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 underwritten by:

The Kansas State Employees Health Care Commission

Third Party Administrator (TPA): Aetna has been retained to administer claims under this Program. The TPA provides Administrative Services Only under this Benefit Description including claims processing and the administration of appeals and grievances. For answers to questions regarding claims payments, eligibility for benefits and other information about this Program, contact:

Aetna

9401 Indian Creek Parkway, Ste 1300

Overland Park, KS 66210

1-866-851-0754

Company is not the insurer under this Program and does not assume any financial risk or obligation with respect to claims.

Benefit Description 2016

Section I Coverage **1**

Part 1: General Provisions 1

Responsibilities of the TPA 1
Case Management/Cost Effective Care 1
How to Contact the Plan 1
Services from Non Network Providers 2
Transfer of Care 2

Part 2: Prior Authorization 3

Prior authorization Process 3
Prior Authorization – *Behavioral Health Services* 4

Part 3: Schedule of Benefits 5

Part 4: Definitions 10

Part 5: Covered Services 19

Part 6: General Exclusions 42

Section II Administrative Provisions **49**

Part 1: Eligibility, Enrollment, Effective Dates of Coverage 49
Eligibility 49
Enrollment 49
Effective Date of Coverage 49

Part 2: Termination, Extension of Benefits 50
Termination of Coverage 50
Benefits When Your Eligibility Terminates 50
Certificate of Creditable Coverage 51
Continuation 51

Part 3: Appeal and External Review **52**
Definitions 52
Authority as Claims Fiduciary 53
Appeal Procedures 53
Process for Submitting an Appeal 53
Procedure for Pursuing an External Review 54
Right to a Judicial Review 55

Part 4: Coordination of Benefits 56
Order of Benefit Determination Rules 56
Effect on the Benefits of this Plan 58
Coordination of Benefits with Medicare - Option 1 58
Coordination of Benefits with Medicare Active Employees
and Spouses Aged 65 and Older - Option 2 58
Coordination of Benefits for Retirees 59

Part 5: General Information 61

Part 6: Autism Rider 75

Part 7: Bariatric Rider 80

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 can change 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 informal language. The terms under which the State Employee Health Plan administers benefits are contained in this booklet. Carefully read this document.

When Your claims for any services are processed, You will receive an Explanation of Benefits (EOB) to help explain Your claim payment.

You Must Notify The 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 TPA

The TPA's Responsibility is limited. The TPA does not guarantee that any specific type of room or kind of service will be available. The TPA is obligated to provide benefits for the services 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 Abuse, or a Mental Illness does not mean that the procedure or treatment is covered. The Plan shall have the right, subject to Your rights in this Benefit Description, to interpret the benefits of the Benefit Description and other terms, conditions, limitations and exclusions set out in the Plan in making factual determinations related to the Plan, its benefits, and 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

Case Management will identify at risk Members with the specific Chronic Condition(s) and provide interventions approved by the case manager to maintain or improve the Member's health status to avoid complications from the chronic disease.

The program may include both Covered and Non Covered Services with the exception of specifically stated exclusions. The fact that the Case Management/Cost Effective Care program authorizes 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 such written approval for coverage is granted, payment for benefits under this policy for such services or supplies shall be on the same basis as if such services or supplies were Covered Services under the terms and provisions of this Benefits Description.

You are not required to accept an alternate treatment plan recommended by the case manager. The plan is not required to provide alternative treatment at your request.

If the TPA elects to provide benefits for a Member or their Dependents in one case, it shall not obligate the TPA to provide the same or similar benefits for the same or another Member in the same or another case.

HOW TO CONTACT THE PLAN

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.

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 in addition to any 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 may elect to continue with the Non Network Provider, understanding that claims 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 of the Plan, You are responsible for requesting it Prior Authorization is required for certain health care services as determined by TPA. Coverage is subject to eligibility and benefits at the time services are rendered. TPA has the right to request and obtain whatever 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 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 can be telephoned to the TPA at the telephone number on the Identification Card. Providers may contact the TPA for Prior Authorization. You, the Hospital and the admitting Physician will be notified of the decision.

If You fail to obtain a necessary Prior Authorization for an inpatient stay, the TPA will review that admission for Medical Necessity. No coverage will be provided for services determined by the TPA to be medically unnecessary. Only that portion of the Inpatient claim that would normally be payable if services were received as an Outpatient will be covered.

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 initiation of treatment. Please refer to the Autism Rider for specific qualifications and periodic evaluations.

The following services require prior authorization:

- All 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 office>$1,000 excluding cancer treatment.)
- Prosthetics greater than $1,000
- Repair or Replacement of Orthotic and/or Orthopedic Devices greater than $750
- Transplants except cornea and kidney

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 can be telephoned to the TPA at the telephone 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 abuse. Prior Authorization may be obtained by calling: 1-800-424-4047 twenty-four hours a day, 7 days a week.

Section I – Coverage

Part 3: Schedule of Benefits

State(s) of Issue: Kansas		
Plan: 2016 SEHP Plan C		
	When Receiving Services from Network Providers	**When Receiving Services from Non Network Providers**
Annual Plan Deductible Deductible does not apply to preventive care	$2,750 Single / $5,500 Family	$2,750 Single / $5,500 Family
Coinsurance For All Eligible Expenses (unless otherwise noted)	0% Coinsurance	20% Coinsurance
Annual Deductible and Coinsurance Maximum	$2,750 Single / $5,500 Family	$4,100 Single / $8,200 Family

Covered Services	**Cost to Members When Receiving Services from Network Providers**	**Cost to Members When Receiving Services from Non Network Providers**
PREVENTIVE CARE		
Age Appropriate Physical Exam and Routine Health Screening	**Limited to one visit or service per year unless otherwise noted**	
Well Baby Exams – Includes newborn screenings for: • Congenital hypothyroidism • Sickle cell disease • Gonococcal opthalmia neonatorum including topical medication for prevention • Phenylketonuria (PKU) • Hearing Check	**Covered in Full**	**Not Covered**
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**	**Not Covered**

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 Includes screenings for: • Prostate exam • Sexually Transmitted Infections (STI's) • HIV • High blood pressure • Cholesterol • Diabetes • Depression • Colorectal Cancer At the time of exam, counseling for: • Alcohol usage • Aspirin usage • Healthy diet • Obesity/Weight Management • Tobacco usage • STI's	**Covered in Full**	**Not Covered**
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**	**Not Covered**

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 • Bacteruria • 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) • RH Incompatibility • Gestational Diabetes testing after 24 weeks Counseling for: • Breastfeeding support • Breastfeeding supplies/rental	**Covered in Full**	**Not Covered**
Age Appropriate Bone Density Screening	Covered in Full	Not Covered
Colonoscopy Screenings (not limited to one) • Including polyp removal	Covered in Full	Not Covered
Contraception/Sterilization • Implantable/Injectable contraceptives • Sterilization procedures (vasectomy or tubal ligation)	Covered in Full Covered in Full	Not Covered Not Covered
Immunizations: • Under Age 18 • Over Age 18	Covered in Full Covered in Full	Covered in Full to Age 6, Otherwise Deductible plus 20% Coinsurance Not Covered
Mammography (not limited to one)	Covered in Full	Deductible plus 20% Coinsurance
Routine Hearing Exam	Covered in Full	Not Covered
Vision Exam	Covered in Full	Not Covered

Covered Services	Cost to Members When Receiving Services from Network Providers	Cost to Members When Receiving Services from Non Network Providers
Ultrasonography for Aortic Aneurysm • Men Age 65 to 75 • History of Tobacco use • Once per Lifetime	Covered in Full	Not Covered
MEDICAL TREATMENT		
Inpatient Services Services must be pre-approved by health plan	Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance
Outpatient Services	Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance
Office Visits – • Primary Care Provider Office Visits • Specialist Office Visits • Urgent Care Center	Deductible plus 0% Coinsurance Deductible plus 0% Coinsurance Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance Deductible plus 20% Coinsurance Deductible plus 20% Coinsurance
Allergy Testing	Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance
Allergy Shot & Antigen Administration Desensitization/Treatment	Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance
Ambulance/Emergency Transportation Ground or Air	Deductible plus 0% Coinsurance	Deductible plus 0% Coinsurance
Autism Services	See Separate Rider	See Separate Rider
Dietician Consultation	Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance
Durable Medical Equipment (DME) Any charges exceeding $750 require pre-approval by health plan	Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance
Durable Medical Equipment (DME) Repairs Any charges exceeding $750 require pre-approval by health plan	Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance

Covered Services	Cost to Members When Receiving Services from Network Providers	Cost to Members When Receiving Services from Non Network Providers
Emergency Room Services	Deductible plus 0% Coinsurance	Deductible plus 0% Coinsurance
Formula & Low Protein Modified Foods for PKU & Amino Acid Disease Limited to $5,000 per calendar year	Deductible plus 0% Coinsurance	Deductible plus 0% Coinsurance
Home Health Care Services must be pre-approved by health plan	Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance
Hospice Care Services must be pre-approved by health plan Inpatient Hospice care limited to 6 months	Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance
Major Diagnostic Testing (Includes but is not limited to PET Scans, CT Scans, Nuclear Cardiology Studies, MRI Computerized Topography/Angiography)	Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance
Spinal Manipulation Therapies Limited to 30 visits per year	Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance
Mental Health and Substance Abuse • Inpatient Services • Outpatient Services • Office Visits • Group Therapy Sessions	Same as Medical	Same as Medical
Outpatient Laboratory Services	Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance
Outpatient Surgery Surgery/Anesthesia/Assistant Surgeon	Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance
Prosthetic Devices Any charges exceeding $1,000 require pre-approval by health plan	Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance
Rehabilitation Services		
• Inpatient Facility Services	Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance
• Outpatient Facility Services	Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance
• Office Services	Deductible plus 0% Coinsurance	Deductible plus 20% Coinsurance

Network and Non Network out of pocket accumulate separately.

Section I - Coverage

Part 4: Definitions

Administrative Service Contract: The written agreement entered into by the Group and the Third Party Administrator 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.

Administrator: The party financially responsible for the payments from the Plan.

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. The term shall include denial for a benefit resulting from the application of any utilization review resulting in a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental, Investigational or not Medically Necessary.

Alcohol, Chemical, Drug or Substance Abuse: The psychological or physiological dependence upon and/or abuse of alcohol, chemical(s), drug(s) or substance(s), characterized by withdrawal and impairment of functioning or both.

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

Alternate Recipient: means any child of a Member who is recognized by the plan 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 Agreement and/or 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 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 of a service request or benefit that You believe You are entitled to receive.

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

Authorization/Prior Authorization: The Plan 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 yearly.

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

Certificate of Creditable Coverage: The certificate that documents the individual's Creditable Coverage. Under the terms of HIPAA, the written certification must be furnished automatically to individuals when normal Coverage terminates and again when Coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) terminates. A certificate must also be furnished upon written request made within 24 months after the Plan Coverage terminates.

Claim for Benefits or Claim(s): A request for payment of 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 this Benefit Description. 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 payable by You usually based on a percentage of the Allowed Amount for Covered Services under the terms of the Benefit Description.

Confinement and Confined: An uninterrupted stay following formal admission to a Hospital or approved alternative facility or Participating Skilled Nursing Facility.

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 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, 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 an institutionalized Member 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 which 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.

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.

Covered Member: A Member covered under the Benefit Description.

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

Credible Evidence: Means only published reports and articles in the 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 claims were processed.

Deductible: The amount of Allowable Charges for Covered Services to be paid by a Member before benefits can be provided for a Covered Service. 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 for the remainder of that Calendar Year.

Dependent: A covered spouse or child of a Member.

Durable Medical Equipment(DME): Medical equipment covered under 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.

Emergency Medical Condition or Medical Emergency: The sudden, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required. An emergency medical condition means that a delay in receiving care could seriously jeopardize the life or

health of the Covered Member or, in the opinion of a Physician with knowledge of the Covered Member's condition, would subject the Covered Member to severe pain that could not be adequately managed without care or treatment. Examples of Emergency Medical Conditions include but are not limited to, heart attacks, cerebrovascular accidents, 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 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.
- Creditable evidence shall mean only published reports and articles in the authoritative medical and scientific literature.

Expedited Appeal: Means an Appeal that may be requested either orally or in writing 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.

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.

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

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 or Medical Care Facility.

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 are considered appropriate.

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 are 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 for medical coverage.

Members: is the Member and his or her covered Dependents

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 if enrolling 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.

Open Enrollment Period: means a period, defined by the Group, during which the Member may enroll in the Plan and 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 or a Physician's office.

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 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 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 a valid claim exists.

Provider:

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

- Rehabilitation Centers/Facilities, and
- Swing Bed units of a hospital.

- ***Network Provider*** means a Professional or Institutional provider that has entered into a written agreement with the TPA's PPO Network 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:
  - general practice,
  - family practice,
  - internal medicine,
  - pediatrics,
  - geriatrics,
  - Physician Assistants
  - Advance Practice Registered Nurse (ARNP)

  Note: Physician extenders (physician assistants and advance practice registered nurse) are treated as PCPs regardless of the specialty of the physician for whom they work.

- ***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 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 on the opposite breast to restore symmetry and Prosthetic Devices/implants or reduction mammoplasty; and reconstructive surgery for a covered newborn.

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.

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.

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.

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 set forth in this section. (See the Prior Authorization List for services requiring Prior Authorization.)

Ambulance Services: Coverage is provided for licensed air or ground ambulance following a Medical emergency when transport by other means is not medically safe. 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 safe and to the nearest appropriate place of treatment. In no instance shall 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 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 Expense Program).

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: Coverage will be provided for all routine patient care costs associated with the provision of healthcare services, including drugs, items, devices, treatments, diagnostics, and services that would otherwise be covered if those drugs, items, devices, treatments, diagnostics and services were not provided in connection with an approved clinical trial program for Cancer or other Diagnoses that are life threatening or severely and chronically disabling that have failed to respond with conventional treatments. Services covered will include those health care services typically provided to patients not participating in a clinical trial. Prior Authorization with the TPA is recommended prior to beginning treatment under a clinical trial for diagnoses other than Cancer.

Routine patient care costs shall not include the costs associated with the provision of any of the following:

- Drugs or devices that have not been approved by the federal food and drug administration and that are associated with the clinical trial;
- Services other than healthcare services, including travel, housing, companion expenses, and other nonclinical expenses, that a Member could require as a result of the treatment being provided for purposes of the clinical trial;
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient;
- Healthcare services that, except for the fact that they are being provided in a clinical trial are otherwise specifically excluded from coverage under the policy or certificate; or
- Healthcare services customarily provided by the research sponsors of a trial free of charge for any insured in the trial.

Coverage for routine patient care costs for persons is available when the following conditions are met:

- The Member has been diagnosed with cancer or other qualifying condition and accepted into a phase I, phase II, phase III or phase IV clinical trial.
- The treating physician who is providing covered health care services to the Member recommends participating in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Member.
- The drug, device, medical treatment or procedure is not excluded by another provision of this Benefits Description. Coverage is not available for drugs and biologicals that are available under the prescription drug program sponsored by the State Employee Health Plan.

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 sound natural teeth should be processed by the dental coverage. Services covered by the State Employee Health Plan dental coverage are not eligible for additional payment by the medical coverage.

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. To include 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 without dollar limitation when deemed Medically Necessary and purchased from a Network 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 State Employee Health Plan prescription benefit.

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 their symptoms and is appropriate for home use.
- Generally not useful to a person in the absence of an illness, injury or their 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 only for the basic piece of equipment. Prior authorization is required for DME purchases that exceed $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 patient comfort or convenience, and determined by the TPA to be not 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 medical criteria and guidelines. The determination of rental or purchase will be made 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 is in excess 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 a 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 includes batteries and repairs required to keep the device operational.

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

Exclusions (even if the above criteria are met):

- 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.
- Devises 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. Adequate nutrients must not be possible by dietary adjustment and/or oral supplements.

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

Exclusions (even if the above criteria are met):

- 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.
- Consumable medical supplies administered or used in the course of Home Health Services.

Eating Disorders: See Mental Health Services Benefit.

Emergency Services the Plan will 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.

Eye Glasses And Corrective Lenses: the initial purchase of glasses or contact lenses is covered to a maximum of $150 per surgery to a benefit period maximum of $300 for cataracts, aphakia, pseudophakia, or corneal transplant.

- An Insured under 12 years of age is eligible to receive benefits for the initial eyeglasses/contacts following surgery as well as subsequent eyeglasses/contacts until they reach the age of 12 years. Coverage is limited to three pair of lenses or frames per calendar year with a $150.00 maximum per pair.

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:

- Genetic testing when performed primarily for routine screening purposes.
- Genetic testing when performed primarily for the medical management of other family Members who are not covered under the Plan.
- Genetic testing when performed primarily for purposes of embryonic pre-selection.
- Genetic testing performed when there is already a child within the immediate family that has been diagnosed with the same inheritable disease.
- Genetic testing performed when one parent has previously been determined to be a carrier of the same inheritable disease.

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: Coverage is provided for one hearing screening per Member per Calendar Year to determine hearing loss.

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 or other Facility;
- The service is ordered by a Physician;
- Services required are of a type which can only be performed 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 licensed occupational therapist
    - 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:

- Services provided by a member of your immediate family;
- Services provided by a person who normally lives in the 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, and
- Educational services.

Limitation: Inpatient Hospice Care is limited to six (6) months.

Immunizations: See Preventive Services.

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

Covered Services by a Hospital or Facility 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 Federal Food and Drug Administration 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 a necessary Prior Authorization, the TPA will review the admission for Medical Necessity. No coverage will be provided for services determined by the TPA to be medically unnecessary. Only that portion of the Inpatient claim that would normally be payable if services were received as an Outpatient will be covered.

Limitations: Coverage may include semi-private accommodations and associated professional and ancillary services in a licensed Skilled Nursing Facility if the patient meets the criteria for inpatient coverage in an acute care or rehabilitation facility. Care must be prior authorized. Skilled nursing care is for medical care and treatment and must be medically necessary and appropriate. Skilled Nursing care would not include care which is primarily custodial in nature to assist with the activities of daily living.

Exclusion: 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 as 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 Medical Necessity is supported when the claim is adjudicated.

Exclusion: Injectable medications covered under the State Employee Health Plan prescription drug benefit.

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 be covered at 100%. All other laboratory services are subject to deductible and coinsurance.

Manipulative Therapies: Spinal manipulation services rendered in the office setting outpatient basis are covered as Medically Necessary and significant improvement is shown 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. 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 a cesarean section after delivery. If the period is shortened, it must be agreed upon between you and your Provider. 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.

Your attendance at a child birth 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. A reimbursement form and proof of payment and class completion must be submitted to the TPA. A maximum of $30.00 per family unit will be paid by the TPA per pregnancy.

Exclusions:

- 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 or as an Inpatient in a Skilled Nursing Facility.
- 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 or Medical Care Facility (including those services provided for a condition included in the definition of Mental Illness)
- Visits by the attending Doctor.

Limitations:

- o During a hospital stay, if treatment is provided by two (2) or more providers for the same diagnosis only one (1) provider will be paid unless medical necessity is documented.
- o 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.

Exclusions:

- o 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 conditions. Inpatient care must be pre-approved. 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.

Exclusions:

- o Residential care for treatment of mental health, eating disorders or alcohol/substance abuse is not covered.

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.

Obesity Services: Coverage is provided for nutritional counseling, physician office visits and appropriate lab work when for the purposes of treating obesity. 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 or change in condition or routine wear and tear. Orthotics or Orthopedic Devices will be replaced for documented growth in a Dependent child requiring 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. Repairs of Orthotic or Orthopedic Devices in excess of $750 require Prior Authorization of 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 or other 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 provider's office where surgery is completed.

PKU or any other Amino and Organic Acid Inherited Disease Formula/Food: for formula used for PKU or any other amino and organic acid inherited disease that is recommended by a Network Provider as determined by the Plan to be Medically Necessary. See schedule of benefits for the maximum per member per calendar year.

Preventive Services: Preventive services when received from a Network Provider are covered in full. Claims submitted with a diagnosis of anything other than preventive are subject to the appropriate copay, deductible and coinsurance. Services will include:

Prenatal Services:

- Initial screenings for:
  - Hepatitis B
  - Bacteruria
  - 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)

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 opthalmia 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
- Implantable/Injectable contraceptives,
- Sterilization procedures (vasectomy or 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.

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

- Colonoscopy for colorectal cancer screening, including the anesthesia that would be needed for a colonoscopy.
- Polyp removal during a colonoscopy
- 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 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 devises 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 a Dependent child. The determination of whether to repair or replace a Prosthetic Device will be made by the TPA. Repairs of Prosthetic Devices in excess of $750 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 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 of 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 medical information it considers needed to determine whether benefits should be approved or not.

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

Exclusions: Benefits are not provided for:

- services of sleep laboratories for nocturnal penile tumescence testing,
- services eligible for coverage under a Prescription Drug Expense Program, or
- prescription drugs or medications used by the Covered Member at home.

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 whose program has been approved by the TPA.

In addition to the above, the TPA may approve the payment of benefits for Rehabilitation Services that are received in an institution other than a Hospital.

In order to obtain benefits for Cardiac and Pulmonary therapy services, You or Your Provider must contact the TPA prior to receipt of such services. The prior approval is for cardiac and pulmonary rehab. The TPA has the right to request and obtain whatever information it considers necessary to determine the appropriateness of such services. Such information may include, but not be limited to, the condition of the Member for whom treatment is being requested, data indicating the charging practices of the facility in which treatment is being contemplated, and a written report of the recommended measurable treatment, goals and expected outcomes. This information must be received by the TPA before services are rendered. If such services are deemed appropriate by the TPA, the TPA will notify You, the facility and the admitting physician of approval.

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 TPA will be entirely responsible for the costs associated with such a second opinion

Exclusions:

- 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 of 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 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.

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:

- 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 of surrogate motherhood;
- Any experimental procedure; and
- Office visits, laboratory, x-ray and other testing associated with any Non-Covered Service.

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.

Substance Abuse: The Plan provides treatment for Alcohol, Chemical, Drug and Substance Abuse Coverage the same as for medical conditions. Inpatient care must be pre-approved. Both inpatient and outpatient care are subject to medical necessity and appropriateness guidelines. The TPA contracts with an outside vendor to coordinate and determine Medical Necessity of the diagnosis and treatment of all Substance Abuse. If You have any questions about Your Substance Abuse Coverage, the appropriate way to access Coverage, or how to prior authorize care for Substance Abuse, you must contact the contracted vendor.

The vendor's name and telephone number are listed on the back of Your ID card.

Exclusions: Residential care for treatment of mental health, eating disorders or alcohol/substance abuse is not covered.

Tobacco Cessation: the plan provides coverage for office visits for tobacco cessation and treatment of nicotine addiction.

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 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 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:

- 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. Please see the Preventive section regarding routine eye exams. Please also see the Exclusions Section regarding vision care that is specifically denied under the Plan.

Section 1 - Coverage

Part 6: General Exclusions

The following items are excluded from Coverage:

Abortions: except in those situations 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 surgery.
- fetal cord blood harvesting and storage.
- payment to donors of blood
- 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 diagnostic testing
- Therapeutic Touch
- Vision Therapy
- Wilderness Therapy

Charges for completion of forms

Communication devices: Designed and used for enhancing or enabling communication except for an electro larynx.

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 by this policy. (See definitions section.)

- Male Gynecomastia - Those services and associated expenses for treatment of male gynecomastia.
- 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 benefits sections of this Benefit Description.

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 stated otherwise in the covered Health 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 provide 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
- Communication devices designed and used for enhancing or enabling communication except for an electrolarnynx

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 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 military service connected disabilities 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 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 this Benefit Description as primary 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 stated otherwise in the Covered Health Services section or treatment not specifically provided herein.

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 Provider through misrepresentation of material fact or fraud.

Ineligible Providers: Services received from providers not defined as eligible for coverage.

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, 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 subject of or related to that settlement.

Newborn: Medical and Hospital care and costs for the infant child of a Dependent once the mother has been discharged, unless this infant child is otherwise eligible under this Benefit Description..

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 Abuse 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 provider's being Non-Network is 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 described in this Benefit Description.

Note: If You fail to obtain a necessary Prior Authorization, the TPA will review that admission for Medical Necessity. No coverage will be provided for services determined by the TPA to be medically unnecessary. Only that portion of the Inpatient claim that would normally be payable if services were received as an Outpatient will be covered.

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, Room and board charges in a Swingbed situation once the patient is no longer receiving acute care. 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 Agreement, but rendered after the date Coverage under the benefit description terminates, including services for medical conditions arising prior to the date individual Coverage under this benefit description terminates; and Eligible Expenses - Any otherwise Eligible Expenses that exceed the maximum allowance or benefit limit.

Prescription Drugs: All prescription drugs, nonprescription drugs and Investigational and Experimental drugs except as described as covered 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 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 are. Residential Care is not a covered benefit. Residential level of care for treatment of mental health, eating disorders or alcohol/substance abuse is not covered.

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 drugs will not be able to be also ran thru your Pharmacy reimbursement on that same drug to provide more payment by the carrier for that same service.

Routine Foot Care: including the paring and removing 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 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 providers 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 may have been paid for by the member, or by another health plan. However, if the service is not a

covered service 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.

Sex Transformation/Sexual Orientation Services: Services and associated expenses for sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation including any treatment or studies related to sex transformation. Also excluded is hormonal support for sex transformation services or supplies provided directly for or relative to sex changes, sexual dysfunctions or inadequacies. All related complications are also excluded. (See Basic Benefits for exception for penile prosthesis and other Covered Services required for physiological [not psychological] impotence.)

Speech therapy: or voice training when prescribed for stuttering, hoarseness or delays in learning, motor skills, communication or developmental delay. Communication devices designed and used for enhancing or enabling communication except for an electrolarynx.

Surrogate Mother: Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of 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 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 section of this Benefit Description. Wigs, hairpieces and hair prostheses and hair styling, including those ordered by a provider, are not covered. Unless provided for in the 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 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 for participation in the health benefit program.
- Dependent
  - To be eligible to enroll as a Dependent, an individual must:
    - Meet and continue to meet all eligibility requirements for participation in the health benefit program.

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 should notify the Administrator of the plan in writing of the Dependent's name, date of birth, gender and relationship to the Member and the Dependent's social security number.
  - Notification must be made according to the enrollment requirements established by the Administrator.
  - It is required that each Member be recorded on the records for benefits. Claims for Dependents not on record 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 this qualifies as an Order by the Administrator.
    - Medical Child Support Orders must be qualified pursuant to specifications of Federal and state law.
    - The procedure for qualification is to timely submit the Medical Child Support Order for initial qualification or rejection.
    - The Administrator will forward the Order to the TPA for an Identification Card, Benefit Description and claim form to be issued to the Alternate Recipient.

EFFECTIVE DATE OF COVERAGE

Coverage of a Member or a Dependent shall become effective at 12:01 a.m. on the first day of compliance with the eligibility requirements and subject to applicable payment. If a Member or a 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 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 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 this Program.
- 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.
- Dependent Children who no longer meet the requirements of an eligible Dependent.
- If a Member permits the use of their or any other Member's Identification Card by any other person or uses another Member's card, all rights of the Member may be terminated effective immediately upon written notice.
- If a Member fails to disclose information requested by TPA or misrepresents information provided to 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 terminated effective immediately 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.

When a Member is determined to be ineligible for coverage, all rights of the Member may be terminated effective immediately upon written notice and coverage may be retroactively cancelled effective the first day of the month following the date on which the Member became ineligible for coverage. At the effective date of such termination, prepayments received on account of such terminated Insured applicable to periods after the effective date of termination shall be refunded.

BENEFITS WHEN YOUR ELIGIBILITY TERMINATES

Coverage under 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 person'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 termination date of the 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 Deductible and Coinsurance and maximum benefit limitations applicable to 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

COBRA is a federal law which permits persons to continue coverage under an employer group health plan. 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 third party administrator (in the case of a self-funded arrangement), the right to continuation 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.

USERRA Continuation Coverage - Federal Law

If you leave your job to perform military service, you have the right under the Uniformed Services Employment and Reemployment Rights Act (USERRA) to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g. pre-existing conditions exclusions) except for service-connected illnesses or injuries.

Section II – Administrative Provisions

Part 3: Appeal and External Review

Benefits are paid under this plan only if the services provided are Medically Necessary and are Covered Services under this Agreement. If You wish to appeal an Adverse Benefit Decision of the Third Party Administrator (TPA)

You may do so by submitting a written Appeal to the TPA.

Contact Information for the TPA is:

By phone: 1-866-851-0754

By facsimile: 1-859-425-3379

By mail: Aetna

Attn: National Accounts CRT

P.O. Box 14463

Lexington, KY 40512

DEFINITIONS:

- **Claim Eligible for External Review:** In cases other than an Emergency Medical Condition, a Claim for a proposed or delivered Health Care Service which would otherwise be covered under this Benefit Description but for which the Covered Member has received an Adverse Benefit Determination indicating a denial due to the fact that the service is not or was not Medically Necessary, or the health care treatment has been determined by the TPA to be Experimental or Investigational, and the denial leaves the Covered Member with a financial obligation or prevents the Covered Member from receiving the requested services. In the case of an Emergency Medical Condition, external review would look at a Claim for which an initial Adverse Benefit Decision by the TPA that a proposed health care service, which would otherwise be covered under this Benefit Description, is not Medically Necessary or the health care treatment has been determined by the TPA to be Experimental or Investigational and the denial would leave the Covered Member with a financial obligation or prevent the Covered Member from receiving the requested service.

- **External Review:** The review of an Adverse Benefit Decision by an external review organization, which conducts independent External Reviews of Adverse Benefit Decisions pursuant to a contract with the Kansas Insurance Department. External Review is limited to claims denied for Experimental, Investigational treatment or not medically necessary.

- **Medical Necessity Appeal:** Review that is based in whole or in part on a medical judgment that includes an admission, availability of care, continued stay or other service which has been reviewed and, based on the information provided, does not meet the Benefit Description's requirements for medical

necessity, appropriateness, health care setting, level of care or effectiveness, and payment for the service is denied, reduced or terminated.

- **Pre-Service Appeal:** An appeal for which an Adverse Benefit Determination has been rendered for a service that has not yet been provided and which requires Prior Authorization.

- **Pre-Service Claim:** A request for a Claims decision when Prior Authorization of the Covered Service is required by the TPA, unless the Claim involves Urgent Care. Requests for advance information of the TPA's possible coverage of items or services or advance approval of Covered Services where such approval is not required by this Benefits Description do not constitute Pre-Service Claims unless the Covered Member requests the name of a Network Provider and there is not a provider in the network who can perform the requested service. For example, if a Covered Member requests advance approval of a service and the Network cannot offer the Covered Member the name of one or more network providers who could perform the service, such inquiry would be considered a Pre-Service Claim.

- **Urgent Care Appeal:** An Appeal for which a requested service requires prior authorization, an Adverse Benefit Determination has been rendered, the requested service has not been provided, and the application of non-urgent care Appeal time frames could seriously jeopardize: (a) the life or health of the Member or the Member's unborn child; or (b) the Member's ability to regain maximum function. In determining whether an Appeal involves urgent care, the TPA should apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

AUTHORITY AS CLAIMS FIDUCIARY:

TPA shall serve as the claims fiduciary with respect to pre-authorization review of Claims arising under the Plan, first-level review of appeals of Pre-Service Claims, and review of Post-Service Claims. TPA shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties. TPA is not responsible for the conduct of any Medical Necessity review of covered services performed by an Independent Review Organization (IRO)

APPEAL PROCEDURES:

This section outlines the procedures applicable to Claims decisions and Appeal decisions for Urgent Care Claims, Pre-Service Claims, and Post-Service Claims. In order to be eligible for an appeal the recommended treatment has to be listed as a covered service within the benefit description. It is the policy of the TPA to provide Covered Members a full and fair review of Claims and Appeal decisions.

PROCESS FOR SUBMITTING AN APPEAL:

If the covered member is not satisfied with the outcome of a claim, a first level of appeal can be requested in writing. The covered member should notify the TPA of a request to

file an appeal within a reasonable amount of time following the initial Adverse Benefit Determination but in no event later than 180 days following the receipt of notice. Please include any additional information, medical records or correspondence from the physician to appeal the claim.

A Covered Member or the Covered Member's Authorized Representative has the right to obtain, without charge, copies of the documents relating to the Adverse Benefit Decision and may Appeal an Adverse Benefit Decision from an initial Claims decision by contacting the TPA.

If the Covered Member believes his or her health would be seriously harmed by waiting for a decision on a Pre-Service Claim he or she may make an oral request for an Expedited Appeal by calling Member Services at toll free phone number above. For an Urgent Care Pre-Service Claim, the TPA will respond within 72 hours of receipt of the appeal request. For other Pre-Service Claims, the TPA will respond within 15-days of the receipt of the appeal request. For Post-Service Claims, the TPA will respond within 30-days of the receipt of the appeal request.

There are times when additional information is required to review the claim in question. This will extend the period of time the TPA has to complete the review. The TPA will request the necessary information from the physician or member as appropriate. Requested information must be received within 45-days or the appeal will be processed based upon information that the TPA has at the time of review. This may result in a denial or partial denial of the claim.

Appeals should include:

- The Covered Member's name and ID number.
- Specific information relating to and reason for the Appeal.
- The Covered Member's expectation for resolution.
- Copies of medical records or other documentation that the Covered Member wishes to be considered in the Appeal.

The appeals process will be handled by individuals not involved in a previous determination. Appeals involving clinical issues will be reviewed by a practitioner in the same or a similar specialty that typically manages the medical condition, procedure or treatment in question. If time permits, the Covered Member may at the TPA's option be referred for a second opinion.

The Member has a right to receive from the TPA, upon request without charge, copies of all documents, records and other information that are not confidential or privileged relevant to the Insured's request for benefits.

PROCEDURE FOR PURSUING AN EXTERNAL REVIEW:

The Covered Member has the right to request an External Review when the reason for the final Adverse Benefit Decision was that the service was not medically necessary or was experimental or investigational. The TPA will notify the Covered Member in writing regarding a final Adverse Benefit Decision and of the opportunity to request an External Review.

Within 120 days of receipt of the notice of the final Adverse Benefit Decision on the initial Appeal, the Covered Member, the treating Physician or health care provider acting on behalf of the Covered Member with written authorization from the Covered Member, or a legally authorized designee of the Covered Member must make a written request for an External Review to the State Employee Health Plan, 900 SW Jackson, Rm. 900 N, Topeka, Kansas 66612. The State Employee Health Plan will work with the Kansas Insurance Department to obtain an external review.

Within 10 business days of receipt of such request (immediately, when the request for External Review involves an Emergency Medical Condition), the Kansas Insurance Department will notify the Covered Member and other involved parties as to whether the request for External Review is granted.

For those requests that qualify for External Review, the External Review Organization will issue a written decision to the Covered Member and the Kansas Insurance Department within 30 days. The External Review Organization will issue its written decision within 7 business days after receipt of said request when the request for External Review involves an Emergency Medical Condition. If any party is not satisfied with the decision of the External Review organization, they may pursue normal remedies of law.

The right to External Review shall not be construed to change the terms of coverage under this Benefit Description. In no event shall more than one External Review be available for any claim or claims arising from the same illness/injury. A Covered Member may not pursue, either concurrently or sequentially, an External Review under both state and federal law.

RIGHT TO A JUDICIAL REVIEW:

After you have pursued the appeals process of an Adverse Benefit Decision, you have the right to pursue an action in federal or state court, even if you do not request External Review. In all events, such action or proceeding must be commenced no later than five (5) years after the date from the time written proof of loss is required to be given.

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."

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 the total allowable expense.

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 regulation is always primary. There is one (1) exception: coverage that is obtained by virtue of Membership in a group that is designed to supplement a part of a basic package of benefits. Examples of these types of situations 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 provided 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 to use.

1) **Non-Dependent or Dependent**
   The plan that covers the person other than as a dependent, for example as an employee, Member, subscriber 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.

2) **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.

3) 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.

4) Continuation Coverage

If a person whose coverage is provided under a right of continuation 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 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.

5) 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 its contract,
- 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. This Benefit Description will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid.

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

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 we determine through some other means that we are 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 in this Agreement 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 this Agreement 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 Agreement. 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 Agreement. 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 Agreement, the Plan 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 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 provider of service. 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 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 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 is needed in order to process Your claim. You have 90 days from the date this information is requested to furnish this additional information. If the additional information is not received by the TPA within 90 days from the timely filing period, the claim will be denied.

Adjustment of Claim: After 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 claims that have involved fraudulent billing. Please note this includes audits of the State Employee Health Plan and/or the Third Party Administrator. It does not include audits done by third parties, such as Medicare, on their own claims.

Enrollment Automatically Renews Each Year: For all members who had coverage during the last plan year, please be advised that if you do not actively select or de-select coverage during the Open Enrollment period, your coverage as it existed during the last plan year will continue into the new plan year and you will not be able to make any changes without a qualifying event.

Legal Actions: No legal action may be brought to recover on this Benefit Description within 60 days after written proof of loss has been given as required by this Benefit Description. No such 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 fraudulent claims.

Fraudulent, Gross Misbehavior or Misrepresentation: You and Your dependent's coverage may be terminated and other appropriate action taken as determined by the Plan Sponsor if You or Your dependents participate in any act that constitutes fraud, gross misbehavior, misrepresentation or omission of pertinent facts in applying for or seeking benefits under the Plan. This shall also include other improper action as determined by the Plan Sponsor. This includes but is not limited to:

- Misrepresentation or omission of material facts to obtain coverage or allowing unauthorized persons use of Your State Employee Health 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 which You are not otherwise entitled to receive. In this instance, Coverage for You and/or any covered dependent(s) may be terminated by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor may be taken.
- Permitting the unauthorized use of Your State Employee Health Plan identification card(s) to obtain health care services or supplies for someone not covered under Your State of Kansas health membership. In this instance, Coverage of the member and/or dependent(s) may be terminated by the Plan

Sponsor and any other action determined appropriate by the Plan Sponsor may be taken.

- Using another State Employee Health Plan member's identification card(s) to obtain health care services, medication or supplies for Your or some other third party not specifically covered under that membership may result in the termination of your coverage and that of your dependents by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor.

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

Benefits Payable: Claims will be paid to the 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 of 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 Benefit Description are made, new Benefit Descriptions or riders or amendments will also be issued.

Written Proof of Loss: It is required that written proof of the loss be provided to the TPA to be paid.

Claim Form: If you are in need of a claim form it will be provided to you by contacting the TPA.

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 Covered Person 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

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 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 provider obtain authorization from the Plan or the Claims Administrator 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 explanation of these rights and practices. The Notice of Privacy Practices for the Kansas State Employees Health 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?
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 agreement. 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 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 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 who do these things for us. The SEHP or a business associate on behalf of the plan tells your providers whether you are eligible for coverage, the types of services covered, or what percentage of the bill will be paid by the SEHP.

- **To operate our business.** We use and disclose your PHI to operate our health 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. Before we share PHI with other organizations, they must agree to keep your PHI private.

- **To meet legal requirements.** We share 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 share PHI.

- **To report public health activities.** We share PHI with government officials that collect public health information, or conduct public health investigations, surveillance, or interventions. For example, we share PHI about births, deaths, and some diseases with local and state health departments.

- **For health oversight activities.** We share 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 provide PHI to law enforcement or people who may be able to stop or lessen the harm.

- **For workers' compensation purposes**. We share 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 give 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 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 agreement. 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 Privacy 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.

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 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.
- Stating confidentiality and 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 our 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 give out 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 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 Privacy 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. You may be assessed reasonable charges to comply with your request, which must be paid in advance. Send your request to the SEHP Privacy 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 Privacy 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 you will include:

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

The list will not include:

a) Disclosures we made so you could get treatment;
b) Disclosures we made so we could receive payment for your treatment;
c) Disclosures we made in order to operate our business;
d) Disclosures made directly to you or to people you designated;
e) Disclosures made for national security or intelligence purposes;
f) Disclosures made to corrections or law enforcement personnel;
g) Disclosures we made before we sent you this message;
h) Disclosures we made when we had your written permission; or
i) 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 in advance that we will charge. To make this request, write to the SEHP Privacy 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 Privacy 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 can 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:

1. Already correct and complete;
2. Not created by us;
3. Not allowed to be disclosed; or
4. 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 give it out in the future. You can send this request in writing to the SEHP Privacy 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 785-291-3951 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 Privacy 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 also 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 January 31, 2014. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/	

Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid	MONTANA – Medicaid
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	NEBRASKA – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	NEVADA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392
MAINE – Medicaid	

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	VERMONT– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	WASHINGTON – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiu

	mpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2014, 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/ebsa www.cms.hhs.gov
1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565
OMB Control Number 1210-0137 (expires 10/31/2016)

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 Benefit Description apply to benefits outlined in this Autism Rider, including deductibles, copays, coinsurance, 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 Specialist means a person who:

- Has at least a master's degree in human services or education or fully Board Certified Behavior Analysis; and
- Maintains all standards, certifications, and licenses required for their specific Professional field; and
- Has successfully completed the state approved curriculum and passed the test with a score of at least 80%; and
- Has 2,000 hours of supervised experience working with a child with an Autism Spectrum Disorder; and
- Has successfully passed a background check with the Kansas Bureau of Investigation (KBI), or Adult Protective Services (APS), or Child Protective Services (CPS), or Kansas Department of Health and Environment (KDHE), or the Kansas Nurse Aid Registry, and the Motor Vehicle screen; and
- Is a Medicaid Enrolled Provider

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

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

Intensive Individual Service Provider means a person who:

- Has at least a bachelor's degree in human services or education; and
- Maintains all standards, certifications, and licenses required for their specific license/certification; and
- Has successfully completed the state approved curriculum and passed the test with a score of at least 80%; and
- Has 1,000 hours of supervised experience working with a child with an Autism Spectrum Disorder; and
- Has successfully passed a background check with the Kansas Bureau of Investigation (KBI), or Adult Protective Services (APS), or Child Protective Services (CPS), or Kansas Department of Health and Environment (KDHE), or the Kansas Nurse Aid Registry, and the Motor Vehicle screen; and

- Adheres to the DBHS/CSS training and professional development requirements; and
- Is a Medicare Eligible Provider for intensive individual supports; and
- Works under the direction and supervision of an Autism Specialist.

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 provider. Statistically significant improvement in the stated goals and objectives of treatment must be achieved to authorize continued treatment. A Vineland II Survey will be required on at least every six (6) months. An annual IQ test is optional.

Significant Improvement - 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 BCBA 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 a provider or group of providers and signed by both the 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 six (6) months to establish improvement.

Covered Services for Network and Non Network Applied Behavior Analysis combined is limited. The number of hours of Applied Behavioral Analysis available:

A) For patients with an initial date of diagnosis of autism spectrum disorder prior to age 5, beginning with the initial diagnosis date, patients are eligible for 1,300 hours of Applied Behavior Analysis per calendar year for four (4) years. The time period runs from the date of diagnosis regardless of whether or not the member was covered under this plan at the time.

   Or

B) 1,300 hours of Applied Behavior Analysis up to the age 7, whichever provides the greater benefit to the patient.

C) Except as provided above in A)., for children between age 7 but less than 19 years of age, Applied Behavior Analysis (ABA) is limited to 520 hours per calendar year.

   All services are subject to the applicable deductible, coinsurance and copay arrangements of the health plan. ABA services beyond the maximum benefit limit must be prior-approved by the Plan Administrator and medically necessary. Except for the limit on ABA services, other covered services provided for the medically necessary treatment of autism are covered. Providers will be reimbursed based upon network status.

All health claims with a diagnosis of Autism Spectrum Disorder will be subject to the limitations stated above.

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 Plan Administrator 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 health 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:

- Respite care
- Vocational rehabilitation
- Residential care
- Transportation
- Animal based therapy programs
- Hydro Therapy
- Camps
- Vitamin Therapy
- Programs and/or services administered within the Public, Private or Home School
- Vocational or Job training programs
- Services provided by relatives

Section II – Administrative Provisions

Part 8: Bariatric Rider

This rider outlines the coverage provided for treatment of Bariatric services for members over the age of Eighteen (18). Unless otherwise specified all other provisions of the Benefit Description apply to benefits outlined in this Bariatric Rider, including deductibles, copays, coinsurance requirements, 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 and Copayment requirements outlined in the Schedule of Benefits of the Benefit Description to which this rider is attached.

You must meet all of the criteria 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 be prior authorized by the Plan.

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

- 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 Plan. You will be required to continue working with the Plan care manager for at least six (6) months post operatively to provide you with support for 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 are only covered when performed at facilities that are: (1) certified by the American College of Surgeons as a Level 1 Bariatric Surgery Center (program standards and requirements in effect on February 15, 2006); or (2) certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (program standards and requirements in effect on February 15, 2006). A list of approved facilities and their approval dates are listed and maintained at: www.mbsaqip.org/?page_id=56. You will also need to review the Network of the Plan to make sure that the provider of services is in the Network of your Plan. Using a Non Network provider will result in greater out of pocket cost for You.

Surgical Revisions:

Surgical revision of a bariatric surgery must be prior approved by the Plan. 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 one of the following medical necessity criteria must be met:

1. Conversion to a 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) two (2) years following the primary bariatric surgery procedure and the member has been compliant with the prescribed diet and exercise program.
2. Revision is required due to dilation of the gastric pouch or dilation of the gastrojejunostomy anastomosis if the 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.
3. 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 this Plan paid for the procedure.
- Bariatric Surgical services not specifically listed as covered are excluded.
- Bariatric surgery is not covered for the treatment of:
  - Infertility
  - Idiopathic intracranial hypertension