of An Urgent Care Claim"). Generally, an urgent care situation is one in which the Member's or Eligible Dependent's health may be in serious jeopardy or, in the opinion of his or her health care professional, they may experience pain that cannot be adequately controlled while awaiting a decision on an internal appeal.
- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and the Member or Eligible Dependent may proceed to external review. If a Member or Eligible Dependent thinks that this situation exists, and the Plan disagrees, he or she may request that the Plan explain in writing why he or she is not entitled to seek external review at this time. Note: The Plan's internal claims and appeals process will not be deemed exhausted based on a minor error committed by the Plan that does not cause, and is not likely to cause, prejudice or harm to the Member or Eligible Dependent so long as the Plan demonstrates that the failure was for good cause or due to matters beyond the control of the Plan and that the failure occurred in the context of an ongoing, good faith exchange of information between the Plan and the Member or Eligible Dependent. This exception is not available if the failure is part of a pattern or practice of failures by the Plan. The Member or Eligible Dependent may request a written explanation from the Plan, and the Plan must provide an explanation of the failure within ten (10) ten days of the request,

including a specific description of its bases, if any, for asserting that the failure should not cause the internal claims and appeals process to be deemed exhausted.

External Review Of A Standard (Non-Urgent Care) Claim

A Member's or Eligible Dependent's request for external review of a standard (not Urgent Care) claim must made in writing within 120 days after receiving notice of an adverse benefit determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after a Member or Eligible Dependent receives a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

To begin the standard external review process, the Member or Eligible Dependent (or his or her authorized representative or health care professional) must contact the KID during 8 a.m. and 5 p.m. CST, Monday through Friday at:

Online: https://insurance.kansas.gov/

By Email: kid.commissioner@ks.gov

Consumer Assistance Hotline: 800-432-2484

Main Number: 785-296-3071

By Mail: 1300 SW Arrowhead Rd., Topeka, KS 66604

By Fax: 785-296-5806

Preliminary Review Of A Standard (Non-Urgent Care) Claim By The KID

Within ten (10) business days of the KID's receipt of a request by a Member or Eligible Dependent (or his or her authorized representative or health care professional) for external review of a standard claim, the KID will complete a preliminary review of the request to determine whether:

- The Member or Eligible Dependent is/was covered under the Plan at the time the health care item or service is/was requested; or, in the case of a retrospective review, the Member or Eligible Dependent was covered at the time the health care item or service was provided.
- The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to a Member's or Eligible Dependent's failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage.
- The Member or Eligible Dependent has exhausted the Plan's internal claims and appeals process (or a limited exception allows him or her to proceed to external review before that process is completed).

- The Member's or Eligible Dependent's request is complete, meaning that he or she has provided all of the information or materials required to process an external review.

Within ten (10) business days of receiving the request for external review (during which time it completes its preliminary review), the KID will notify the Member or Eligible Dependent (or his or her authorized representative or health care professional) and the Plan in writing whether:

- The request is complete and eligible for external review. Within the ten (10) business day timeframe, the KID will assign an IRO and notify the Member or Eligible Dependent (of his or her authorized representative or health care professional) and the Plan of the IRO's name, address, and telephone number.
- The request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available and provide contact information for the KID Consumer Assistance Division at 800-432-2484 (toll-free).
- The request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. The Member or Eligible Dependent (or his or her authorized representative or health care professional) must provide the necessary information or materials before the end of the 120 day filing period.

Review Of A Standard (Not Urgent Care) Claim By The IRO

If the request is complete and eligible for external review, the KID will assign it to an accredited IRO. The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

Once the claim has been assigned to an IRO, the following procedures apply:

- The KID will timely notify the Member or Eligible Dependent (or his or her authorized representative or health care professional) and the Plan in writing that the request is accepted for external review.
- Within seven (7) business days after receipt of the KID notice that a request for external review has been accepted, the Member or Eligible Dependent (or his or her authorized representative or health care professional) and the Plan may provide the assigned IRO with additional documentation and information for the IRO to consider in its review.
- Within five (5) business days after the Plan receives notification from KID that the request has been accepted for external review and that an IRO has been assigned, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.
- If the Member or Eligible Dependent (or his or her authorized representative or health care professional) submit additional information to the IRO related to his or her claim, the IRO must forward that information to the Plan within one (1) business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If Plan reverses its determination after it has been assigned to an IRO, the Plan will immediately provide written notice of its decision to the Member or Eligible

Dependent (or his or her authorized representative or health care professional) the IRO, and the KID. Upon receipt of such notice, the assigned IRO will terminate its external review.

- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo, meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.
- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from the Member's or Eligible Dependent's medical records, any recommendations or other information from his or her treating health care providers, any other information from the Member or Eligible Dependent or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
- In a standard case, the IRO will provide written notice of its final decision to the Member or Eligible Dependent (or his or her authorized representative), the Plan and the KID within thirty (30) business days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- A general description of the reason(s) for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial.
- The date that the IRO received the assignment from the KID to conduct the external review, the date(s) of external review was conducted, and the date of the IRO decision.
- References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.
- A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon.
- A statement that the IRO's decision is binding on the Member or Eligible Dependent and the Plan, except to the extent that other remedies may be available to the Member or Eligible Dependent or the Plan under applicable state or federal law.
- A statement that judicial review may be available to Member or Eligible Dependent.

  A statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act. You may contact KID Consumer Assistance Division at 800-432-2484 (toll-free) for more information and assistance.

Expedited External Review Of An Urgent Care Claim

A Member or Eligible Dependent (or his or her authorized representative or health care professional) may request an expedited external review in the following situations if:

- The Member or Eligible Dependent receives an adverse benefit determination regarding his or her initial claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize his or her life or health or would jeopardize his or her ability to regain maximum function, and the Member or Eligible Dependent (or his or her authorized representative or health care provider) has filed a request for an expedited internal appeal.
- The Member or Eligible Dependent receives a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize his or her life or health, or would jeopardize his or her ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which he or she received emergency services, and the Member or Eligible Dependent has not yet been discharged from a facility.

To begin the expedited external review process, the Member or Eligible Dependent (or his or her authorized representative or health care professional) must contact the Kansas Insurance Department (KID) during 8 a.m. and 5 p.m. CST, Monday through Friday at:

Online: https://insurance.kansas.gov/

By Email: kid.commissioner@ks.gov

Consumer Assistance Hotline: 800-432-2484

Main Number: 785-296-3071

By Mail: 1300 SW Arrowhead Rd., Topeka, KS 66604

By Fax: 785-296-5806

Preliminary Review Of An Urgent Care Claim By The KID

Immediately upon receipt of a request for expedited external review, the KID will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the standard claim external review process). The Plan will defer to the Member's or Eligible Dependent's treating health care professional's determination that a claim constitutes "urgent care." The KID will immediately notify the Member or Eligible Dependent (or his or her authorized representative or health care professional and the Plan (e.g., via telephone, fax, or electronically (if applicable)) whether the request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review Of An Urgent Care Claim By The IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the KID will assign an accredited IRO. The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Plan will expeditiously (but in no event later than 5 p.m. CST of the next business day after receiving notice of a request for external review from KID) provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim de novo meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice to the Member or Eligible Dependent (or his or her authorized representative), the Plan, and KID of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as the Member's or Eligible Dependent's medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided in writing, the IRO must provide written confirmation of the decision to the Member or Eligible Dependent (or his or her authorized representative), the Plan, and KID within two (2) business days after it is made.

What Happens After The IRO Decision Is Made?

- If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
- If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.
- If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under Kansas Statutes Chapter 40. Insurance section 13 40-22a16.

Section II – Administrative Provisions

Part 4: Coordination of Benefits

This coordination of benefits (COB) provision applies when a Member has health care coverage under more than one (1) plan as defined in the "Definitions section" of this Benefit Description.

The order of benefit determination rules listed below determines which plan will pay as the primary plan. The primary plan pays first and pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100 percent of total allowable expenses.

ORDER OF BENEFIT DETERMINATION RULES

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. A plan that does not contain a coordination of benefits provision that is consistent with this provision will be primary payor subject to: one (1) exception: coverage that is obtained by virtue of Membership in a group plan that is designed to supplement a part of a basic package of benefits. Examples of these types of coverage are major medical coverage that are superimposed over base plan hospital and surgical benefits, and insurance type coverage that is written in connection with a closed panel to provide out-of-network benefits. A plan may consider the benefits paid or covered by another plan in determining its benefits only when it is secondary to that other plan.

The first of the following rules that describes which plan pays its benefits before another plan is the rule that will apply:

- **Non-Dependent or Eligible Dependent**
  The plan that covers the person other than as an Eligible Dependent, for example as an employee, Member, or retiree, is primary and the plan that covers the person as a dependent is secondary. 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 (2) plans is reversed so that the plan covering the person as an employee, Member or subscriber or retiree is secondary and the other plan is primary.
- **Child covered Under More Than One (1) Plan**
  The order of benefits when a child is covered by more than one (1) plan is:
  - The primary plan is the plan of the parent whose birthday is earlier in the year if:
    - The parents are married;
    - The parents are not separated (whether or not they ever have been married); or
    - A court decree awards joint custody without specifying that one (1) party has the responsibility to provide health care coverage.
    - If both parents have the same birthday, the plan that has covered either of the parents longer is primary.
  - If the specific terms of a court decree state that one (1) of the parents is responsible for the 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.
  - If the parent with financial responsibility has no coverage for the child's health care services or expenses, but the parent's spouse does, the spouse's plan is primary.

- This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.
- If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
    - the plan of the custodial parent;
    - the plan of the spouse of the custodial parent;
    - the plan of the non-custodial parent; and then
    - the plan of the spouse of the non-custodial parent.

- **Active or Inactive Employee**
  The plan that covers a person as an employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled Non-Dependent or Dependent.
- **Continuation of Coverage (COBRA)**
  If a person whose coverage is provided under a right of continuation of Coverage provided by federal or state law also is covered under another plan, the plan covering the person as an employee, Member, subscriber, or retiree (or as that person's dependent) is primary, and the continuation of coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- **Longer or Shorter Length of Coverage**
  The plan that covered the person as an employee, Member, subscriber, or retiree longer is primary.

If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

EFFECT ON THE BENEFITS OF THIS PLAN

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a Claim determination period are not more than 100 percent of the total allowable expenses. As each Claim is submitted, this plan will:

- Determine its obligation to pay or provide benefits under the terms of the Plan,
- Determine whether a benefit reserve has been recorded for the Member, and
- Determine whether there are any unpaid allowable expenses during that Claim determination period.

If there is a benefit reserve, the secondary plan will use the Member's benefit reserve to pay up to 100% of total allowable expenses incurred during the Claim determination period. At the end of the Claim determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new Claim determination period.

If a Member is enrolled in two (2) 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 (1) closed panel plan, COB shall not apply between that plan and other closed panel plans.

COORDINATION OF BENEFITS WITH MEDICARE- OPTION 1

Benefits of this Benefit Description will not duplicate benefits provided under Federal, State, or local laws, regulations, or programs. Examples of such programs are: Medicare; Tri-Care; services in any veteran's facility when the services are eligible for coverage by the government. Coverage will be provided under the terms of the Plan, and as set forth in this Benefit Description, 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.

COORDINATION OF BENEFITS WITH MEDICARE - Active Employees and Spouses Age 65 and Older – OPTION 2

If an employee is eligible for Medicare and works for an Employer Group with fewer than twenty (20) employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding Calendar Year, then Medicare will be the primary payer. Medicare will pay its benefits first. The Plan will pay benefits on a secondary basis.

If an employee works for an Employer Group with more than twenty (20) employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding Calendar Year, the Plan will be primary. However, an employee may decline Coverage under the Plan and elect Medicare as primary. In this instance, the Plan, by law, cannot pay benefits secondary to Medicare for Medicare-Covered Services.

You will continue to be covered by the Plan as primary unless You (a) notify the Plan, in writing, that You do not want benefits under the Plan, or (b) otherwise cease to be eligible for benefits under the Plan, or (c) if the TPA determines through some other means that the Plan is not the primary carrier.

Disability

If You are under age 65 and eligible for Medicare due to disability, and actively work for an Employer Group with fewer than one hundred (100) employees, then Medicare is the primary payer. The Plan will pay benefits on a secondary basis.

If You are age 65 or older and actively work for an Employer Group with at least one hundred (100) employees and You become entitled to benefits under Medicare due to disability (other than ESRD as discussed below) the Plan will be primary for You and Your Eligible Dependents and Medicare will pay benefits on a secondary basis.

End Stage Renal Disease (ESRD)

If You are entitled to Medicare due to End Stage Renal Disease (ESRD), the Plan will be primary for the first thirty (30) months. If the Plan is currently paying benefits as secondary, the Plan will remain secondary upon Your entitlement to Medicare due to ESRD.

COORDINATION OF BENEFITS FOR RETIREES

If You are retired and You or one of Your Dependents is covered by Medicare Part A and/or Part B (or would have been covered if complete and timely application had been made), benefits otherwise payable for treatment or services described within the terms of the Plan will be paid after:

- Amounts payable are paid for treatment or services by Medicare Parts A and/or Part B; Amounts that would have been payable (paid) for treatment or service by Medicare Parts A and/or Part B, if You or Your Dependents had been covered by Medicare; or
- Amounts paid under all other plans in which You participate.

Right to Receive and Release Needed Information

By accepting Coverage under the terms of the Plan You agree to:

- Provide the Plan with information about other Coverage and promptly notify the Plan of any Coverage changes;
- Give the Plan the right to obtain information as needed from others to coordinate benefits;

Facility of Payment

A payment made under another plan may include an amount that should have been paid under the terms of the Plan. If it does, the Plan may pay the amount to the organization that made the payment. The amount will then be treated as though it was a benefit paid under the Plan. The Plan 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 reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of payment made by the Plan, including the reasonable cash value of any benefits provided in the form of services, is more than it should have paid under the terms of the Plan, the TPA may recover the excess payments from one (1) or more of:

- The person(s) it has paid;
- The person for whom a claim was paid;
- Another Insurance company which should have paid; or
- Any Other organizations with liability for the services.

Section II – Administrative Provisions

Part 5: General Information

Member/Provider Relationship: The choice of a provider is solely the Member's. The use or non-use of an adjective such as Network or Non Network in modifying any provider is not a statement as to the ability of the provider.

Your Identification Card: You must tell Your Institutional Provider or Professional Provider that You are eligible for Covered Services. When You receive services, show Your Identification Card at the provider's office. Show only the current card.

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

- **The TPA is obligated to** provide benefits for the services of Your Professional Provider only to the extent provided under the terms of the Plan, and as described in this Benefit Description. The TPA does not guarantee the availability of a provider.
- **The TPA will not be liable** for any acts or wrongs of a Service Provider. This includes negligence, misconduct, malpractice, refusal to give service, and breach of contract because of anything done or not done by a provider.

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

- **If the TPA 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.

Notice of Claim: Notice of Your claim must be given to the TPA within 90 days after You receive services.

- You are responsible for making sure Your Network Provider knows You are eligible for Covered Services and submits a claim for You.
- If Your Non Network 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 TPA within one (1) year and 90 days after You receive services.

Time of Payment of Claims: Benefits payable under the terms of this Plan, and as described in this Benefit Description will be paid immediately upon receipt of proper written proof of loss provided all necessary information is available for processing and it is administratively possible to process the claim. Please refer to Section 2 Part 3 for Appeal and External Review stipulations and timelines. All appeals must be received within 180 days of receiving the denial notice.

Request for Additional Information: There may be occasions when additional information will be needed to process Your claim. You will have 90 days from the date the information is requested to furnish the additional information to the TPA. If the additional information is not received by the TPA within the 90 days from the timely request date, the claim will be denied.

Adjustment of Claim: After a period of 1 year and 90 days from the date of service only claims that require adjustments due to legal findings or audits will be adjusted if the request is received within 180 days of the completion of the legal findings or audit. There will be no limit on adjusting claims that involve fraudulent billing. Please note this includes audits of the Plan and/or the TPA. It does not include audits done by third parties, such as Medicare, on their own claims.

Legal Actions: No legal action may be brought to recover under the Plan, and as described in this Benefit Description, within 60 days after written proof of loss has been given as required under the Plan and described in this Benefit Description. No legal action may be brought after five (5) years from the time written proof of loss is required to be given.

Errors Related to Your Coverage: The TPA has the right to correct benefit payments which are made in error. Providers and/or You have the responsibility to return any overpayments to the TPA. The TPA has the responsibility to make additional payments if an underpayment has been made. There is no timeline for correcting fraudulent claims.

Physical Exam and Autopsy: Physical exams will not be covered if they are required for employment purposes. Autopsies will not be covered under the Plan unless required by law.

Benefits Payable: Claims will be paid to the Service Provider unless there are unusual circumstances, i.e., you are being reimbursed for the claim that you paid.

Notice From the TPA to a Member: A notice sent to a Member by the TPA is considered “given” when mailed to the Member at his address as it appears on the records maintained by the TPA.

Notification of Change: The Members will be given notice of any approved benefit change by a rider, amendment, or any other proper written means. If major changes to the terms of the Plan, as described in this Benefit Description, are made, new Benefit Descriptions, riders, or amendments will be issued.

Written Proof of Loss: A Member is required to provide written proof of the loss to the TPA in order for a claim to be paid.

Claim Form: If you need a claim form You can obtain it by contacting the TPA at the number provided on Your identification card.

Important Notices

The Women's Health and Cancer Rights Notice

In accordance with the Women's Health and Cancer Rights Act of 1998 (WHCRA), the following coverage is offered to a Member who elects the following services in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Newborns' and Mothers' Health Protection Act (the Newborns' Act)

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Service Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a Service Provider obtain authorization from the medical carrier or the TPA for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA Privacy

The HIPAA Privacy Rule (45 C.F.R. parts 160 through 164) gives individuals a fundamental right to be informed of the privacy practices of their health plans, as well as to be informed of their privacy rights with respect to their Protected Health Information (PHI). Health plans and covered health care providers are required to develop and distribute a Notice of Privacy Practices that provides a clear, and user friendly explanation of these rights and practices. The Notice of Privacy Practices for the Plan is found below.

State Employee Health Plan (SEHP)

NOTICE OF PRIVACY PRACTICES

For the Use and Disclosure of Protected Health Information

State Employees Health Benefit Plan

(Para obtener una copia de esta nota en español, contacta al Oficial de la Privacidad de SEHP en 785.296.3981.)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA). PLEASE REVIEW IT CAREFULLY.

HIPAA Effective Date: April 14, 2003 Date of This Notice: June 23, 2014

Why is SEHP sending you this Notice?

We want to protect the privacy of your personal information. Federal law requires us to make sure your Protected Health Information (PHI) is kept private. That law is known as the Health Insurance Portability and Accountability Act (HIPAA). We must give you this Notice of our legal duties and privacy practices with respect to your PHI.

We must also follow the terms of the Notice that are in effect right now. We reserve the right to change the terms of this Notice and our privacy policies at any time. If we make these changes, they will affect all PHI we maintain. This includes PHI we received or created before the change. If we do change the terms of our privacy policy, we will post a new Notice on our website and send a copy to each head of household within 60 days.

PHI is information that we have created or received about your past, present, or future health or medical condition. This information could be used to identify you. It also includes information about medical treatment you have received and about payment for health care you have received. It may include your name, age, address, and social security number. We must tell you how, when, and why we use and/or share your PHI.

PHI also includes your genetic information, and we are not permitted to use your genetic information for any underwriting purposes.

How do we collect your Protected Health Information (PHI)?
We collect PHI from you. We also receive PHI from your health care providers. For example, we might get PHI from your health care providers when they submit a claim to be paid for services, they provided to you. We get PHI from you when you fill out your application for health care coverage. PHI does not include health information contained in employment records (such as disability, work-related illnesses/injury, sick leave, Family or Medical Leave (FMLA), life insurance, dependent care, etc.).

How and when can we use or disclose your PHI?
HIPAA and other laws allow or require us to use or disclose your PHI for many reasons. Sometimes we are not required to get your written permission. For other reasons, we may need you to agree in writing that we can use or disclose your PHI. In this Notice, we have listed reasons we are allowed to use your PHI without getting your permission. Not every use or disclosure is listed. The ways we can use and disclose information fall within one of the descriptions below:

- **So, you can receive treatment**. We may use and disclose your PHI to those who provide you with health care services or who are involved in your care. These people may be doctors, nurses, or other health care professionals. For example, the SEHP discloses the name of your primary care physician to a specialist so they can share information about your treatment.
- **To get payment for your treatment.** We may use and disclose your PHI to pay providers for treatment and services you receive. For example, we may give parts of your PHI to our claims department or others so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. The TPA notifies the providers whether you are eligible for coverage, the types of services covered, or what percentage of the bill will be paid by the Plan.
- **To operate our business.** We use and disclose your PHI to operate the Plan, including research and organ donation. We also use PHI to give you information about other health care treatment, services, or benefits. For example, to review and improve the quality of health care services, you get. The SEHP uses information from your medical claims to refer you to health management programs, to project future benefit costs, to audit claims processing and other activities related to funding and operating a business. These uses and disclosures are necessary to make sure that all of our participants receive quality care and in order to operate and manage our health care operations. Before we share PHI with other organizations, they must agree to keep your PHI private.
- **To meet legal requirements.** We will disclose PHI with government or law enforcement agencies when federal, state, or local laws require us to do so. We also share PHI when we must in a court, administrative proceedings, or other legal proceedings. For example, when the law says we must report PHI in emergency situations or about people and children, who have been abused, neglected, or are victims of domestic violence, we comply with the law
- **To report public health activities.** We may disclose PHI with government officials who collect public health information, or conduct public health investigations, surveillance, or interventions. For example, we may share PHI about births, deaths, and some diseases with local and state health departments.
- **For health oversight activities.** We may disclose PHI if a government agency is investigating or inspecting a health care provider or organization, or as otherwise authorized by law.

- **To avoid harm**. In order to avoid a serious threat to the health or safety of a person or the public, we may disclose PHI to law enforcement or people who may be able to stop or lessen the harm.
- **For workers' compensation purposes**. We may release PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- **To coroners, medical examiners, or funeral directors.** We may release PHI to coroners, medical examiners, or funeral directors for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We also may disclose to authorized federal officials PHI required for lawful military and veterans' activities, protective services for the President and others, medical suitability determinations, correctional institutions, and other law enforcement custodial situations, for intelligence, counter-intelligence, and other national security activities and in some situations to agencies administering a government program.

Other uses and disclosures require your prior written permission. In other situations, such as psychotherapy notes and marketing, we will ask for your written authorization before we use or disclose your PHI. Your authorization to let us use or disclose your PHI can be changed at any time. You cannot change your decision about information already released with your authorization. Requests to not disclose PHI must be made in writing to the SEHP Compliance Officer. That address is at the end of this Notice.

Breach Notification. You have the right to be notified when the privacy and security of your health information has been compromised and is considered to meet the definition of a "breach" under HIPAA, i.e., the unauthorized access to or disclosure of your PHI.

Fundraising Activities. We will not use your PHI for fundraising activities.

Will you give my PHI to my family, friends, or others?
A friend or family member may be helping you get, or pay for, your medical care. For example, you may be talking to a Service Provider and your mother is with you. We may discuss your PHI with you in front of her. We will not discuss your PHI with you when others are present if you tell us not to.
There may be a time when you are not present, or you are unable to make health care decisions for yourself. For example, you may not be conscious, but a friend is with you. If our professional judgment is that sharing your PHI with your friend is what is best for you, we will do so.

How do we protect your Protected Health Information?
We protect your PHI by:

- Treating all PHI that we collect about you as confidential.
- Developing privacy policies and procedures for the management of PHI.
- Stressing the confidentiality and importance of following privacy policies and practices in our HIPAA training.
- Creating disciplinary measures for privacy violations.
- Restricting access to your PHI only to those employees who need to know about you to provide services to you, like paying a claim for a covered benefit.
- Disclosing the minimum PHI needed for a service company to perform its function. We make sure the company agrees to protect and maintain the confidentiality of your PHI.
- Maintaining physical, electronic, and procedural safeguards that comply with federal and state regulations to guard your PHI.

What are your rights with respect to your PHI?
You have a qualified right to ask that we restrict how we use and disclose your PHI. You can also request a limit on the PHI we give to someone who is involved in your treatment, payment, or our healthcare operations. For example, you could ask that we not use or disclose information about a treatment that you had to a family member or friend. You must tell us in writing what you want. We will consider your request. We are not required to agree to any requested restriction. If we accept your request, we will put any applicable limits in writing. We will honor these limits except in emergency situations. You may not limit the way we use and disclose PHI when we are required by law to make the use or disclosure. Send your request to the SEHP Compliance Officer. The address is on the last page of this Notice.

You have a qualified right to ask us to send your PHI to an address of your choice or to communicate with you in a certain way within reason.
You must tell us in writing what you want. You must tell us if you are making the request because you believe that the disclosure of all or part of the PHI could put you in danger if we do not meet your request. For example, you can ask us to send PHI to your work address instead of your home address. We will accommodate reasonable requests. You may be assessed reasonable charges to comply with your request, which must be paid in advance. Send your request to the SEHP Compliance Officer. The address is on the last page of this Notice.

You have a qualified right to look at or get copies of your PHI that we have.
You have a right to ask for and receive copies of your PHI. You have a right to receive electronic copies of your PHI as well. You must make that request in writing. You may be assessed reasonable fees to provide these copies. If we do not have your PHI, we will tell you how you may be able to get it. We will respond to you within 30 days after we receive your written request. (Response may take longer if the information is not stored on-site.) In the event that 30 days is not enough time to retrieve the information you are requesting, we will advise you of an additional extension of up to 30 days.

In certain situations, we may deny your request. If we do, we will tell you, in writing, the reasons we are denying your request. We will also explain your right in limited situations to have our denial reviewed. Send your request to the SEHP Compliance Officer. The address is on the last page of this Notice.

You have a qualified right to a list of times we have shared your PHI.
Your request for the list can go back as far as six years. We will respond within 60 days of receiving your written request for your PHI.

The disclosure list we send to you will include:

- The date of the disclosure;
- The person to whom PHI was disclosed (including their address, if known);
- A brief description of the information disclosed; and
- A brief statement of the purpose of the disclosure.

The list will not include:

- Disclosures we made so you could get treatment;
- Disclosures we made so we could receive payment for your treatment;
- Disclosures we made in order to operate our business;
- Disclosures made directly to you or to people you designated;
- Disclosures made for national security or intelligence purposes;
- Disclosures made to corrections or law enforcement personnel;
- Disclosures we made before we sent you this message;
- Disclosures we made when we had your written permission; or

- Disclosures made before April 14, 2003.

You may request one free disclosure list each calendar year. If you ask for another list in the same calendar year, we will send you one if you agree to pay the reasonable fee we charge in advance. To make this request, write to the SEHP Compliance Officer. The address is at the end of this Notice.

You have a qualified right to ask us to correct your PHI or add missing information if you think there is a mistake.
Your request must be in writing to the SEHP Compliance Officer. The address is on the last page of this notice. Your request must give the reason for the changes. We will respond within 60 days of receiving your written request. We may use an extension of 30 days if we need it. If we approve your request, we will make the change to your PHI. We will tell you that we have made the change. We will also tell others who need to know about the change to your PHI.

We may deny your request if your PHI is:
- Already correct and complete;
- Not created by us;
- Not allowed to be disclosed; or
- Not part of our records.

If we deny your request, we will tell you why in writing. Our written denial will also explain your right to file a written statement of disagreement. You have the right to ask that your written request, our written denial, and your statement of disagreement be attached to your PHI any time we disclose it in the future. You can send this request in writing to the SEHP Compliance Officer at the address at the end of this Notice.

How can you get a paper copy of this notice? If you are a State employee, you can download the Notice from the SEHP website at http://www.kdheks.gov/hcf/ or you may call SEHP at 785-296-1333 and request a copy of this Notice.

How can you reach us to register a complaint about our privacy practices or get further information about matters covered by this Notice? If you think that we may have violated your privacy rights, you may send your written complaint within 180 days of the alleged violation to the address listed below, or you may get further information about matters covered by this Notice or obtain a paper copy of this notice by writing to:

SEHP Compliance Officer
KDHE Legal Department
Curtis State Office Building
1000 SW Jackson Street, Suite 560
Topeka, KS 66612-1371
785-291-3951

Additionally, if you believe your privacy rights have been violated, you may make a complaint to the Secretary of the United States Department of Health and Human Services. You will not be penalized for filing a complaint about our privacy practices. The contact information is:

U.S. Department of Health & Human Services
Office for Civil Rights
601 East 12th Street – Room 248
Kansas City, MO 64106
(816) 426-7277; (816) 426-7065 (TDD); (816)426-3686 FAX

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1- 877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
U.S. Department of Health and Human Services
Employee Benefits Security Administration
Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa
www.cms.hhs.gov
1-866-444-EBSA (3272)
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Section II – Administrative Provisions

Part 6: Autism Rider

This rider outlines the coverage provided for treatment of autism in covered children under the age of Nineteen (19). Unless otherwise specified all other provisions of the Plan, and as described in the Benefit Description, apply to benefits, outlined in this Autism Rider, including deductibles, copays, coinsurance, out of pocket maximum, network provider arrangements and prior authorization.

Definitions:

Autism Spectrum Disorder means the following disorders within the autism spectrum:

- Autistic disorder,
- Asperger's disorder,
- Pervasive Developmental Disorder, Not Otherwise Specified (PDD-NOS), as specified within the diagnostic and statistical manual of mental disorders, fourth edition, text revision (DSM-IV), of the American psychiatric association.
- Rett's disorder,
- Childhood Disintegrative disorder.

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.

Autism Service Provider means any person that provides diagnostic or treatment service for Autism Spectrum Disorders who is licensed or certified by the State of Kansas; or who is licensed by the Behavioral Sciences Regulatory Board as a Licensed Behavior Analyst.

Comprehensive Assessment means completion (by an appropriate professional) and submission of results of:

- A Vineland II Survey Interview Adaptive Behavior Scales by a qualified evaluator who is a level 3 user based on the Pearson Assessments; and
- A Neurological evaluation by a medical doctor to rule out primary neurological disorder; and
- A lead poisoning assessment; and
- A Speech Assessment to rule out primary speech disorder; and
- A Hearing Assessment to rule out primary hearing disorder; and
- An IQ Test (optional); and
- DSM-IV Diagnostic Criteria; and

An Assessment by one of the following:

- Checklist for Autism in Toddlers (CHAT);
- Childhood Autism Rating Scale (CARS);
- Modified Checklist for Autism in Toddlers (M-CHAT);
- Screening Tool for Autism in two-year olds (STAT);
- Social communication Questionnaire (SCQ) (recommended for children four-years of age or older);
- Autism Behavior checklist (ABC);
- Gilliam Autism Rating Scale (GARS);
- Autism Diagnostic Observation Scale (ADOS);
- Autism Diagnostic Interview – Revised (ADI);
- Autism Spectrum Screening Questionnaire (ASSQ);
- Childhood Asperger Syndrome Test (CAST);
- Krug Asperger's Disorder Syndrome (ASAS);
- Australian Scale for Asperger Syndrome (ASDS);
- Asperger Syndrome Diagnostic Scale (ASDS); or
- Pervasive Developmental Disabilities Screening Test (PDD-ST).

Licensed Behavior Analyst or ''LBA'' means an individual who is certified by the certifying entity as a certified behavior analyst and meets the licensing criteria as established by the Behavioral Sciences Regulatory Board by rules and regulations.

Line Therapist means an individual who provides supervision of an individual diagnosed with Autism Spectrum Disorder and other neurodevelopmental disorders pursuant to the prescribed Treatment Plan; and implements specific behavioral interventions as outlined in the prescribed Treatment Plan under the direct supervision of a Licensed Behavior Analyst.

Periodic Assessment means an evaluation that shows an assessment of the improvement in the individual based upon the diagnosis and approved treatment plan. Timing of the periodic assessments will be based upon the treatment plan, but no more often than every six months, unless agreed upon by the Plan and Autism Service Provider. Statistically significant improvement in the stated goals and objectives of treatment must be achieved as a condition to authorize continued treatment. A Vineland II Survey will be required at least annually.

Significant Improvement means the primary outcome measure to define significant improvement is mastery of a minimum of 50% of stated goals and/or objectives found in the submitted treatment plan. This must be achieved at each concurrent review to allow authorization for continued treatment. This is demonstrated through pre- and post- data including documented generalization of skills developed through goals across settings and people.

Treatment plan goals must be related to core deficits of autism, identified by most recent assessments completed by the LPA with reasonable expectation of mastery within 6 months. Treatment hours requested will be reviewed and authorized based on Medical Necessity and goal outcomes, as related to specified treatment plan goals.

If the net number of goals met is less than 25% of those proposed in the Treatment Plan, benefit denial will be considered. If the net goal met was over 25%, but less than 50%, a battery of psychological testing may be obtained to use as a baseline for future concurrent reviews.

Treatment Plan means a submission by an Autism Service Provider or group of Autism Service Providers, and signed by the Autism Service Provider(s) and parent(s)/caregiver(s) that includes:

- The type of therapy to be administered and methods of intervention,
- The goals, including
- Specific problems or behaviors requiring treatment
- Frequency of services to be provided
- Frequency of parent or caregiver participation at therapy sessions
- Description of supervision, and
- Periodic measures for the therapy, including the frequency at which goals will be reviewed and updated,
- Who will administer the therapy, and
- The patient's current ability to perform the desired results of the therapy.

Benefit Provisions

Autism Spectrum Disorder (ASD) Coverage is available for the diagnosis and treatment of ASD as defined. Diagnosis shall be the appropriate listed assessment instrument from the listed options, performed by an appropriately licensed medical provider. Benefits must be pre-approved by the Plan and may include Applied Behavioral Therapy, developmental Speech Therapy, developmental Occupational Therapy, or developmental Physical Therapy as appropriate. Periodic re-evaluations and assessments are required, and continuous improvement must be shown in order to qualify for continued treatment. Results of a Vineland II Survey will be required for the initial assessment to establish a baseline and must be repeated at least every year to establish improvement.

All services are subject to the applicable Deductible, Coinsurance/Copayment amounts and Out of Pocket Maximum under the Plan. Providers will be reimbursed based upon network status.

Prior Approval: To qualify for this benefit, a Comprehensive Assessment may be required (see submission guidelines below). The Treatment Plan must be submitted to the TPA in advance of the initiation of treatment and outline measurable goals and objectives for treatment of the member. Benefits will be provided for the initial Comprehensive Assessment whether or not the Member is approved for continued treatment. If approved for continued treatment, benefits will be available only for services received following the approval of the Treatment Plan.

The provider must submit:

- For newly diagnosed Members with eligible autism diagnosis, a Comprehensive Assessment must be completed and submitted within 90 days of treatment beginning under this rider.
- All members must have a treatment plan detailing the individuals who will be performing the various therapies and/or interventions and the type and frequency of the services to be performed. Services must be pre-approved by the Plan. Periodic Assessments must be submitted every six months and include objective evidence of progress (a Vineland Survey) and behavior assessment scales such as the Verbal Behavior Milestones Assessment and Placement Program (VB_MAPP), Assessment of Basic Language and Learning Skills (ABLLS) or other age appropriate behavioral assessment.

Exclusions- The Following services are not covered under the Plan:

- Respite care
- Vocational rehabilitation
- Residential care
- Transportation
- Animal based therapy programs
- Hydrotherapy
- Camps
- Vitamin Therapy
- Programs and/or services administered within the Public, Private or Home School, to the extent the programs and/or services are funded by the school system.
- Vocational or Job training programs
- Services provided by relatives

[1] Under the Kansas SEHP if an individual has been determined to have autism and treatment has been requested by an attending provider, treatment will be approved while a comprehensive assessment is underway, not to exceed 90 days from the initial date of treatment. If upon the completion of the 90-day period, a comprehensive assessment is not completed or an individual is determined not to have autism, no claims that were authorized in the initial 90-day period will be denied. However, further coverage will only be approved as determined based on the completed assessment and treatment plan.

Section II – Administrative Provisions

Part 7: Intravenous and Injectable Anti-Cancer Drug Rider

This rider provides the terms of coverage provided for intravenously (IV) or injected anti-cancer medication therapies under the Plan.

Definitions

Allowed Charge: Means the maximum monetary payment for health care services rendered to You and authorized by the Plan.

Anti-Cancer Medication: Anti-cancer medication therapies administered intravenously (IV) or by injection to kill or slow the growth of cancerous cells.

Benefit Provisions

Coverage for Anti-Cancer IV or Injectable Medication Therapies:

The Plan provides coverage for IV and injected Anti-Cancer medication therapies, if all of these conditions are met:

- You are an eligible Member in the Plan; and
- it is Medically Necessary;
- the IV therapy or Injectable medications are covered under the Plan, and it is dispensed according to Plan guidelines.

Benefits are provided for each eligible Intravenous or Injectable Anti-Cancer medication treatment, subject to payment of any applicable Coinsurance. The Provider and the patient, not the Plan or the employer determine the course of treatment. Whether or not the Plan will cover all or part of the cost for treatment is secondary to the decision of what the treatment should be. The Plan retains the final discretionary authority on what constitutes an eligible anti-cancer medication. This list of covered IV and Injectable medications is subject to periodic review and modification.

Intravenous and Injectable Anti-Cancer Drug Rider	
Coverage	**Member Responsibility**
Coinsurance	Deductible and 20% Coinsurance per date of service

NOTE: Non Network Provider will pay at the Network benefit level.

IV and Injectable Anti-Cancer Medication Therapies

Your responsibility is Deductible then 20% Coinsurance of the Allowed Charge not to exceed your out of pocket maximum for covered anti-cancer IV or Injectable medication therapies. Once the Out of Pocket Maximum has been met, the Plan pays 100% of the Allowed Charged for covered IV and Injectable Anti-Cancer covered under this rider for the remainder of the calendar year.

Exclusions:

The Plan does not cover the following:

- Benefits are not available to the extent an Anti-Cancer medication has been covered under another contract, certificate or rider issued by the Plan Sponsor.
- Medication therapies furnished to a Member by any local, state, or federal government entity; except as otherwise provided by law, any medication therapy to the extent payment or benefits are provided or available from any local, state, or federal government entity (for example, Medicare) regardless of whether payment or benefits are received.
- Treatment for any condition, illness, injury, or sickness arising out of or in the course of employment for which compensation benefits are available under any Worker's Compensation Law or other similar laws, regardless of whether the Member makes a claim for, or receives such compensation or benefits.
- Compounded drugs not containing at least one (1) ingredient with a valid National Drug Code (NDC) number and requiring a Physician's Order to dispense.
- Prescription Drug Products that the Plan determines are not medically necessary.
- Experimental or unproven prescription drug products, treatments, or therapies.
- Prescription Drug Products that have not been approved by the Federal Food and Drug Administration.
- Health care services and drugs customarily provided by the research sponsors of a clinical trial free of charge for any insured participating in a clinical trial.
- Charges to administer or inject any drug.
- Prescription Drug Products for which there is normally no charge in professional practice.
- Charges for the delivery of any drugs.
- The Plan has the right to deny benefits for any drug prescribed or dispensed in a manner that does not agree with normal medical or pharmaceutical practice.
- Benefits are not available for any Prescription Drug Products for which a claim for benefits has already been processed under another contract, certificate or rider issued by the TPA.

Section II – Administrative Provisions

Part 8: Bariatric Rider

(Revised: 04/01/2022)

This rider provides the terms of coverage provided for treatment of Bariatric services. Using the Medical Necessity guidelines and Pre-Authorization review, in conjunction with the pre-surgery and post-surgery compliance guidelines, sufficient controls remain in place to allow adolescents who may qualify for these procedures to meet the guidelines and receive the benefits.

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, copayments, coinsurance, out of pocket maximum amounts, network provider arrangements and prior authorization.

Definitions

BMI: means Body Mass Index

Co-morbid conditions: Means for the purposes of the Bariatric Surgery benefit, the following chronic health conditions:

- Cardiomyopathy
- Type 2 Diabetes
- Coronary Heart Disease
- Hypertension
- Gastroesophageal reflux disease (GERD)
- Clinically significant obstructive sleep apnea

Multi-disciplinary surgical preparatory regimen: Means, 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:

- Includes participation in a behavior modification program supervised by qualified professionals.
- Includes participation in a reduced calorie diet program in consultation with a dietician.
- Includes participation in an exercise regimen (unless contraindicated in medical records) supervised by a physical therapist to improve pulmonary reserve prior to surgery.
- 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.

Physician supervised nutrition and exercise program: Means 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.

Coverage

All covered services provided under this rider are subject to the applicable Deductible, Coinsurance, Copayment requirements and Out of Pocket maximum amounts as outlined in the Schedule of Benefits and set forth 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 TPA.

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

- Equal to 35 and less than 40 with two or more co-morbid conditions
- 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 TPA. You will be required to complete at least 6 discussions with the TPA care manager within 8 months following your surgery. The TPA 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:

- Open or Laparoscopic Roux-en-Y (RYGB)

- Open or Laparoscopic Biliopancreatic Diversion (BPD) with or without duodenal switch (DS)
- Laparoscopic Sleeve Gastrectomy
- 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 must be performed at facilities accredited for Bariatric Surgery procedures by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). A list of approved facilities and providers, and their approval dates may be found here: https://www.facs.org/search/bariatric-surgery-centers. The Service Provider must also be included in the medical plan Network as a contracted provider. Services covered under this rider are not covered when using a Non Network provider.

Surgical Revisions:
Surgical revision of a bariatric surgery must receive prior approval from the TPA. 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:

- Conversion to a Laparoscopic Sleeve Gastrectomy, RYGB or BPD/DS may be considered Medically Necessary for Members who have not had adequate success (defined as loss of more than fifty (50) percent of excess body weight which is based on a BMI or 30) two (2) years following the primary bariatric surgery procedure and the member has been compliant with the prescribed diet and exercise program.
- Revision is required due to dilation of the gastric pouch or dilation of the gastrojejunostomy anastomosis if the Member has been compliant with the prescribed diet and exercise program and the primary surgery was successful in inducing weight loss prior to the dilation.
- Replacement of an adjustable band due to complications (Example: port leakage, slippage) that cannot be corrected with band manipulation or adjustments.

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:
  - Infertility
  - Idiopathic intracranial hypertension

Section II – Administrative Provisions

Part 9: Blue Cross Blue Shield of Kansas Telehealth Consultation Rider

This rider provides the terms of coverage provided for Telehealth Service through American Well (AmWell) under the Plan. Blue Cross Blue Shield of Kansas is contracting with AmWell to be a Network Provider of Telehealth services. AmWell provides members and covered dependents 24/ 7/ 365 access to consult with a licensed medical doctor in the AmWell network using video and audio to treat, diagnose and prescribe medication.

Definitions

Telemedicine: means the use of telecommunications technology to provide, enhance, or expedite health care services, as by accessing off-site databases, linking clinics or physicians' offices to central hospitals, or transmitting x-rays or other diagnostic images for examination at another site.

Telehealth Service: the use of person to person electronic communication between the companies designated Telehealth provider and the member to provide HIPAA-compliant remote access for diagnosis, intervention, consultation, supervision, and information in an outpatient setting. This electronic communication uses interactive telecommunications equipment that includes audio and video. Services do not include the means, or technology, or support required to receive such services.

Benefit Provisions

Coverage for Telehealth Service: Telehealth services when received from the AmWell Network Provider, contracted through Blue Cross Blue Shield of Kansas, for conditions can recommend treatment, diagnose, and prescribe medication, when appropriate, for medical issues. Claims submitted will be subject to the appropriate deductible and coinsurance.

Telehealth Consultation Rider	
Service	**Member Responsibility**
Telehealth Service	Deductible plus 10% Coinsurance

NOTE:

- When using a Network provider other than the *preferred telehealth vendor*, AmWell, the telehealth consultations will be subject to the Network deductible and coinsurance.
- Consultations with Non Network Providers will be subject to the Non Network deductible and coinsurance amounts of the plan.