# *BlueSelect*

*Offered by Blue Cross and Blue Shield of Kansas City*

**DIRECT ENROLLMENT**
Health Benefits Contract

KANSAS
PSK00000
**Contract Effective Date: January 1, 2017**

**NOTICE**
**The application, which You completed was delivered to You as a part of the Contract. The Contract was issued on the basis that answers to all questions and information shown on the application is correct and complete. Please read over Your copy of the application and carefully check it.**

**You may return this Contract within 10 days of its receipt for full refund of any Premiums paid if, after examining it, You are not satisfied for any reason. Write to Us within 10 days if any information shown on it is not correct and complete.**

The Contract describes the Benefits for Health Care Services covered by Blue Cross and Blue Shield of Kansas City and the extent to which Benefits may be limited. The Contract may be terminated by Us as described in the Contract.

2301 Main . P.O. Box 419169 . Kansas City, MO 64141-6169 . 1-888-989-8842

**Discrimination is Against the Law**

Blue KC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue KC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue KC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Cynthia Aron, 816-395-6340 (local), 844-395-7126 (Toll free), languagehelp@bluekc.com

If you believe that Blue KC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Denise Soliz, Appeals Supervisor, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, Denise Soliz, Appeals Supervisor is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you, or someone you're helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-844-395-7126.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue KC, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-989-8842

Chinese: 如果您，或是您正在協助的對象，有關於 Blue KC方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話1-844-395-7126。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-395-7126

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-395-7126 an.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 [Blue KC]에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-395-7126 로 전화하십시오.

SAMPLE

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-844-395-7126.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-395-7126.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue KC, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-395-7126.

French: Si vous, ou quelqu'un que vous êtes en train d’aider, a des questions à propos de Blue KC, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-395-7126.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue KC, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-395-7126.

Laotian: ຖ້າທ່ານ, ຫຼືຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ, ມີຄໍາຖາມກ່ຽວກັບ Blue KC, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-844-395-7126.

Pennsylvanian Dutch: Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Blue KC, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-844-395-7126 uffrufe.

Persian:
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue KC ، داشته باشید حق این را دارید که کمکو اطالعات به زبان خود را به طور رایگان دریافت نمایید 1-844-395-7126 .تماس حاصل نمایید.

Cushite: Isin yookan namni biraa isin deeggartan Blue KC irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta’een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-844-395-7126 tiin bilbilaa.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue KC, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-395-7126

For TTY services, please call 1-816-842-5607

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## SECTION A. DEFINITIONS

This section explains the meaning of some of the more important words used in the Contract. Please read this section carefully. It will help You to understand the rest of the Contract. All of these defined words are capitalized when used in the Contract.

**Accidental Injury** Means accidental bodily injury sustained by a Covered Person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause.

**Admission** Begins the first day a Covered Person becomes a registered Hospital bed patient or a Skilled Nursing Facility patient and continues until he is discharged.

**Adverse Determination** Means a determination by Us that a proposed or delivered Health Care Service which would otherwise be covered under the Contract is not or was not Medically Necessary or the health care treatment has been determined to be Experimental/Investigative and:

a. The requested service is provided in a manner that leaves the Covered Person with a financial obligation to the provider or providers of such service; or

b. The Adverse Determination is the reason for the Covered Person not receiving the requested services.

**Allowable Charge** Means the dollar amount upon which Benefits will be determined. Any amounts for Covered Services (other than Copayments) a Covered Person is required to pay will be based on this Allowable Charge. Benefit limits, if any, will also be based on this Allowable Charge. The Allowable Charge may vary depending upon whether or not the provider has a contract with Us and the terms of such contract. Providers are identified as Preferred, Non-Preferred, Participating, and Non-Participating.

You may be responsible for the difference between the amount that the Non-Preferred Provider that is Non-Participating bills and the payment We will make for the Covered Services as set forth in this paragraph.

Unless otherwise specified the following explains what the Allowable Charge is for different providers:

a. For Hospitals, other institutional health care facilities, Physicians or suppliers of medical goods and services which are PPO Providers-

   The Allowable Charge is the lesser of:

   (1) The amount the provider has agreed to accept as payment in full as of the date of service; or

(2) The provider's billed charges.

b. For Hospitals, other institutional health care facilities, Physicians or suppliers of medical goods and services which are Non-Preferred Providers, but are Participating Providers-

The Allowable Charge is the lesser of:

(1) The amount the provider has agreed to accept as payment in full as of the date of service; or

(2) The provider's billed charges.

c. For Hospitals, other institutional health care facilities, Physicians or suppliers of medical goods and services which are Non-Preferred Providers and Non-Participating Providers inside Our Service Area-

The Allowable Charge is the lesser of:

(1) The amount the provider has agreed to accept as payment in full as of the date of service; or

(2) Our participating fee schedule amount for the same services or supplies for such provider-type, if any; or

(3) The provider's billed charges.

d. For Ambulance services provided by Non-Preferred and Non-Participating Providers inside Our Service Area –

The Allowable Charge is the lesser of:

(1) The amount the provider has agreed to accept as payment in full as of the date of service; or

(2) An amount that is based on 150% of the Medicare fee schedule. This percentage will be periodically evaluated and adjusted if deemed appropriate by Blue KC. If the fee schedule does not include a specific code for the service provided, Blue KC will apply the same methodology used to establish an Allowable Charge for a Participating Provider; or

(3) The provider's billed charges.

e. For participating pharmacies-

The Allowable Charge is the lesser of:

(1) The amount the pharmacy has agreed to accept as payment in full as of the date of service; or

(2) The Usual and Customary Charge

For purposes of this paragraph, Usual and Customary Charge means the amount that the participating pharmacy would have charged You if You were a cash paying customer. Such amount includes all applicable discounts, including, without limitation, senior citizen's discounts, coupon discounts, non-insurance discounts, or other special discounts offered to attract customers.

f. For Non-Participating pharmacies –

The Allowable Charge is the provider's billed charges.

g. For pediatric vision eyewear provided by Preferred, Non-Preferred, or Non-Participating Providers -

The Allowable Charge is the lesser of:

(1) The amount the provider has agreed to accept as payment in full as of the date of service; or

(2) The provider's billed charges; or

(3) $130 per set of eyeglass frames and any additional lens services/features or $300 for an annual supply of contact lenses provided in lieu of eyeglasses.

**Ambulance** Means a vehicle designed and operated to provide medical services and that is licensed by state and local laws.

**Ambulatory Review** Means Utilization Review of Health Care Services performed or provided in an outpatient setting.

**Annual Enrollment Period** Means a period of time each Calendar Year during which eligible persons who have not enrolled with Us may do so.

**Benefits** Means the amount of Allowable Charges We pay for Covered Services after the Cost-Sharing requirements have been met.

**Benefit Schedule** Means a listing of certain Covered Services specifying Copayments, Coinsurance, Deductibles and visit limitations under the Contract.

**Blue Cross and Blue Shield of Kansas City** Means the company legally responsible for providing the Benefits under the Contract. Blue Cross and Blue Shield of Kansas City is referred to as "We," "Us" and "Our."

**Calendar Year** Means January 1 through December 31 of the same year.

**Calendar Year Maximum** Means a maximum dollar amount or a maximum number of days, visits, or sessions for which Benefits for Covered Services are provided for a Covered Person in any one Calendar Year. Once a Calendar Year Maximum for a specific Covered Service is met, no more Benefits for such Covered Services will be provided during the same Calendar Year.

If the Contract replaces any health plan issued by Blue Cross and Blue Shield of Kansas City under which a Covered Person was covered, then this maximum will be reduced by the amount of Benefits a Covered Person received through the previous plan(s) during that Calendar Year.

**Case Management** Means a method of review whereby a Covered Person's health, or catastrophic or complex health problem or general health is evaluated and a plan of care is developed and implemented which meets that Covered Person's particular needs and is the most cost-effective.

**Certification** Means a determination by Us that an Admission, availability of care, continued stay or other Health Care Service has been reviewed and, based on the information provided, satisfies Our requirements for Medical Necessity, appropriateness, health care setting, level of care and effectiveness.

**Claim** Means a request for: (1) services that require Prior Authorization made in accordance with the procedures outlined in the Utilization Review Section; (2) payment for Covered Services rendered in accordance with the procedures outlined in the How to File a Claim Section; or (3) an appeal of a benefit determination ("Grievance") made in accordance with the procedures outlined in the Complaint and Grievance Procedures Section.

**Coinsurance** Means the percentage of an Allowable Charge that You must pay for a Covered Service.

**Complications of Pregnancy** Means non-routine care (medical or surgical) required due to medical complications occurring as a result of or during the pregnancy. This does not include the actual obstetrical procedure itself which is defined as a normal delivery, cesarean section, miscarriage or elective pregnancy termination.

**Concurrent Review** Means Utilization Review conducted during a Covered Person's Hospital stay or course of treatment.

**Confinement** Means an uninterrupted stay following formal Admission to a Hospital or Skilled Nursing Facility. It starts with the Admission and ends the day the Covered Person is discharged from the Hospital or Skilled Nursing Facility.

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| **Contract** | Means the agreement between the Contractholder and Us that contains all of the terms of coverage. The Contract includes this booklet, Your application for coverage, and any amendments/riders. |
| **Contractholder** | Means the person who originally applies for and is accepted for coverage by Us under the Contract. |
| **Copayment** | Means the dollar amount of a charge that a Covered Person must pay for certain Covered Services. |
| **Cost Sharing** | Means the applicable Copayment, Coinsurance, or Deductible that must be paid by the Covered Person for a Covered Service. Cost-Sharing does not include Premiums, amounts incurred for non-Covered Services, or any amount above the Allowable Charge. |
| **Covered Person** | Means the Contractholder or any of the Contractholder's Dependents whose coverage is in effect under the Contract. |
| **Covered Services** | Means services, supplies, equipment and care specifically listed in the "Covered Services" section of the Contract. |
| **Custodial Care** | Means care furnished mainly to train or assist in personal hygiene or other activities of normal daily living such as dressing, feeding, and walking, rather than to provide medical treatment. |
| **Deductible** | Means the portion of Allowable Charges for Covered Services You must pay each Calendar Year before We will provide Benefits unless otherwise specified. The application of the Deductible during any Calendar Year will be based upon the date when Covered Services were actually received. Except as specifically provided, each Covered Person must satisfy a Deductible each Calendar Year before Benefits will be paid. |
| **Dependent** | Means a person in the Contractholder's family who meets the Dependent eligibility requirements of the "Eligibility, Enrollment and Effective Date" section of the Contract. |
| **Discharge Planning** | Means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility. |
| **Due Date** | Means the first day of each month when Premiums are due and payable. |
| **Effective Date** | Means the date coverage begins for a Covered Person under the Contract. |

**Emergency Medical Condition**

Means a medical condition manifesting itself by an unexpected onset of symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a. Serious impairment to a bodily function;

b. Serious dysfunction of any bodily organ or part; or

c. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

**Emergency Services**

Means Ambulance services and health care items and services furnished or required to evaluate and treat an Emergency Medical Condition, as directed or ordered by a Physician.

**Experimental / Investigative Services**

We will use the following criteria to determine whether drugs, devices and medical treatment or procedures and Related Services and Supplies are Experimental or Investigative.

A drug, device or medical treatment or procedure is Experimental or Investigative if:

a. The drug or device cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

b. Reliable evidence shows that the drug, device or medical treatment or procedure:

    (1) Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the maximum tolerated dose, safety, toxicity, or efficacy as its objective;

    (2) Is provided pursuant to a written protocol or other document that lists an evaluation of its safety, toxicity, or efficacy as its objective; or

    (3) Is Experimental/Investigative per the informed consent document utilized with the drug, device, or medical treatment.

c. The national Blue Cross and Blue Shield Association's uniform medical policy (as amended from time to time) has determined the device or medical treatment or procedure ("technology") is investigational based on the following criteria:

(1) Final approval from the appropriate governmental regulatory bodies has not been received; or

(2) Scientific evidence does not permit conclusions concerning the effect of the technology on health outcomes; or

(3) The technology does not improve the net health outcome; or

(4) The technology is not as beneficial as established alternatives; or

(5) The improvement is not attainable outside the investigational settings; or

d. To the extent paragraphs a., b., and c. above do not apply, the drug, device, medical treatment, or procedure and Related Services and Supplies will still be considered Experimental or Investigative if:

(1) We, utilizing additional authoritative sources of information and expertise, have determined that the technology does not meet the criteria listed in paragraph c. 1-5 above; or

(2) There is not sufficient evidence based peer reviewed studies published in medical literature to establish the safety and efficacy of the technology.

"Related Services and Supplies" for the purposes of this definition shall mean any service or supply that We determine is primarily related to the application or usage of a drug, device, medical treatment or procedure that is Experimental or Investigative.

**Health Care Service** Means a service for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

**Home Health Agency** Means an organization or entity that is licensed to provide Health Care Services in the home.

**Hospice** Means an organization or entity that furnishes medical services and supplies only to patients who are considered to be Terminally Ill.

**Hospital** Means a facility that:

a. Operates pursuant to law;

b. Provides 24-hour nursing services by Registered Nurses on duty or call; and

c. Provides Health Care Services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of a Physician or a staff of Physicians.

Hospitals are classified as follows:

a. Preferred Provider Hospital. See definition of Preferred Provider.

b. Non-Preferred Provider Hospital. A Non-Preferred Hospital may or may not be a Participating Provider. See definition of Non-Preferred Provider.

c. Participating Provider Hospital means a Hospital that contracts with Us or any Blue Cross and/or Blue Shield Plan to provide the Hospital services described in the Contract and accepts the Allowable Charge as full payment for Covered Services except for Copayments, Coinsurance and Deductibles, if any. A Participating Provider Hospital may or may not be a Preferred Provider Hospital.

d. Non-Participating Provider Hospital means a Hospital that does not have a Participating Provider Hospital contract with Us.

Hospital does not include residential or nonresidential treatment facilities; health resorts; nursing homes; Christian Science sanatoria; institutions for exceptional children; Skilled Nursing Facilities; places that are primarily for the care of convalescents; clinics; Physicians' offices; private homes; ambulatory surgical centers; or Hospices.

We have the right to determine whether a facility is a Hospital.

**Immediate Family Member**

Means a parent, spouse, child, or sibling and such person's spouse.

**Late Enrollee**

Means a person who requests coverage under the Contract following the Annual Enrollment Period and who does not qualify to enroll under a Special Enrollment Period.

**Medically Necessary (Medical Necessity)**

Means services and supplies which We, utilizing additional authoritative sources of information and expertise, determine are essential to the health of a Covered Person and are:

a. Appropriate and necessary for the symptoms, diagnosis and treatment of a medical or surgical condition;

b. In accordance with Our local medical policies, which are consistent with acceptable medical practice according to the national Blue Cross and Blue Shield Association's uniform medical policy (as amended from time to time);

c. Not primarily for the convenience of the Covered Person, nor the Covered Person's family, Physician or another provider;

d. Consistent with the attainment of reasonably achievable outcomes; and

e. Reasonably calculated to result in the improvement of the Covered Person's physiological and psychological functioning.

Our determinations regarding Medical Necessity, just like any other determination, may be appealed pursuant to the grievance procedure.

**Medicare** — Means Part A or Part B of the insurance program established by Title XVIII, of the United States Social Security Act, as amended.

**Mental Illness Substance Abuse** — Means any disorder as such terms are defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994).

**Minimum Essential Coverage** — Means one of the following: (1) medical coverage under a specified government sponsored program (e.g. Medicare, Medicaid, CHIP, etc.); (2) medical coverage under an eligible employer-sponsored plan; (3) medical coverage under a health plan offered in the individual market within a State (excluding short-term limited duration policies); (4) coverage under a grandfathered health plan; or (5) other medical coverage that the Secretary of Health and Human Services, in coordination with the Secretary of the Treasury Department, recognizes for purposes of section 5000A(f).

**Non-Participating Provider** — Means a provider who does not meet the definition of a Participating Provider.

**Non-Preferred Provider (Non-PPO)** — Means a Hospital, Physician or other provider of medical services and supplies that does not have a contract to provide services at negotiated rates for Your coverage under a Preferred Provider contract with Us.

**Organ Transplant** — Means surgically removing an organ or tissue from one person (donor) and placing it in another person (recipient) or returning the organ or tissue from the donor to the donor (same person), an autologous Organ Transplant.

**Out-of-Pocket Maximum** — Means the total amount of Cost-Sharing a Covered Person must pay each Calendar Year before amounts incurred for Covered Services will be paid in full. The Out-of-Pocket Maximum does not include.

a. Any amount that is above the Allowable Charge;

b. Any amount that exceeds a specific maximum for Benefits;

c. Any amount for Covered Services incurred in a Non-Participating outpatient facility or in a Non-Participating Provider Hospital in Our Service Area, except for Emergency Services;

d. Any amount for Covered Services incurred at a non-Designated Transplant Provider for an Organ Transplant;

Amounts You pay for non-Covered Services and for services that are denied by Us as not Medically Necessary will not apply to the Out-of-Pocket Maximum.

**Participating Provider** Means a Hospital, health care facility, Physician, or other provider of medical care or supplies, which has entered into a contract that defines the method We will use to determine the Allowable Charges for Covered Services. Participating Providers have agreed to accept Our Allowable Charge as payment in full for Covered Services. However, You are responsible for amounts incurred for Non-Covered Services, amounts in excess of any Benefit limits of the Contract, and any applicable Cost-Sharing.

**Physician** Means anyone qualified and licensed to practice medicine and surgery by the state in which services are rendered who has the degree of Doctor of Medicine or Doctor of Osteopathy. Physician also means Doctors of Dentistry and Podiatry as well as Optometrists, Chiropractors and Psychologists when they are acting within the scope of their license.

By use of this term and when We are required by law, We recognize and accept, to the extent of Our obligations under the Contract, other practitioners of medical care and treatment when the services performed are within the lawful scope of the practitioner's license and are provided pursuant to applicable laws.

**Physician Extender** Means a Nurse Practitioner, Physician Assistant, Certified Registered Nurse Anesthetist, or Mid-wife.

Services received from a Physician Extender will be subject to the Cost-Sharing applicable to the place of service where the service was rendered (e.g. services provided in a Specialist's office will be subject to the Cost-Sharing for a Specialist).

**Post-Service Claim** Means a request for payment for Health Care Services rendered.

**Pre-Service Claim** Means a request for Health Care Services that require Prior Authorization.

**Preferred Provider (PPO)** Means a Hospital, Physician, or other provider of medical services and supplies participating under a contract with Us through a Preferred Provider Organization (PPO) as named in the provider directory.

Such Preferred Provider will bill Us directly for Covered Services You receive. However, You are responsible for amounts incurred for Non-Covered Services, amounts in excess of any Benefit limits of the Contract, and any applicable Cost-Sharing.

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| **Premiums** | Means the amount paid on a periodic basis for Your coverage under the Contract. |
| **Primary Care Physician (PCP)** | Means an internist, family practitioner, general practitioner or pediatrician. |
| **Prior Authorization or Prior Authorized** | Means the procedure whereby We determine: (a) based on medically recognized criteria, whether or not an Admission to a Hospital as an inpatient is reasonable for the type of services to be received; or, (b) whether any service to be performed is reasonable and Medically Necessary for the condition being treated and the type of services to be provided. |
| **Prospective Review** | Means Utilization Review conducted prior to an Admission or a course of treatment. |
| **Reinstatement** | Means restoring a Contract that has been terminated (for example, because of nonpayment of Premiums). |
| **Rescission** | Means a retroactive cancellation or discontinuance of coverage under a health benefit plan, unless the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums. A Rescission qualifies as an Adverse Determination. |
| **Retrospective Review** | Means Utilization Review of Medical Necessity that is conducted after services have been provided to a patient, but does not include the review of a Claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment. |
| **Second Opinion** | Means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed Health Care Services. |
| **Service Area** | (Sometimes referred to as "Our Service Area") means the geographic area served by Us. Contact Us to determine the geographic area We serve. Our Service Area includes the following counties in Kansas: Johnson and Wyandotte. Our Service Area includes the following counties in Missouri: Clay, Jackson, Platte. |
| **Skilled Nursing Facility** | Means a facility that:<br><br>a. Operates pursuant to law; |

b. Provides 24-hour nursing services by Registered Nurses on duty or on call; and

c. Provides convalescent and long-term illness care with continuous nursing and other Health Care Services by, or under the supervision of, a staff of one or more Physicians and registered nurses.

The Skilled Nursing Facility may be operated either independently or as part of an accredited general Hospital.

Skilled Nursing Facility also means an extended care facility, convalescent care facility, intermediate care facility or long-term illness facility.

**Special Enrollment Period** Means a period of time during which eligible persons may enroll in coverage.

**Specialist** Means Doctors of Medicine (M.D.), Doctors of Osteopathy (D.O.), except Primary Care Physicians, and other medical practitioners when the services performed are within the lawful scope of the practitioner's license, including, but not limited to, optometrists, chiropractors and psychologists.

**Stabilize** Means with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely to result or occur before an individual may be transferred.

**Terminally Ill** Refers to a Covered Person that a Physician has certified has 6 months or less to live.

**Utilization Review** Means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, Health Care Services, procedures, or settings. Techniques may include Ambulatory Review, Prospective Review, Second Opinion, Certification, Concurrent Review, Case Management, Discharge Planning or Retrospective Review. Utilization Review shall not include elective requests for clarification of coverage.

**We, Us, Our** Means Blue Cross and Blue Shield of Kansas City, the company legally responsible for providing the Benefits for Covered Services under the Contract.

**You, Your** Refers to the Covered Person.

## SECTION B. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

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**1. Eligibility**

To be eligible to enroll, the Contractholder must:

a. Live within Johnson or Wyandotte County;

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**2. Dependent Eligibility**

To be eligible to enroll as a Dependent a person must be:

a. The Contractholder's legal spouse;

b. The Contractholder's or Contractholder's legal spouse's child. Such child includes:

(1) A child by birth;

(2) An adopted child;

(3) A child under the age of 18 who has been placed with the Contractholder for the purpose of adoption for whom the Contractholder has a legal obligation to support; or

(4) A child under the age of 18 who has been placed under the Contractholder's legal guardianship.

Coverage for a Dependent child under this section will apply without regard to whether such child (defined above) is: married, a tax dependent of the Contractholder or Contractholder's legal spouse, a student, actively employed, or residing with or receiving financial support from the Contractholder or Contractholder's legal spouse.

Coverage will be provided until the end of the Calendar Year in which such child reaches the Dependent limiting age; or

c. The Contractholder's or Contractholder's legal spouse's unmarried Dependent child (defined above) who has reached the limiting age but who cannot support himself because of a physical or mental handicap. The Dependent's handicap must have started before the end of the Calendar Year in which the Dependent reached the limiting age and the Dependent must have been continuously covered by Us or a prior health plan at the time of reaching the limiting age.

We must receive satisfactory proof of the Dependent's handicap within 31 days before the child reaches the Dependent limiting age, or within 31 days after the Dependent is enrolled for coverage under the Contract to continue coverage beyond the Dependent limiting age.

The Contractholder is responsible for ensuring Dependent information is current. If necessary Dependent information is not in Our files, claims will be rejected for such individuals.

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## 3. Enrollment

a. Annual Enrollment Period

A Contractholder may choose either coverage for himself or himself and his Dependents. A Contractholder must submit a properly completed and signed application.

b. Special Enrollment Periods

(1) New Dependents

If a new Dependent is acquired by the Contractholder due to marriage, birth of a child, adoption of a child, or placement for adoption of a child, the new Dependent may enroll during this Special Enrollment Period. To enroll during this Special Enrollment Period, the Contractholder must submit a completed Contractholder application and any additional Premium due within 60 days after the date of marriage, birth, adoption, or placement for adoption. Documentation verifying the event must be provided, if requested.

Notwithstanding the above paragraph, if the Contractholder has previously elected Dependent coverage and such coverage is in effect on the date of the newborn child's birth or the date the petition for adoption is filed, then the Contractholder's newborn child will be covered automatically for 31 days from the moment of birth. The Contractholder must submit a completed Contractholder application requesting coverage for such newborn to be added within 60 days of the child's birth in order to continue such child's coverage beyond the initial 31 days. Additional Premium may be due upon adding the child after the initial 31 days. Coverage for such newborn will be subject to all of the terms and conditions of the Contract.

If You notify Us of the birth either verbally or in writing within 60 days of the date of birth, We must:

(a) Provide the Contractholder with forms and instructions; and

(b) Allow an additional 10 days from the date on which enrollment forms and instructions were provided for the Contractholder to complete and return the enrollment materials for the newborn.

If a child placed for adoption is not legally adopted, coverage for such child will end the earlier of the date on which the Contractholder's legal support obligation for the child ends or 280 days after such child's date of placement.

If the new Dependent for which additional Premium is due is not enrolled as a Dependent within 60 days of becoming eligible, then such Dependent will be considered a Late Enrollee.

(2) Loss of Minimum Essential Coverage

If the Contractholder and/or his Dependents had Minimum Essential Coverage under another health plan and are no longer eligible for such coverage, the Contractholder and/or his Dependents may enroll during the Special Enrollment Period provided such loss of coverage was not due to failure to pay premiums for the coverage or Rescission.

The Contractholder must submit a completed Contractholder application and any additional Premium due within 60 days after the loss of such other coverage and provide appropriate documentation verifying the loss of such other coverage, if requested.

(3) Eligibility for Government Assistance

(a) If a Contractholder and/or his Dependent become eligible for premium assistance under Medicaid or CHIP and the coverage provided under the Contract is not a high deductible health plan as defined under IRS Code §223, the eligible Contractholder and/or his eligible Dependents may enroll during this Special Enrollment Period. To enroll during this Special Enrollment Period, a Contractholder must submit a completed Contractholder application and any additional Premium due within 60 days after eligibility is determined and provide appropriate documentation verifying the eligibility, if requested.

(b) If the Contractholder and/or his Dependents gain or lose eligibility for government assistance for Premiums or Cost-Sharing, the eligible Contractholder and/or his eligible Dependents may be able to enroll during this Special Enrollment Period. To enroll during this Special Enrollment Period, a Contractholder must submit a completed Contractholder application and any additional Premium due within 60 days after eligibility is determined and provide appropriate documentation verifying the eligibility, if requested.

(4) Error in Enrollment

If the Contractholder and/or his Dependents enroll or fail to enroll due to an error, misrepresentation, or inaction by Us or a governmental entity, the eligible Contractholder and/or his eligible Dependents may enroll during this Special Enrollment Period. To enroll during this Special Enrollment Period, a Contractholder must submit a completed Contractholder application and any additional Premium due within 60 days of becoming aware of the error.

(5) Material Violation of Contract

If a Contractholder and/or his Dependents adequately demonstrate that We or another entity substantially violated a material provision of the health benefit contract in which he is enrolled, the eligible Contractholder and/or his eligible Dependents may enroll during this Special Enrollment Period. To enroll during this Special Enrollment Period, a Contractholder must submit a completed Contractholder application and any additional Premium due within 60 days of becoming aware of the violation.

(6) Permanent Move

If a Contractholder and/or his Dependents gain access to coverage as the result of a permanent move, the eligible Contractholder and/or his eligible Dependents may enroll during this Special Enrollment Period. To enroll during this Special Enrollment Period, a Contractholder must submit a completed Contractholder application and any additional Premium due within 60 days after the permanent move.

c. Contractholder Application

The Contractholder must fully and accurately complete and sign the Contractholder application. Coverage for all Covered Persons may become null and void from inception if it is determined that You intentionally misrepresented material facts or committed fraud.

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**4. Effective Date of Coverage**

a. Annual Enrollment

Coverage is effective at 12:01 a.m. on January 1st and is subject to Our receipt of the required Premium.

b. Special Enrollment

(1) New Dependents

If an individual enrolls during a Special Enrollment Period due to acquiring a new Dependent, coverage is effective as follows:

(a) In the case of marriage, no later than the first day of the month following enrollment.

(b) In the case of the birth of a child, the date of such birth.

(c) In the case of adoption of a child, the earlier of:

(i) The moment of birth for a newborn child if a petition for adoption was filed within 31 days of the birth of a child;

(ii) The date the petition for adoption was filed; or

(iii) The child's date of placement. Date of placement means the date the Contractholder assumed the legal obligation for total or partial support of the child to be adopted in connection with formal adoption proceedings.

(2) Loss of Minimum Essential Coverage

If an individual enrolls during a Special Enrollment Period due to loss of Minimum Essential Coverage, coverage is effective no later than the first day of the month following enrollment.

(3) Eligibility for Government Assistance

If an individual enrolls under the Special Enrollment Period due to becoming eligible or ineligible for government assistance, coverage is effective on the first day of the month following enrollment if enrollment occurs between the first and fifteenth of the month or the first day of the second month following enrollment if enrollment occurs between the sixteenth and the last day of the month.

(4) Error in Enrollment

If an individual enrolls under the Special Enrollment Period due to an error in enrollment, coverage is effective on the first day of the month following enrollment if enrollment occurs between the first and fifteenth of the month or the first day of the second month following enrollment if enrollment occurs between the sixteenth and the last day of the month.

(5) Material Violation of Contract

If an individual enrolls under the Special Enrollment Period due to a material violation of contract, coverage is effective on the first day of the month following enrollment if enrollment occurs between the first and fifteenth of the month or the first day of the second month following enrollment if enrollment occurs between the sixteenth and the last day of the month.

(6) Permanent Move

If an individual enrolls under the Special Enrollment Period due to a permanent move, coverage is effective on the first day of the month following enrollment if enrollment occurs between the first and fifteenth of the month or the first day of the second month following enrollment if enrollment occurs between the sixteenth and the last day of the month.

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**5. Other Changes in Coverage**

If You want to change Your coverage because of a divorce, the change will be effective on the date of the divorce.

If You are a surviving Dependent of a deceased Contractholder, You have the right to continue coverage under the Contract. The change will be effective on the day after the date of death.

If the Contractholder terminates coverage because he became covered under a Medicare supplement or Medicare Advantage policy with Us, any other Covered Person has the right to continue coverage under this Contract. The change will be effective on the effective date of the Medicare supplement policy.

When a Dependent child reaches the limiting age as provided in the Benefit Schedule, he will be issued his own coverage under a similar direct enrollment Contract. He will not be required to complete an application provided he has been covered under the Contract and currently resides within Our Service Area. When an individual is issued coverage in this manner, any references in the Contract to the individual having to complete an application will not apply. Such coverage will be effective the day following the date of termination of his previous coverage if he pays the required Premium for his new Contract within 60 days of the termination of his previous coverage. Any Dependents added later to his new coverage will be subject to all the provisions of the Contract.

## SECTION C. COVERED SERVICES

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This section describes the Benefits for Covered Services available under the Contract. All Covered Services are subject to the conditions, limitations and exclusions of the Contract.

**Covered Services**

Covered Services under the Contract are set forth in this section. All Covered Services are subject to the Cost-Sharing requirements and the limitations and exclusions of the Contract.

The specified services and supplies will be Covered Services only if they are:

a. Incurred for a Covered Person while coverage is effective;

b. Performed, prescribed or ordered by a Physician;

c. Medically Necessary for the treatment of Your injury or illness, except for specifically listed routine preventive or diagnostic services;

d. Not excluded under the Contract; and

e. Received in accordance with the requirements of the Contract.

**Benefits**

We provide Benefits for Covered Services in excess of Cost-Sharing. All Covered Services are subject to the maximums and other limits and conditions specified in the Contract.

Benefits are different depending on whether Covered Services are received from a Preferred Provider or a Non-Preferred Provider and Participating Providers. Benefits for Covered Services will be greater if Covered Services are received from Preferred Providers. **It is Your responsibility to ensure that You use Preferred Providers to receive the maximum Benefits**. Failure to do so will increase Your financial responsibility.

**Deductible**

The Deductible is applied each Calendar Year. Except as specifically provided, the Calendar Year Deductible must be satisfied before we will provide Benefits for Covered Services. After 2 covered family members have satisfied the individual Deductible for a Calendar Year, the Deductible will be considered satisfied for all family members. No Covered Person is allowed to contribute more than his own individual Deductible to the family Deductible per Calendar Year.

You must satisfy the Deductible requirement for services received from Preferred Providers and a separate Deductible requirement for services received from Non-Preferred Providers. Amounts You pay towards satisfaction of the Deductible requirement for Emergency Services will apply to Your Preferred Provider Deductible regardless of whether services are received from a Preferred or Non-Preferred Provider.

**Copayments**

Copayments are a specified amount that You must pay each time You receive a service of a particular type or in a designated setting. Whenever a Copayment applies toward a Covered Service, the Deductible does not apply, except as specified in the Benefit Schedule.

Copayments, if any, are indicated in the Benefit Schedule.

**Out-of-Pocket Maximum**

After 2 or more covered family members have satisfied the individual Out-of-Pocket Maximum for a Calendar Year, the Out-of-Pocket Maximum will be considered satisfied for all family members.

You will have an Out-of-Pocket Maximum for services received from Preferred Providers and a separate Out-of-Pocket Maximum for services received from Non-Preferred Providers. Cost-Sharing for services provided by Preferred Providers will apply to Your Preferred Provider Out-of-Pocket Maximum. Cost-Sharing for services provided by Non-Preferred Providers will apply to Your Non-Preferred Provider Out-of-Pocket Maximum. The only exception is for Cost-Sharing for Emergency Services, which will apply to Your Preferred Provider Out-of-Pocket Maximum regardless of whether services are received from a Preferred or Non-Preferred Provider.

Expenses that do not apply toward the Out-of-Pocket Maximum are indicated in the Out-of-Pocket Maximum definition.

**Prior Authorization**

**Services that must be Prior Authorized by Us will state so in the applicable Covered Service subsection.** The consequences of obtaining such services when they have not been Prior Authorized are as follows:

<u>Services Received from Preferred Providers Inside Our Service Area</u> – If these services are not Prior Authorized, the admitting Physician, provider and/or Hospital will be responsible for the cost associated with such services, regardless of Medical Necessity.

<u>Services Received from Non-Preferred Providers or Preferred Providers Outside Our Service Area</u> – If these services are Covererd Services and not Prior Authorized, You will be responsible for the cost associated with such services, regardless of Medical Necessity.

In the case of a maternity or an inpatient Admission due to an Emergency Medical Condition, You must notify Us within 48 hours of the Admission or as soon thereafter as reasonably possible.

Benefits will be limited to the length of stay approved by Us. When the approved length of stay must be extended for Medically Necessary reasons, You or Your attending Physician, on Your behalf, must contact Us in advance to obtain Our approval for the additional days. Failure to provide such notice or obtain Prior Authorization or approval for additional days will result in You being responsible for the cost of the service, regardless of Medical Necessity.

**The following information provides a detailed description of Covered Services:**

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**1. Accident-Related and Other Dental Services**

Accidental Injury

We provide Benefits for dental services only when such services are for treatment of an Accidental Injury. Covered Services are limited to treatment of natural teeth and the purchase, repair or replacement of dental prostheses needed as a direct result of an Accidental Injury (except injury resulting from biting or chewing). Treatment must be completed within 12 months of the date of the Accidental Injury to be considered a Covered Service, unless the medical condition of the Covered Person prevents treatment from being rendered within 12 months of the date of the Accidental Injury.

Covered Services also include treatment of jaw fractures or complete dislocations and diagnostic x-rays in connection with these fractures and dislocations.

Tooth Extractions

We provide Benefits for the extraction of teeth and services related to such extractions when performed in conjunction with the treatment of head or neck tumors.

Dental Implants

We provide Benefits for dental implants and bone grafts for the following conditions:

a. The repair of defects in the jaw due to tumor/cyst removal;

b. Severe atrophy in a toothless arch;

c. Exposure of nerves;

d. Non-union of a jaw fracture;

e. Loss of teeth due to an Accidental Injury; and

f. Correction of a defect diagnosed within 31 days of birth.

Dental prostheses over an implant are not covered unless the dental implant was due to an Accidental Injury or due to a correction of a defect diagnosed within 31 days of birth.

**Dental implants and bone grafts must be Prior Authorized by Us.**

Orthognathic Surgery

We provide Benefits for Orthognathic surgery for the following conditions:

a. Correction of a defect diagnosed within 31 days of birth; or

b. Correction of a defect due to an Accidental Injury. Treatment for correction of a defect due to an Accidental Injury must be completed within 12 months of the date of the Accidental Injury to be considered a Covered Service, unless the medical condition of the Covered Person prevents treatment from being rendered within 12 months of the date of the Accidental Injury.

Temporomandibular Joint Disorder

We provide Benefits for the surgical treatment of temporomandibular joint disorder. We provide Benefits for the medical or dental management of temporomandibular joint disorder only in connection with acute dislocation of the mandible due to accidental bodily injury, fractures, or tumors.

Complications of Dental Treatment

We provide Benefits for inpatient Hospital services required as a result of complications of dental treatment. Covered Services are limited to services that cannot be adequately provided in an outpatient setting.

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**2. Allergy**

We provide Benefits for allergy services provided in a Physician's office. Covered Services are limited to office visits and Medically Necessary testing, injections, and allergy antigens.

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**3. Ambulance Service**

We provide Benefits for transportation by a licensed Ambulance service when it is Medically Necessary to transport You from the place where an Accidental Injury or other Emergency Medical Condition occurred to the nearest facility where appropriate treatment can be obtained**.**

Covered Services include transportation by an air Ambulance only when it is Medically Necessary to utilize an air Ambulance and will be limited to transportation to the nearest facility where appropriate treatment can be obtained.

## 4. Anesthesia

Medical

We provide Benefits for anesthesia materials and their administration if the surgical, orthopedic, diagnostic, or obstetrical service requiring the anesthesia is covered. Covered Services must be provided by a Physician (other than the operating Physician) or Certified Registered Nurse Anesthetist (CRNA).

Anesthesia services provided in a facility will be subject to the Preferred Provider Deductible and Preferred Provider Out-of-Pocket Maximum provisions of the Contract and will be paid at the Preferred Provider Coinsurance level.

Dental

We provide Benefits for general anesthesia materials, their administration, and medical care facility charges for dental care when such services are provided in a Hospital, surgical center or office to the following Covered Persons:

a. Children age 5 and under;

b. Persons who are severely disabled; or

c. Persons who have medical or behavioral conditions requiring hospitalization or general anesthesia when dental care is provided;

Covered Services must be provided by a Physician, Certified Registered Nurse Anesthetist (CRNA) or Dentist.

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## 5. Bone Marrow Testing

We provide Benefits for bone marrow testing. Covered Services are limited to Human Leukocyte Antigen testing for A, B and DR antigens used in bone marrow transplantation.

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## 6. Chemotherapy

We provide Benefits for chemotherapy, including oral chemotherapy drugs.

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## 7. Clinical Trials

We provide Benefits for Routine Patient Care Costs as the result of a Phase I, II, III, or IV clinical trial for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition, if approved by one of the following entities and the treating facility and personnel have the expertise and training to provide the treatment and treat a sufficient number of patients:

a. National Institute of Health (NIH);

b. Center for Disease Control and Prevention (CDC);

c. Agency for Health Care Research and Quality;

d. Centers for Medicare and Medicaid Services;

e. A cooperative group or center of those listed in a. through d., or of the Department of Defense or Veteran Affairs;

f. A qualified non-research entity identified in the guidelines issued by the NIH;

g. If certain conditions are met, the Department of Veteran Affairs, the Department of Defense, or the Department of Energy;

h. The FDA in the form of an investigational new drug application; or

i. A drug trial that is exempt from the requirement of a FDA new drug application.

Routine Patient Care Costs are defined as follows:

a. Drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's particular condition;

b. Reasonable and Medically Necessary services needed to administer a drug or device under evaluation in a clinical trial; and

c. All other items and services that are otherwise generally available in the clinical trial, except:

    i. The Investigational item, device, or service itself;

    ii. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;

    iii. Costs for services clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and

    iv. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

**These services must be Prior Authorized by Us.**

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**8. Cochlear Implants**

We provide Benefits for cochlear implants. Covered Services include the initial cochlear implant, Medically Necessary repairs and replacements

that are no longer covered under warranty, and related implant services (including batteries).

**Initial and replacement cochlear implants must be Prior Authorized by Us. Implant repairs and replacement parts (including batteries) do not require Prior Authorization.**

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**9. Diabetes**

We provide Benefits for the treatment of diabetes. Covered Services are limited to self-management training (including diet counseling from a registered dietician or certified diabetes educator) and Physician prescribed Medically Necessary equipment and supplies used in the management and treatment of diabetes. Benefits are available only for Covered Persons with gestational, type I or type II diabetes. Insulin, oral anti-diabetic agents, syringes, test strips, lancets, needles and glucometers are Covered Services under the Outpatient Prescription Drug Benefit.

We provide Benefits for one pair of diabetic shoes and up to a maximum of 3 pairs of inserts for the diabetic shoes per Covered Person per Calendar Year.

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**10. Diagnostic Services**

We provide Benefits for diagnostic services including x-ray examinations, laboratory services, other diagnostic procedures and tests required to diagnose an illness, injury, or other Covered Service. Covered Services include Echocardiogram and Stress Echocardiogram. Covered Services do not include screening examinations or routine physical examinations unless these services are specifically listed as Covered Services under the Routine Preventive Care Benefit in this section. Benefits for diagnostic services may vary based on where the services are rendered as indicated in the Benefit Schedule.

MRI, MRA, Nuclear Medicine, Cardiac Nuclear Medicine, CT, CTA, and PET scans are Covered Services under the High-Tech Diagnostic Benefit.

We provide Benefits for lab tests, x-rays, other necessary diagnostic tests and exams ordered by Your Physician prior to an outpatient or inpatient surgery covered under the Contract.

Radiology services and pathology services provided in a facility will be subject to the Preferred Provider Deductible and Out-of-Pocket Maximum provisions of the Contract and will be paid at the Preferred Provider Coinsurance level.

**Echocardiograms and Stress Echocardiograms must be Prior Authorized by Us.**

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**11. Dialysis**

We provide Benefits for hemodialysis and peritoneal dialysis services.

**12. Durable Medical Equipment**

We provide Benefits for the rental or purchase of durable medical equipment (DME) for use outside a Hospital subject to the following conditions:

a. Use of DME will be authorized for a limited period of time;

b. We retain the right to possess the equipment and You agree to cooperate with Us in arrangements to return the equipment following Your authorized use; and

c. We have the right to stop covering the rental when the item is no longer Medically Necessary.

Covered Services are limited to the basic DME which meets the minimum specifications and are Medically Necessary. Covered Services include:

a. Hand-operated wheelchairs;

b. Hand-operated hospital-type beds;

c. Oxygen and the equipment for its administration;

d. Mechanical equipment for the treatment of chronic or acute respiratory failure (ventilators and respirators); and

e. Oral appliances for sleep apnea.

When Medically Necessary, an electrically operated bed or wheelchair may be covered.

The wide variety of DME and continuing development of patient care equipment makes it impractical to provide a complete listing. Covered DME includes those items covered by Medicare unless otherwise specified.

Covered Services include some warning or monitoring devices, including but not limited to home apnea monitors for infants, 24 hour event monitors (not including 24 hour blood pressure devices), 24 hour ECG monitors (“Holter”), and home oximetry monitors.

Covered Services do not include repair or replacement required as a result of abuse or misuse of DME. Covered Services also do not include repair or replacement required as the result of stolen, lost, destroyed or damaged DME. If repair or replacement of DME is authorized, We retain the option to determine whether to repair or replace the equipment. Covered Services do not include muscle stimulators; portable paraffin bath units; sitz bath units; stethoscopes, or blood pressure devices; nor items for comfort or

convenience, such as but not limited to spas, whirlpools, Jacuzzis, hot tubs, humidifiers, dehumidifiers and air conditioners. Covered Services also do not include DME that would normally be provided by a Skilled Nursing Facility. See the Exclusions section of the Contract for additional exclusions which may apply.

**DME must be Prior Authorized by Us.**

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**13. Elective Sterilization**

We provide Benefits for elective sterilization. Covered Services include elective sterilization for men. Elective sterilization services for women are Covered Services under the Routine Preventive Care Benefit.

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**14. Electrical Stimulation**

We provide Benefits for the following: spinal cord electrical stimulation and electrical stimulation for bone growth; electrical stimulation of the spine as an adjunct to spinal fusion and sacral nerve neuromodulation; spinal cord stimulation for chronic pain unresponsive to standard therapies; electrical bone growth stimulation for fracture nonunions or congenital pseudoarthroses; electrical bone growth stimulation of the spine as an adjunct to spinal fusion; and sacral nerve neuromodulation for urinary dysfunction.

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**15. Emergency Services and Supplies**

We provide Benefits for the treatment of Emergency Medical Conditions.

You must notify Us of any emergency Admission within 48 hours of the time of the Admission or as soon as is reasonably possible.

Services will be covered under this Benefit to evaluate or treat an Emergency Medical Condition. If You become stabilized and Your health condition no longer meets the definition of an Emergency Medical Condition, then any subsequent admission to the hospital will be covered under the Inpatient Hospital Services benefit and subject to the applicable Preferred or Non-Preferred Provider Cost-Sharing.

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**16. Genetic Testing**

We provide Benefits for the genetic testing for colorectal cancer and the following genetic tests for breast cancer: BRCA1, BRCA2, and Oncotype DX. We also provide Benefits for genetic testing when such testing is required to determine the Medical Necessity of certain prescription drugs or a bone marrow transplant. Covered Services are limited to selected genetic tests and the associated pre-test and post-test genetic counseling. Certain genetic testing for women who have a family history that is associated with an increased risk for mutations in the BRCA1 or BRCA2 genes is a Covered Service under the Routine Preventive Care Benefit.

**Genetic Testing must be Prior Authorized by Us.**

**17. High-Tech Diagnostic Testing**

We provide Benefits for High-Tech Diagnostic Testing. Covered Services include MRI, MRA, Nuclear Medicine, Cardiac Nuclear Medicine, CT, CTA, and PET scans. X-rays, radiology, and other diagnostic procedures are Covered Services under the Diagnostic Services Benefit.

**These services must be Prior Authorized by Us.**

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**18. Home Health Services**

We provide Benefits for home health services, including 3 educational visits, provided in the home or other outpatient setting. Covered Services are subject to all of the following conditions:

a. Covered Services are limited to part-time skilled nursing care, part-time services from home health aides, private duty nursing, physical therapy, occupational therapy or speech therapy;

b. The services are received as an alternative to inpatient Confinement in a Hospital or Skilled Nursing Facility; and

c. Your Physician determines that You need home health care and designs a home health care plan for You.

A visit is defined as no more than 2 hours. If private duty nursing is approved, services exceeding the 2 hour limit will accumulate as one or more additional visits.

Covered Services do not include meals delivered to Your home, custodial care, companionship, and homemaker services.

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**19. Hospice Services**

Home Hospice

We provide benefits for home hospice services if a Physician certifies You are Terminally Ill. Covered Services are limited to palliative care. If We determine the care provided is not palliative care, Benefits under Hospice Services are not Covered Services.

a. Covered Services are limited to the following home Hospice services:

(1) Assessment and initial testing;

(2) Family counseling of Immediate Family Members;

(3) Non-prescription pharmaceuticals;

(4) Medical supplies;

(5) Respite care;

(6) Professional, medical, social, and pastoral counseling services provided by salaried employees of the Hospice; and

(7) Supportive services to the bereaved family members for up to 3 months following the death of the Covered Person.

b. Covered Services do not include:

(1) Services for which there is no charge;

(2) Services related to organization or dispensation of nonmedical, personal, legal, and financial affairs such as, but not limited to, the execution of a will;

(3) Services received in a free standing Hospice facility, a Hospital-based Hospice, or provided to a Hospital bed patient except that Covered Services will be provided for an assessment visit, family counseling and supportive services to the bereaved Immediate Family Members; or

(4) Services received by persons other than the Covered Person or his Immediate Family Members.

Inpatient Hospice

We provide Benefits for Inpatient Hospice.

a. Covered Services are limited to services and supplies furnished by an Inpatient Hospice. Covered Services are limited to those You are eligible to receive as a Hospital bed patient and that would otherwise require confinement in a Hospital or Skilled Nursing Facility and also include the following services:

(1) Assessment and initial testing;

(2) Family counseling of Immediate Family Members;

(3) Professional, medical, social, and pastoral counseling services provided by salaried employees of the Hospice; and

(4) Supportive services to the bereaved family members for up to 3 months following the death of the Covered Person.

b. Covered Services do not include:

(1) Services for which there is no charge;

(2) Services related to organization or dispensation of nonmedical, personal, legal, and financial affairs such as, but not limited to, the execution of a will;

(3) Services received by persons other than the Covered Person or his Immediate Family Members;

(4) Respite care.

**Inpatient Hospice services must be Prior Authorized by Us.**

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**20. Infertility**

We provide Benefits for services received for (or in preparation for) any diagnosis of infertility. Treatment of infertility is limited to prescription drugs as indicated in the Benefit Schedule. Other Covered Services related to infertility are provided under this Benefit.

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**21. Infusion Therapy and Self-Injectables**

Infusion Therapy

We provide Benefits for infusion therapy services and supplies.

Infusion therapy is the administration of drugs or nutrients using specialized delivery systems which otherwise would have required You to be hospitalized. Infusion therapy in Your home or a Physician's office will be a Covered Service only if all of the following conditions are met:

a. If You did not receive infusion therapy at home or in Your Physician's office, You would have to receive such services in a Hospital or Skilled Nursing Facility; and

b. The services are ordered by a Physician and provided by an infusion therapy provider or Physician licensed to provide such services.

**These services must be Prior Authorized by Us.**

Injectables

We provide Benefits for injectables administered in the Physician's office or in the home setting**.** Covered Services include growth hormones, subject to the criteria defined in Our medical policy. Most injectables are covered under Your Outpatient Prescription Drug Benefit; however, certain injectables may be covered under this medical Benefit. Please refer to the Prescription Drug List for a listing of injectables that are covered under this medical Benefit or visit Our website at www.BlueKC.com for a current listing. This list is subject to change without prior notice and is based on the recommendations of community Physicians and pharmacists.

**These services may require Prior Authorization by Us.** Please contact Us at the telephone number listed on Your ID card for the current list of injectables that must be Prior Authorized.

Allergy injections and insulin are Covered Services under the Allergy and Diabetes Benefits.

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**22. Inpatient Hospital Services**

We provide Benefits for inpatient services at a Hospital for evaluation or treatment of conditions that cannot be adequately treated in an outpatient setting. Covered Services include room and board; general nursing care; intensive care services; operating and treatment rooms and their equipment; drugs, medications, and biologicals; durable medical equipment; emergency rooms and their equipment and supplies; dressings, splints, and casts; electroshock or drug-induced shock therapy; blood and the administration of blood and blood products. We may approve a lower level setting (such as Skilled Nursing Facility) in lieu of a Hospital through Case Management. **Personal care or convenience items are not covered.**

**All Admissions, except maternity and emergency Admissions, must be Prior Authorized by Us.** We require notification of emergency and maternity Admissions within 48 hours of the Admission or as soon as reasonably possible.

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**23. Maternity Services and Related Newborn Care**

We provide Benefits for maternity services. Covered Services include a nuchal translucency scan at 12-14 weeks gestation and a routine obstetrical ultrasound at 20 weeks. Covered Services are limited to pre-natal, obstetrical and postpartum services. Covered Services also include genetic testing of fetal tissue. Covered Services do not include carrier genetic testing.

Covered Services include an inpatient stay of at least 48 hours for a covered mother and covered newborn child following any vaginal delivery or 96 hours following a cesarean section delivery. If the attending Physician, after consulting with the mother, authorizes a shorter inpatient Confinement, We will provide Benefits for post discharge care. If the mother and newborn child are discharged early, Covered Services include post-discharge care for a covered mother and a covered newborn child by a Physician or registered professional nurse with experience in maternal and child health nursing. Such services include, but are not limited to, physical assessment of the mother and newborn child; parent education; assistance and training in breast or bottle feeding; education and services for immunizations; and, appropriate chemical tests and submission of a metabolic specimen to the state laboratory.

Services provided for a newborn child and routine Hospital nursery services provided during the Hospital Confinement are eligible for Benefits. Benefits shall also include coverage during the confinement for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

If a child is adopted by You within 90 days of birth, Covered Services include obstetrical and delivery expenses only for the birth mother incurred at the time of the birth of such child.

Complications of Pregnancy

Covered Services include care (medical or surgical) required for medical Complications of Pregnancy resulting from or occurring during a pregnancy.

Covered Services do not include elective pregnancy termination. Elective pregnancy termination does not include spontaneous abortion or services to prevent the death of the mother upon whom the procedure is performed.

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**24. Mental Illness and Substance Abuse**

We provide Benefits for the treatment of Mental Illness and Substance Abuse as indicated in the Benefit Schedule. New Directions Behavioral Health ("New Directions") performs intake services designed to provide crisis intervention, assessment, benefits management and referral services. Covered Services are provided for Medically Necessary outpatient evaluation and treatment of Mental Illness and Substance Abuse. For coverage for psychotherapeutic drugs, please see the Outpatient Prescription Drugs Benefit. Services for outpatient treatment will be covered to the same extent as any other illness as indicated in the Benefit Schedule. Covered Services for inpatient services are limited to Hospital and Physician services when You are confined in any Hospital or other residential facility licensed to provide such treatment. Services for inpatient treatment will be covered to the same extent as any other illness as indicated in the Benefit Schedule.

**Inpatient and Residential Mental Illness and Substance Abuse Services must be Prior Authorized by New Directions.**

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**25. Organ Transplants**

We provide Benefits for Organ Transplants**. These services must be Prior Authorized by Us.** In the event that You need an Organ Transplant, We encourage You to review these Covered Services with Your Physician.

Covered Organ Transplant Services

Covered Services are limited to services and supplies for Organ Transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ procurement, and ancillary services. Coverage is limited to the following transplants only when such transplants are Medically Necessary in accordance with Our Policies for transplantation services:

- Liver
- Cornea
- Kidney
- Pancreas
- Autologous Islet Cell

- Small Bowel
- Heart
- Lung(s)
- Kidney and Pancreas
- Small Bowel and Liver
- Small Bowel and Liver and Pancreas
- Small Bowel and Liver and Stomach
- Small Bowel and Liver and Colon
- Small Bowel and Liver and Pancreas and Stomach
- Small Bowel and Liver and Pancreas and Colon
- Small Bowel and Liver and Stomach and Colon
- Small Bowel and Liver and Pancreas and Stomach and Colon
- Heart and Lung(s)
- Allogenic and Autologous Bone Marrow and Stem Cell Transplants

Benefits will be paid at the Preferred Provider level only if Organ Transplant services are provided at a Designated Transplant Provider.

If Organ Transplant Services are provided at a provider that is not a Designated Transplant Provider, Benefits will be provided at the Non-Preferred Provider level.

Designated Transplant Provider

A Designated Transplant Provider is a provider who has entered into an agreement with Us, or through a national organ transplant network with which We contract to render Organ Transplant Services if designated by Us. Designated Transplant Providers will be determined by Us and may or may not be located within Our Service Area.

Donor Covered Services

The following apply when a human Organ Transplant is provided from a living donor to a transplant recipient:

a. When both the recipient and the donor are covered under the Contract, Health Care Services received by the donor and recipient will be covered.

b. When only the recipient is covered under the Contract, both the donor and the recipient are entitled to the Covered Services of the Contract. The donor's Covered Services are limited to only those benefits which are not provided by or available to the donor from any other source. This includes but is not limited to, other health care plan coverage or any government program.

c. When only the donor is covered under the Contract, Covered Services are limited to only those services which are not provided by or available to the donor from any other source. This includes, but is not limited to, other health care plan coverage or any government

program. Covered Services will only be provided to a transplant recipient who is a Covered Person.

d. Covered Services do not include any organ or tissue that is sold rather than donated to a recipient covered under the Contract. However, other costs related to evaluation and organ "Procurement Services" are covered.

As used herein, "Procurement Services" are the services provided to match the human organ donor to the transplant recipient, surgically remove the organ from the donor and transport the organ to the location of the recipient within 24 hours after the match is made.

Immunosuppressant Drugs

We provide Benefits for immunosuppressant drugs required as a result of a covered Organ Transplant under the Outpatient Prescription Drug Benefit.

Limitations

A Covered Person is eligible for Benefits for retransplantation as deemed Medically Necessary and appropriate by Us. Review for a retransplantation request will include review of the Covered Person's compliance with relevant transplant selection criteria including, but not limited to, adherence to medication regimens and abstinence from the use of alcohol and drugs. **All retransplantation must be Prior Authorized by Us.**

Exclusions

You have no Benefit for a nonhuman or mechanical Organ Transplant.

You have no Benefit for testing, typing, or screening when the person does not become a transplant or tissue donor.

You have no Benefit for transportation and lodging expenses associated with a transplant.

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**26. Osteoporosis**

We provide Benefits for the diagnosis, treatment and appropriate management of osteoporosis including bone density studies if Medically Necessary. Bone density studies for screening (non-symptomatic or no medical history) purposes are not covered, except as otherwise specified.

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**27. Outpatient Prescription Drugs**

Introduction/Prior Authorization

We provide Benefits for drugs and medicines for use outside a Hospital and/or obtained at a pharmacy that require a Physician's prescription. Certain medications or classes of medication may require Prior Authorization. To receive Prior Authorization, Your Physician will need to submit to Us a statement of Medical Necessity. Certain medications are subject to utilization programs that require You to try to use a therapeutic

alternative before another medication will be considered a Covered Service. Your Physician may submit to Us a statement of Medical Necessity if the utilization program is not appropriate for Your medical condition. Certain medications may be subject to a utilization program that limits the dispensed quantity of prescription medications in compliance with FDA-approved dosage guidelines.

Drug Rebates and Credits

We contract with a pharmacy benefit manager ("PBM") for certain prescription drug administrative services, including prescription drug rebate administration and pharmacy network contracting services.

Under the agreement, the PBM obtains rebates from drug manufacturers based on the utilization of certain prescription products by You and other Covered Persons, and PBM retains the benefit of the rebate funds prior to disbursement. In addition, pharmaceutical manufacturers pay administrative fees to the PBM in connection with PBM's services of administering, invoicing, allocating, and/or collecting rebates. Such administrative fees retained by the PBM in connection with its rebate program do not exceed the greater of (i) 4.58% of the Average Wholesale Price, or (ii) 5.5% of the wholesale acquisition cost of the products. AWP does not represent a true wholesale price, but rather is a fluctuating benchmark provided by third party pricing sources. PBM may also receive other service fees from manufacturers as compensation for various services unrelated to rebates or rebate-associated administrative fees.

In addition, We and the PBM also contract with pharmacies to provide prescription products at discounted rates for Covered Persons. The discounted rates paid by the PBM and Us to these pharmacies differ among pharmacies within a network, as well as between networks. For pharmacies that contract with the PBM, We pay a uniform discount rate under Our contract with the PBM regardless of the various discount rates PBM pays to the pharmacies. Thus, where our rate exceeds the rate the PBM negotiated with a particular pharmacy, the PBM will realize a positive margin on the applicable prescription. The reverse may also be true, resulting in negative margin for the PBM. In addition, when the PBM receives payment from Us before payment to a pharmacy is due, the PBM retains the benefit of the use of these funds between these payments. We are guarantee a minimum level of discount whether through the PBM or where we directly contract with network pharmacies, which could result in the amount paid by You to be more or less than the amount PBM and/or We pay to pharmacies.

We are not acting as a fiduciary with respect to rebate administration, pharmacy network management, or the prescription drug plan. We receive rebates from the PBM and may receive positive margin in connection with the pharmacy network, as well as other financial credits, administrative fees and/or other amounts from network pharmacies, drug manufacturers or the PBM (collectively "Financial Credits"). We retain sole and

exclusive right to all Financial Credits, which constitute Our property (and are not plan assets), and We may use such Financial Credits in Our sole and absolute discretion, including, for example, to help stabilize Our overall rates and to offset expenses, and We do not share Financial Credits with You.

Without limitation to the foregoing, the following ("Financial Credit Rules") apply: (1) You have no right to receive, claim or possess any beneficial interest in any Financial Credits; (2) Applicable drug benefit Copayment, Coinsurance, ,Deductible and/or maximum allowable benefits (including without limitation Calendar Year Maximum and Lifetime Maximum benefits) are in no way adjusted or otherwise affected as a result of any Financial Credits, except as may be required by law; (3) Any Deductible and/or Coinsurance that you must pay for prescription drugs is based upon the Allowable Charge at the pharmacy, and does not change as a result of any Financial Credits, except as may be required by law; and (4) Amounts paid to pharmacies or any prices charged at pharmacies are in no way adjusted or otherwise affected as a result of any Financial Credits.

Covered Drugs

We provide Benefits for Outpatient Prescription Drugs as identified in the Benefit Schedule, including psychotherapeutic drugs. To determine the applicable Outpatient Prescription Drug category and respective Cost-Sharing level for a drug, call the telephone number listed on Your ID card for a copy of the Prescription Drug List or visit Our website at www.BlueKC.com for the most current information. The list of drugs is subject to change without prior notice based on the recommendations of community Physicians and pharmacists.

Covered Services are limited to:

a. Legend drugs that, by federal law, can only be dispensed upon written prescription from an authorized prescriber

b. Compound medications that contain at least one legend drug in a therapeutic amount.

c. Off-label use of prescription drugs when treatment of the indication is recognized in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature. Your Physician must submit documentation supporting the proposed off-label use or uses if requested by Us

   For this specific Benefit, the following terms are defined as follows:

   "Peer-reviewed medical literature" means a published scientific study in a journal or other publication in which original manuscripts have been published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and that has been determined by the international committee of medical

journal editors to have met the uniform requirements for manuscripts submitted to biomedical 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 or health carrier.

"Off-label use of prescription drugs" means prescribing prescription drugs for treatments other than those stated in the labeling approved by the Food and Drug Administration.

"Standard reference compendia" means the United States pharmacopoeia drug information, the American Hospital formulary service drug information, or the American Medical Association drug evaluation or other sources that We deem credible.

d. Insulin, syringes, needles, lancets, test strips, oral anti-diabetic agents and glucometers

e. Oral and injectable contraceptive drugs

f. Contraceptive devices and implants which require a Physician's prescription; (medical services related to the administration of covered contraceptive devices and implants are Covered Services under the Contract).

g. Smoking cessation agents by prescription only, except as otherwise provided.

Covered Services are limited to drugs and medicines that have been approved for use in the United States by the Federal Food and Drug Administration (FDA) regardless of where the drugs are obtained. Drugs or medicines approved by the FDA for Experimental or Investigative Services are not covered. We may impose administrative limits on the quantity or frequency by which a drug may be dispensed. These limits will be based on recommendations of the drug manufacturer or by community Physicians and pharmacists.

Short-Term Supplies

Short-term prescriptions are for up to a 34 day supply. If Your Physician prescribes a prescription for more than a 34 day supply, You must obtain a refill for any quantity above the 34 day supply. The pharmacy will then file the claim for the prescription. See Your provider directory for a listing of participating pharmacies.

If the prescription is dispensed in a combination of different manufactured dosage amounts, You are only subject to Cost-Sharing for one prescription as indicated in the Benefit Schedule. If you are required to pay more than the Cost-Sharing for one prescription indicated in the Benefit Schedule at the pharmacy, You must submit a claim to Us for reimbursement.

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| Non-Participating Pharmacies | When a prescription is purchased at a non-participating pharmacy, You must pay the pharmacy for the cost of the prescription and submit a claim form to Us. We will reimburse You as indicated in the Benefit Schedule. |
| Long-Term Supplies | We provide Benefits for certain long-term prescriptions when obtained from a designated mail order prescription drug program. Call Us for instructions and forms for obtaining prescription drugs through the mail. Long-term prescriptions are for a 35 to 102 day supply. |
| Specialty Pharmaceuticals | We provide Benefits for Specialty Pharmaceuticals. Please refer to the Prescription Drug List for a listing of Specialty Pharmaceuticals and specialty pharmacies. In some cases, these drugs will be delivered to Your home.<br><br>Specialty Pharmaceuticals mean biotechnology drugs or other drug products that may require special ordering, handling, clinical monitoring and/or customer service. Specialty Pharmaceuticals are limited to a 34 day supply and are subject to the applicable Cost-Sharing indicated in the Benefit Schedule.<br><br>If You obtain Your specialty drug from a retail pharmacy, You will be required to pay higher Cost-Sharing for all fills of that specialty drug at a retail pharmacy, as indicated in the Benefit Schedule. Certain specialty drugs are required to be obtained from a designated specialty pharmacy. Please contact Customer Service for a list of such specialty drugs. |
| Maintenance Drugs | We provide Benefits for prescription maintenance drugs. Maintenance drugs are those medications that must be used on a continuing basis to treat a chronic condition. Maintenance drugs may be obtained from a retail pharmacy on a short-term basis or a designated mail order prescription drug program under the long-term supply prescription drug benefit. If You obtain Your maintenance drug from a retail pharmacy, after obtaining Your second refill of that specific maintenance drug, You will be required to notify Us, and/or Our pharmacy benefit manager (PBM), whether You intend to continue to obtain the maintenance drug from the retail pharmacy, or if You would like to begin obtaining such drug from a designated mail order pharmacy. Subsequent refills of the prescription maintenance drug must be obtained using Your designated method.<br><br>If You do not notify Us, and/or Our PBM, of Your preferred method after the second refill, You may be responsible for the entire cost of the medication.<br><br>You may change Your preferred method by notifying Us, and/or Our PBM prior to obtaining Your next maintenance drug refill.<br><br>You must pay the applicable Cost-Sharing for each prescription if indicated in the Benefit Schedule. |

Exclusions

Benefits for prescription drugs are subject to the exclusions stated in the Exclusions section of the Contract. In addition, Covered Services do not include any of the following:

a. Appetite suppressants, anorexiants and anti-obesity drugs;

b. Compounded medications with ingredients that do not require a prescription;

c. Experimental, Investigative or unproven services and medications; medications used for Experimental indications and/or dosage regimens determined by Us to be Experimental (including, but not limited to those labeled "caution - limited by federal law to Investigational use" and drugs found by the Food and Drug Administration to be ineffective);

d. Medications for cosmetic purposes, such as but not limited to isotretinoin, tretinoin (Retin-A), topical minoxidil, and finasteride;

e. Non-prescription/over-the-counter medications for smoking cessation or smoking deterrents (such as but not limited to nicotine replacement or other pharmacological agents used for smoking cessation);

f. Medications and other items available over-the-counter, including any medication that is equivalent to an over-the-counter medication, that do not require a prescription order or refill by federal or state law (whether provided with or without a prescription, except as otherwise specified in the Routine Preventive Care Benefit);

g. Medications with no approved FDA indications;

h. Immunization agents;

i. Drugs related to treatment that is not a Covered Service under the Contract;

j. Prescription drugs that are not Medically Necessary unless otherwise specified;

k. Anabolic steroids, anti-wrinkle agents, dietary supplements, Fluoride supplements, blood or blood plasma, irrigational solutions and supplies;

l. Lifestyle enhancing drugs, unless otherwise specified;

m. Medications and devices used for the treatment of impotency;

n. Drugs and devices that are intended to induce an abortion; or

o. Drugs obtained outside the United States for consumption in the United States.

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**28. Outpatient Surgery and Services**

We provide Benefits for outpatient surgery provided under the direction of a Physician at a Hospital or an outpatient facility. Covered Services are limited to the same services You would receive under the same conditions in a Hospital as a bed patient, except for the Hospital daily service charge.

**Certain outpatient surgeries and services must be Prior Authorized by Us in order to be Covered Services: Please contact Us at the telephone number listed on Your ID card for the current list of outpatient surgeries and services that must be Prior Authorized.**

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**29. Pediatric Dental**

We provide Benefits for dental services for children age 18 and under.

Basic Services

We provide Benefits for Basic Services. Basic Services include oral evaluations, x-rays, teeth cleanings, fluoride treatments, sealant treatments, and space maintainers.

Oral evaluations and prophylaxes (teeth cleanings) are limited to 2 per Calendar Year. Complete mouth survey x-rays or panoramic x-rays are limited to 1 every 3 Calendar Years. Bitewing x-rays are limited to 2 occurrences per Calendar Year. Fluoride treatments are limited to 3 per Calendar Year. Topical application of sealant on a posterior tooth is limited to no more than 1 treatment per tooth every 12 months.

Intermediate Services

We provide Benefits for Intermediate Services. Intermediate Services include fillings, recementation, sedative fillings, root canal therapy, endodontics, tooth extractions, alveoloplasty and general anesthesia.

Limitations: Benefits are not available for more than 1 direct pulp cap per tooth. Benefits are limited to 1 course of root canal therapy per tooth.

Major Services

We provide Benefits for Major Services. Major Services include crowns, inlays, onlays, bridges, dentures, partial dentures, maintenance of prosthodontics, and periodontics.

Limitations: Payment will not be provided for the relining of a denture if less than 6 months has elapsed since the date of insertion. Only 1 relining of a denture will be provided during any 2 Calendar Year period. Occlusal guard appliances (biteguards) will be provided only after active periodontal treatment and are limited to 1 every Calendar Year. Crowns are limited to 1 per tooth every 60 months. Prefabricated posts and cores that are in addition to a crown are limited to 1 per tooth every 60 months. Dentures are limited to 1 every 60 months.

Major Services include orthodontics only in the case of severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or traumatic facial injury resulting in serious health impairment to the Covered Person. Services for orthodontics must be Prior Authorized by Us.

Accident-related and other dental services for all Covered Persons are Covered Services under the Accident-Related and Other Dental Services Benefit.

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**30. Pediatric Vision**

We provide Benefits for vision services when provided to a Covered Person age 18 and under.

Covered Services include routine eye exams, eyeglasses, and contact lenses when received in lieu of eyeglasses. Services may be limited as indicated in the Benefit Schedule.

Covered Services for eyewear will be limited to the eyewear that meets the minimum specifications and is Medically Necessary. Covered Services do not include non-prescription (Plano) lenses, two pairs of eyeglasses in lieu of bifocals, or services/supplies that are cosmetic in nature. Covered Services do not include replacement of lost or stolen eyewear.

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**31. Physician Services**

We provide Benefits for Physician services unless otherwise noted. Covered Services are limited to the following:

a. Office visits.

b. Surgical and orthopedic services. Covered Services are limited to cutting and other operative procedures for treating illness or injury.

c. Surgical assistant services provided by a Physician. Covered Services are limited to the assistance at the operating table which is given to the operating Physician by another Physician. This assistance must be Medically Necessary, as determined by Us and in connection with procedures that normally require assistance. Covered Services do not include any activities of internship or residency, or any type of training.

d. Inpatient Specialist services. Covered Services are limited to those that are provided when a Covered Person has a medical condition that is not in the attending Physician's specialty and the attending Physician asks the opinion of a Physician with that specialty. Covered Services do not include staff consultations required by Hospital rules and regulations.

e. Hospital bed patient care by a Physician.

(1) General care. Covered Services are limited to a Physician's visits to a Covered Person if the reason for the Hospital stay is strictly to treat a medical condition and no surgical, orthopedic or obstetrical services are performed during that Confinement.

(2) Preoperative care. Covered Services are limited to visits by a Physician with a specialty different from that of the operating Physician, assistant surgeon or anesthesiologist for treatment of a condition unrelated to surgery.

(3) Postoperative care. Covered Services are limited to visits by a Physician other than the operating Physician, assistant surgeon or anesthesiologist if the reason for the visits is to treat a Covered Person for an acute phase of a medical condition a Covered Person either had before the surgical services, or that first began during the postoperative period.

(4) Intensive care. Covered Services are limited to visits by a Physician treating a Covered Person for a medical condition that requires constant attendance or frequent visits in a short period of time.

(5) Inpatient Hospice. Covered Services are limited to visits by a Physician treating a Covered Person for a medical condition while in an Inpatient Hospice Setting.

f. Home visits by a Physician.

g. Telehealth services for medical information exchanged from site to another via electronic communication to the extent the same service would be covered if provided through face to face diagnosis, consultation, or treatment. Covered Services do not include site origination fees, technological fees, or costs for the provision of telehealth services. Telehealth services will be subject to the same Cost-Sharing that would be applicable if the service were provided face to face.

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**32. Podiatry**

Routine Care

We provide Benefits for routine foot care only if the Covered Person has a disease such as diabetes that can potentially affect circulation and/or the loss of feeling in the lower limbs. Routine foot care means the paring and removal of corns and calluses or trimming of nails.

Bone Surgery

We provide Benefits for bone surgery on the foot.

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**33. Prosthetic and**

We provide Benefits for prosthetics and orthotics, other than foot orthotics

**Orthotic Devices** (including shoes).

Covered Services are limited to the purchase and fitting of prosthetic and orthotic devices that are necessary as a result of congenital defects, injury or sickness. Repairs or replacement of prosthetics are Covered Services only when necessary because of any of the following:

a. A change in the physiological condition of the patient;

b. An irreparable change in the condition of the device; or

c. The condition of the device requires repairs and the cost of such repairs would be more than 60% of the cost of a replacement device.

Purchase and fitting means the entire process necessary to provide a Covered Person's prosthesis (whether paid by Us or someone else) and may include one or more temporary prostheses, when Medically Necessary.

Repairs and replacement are not Covered Services if the need for repair or replacement is due to misuse or abuse of the device, or to the extent the device is covered under any warranty. Covered Services also do not include repair or replacement required as the result of stolen, lost, destroyed, or damaged devices. Covered Services also do not include replacement of prosthetic and orthotic devices due to changes in technology. Prosthetics that may enhance function after initial purchase are not Covered Services.

Benefits are limited to the amount available for a basic (standard) item which meets the minimum specifications to allow for necessary activities of daily living. Activities of daily living include bathing, dressing, eating, continence, toileting, transferring and/or ambulating. Charges for deluxe prosthetic or orthotic devices are not covered, except for those prosthetic or orthotic devices that are Medically Necessary for the Covered Person.

Diabetic shoes are Covered Services under the Diabetes Benefit.

**Prosthetic and orthotic devices must be Prior Authorized by Us.**

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**34. Radiation Therapy**

We provide Benefits for treatment of a medical condition with x-ray, radium, or radioactive isotopes.

**These services must be Prior Authorized by Us.**

**35. Reconstructive Surgery and Cosmetic Repair**

We provide Benefits for reconstructive surgery and cosmetic repair to correct birth defects or to correct a defect incurred through an Accidental Injury.

We also provide Benefits for reconstructive surgery when a functional impairment is present. A functional impairment is the inability of a body part or organ to perform its specific purpose.

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**36. Reconstructive Surgery / Prosthetic Devices Following a Mastectomy**

We provide Benefits for prosthetic devices and/or reconstructive surgery following a mastectomy. Covered Services are limited to: (1) reconstructive surgery on the breast on which the mastectomy was performed; (2) reconstructive surgery on the unaffected breast that is required to produce a symmetrical appearance; and (3) breast prostheses and physical complications in all stages of mastectomy, including lymphedemas. No time limit will be imposed on a Covered Person for the receipt of a prosthetic device or reconstructive surgery following a mastectomy.

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**37. Rehabilitative and Habilitative Services**

We provide Benefits for physical therapy, occupational therapy, speech therapy, and hearing therapy provided on an outpatient basis. These services may be subject to a Calendar Year Maximum as indicated in the Benefit Schedule.

Physical Therapy

Physical therapy services, including skeletal manipulations, provided by a Physician, Registered Physical Therapist or Licensed Physical Therapist are covered when these services are expected to result in significant improvement in a Covered Person's condition.

Occupational Therapy

Occupational therapy services provided by a Physician or Registered Occupational Therapist are covered when these services are expected to result in significant improvement in a Covered Person's condition. Occupational therapy is provided only for purposes of training Covered Persons to perform the activities of daily living.

Speech and Hearing Therapy

This is treatment for the loss or impairment of speech or hearing disorders provided by a speech pathologist, speech/language pathologist or audiologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association, or both, and which fall within the scope of such license or certification. Covered Services include examination, evaluation, counseling and any testing required to diagnose any loss or impairment of speech or hearing.

Covered Services do not include screening examinations or services arranged by or received under any health plan offered by any governmental body or entity including school districts for their students.

**38. Routine Preventive Care**

We provide Benefits for routine preventive care as required by state or federal law. Covered Services include examinations, labs, and immunizations. In addition, Benefits are provided for preventive care services that are evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force ("USPSTF"). With respect to women, Benefits are provided for evidence-informed preventive care and screenings described in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), as long as they are not otherwise addressed by the recommendations of the USPSTF. This includes coverage for contraceptives that require a prescription and elective sterilization for women. Such contraceptives are limited to Generic Drugs, unless a generic version is not available or Prior Authorization has been obtained for a Preferred or Non-Preferred Drug. If Prior Authorization is not obtained, Preferred or Non-Preferred Drugs are Covered Services under the Outpatient Prescription Drug Benefit. Covered services also include lactation support and counseling, and the cost of 1 breast pump within 6 weeks of delivery when prescribed.

The recommended list of required preventive care services described above may change periodically. When the list of recommended preventive care services changes, We will modify Your coverage when required to do so by federal law. A complete list of the preventive care services can be located at www.BlueKC.com or by contacting Us at the telephone number listed on Your ID card.

Examinations

We provide Benefits for routine preventive examinations and the related office visit. As part of such office visit, Benefits will be provided for screening for gestational diabetes in pregnant women identified to be at high risk for diabetes, and screening and counseling for interpersonal and domestic violence and abuse. Covered Services include prostate exams, pelvic exams, mammograms if ordered by a Physician, colorectal cancer exams consisting of digital rectal exam (including colonoscopy, flexible sigmoidoscopy, and double contrast barium enema), hearing exams, electrocardiograms (EKGs), chest x-rays and bone density screenings for women. Benefits for pelvic exams and mammograms include those performed at the direction of a Physician in a mobile facility certified by the Centers for Medicare and Medicaid Services (CMS).

Covered Services also include evidence-informed preventive care and screenings for infants, children, and adolescents provided for in the HRSA comprehensive guidelines and for newborn hearing screening, audiological assessment and follow-up.

Covered Services do not include the following: examinations or testing for or in connection with extracurricular school activities or any recreational activities; exercise programs or equipment such as, but not limited to, bicycles or treadmills; and examinations and testing for or in connection with entering school, licensing, employment, insurance, adoption, immigration and naturalization, or premarital blood testing.

Immunizations

We provide Benefits for the following routine preventive immunizations and the related office visit. Covered immunizations are limited to the parameters recommended by the Advisory Committee on Immunization Practices and adopted by the Center for Disease Control.

Covered Services include: catch-up for Hepatitis B; catch-up for varicella; catch-up for MMR; Tetanus boosters as necessary, including tetanus, diphtheria and pertussis, diphtheria and tetanus, and tetanus only; Pneumococcal vaccine; Influenza virus vaccine; Meningococcal vaccine; catch-up for Hepatitis A; HPV vaccine; Zoster vaccine; Polio vaccine; and Haemophilus Influenza Type b (Hib) vaccine.

Covered Services also include immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Covered Services do not include immunizations not specifically covered under the Contract, including but not limited to, immunizations required only for travel, work-related immunizations, Anthrax vaccine and Lyme Disease vaccine.

Lab Services

We provide Benefits for the following routine preventive lab services and the related office visit.

Covered Services include the following screenings: metabolic screening; glucose screening; and thyroid stimulating hormone screening. With respect to sexually transmitted infections, the following lab services are covered: HIV screening; HPV testing; Chlamydia Trachomatis testing; and Gonorrhea testing.

Covered Services also include the following tests: lead testing; Hemoglobin/Complete Blood Count (CBC); urinalysis; lipid cholesterol panel; prostate specific antigen (PSA) tests; pap smears; and fecal colon cancer tests (including fecal occult blood test, fecal immunochemical test, and stool DNA test).

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**39. Urgent Care Center and Retail Health Clinics**

We provide Benefits for urgent care services obtained at urgent care centers and retail health clinics. Urgent care services are Health Care Services required in order to prevent serious deterioration of Your health as a result of an unforeseen sickness or injury. Urgent care services

provided in a Physician's office on an urgent basis are covered under the Physician Services Benefit.

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**40. Vision Care**

We provide Benefits for non-routine vision care.

Eyewear following Surgery

We provide Benefits for either the first pair of eyeglasses or non-disposable contact lenses or refractive keratoplasty, only following cataract surgery. Benefits are limited to the amount available for a basic (standard) pair of eyeglasses which meet the minimum specifications to allow for necessary vision correction. Charges for eyeglasses which exceed a basic pair of eyeglasses are not covered, beyond the extent allowed for basic eyeglasses.

Orthoptic Training

We provide benefits for orthoptic training. Covered Services are limited to the treatment of convergence insufficiency for Covered Persons under the age of 18. This Benefit is subject to a Lifetime Maximum of 12 visits.

Eye Exam

We also provide Benefits for eye exams, including refraction, needed as a result of a covered medical illness or Accidental Injury. Vision care services for Covered Persons age 18 and under are Covered Services under the Pediatric Vision Benefit.

## SECTION D. EXCLUSIONS AND LIMITATIONS

**Covered Services do not include, and no Benefits will be provided for any of the following services, supplies, equipment or care; or for any complications, related to, or received in connection with, such services, supplies, equipment or care that are:**

1. For services or supplies received if there is no legal obligation for payment or for which no charge had been made; or for services or supplies received where a portion of the charge has been waived. This includes, but is not limited to full or partial waiver of any applicable Cost-Sharing.

2. For injuries or illnesses related to Your job to the extent You are covered or are required to be covered by a state or federal workers' compensation law or any comparable benefit that provides medical coverage for work-related injuries or illness whether or not You file a claim. If You enter into a settlement giving up Your right to recover past or future medical benefits under a workers' compensation law, We will not pay past or future medical benefits that are the subject of or related to that settlement. In addition if You are covered by a workers' compensation program that limits benefits to certain authorized providers, We will not pay for services You receive from providers, authorized or unauthorized, by Your workers' compensation program.

3. Not Medically Necessary.

4. Not specifically covered under the Contract.

5. Experimental or Investigative as determined by Us, except as specifically provided under the Clinical Trials Benefit.

6. For military service connected disabilities or conditions for which You are legally entitled to services and for which You have no obligation to pay.

7. For losses due in whole or in part to war or any action of war.

8. For Custodial, convalescent, or respite care, except as specifically provided under the Hospice benefit, including but not limited to meals delivered to Your home, companionship, and homemaker services, that do not require services of licensed professional nurses in Our opinion even if provided by skilled nursing personnel.

9. For music therapy, remedial reading, recreational therapy, and other forms of education or special education except as specified under the Diabetes benefit.

10. For marital counseling or counseling to assist in achieving more effective intra or interpersonal development; dietary counseling, except as specifically provided; decisional, social, or educational development; vocational development, or work hardening programs.

11. For removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes; or for cosmetic rhinoplasty, whether an independent procedure or done in conjunction with any other surgical procedure.

12. For cosmetic repair or reconstructive surgery, except as specifically provided for under the Reconstructive Surgery and Cosmetic Repair Benefit.

13. For any equipment or supplies that condition the air including environmental evaluations, heating pads, cooling pads (circulating or non-circulating), including hot water bottles, personal care items, items for comfort and convenience, spas, whirlpools, Jacuzzis, and any other primarily nonmedical equipment, stethoscopes, blood pressure devices, and Durable Medical Equipment that would normally be provided by a Skilled Nursing Facility.

14. For repairs and replacement of prosthetic and orthotic devices, except when necessitated as indicated in the Prosthetic and Orthotic Devices Benefit.

15. For wigs and their care.

16. For biofeedback, including neurofeedback.

17. For genetic testing, except as specifically provided under the Genetic Testing Benefit.

18. For court ordered services, including assessments, examinations, diagnostic tests, and genetic testing.

19. For collection and storage of autologous (self-donated) blood, umbilical cord blood, or any other blood or blood product in the absence of a known disease or planned surgical procedure.

20. Provided by You, Your Immediate Family Members or members of Your immediate household.

21. For vision services, except as otherwise specifically provided in the Contract, including but not limited to pleoptic training, orthoptic training that is not for convergence insufficiency, eyeglasses, contact lenses, and the examination for fitting of these items.

22. For hearing care services, except as otherwise specifically provided in the Contract, including but not limited to, hearing aids and the examination for fitting of these items.

23. Unless specifically covered under the Contract, for all dental services, complications of dental treatment; temporomandibular joint disorder; and orthognathic surgery. Injections for treatment of pain that are in close proximity to the teeth or jaw and due to a dental cause. For orthodontic treatment and surgical correction of a malocclusion.

24. Unless specifically covered under the Contract, for dental splints, dental prostheses, extractions or any treatment on or to the teeth, gums or jaws and other services customarily provided by a dentist. Services related to injuries caused by or arising out of the act of biting or chewing are also excluded.

25. For drugs and medicines that do not require a prescription for their use, except as otherwise specified in the Routine Preventive Care Benefit.

26. For chemosurgery, laser dermabrasion, chemical peel, salabrasion, collagen injections or other skin abrasion procedures associated with the removal of scars, tattoos and/or which are performed as a treatment of scarring secondary to acne or chicken pox.

27. For staff consultations required by Hospital rules and regulations.

28. For the treatment of obesity or morbid obesity, including but not limited to Mason Shunt, banding, gastroplasty, intestinal bypass, gastric balloons, stomach stapling, jejunal bypass, wiring of the jaw, as well as, related office visits, laboratory services, prescription drugs, medical weight reduction programs, nutrients, diet counseling (except as otherwise specified in the Contract) and Health Care Services of a similar nature whether or not it is part of a treatment plan for another illness. This exclusion also applies to any complications arising from any of the above.

29. For surgical procedures on the cornea including radial keratotomy and other refractive keratoplasty procedures, except when used to correct medical conditions other than refractive errors (such as nearsightedness) or following cataract surgery.

30. For hairplasty or hair removal, regardless of reason or diagnosis.

31. For orthotics and foot orthotics (including shoes) unless otherwise specified under the Contract.

32. For support/surgical stockings (for the lower extremities), including but not limited to custom made stockings.

33. For corrective shoes unless permanently attached to a brace.

34. For routine foot care, unless specifically covered under the Contract.

35. For or related to an Organ Transplant, except as specifically provided under the Organ Transplant Benefit.

36. For health and dental services resulting from Accidental Injuries arising out of a motor vehicle accident to the extent such services are payable under any expense payment provisions (by whatever terminology used, including such benefits mandated by law) of any automobile insurance policy.

37. For lodging or travel to and from a health professional or health facility.

38. For interest charges, document processing or copying fees, mailing costs, collection fees, telephone consultations, for charges when no direct patient contact is provided including but not limited to Physician team conferences, charges for missed appointments, charges for completion of forms or other non-medical charges.

39. Provided for an Emergency Medical Condition Admission in excess of the first 48 hours if We are not notified within 48 hours of the Admission, or as soon as reasonably possible.

40. Obtained in an emergency room which are not Emergency Services, unless Medically Necessary.

41. Health Care Services which are related to complications arising from treatments or services otherwise excluded under the Contract.

42. Health Care Services and associated expenses for megavitamin therapy; nutritional-based therapy for alcoholism, chemical dependency, or other medical conditions; services and supplies for smoking cessation programs and treatment of nicotine addiction, except as otherwise specified under the Contract.

43. Mental Illness and/or Substance Abuse services received from a Non-Participating Provider provided in connection with or to comply with involuntary inpatient commitments after the Covered Person has been screened and stabilized, unless the Covered Person cannot be safely transferred or there is not a Preferred Provider who will accept the transfer.

    For any assessment, evaluation, diagnostic test, or genetic test required by a diversion agreement or by order of a court to attend an alcohol or drug safety action program.

44. For assessments, evaluations, diagnostic tests, and genetic tests ordered or requested in connection with criminal actions, divorce, child custody, or child visitation proceedings.

45. For mental illness and substance abuse services received at a residential facility that does not provide for individualized treatment. Mental illness and substance abuse services provided by a residential facility that is not licensed or certified by the state in which such services are provided will not be covered.

46. For non-prescription enteral feedings and other nutritional and electrolyte supplements..

47. For personal care and convenience items.

48. Occupational therapy provided on a routine basis as part of a standard program for all patients.

49. Speech therapy for vocal cord training/retraining due to vocational strain and/or weak cords.

50. For speech therapy due to otitis media and ear infections, unless such services are to restore speech to a previous level of functioning.

51. Screening examinations or services available, arranged by, or received from any governmental body or entity, including school districts.

52. Received for (or in preparation for) any treatment for infertility (except for drugs, as provided under the Contract) by any name called and any related complications, except as specifically provided for under the Infertility Benefit. 'Infertility' as used here means any medical condition causing the inability or diminished ability to reproduce. Treatment for infertility shall include, but not be limited to, reversal of sterilization, all artificial means of conception including but not limited to sperm collection and/or preservation, sperm and egg and/or inseminated egg procurement and processing, banking of sperm and inseminated eggs, artificial insemination, in vitro fertilization, in vivo fertilization, embryo transplants, gamete intra fallopian transplant (GIFT), zygote intra fallopian transplant (ZIFT), and related tests and procedures, surrogate parenting (which includes donating ovum or ova, or carrying the fetus to term for another woman), not Medically Necessary amniocentesis, and any other experimental fertilization procedure or fertility drugs.

53. For Health Care Services and associated expenses for elective pregnancy termination. Elective pregnancy termination does not include spontaneous abortion or services to prevent the death of the mother upon whom the procedure is performed.

54. Received for (or in preparation for) any diagnosis or treatment of sexual dysfunction (including drugs and prosthesis) and any related complications unless the Covered Person has a documented disease resulting in impotence.

55. For cranial (head) remodeling devices, including but not limited to Dynamic Orthotic Cranioplasty ("DOC Bands") except for post-operative care or the treatment of congenital birth defects and birth abnormalities caused by synostotic plagiocephaly and craniosynostosis.

56. Except as specifically provided under Physician Services, for charges incurred as a result of virtual office visits on the Internet, including those for prescription drugs. A virtual office visit on the Internet occurs when a Covered Person was not physically seen or physically examined.

57. For services or supplies received from any provider in a country where the terms of any sanction, embargo, boycott, Executive Order or other legislative or regulatory action taken by the Congress, President or an administrative agency of the United States would prohibit payment or reimbursement by Us for such services.

58. For sales tax, to the extent it exceeds Our Allowable Charge.

59. For services, supplies, equipment or care received in connection with a non-covered service, supply, equipment or care.

60. For extracorporeal shock wave therapy due to musculoskeletal pain or musculoskeletal conditions and for electrical stimulation, except as specifically provided in the Electrical Stimulation Benefit.

61. For nutritional assessment testing and saliva hormone testing.

62. For services and materials not meeting accepted standards of optometric practice.

63. Services and supplies covered by Medicare Part A, Part B, or Part C (Medicare Advantage), regardless of whether or not You are actually enrolled in Medicare. This exclusion applies to all Covered Persons eligible to enroll under Medicare Part A, Part B, or Part C (Medicare Advantage), or otherwise entitled to Medicare benefits, from the date of their eligibility or entitlement to Medicare benefits, including Covered Persons who do not enroll or otherwise make application for Medicare benefits.

64. For the measurement of exhaled nitric oxide or exhaled breath condensate in the diagnosis and management of respiratory disorders.

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

66. For acupuncture, acupressure, rolfing, services provided by a massage therapist, aromatherapy and other forms of alternative treatment.

## SECTION E. HOW TO FILE A CLAIM

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**1. Hospital and Other Facility Services**

**a. For care received *inside* Our Service Area**

(1) Preferred or Participating Providers will file Your Claims for You. The facility will be paid directly by Us. You may be asked to make arrangements with such facility to pay for any non-Covered Services or Cost-Sharing amounts.

(2) If You receive care from a Non-Preferred Provider that is Non-Participating, it will be Your responsibility to make payment arrangements with the facility. Some Non-Preferred Providers that are Non-Participating will submit Your Claim for You. If not, You can obtain a Claim form from Us by calling the telephone number listed on Your ID card. The form will give You instructions for filing the Claim.

**b. For care received *outside* Our Service Area**

Claims should be filed directly with Us. If a Hospital or other facility will not file Your Claim for You, You can obtain a Claim form from Us by calling the telephone number listed on Your ID card. The form will give You instructions for filing the Claim.

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**2. Physician Services**

**a. For care received *inside* Our Service Area**

(1) Preferred or Participating Providers will file Your Claim for You. The Physician will be paid directly by Us. After the Physician receives Our payment, the Physician may bill You for any non-Covered Services or Cost-Sharing amounts for which You are responsible.

(2) Non-Preferred Physicians who are Non-Participating will sometimes file Your Claim for You. If a Non-Preferred Physician who is Non-Participating declines to file Your Claim for You, You can obtain a Claim form from Us by calling the telephone number listed on Your ID card. The form will give You instructions for filing the Claim.

**b. For care received *outside* Our Service Area**

If You ask, a Physician outside Our Service Area will frequently file Your Claim for You. Claims must be filed with Us. If the Physician declines to file Your Claim for You, You can obtain a Claim form from Us by calling the telephone number listed on Your ID card. The form will give You instructions for filing the Claim.

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| **3. Service Received From Providers Other Than Hospitals, Physicians and Facilities** | It is necessary for You to file a completed claim form with Us for these services. Contact Us at the telephone number listed on Your ID card for the proper Claim forms. The form will give You instructions for filing the Claim. |
| **4. Time Limits for Filing Claims** | We must receive proof of a claim for payment for Covered Services no later than 365 days after the end of the Calendar Year in which the service is received, unless it was not reasonably possible to give notice of proof within this time. We will deny any Claim not received within this time limit. |
| **5. Processing of the Filed Claim** | We make Our claim payment decisions based on the information We have when We receive a Claim. We make every effort to process Claims as quickly as possible. Claims will be paid immediately upon receipt of due written proof of loss. If We deny all or part of Your Claim, We will send You an Explanation of Benefits form or a letter explaining why it was denied under the terms of the Contract. We will also notify You if additional information is necessary to process the Claim. Payment of Claims for Covered Services received from Non-Participating Providers will be payable to the Covered Person. |
| **6. Claim Forms** | You may obtain Claim forms by requesting them from Us by calling the telephone number listed on Your ID card. If such forms are not furnished to You within 15 days after You request them, You shall be deemed to have complied with the requirements of this policy as to proof of loss if You submit written proof covering the occurrence, the character and the extent of the loss for which Claim is made within the Time Limits for Filing Claims. |

## SECTION F. COORDINATION OF BENEFITS (COB)

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**1. Coordination Of Benefits**

Individuals typically send their claims for medical services to every Plan that covers them. As a result, most plans have a Coordination of Benefits (COB) provision. A COB provision allows Plans to work together so that the total amount of all payments by all Plans will never be more than the Allowable Expense.

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**2. Definitions Applicable to this Section**

a. **Allowable Expense** means a medical expense or service including Deductibles, Coinsurance or Copayments that is covered in full or in part by one or more of the Plans covering the person for whom the claim is made. An Allowable Expense does not include dental coverage or group-type accident only coverage. If a Plan is advised that all plans covering a Covered Person are high-deductible health plans and the Covered Person intends to contribute to a health savings account, the primary high-deductible health plan's deductible is not an Allowable Expense, except for any health care expense incurred that is not subject to the deductible as described in Section 223(c)(2)(C) of the Internal Revenue Code of 1986. A medical expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense unless the private room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

When benefits are reduced under a primary Plan because a Covered Person did not comply with the Plan provisions, the amount of that reduction will not be considered an Allowable Expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services, or because the Covered Person has a lower benefit because the Covered Person did not use a Preferred Provider.

If the primary Plan is a Closed Panel Plan and the secondary Plan is not a Closed Panel Plan, the secondary Plan will pay or provide benefits as if it were primary when a Covered Person uses a non-Closed Panel provider, except for Emergency Services or authorized referrals that are paid or provided by the primary Plan.

If a Covered Person is covered under 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an Allowable Expense.

If a Covered Person is covered under 2 or more Plans that provide benefits or services on the basis of negotiated fees or if one Plan calculates its benefits or services on the basis of usual, customary and reasonable fees and another Plan provides its benefit on the basis of negotiated fees then any amount in excess of the highest of the Plan's fees is not an Allowable Expense.

b. **Closed Panel Plan** means a plan that provides health benefits to covered persons primarily in the form of services through a panel or provider that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

c. **Plan** means any arrangement that provides coverage for medical services. COB applies to only the following Plans:

(1) Group coverage, including insured, self-funded, accident only, or Closed Panel Plans.

(2) Individual coverage, including insured or Closed Panel Plans, issued on or after January 1, 2014.

(3) Coverage under any governmental program(s) to include any coverage required or provided by statute(s). Benefits available from Part A and Part B of Medicare are included. However, benefits under a state Medicaid program are not included;

(4) The medical care components of group long-term care contracts, such as skilled nursing care.

The term "Plan" applies separately to each policy, contract, or other arrangement for medical services. The term "Plan" also applies separately to that part of any such policy, contract, or other arrangement for medical services that coordinates its benefits with other Plans and to that part that does not.

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**3. Order of Benefit Determination Rules**

Plans use COB to determine which Plan should pay first (primary Plan) for the medical service. Benefits payable under another Plan include the benefits that would have been payable if You had filed a claim for them.

The order of benefit determination is based on the first of the following applicable rules:

**a. Non-Dependent:**

The benefits of a Plan which covers the person as other than a Dependent will be determined before the benefits of a Plan which covers such person as a Dependent.

**b. Dependent Child/Parents <u>not</u> Separated or Divorced:**

Except for a Dependent child whose parents are separated or divorced, the benefits of a Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. The word birthday refers only to the month and day in a Calendar Year, not the year in which the person was born.

If a Plan does not have the provisions of this paragraph b. regarding Dependents, which results either in each Plan determining its benefits before the other or each Plan determining its benefits after the other, the provisions of this paragraph b. shall not apply, and the rule set forth in the Plan which does not have the provisions of this paragraph b. shall determine the order of benefits.

**c. Dependent Child/Parents Separated or Divorced:**

In the case of a Dependent child whose parents are separated or divorced, benefits for the child are determined in this order:

(1) First, the Plan of the parent with custody of the child;

(2) Then, the Plan of the spouse of the parent with custody of the child; and

(3). Then, the Plan of the parent not having custody of the child;

(4) Finally, the Plan of the spouse of the noncustodial parent.

Notwithstanding (1), (2), (3) or (4) above, if there is a court decree which would otherwise establish financial responsibility for the medical expenses with respect to the child, the benefits of a Plan which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a Dependent child. If a court decree states both parents have financial responsibility for the medical expenses, then the provisions of paragraph b. of this subsection apply.

**d. Dependent Child/Joint Custody:**

If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the medical expenses of the child, the Plans covering the child shall follow the rules outlined in paragraph b. above for a Dependent child of parents who are not separated or divorced.

**e. Dependent Child of Non-Parents:**

In the case of a Dependent child covered under more than one plan of individuals wo are not the parents of the child, the order of benefits shall be determined, as applicable, under paragraph b. or c. of this subsection as if those individuals were parents of the child.

**f. Dependent Child / Spouse Coverage:**

If a person has coverage as a Dependent child under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the Plans shall follow the rules outline in paragraph i. below. If the coverage under the Plans began on the same date, the order of benefits shall be determine by applying the birthday rule outlined in paragraph b. above to the dependent's parent(s) and spouse.

**g. Active/Inactive Employee:**

The benefits of a Plan which covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired Employee (or as that Employee's Dependent). 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.

**h. Continuation Coverage:**

If a person whose coverage is provided under continuation of coverage pursuant to federal or state law is also covered under another Plan, benefits are determined in the following order:

(1) First, the Plan covering the person as other than a Dependent (or as that person's Dependent); and

(2) Second, the benefits under the continuation coverage.

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.

**i. Longer/Shorter Length of Coverage:**

If the above rules do not establish an order of benefit determination, the benefits of a Plan which has covered the person for a longer period of time shall be determined before the benefits of a Plan which has covered such person for a shorter period of time.

The claimant's length of time covered under a Plan is measured from his first date of coverage under that Plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

**j. Medicare:**

When benefits under the Contract are being coordinated with any benefits available by Medicare, the Federal Medicare Secondary Payor Rules in effect at that time will apply and this Coordination of Benefits section shall not apply.

**k. Plans without COB Provisions:**

If a Plan does not have a COB provision, it will always be considered as the primary Plan**.**

**l. Plans Share Equally:**

If none of the above rules determine the primary Plan, the Allowable Expenses shall be shared equally between the Plans.

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**4. Effect on the Benefits of this Plan**

a. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans for the claim does not exceed 100% of the total Allowable Expense for that claim. In determining the amount to be paid for any claims, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the Primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-Closed Panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and the other Closed Panel Plan.

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**5. Right to Receive and Release Necessary Information**

In order to decide if this COB section (or any other Plan's COB section) applies to a claim, We (without the consent of or notice to any person) have the right to:

a. Release to any person, insurance company or organization, the necessary claim information; and

b. Receive from any person, insurance company or organization, the necessary claim information.

Any person claiming Benefits under the Contract must give Us any information needed by Us to coordinate those Benefits.

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**6. Facility of Payment**

If another Plan makes a benefit payment that should have been made by Us, then We have the right to pay that other Plan any amount necessary to satisfy Our obligation.

## SECTION G. PREMIUM PAYMENT, GRACE PERIOD AND CHANGES

**1. Premium Payment**

Initial Premiums are due and payable on or before the Contract effective date. Subsequent Premiums are due and payable on or before the monthly Due Date. Premium payments received will be applied first to the oldest month due.

Premiums are owed by the Contractholder. Premiums may not be paid by third parties unless related to the Contractholder by blood or marriage, or unless the third party is one of the following organizations: (1) Ryan White HIV / AIDS Programs, (2) Indian tribes, tribal organizations, or urban Indian organizations, or (3) State and Federal Government Programs. We will not accept premium payments by third parties, including but not limited to hospitals, pharmacies, physicians, automobile insurance carriers, or other insurance carriers, unless required by law to do so. The fact that We may have previously accepted a premium from an unrelated third party does not mean that We will accept premiums from these parties in the future.

**2. Grace Period**

You shall have a grace period of 28 calendar days for the payment of any Premium, during which time the Contract shall continue in force. In no event shall the grace period extend beyond the date the Contract terminates. Coverage under the Contract will automatically terminate at 11:59 p.m. on the last day of the period for which Premiums have been paid if the grace period expires and any Premium remains unpaid.

**3. Reinstatement**

a. Reinstatement for Nonpayment of Premium

Except as provided below, if coverage under the Contract is terminated for nonpayment of Premiums, We have the right to decide whether or not to reinstate the Contract. Such decision will occur in writing within 45 days of receiving Your resubmission of a new application, if one is required, and payment of any outstanding Premium.

b. Reinstatement for Individuals Deployed in Military Service

If You terminate coverage as a result of Your or Your Dependent spouse's activation to military service, You may request Reinstatement of Your Contract for You and Your eligible Dependents who were covered under the Contract on the day before the Contract was terminated. You must request Reinstatement of Your Contract within 30 days following the later, the deactivation or loss of coverage under the federal government sponsored health insurance program and provide proof of loss of coverage, including the termination date, under the federal government sponsored health insurance program.

Notwithstanding the above, if a new Dependent child is acquired by the Contractholder due to the birth of a child or adoption of a child during the period of military activation, the new Dependent child may be enrolled for coverage under the Contract. To enroll, the Contractholder must submit to Us a completed application and any additional Premium due along with the request for Reinstatement of coverage.

Reinstatement rights will not be available for You or Your Dependents if You are discharged from the military under other than honorable conditions.

The Effective Date of the reinstated Contract will be the first of the month following receipt of the notice requesting Reinstatement.

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**4. Changes in Premiums**

Your Premiums are age rated based on You and Your Dependents age classification as of Your enrollment date. We will automatically change the amount of Your Premiums on Your next enrollment date if You or Your Dependents have had a birthday which places You or Your Dependents into the next age classification upon which Premiums are based.

If You or Your Dependents change Your coverage and receive a new enrollment date, We will automatically change Your Premiums if You or Your Dependents have had a birthday which places You or Your Dependents into the next age classification upon which Premiums are based.

Premiums are age-rated and if the Covered Person's age has been misstated, We will adjust the Premium for the Covered Person's coverage under the Contract in a subsequent statement sent to You.

The amount of Your Premium may change if You or any of Your Dependents use or have used tobacco.

The amount of Your Premium may change if You or any of Your Dependents change place of residence.

If We find that You fall into a different risk classification due to a misrepresentation made by You in Your application, We may change the amount of Your Premium. If Your Premium would have been higher had We known the correct information, You will owe Us the difference between what Your Premium would have been and the Premium You were charged. This amount will be calculated from the effective date of Your Contract. You shall have 30 days from the date We notify You to remit this amount.

## SECTION H. TERMINATING THE CONTRACT

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**1. Terminating a Covered Person's Coverage**

We may terminate the Contract and/or a Covered Person's coverage on the earliest of the dates specified below:

a. On the last day of the month for which Premium has been paid if You fail to pay any required Premium. We may recover from You Benefits We paid subsequent to the date of termination;

b. On the last day of the month a Dependent ceases to meet the eligibility requirements set forth in the "Dependent Eligibility" provision of the "Eligibility, Enrollment and Effective Date" section of the Contract, except as otherwise indicated for Dependent children;

c. On the date indicated in writing to You by Us if a Covered Person performs an act of fraud or makes an intentional misrepresentation of a material fact in connection with the coverage, provided that such termination will not occur unless written notice was provided 30 days in advance;

d. On the original Effective Date of coverage if coverage is terminated by Us due to a Covered Person committing fraud or intentionally misrepresenting a material fact on the application;

e. On the last day of the month in which the Contract is terminated because the Contractholder no longer resides in Our Service Area;

f. On the last day of the year in which the Contract is terminated because the Contractholder changes his place of residence within Our Service Area to the state of Missouri. Contact Us for other coverage that may be available to You;

g. On the last day of the month in which coverage under the Contract is terminated because We cease offering the particular type of coverage in the individual market provided by this Contract in accordance with applicable laws and regulations. If We discontinue offering this particular type of coverage, We will provide You 90 days written notice prior to the date coverage is discontinued and will offer You, on a guaranteed issue basis, the option to purchase any other individual health insurance coverage that We are currently offering; or

h. On the last day of the month in which the Contract is terminated because We cease offering all individual health insurance coverage in Kansas in accordance with applicable laws and regulations. If We discontinue all individual health insurance coverage in Kansas, We will provide You 180 days written notice prior to the date all such coverage will terminate.

i. On the last day of the Calendar Year in which You or Your Dependent reach the age of 30.

j. On the last day of the Calendar Year in which You or Your Dependent are no longer eligible for coverage due to a hardship exemption issued by a governmental entity. You or Your Dependent may be required to submit documentation of continued eligibility for such an exemption on an annual basis.

## SECTION I. GENERAL INFORMATION

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| **1. Terms and Conditions of the Contract** | The Contract is subject to amendment, modification or termination. The Contract may be modified at any time by Us as necessary to comply with state or federal laws or regulations. By electing coverage under the Contract, You agree to all terms, conditions and provisions hereof. |
| **2. Statements** | No statement made by a Covered Person in the application for coverage shall void coverage or be used in any legal proceeding against the Covered Person unless the application (or an exact copy) is included in or attached to the Contract or has been furnished to the Covered Person. |
| **3. Medical Examination** | To fulfill the obligations under the Contract, We may require a Covered Person to have a medical examination by a Physician of Our choice and at Our expense. |
| **4. Release of Records** | During the processing of Your Claim, We may need to review Your health records.<br><br>As a Covered Person, You hereby authorize the release to Us of all physical or mental health records related to Your Claim. Such authorization shall remain valid for no more than 24 months. This authorization constitutes a waiver of any provision of law forbidding such disclosure. Your records will be maintained with strict confidentiality. |
| **5. Reimbursement to Us** | a. Errors<br><br>We have the right to recover Benefits paid in error; including any Benefits We paid that exceed the amount needed to satisfy Our obligation. We have the right to recover the excess amount from You or any persons to, or for, or with respect to, whom such payments were made; any insurance companies or services plans; and/or any other organizations. Such individual or organization has the responsibility to return any overpayments to Us. We have the responsibility to make additional payment if an underpayment is made.<br><br>b. Misrepresentations<br><br>We have the right to recover payments from You for Claims submitted on behalf of You or any Covered Person under the Contract in the event that We rescind Your Contract due to fraud or intentional misrepresentation of material fact by Your or any Covered Person in Your application. |

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| **6. Legal Actions** | No action at law or equity shall be brought prior to the expiration of 60 days after written proof of loss has been furnished, nor after the expiration of 5 years after the time written proof of loss is required to be furnished. |
| **7. Conformity with Laws** | If any provision of the Contract conflicts with federal law or the laws of the state in which this Contract was issued for delivery, those provisions are automatically changed to conform to at least the minimum requirements of such laws. |
| **8. Commission or Omission** | No Hospital, Physician or other provider of service will be liable for any act of commission or omission by Us. We will not be liable for any act of commission or omission by: (1) any Hospital or Hospital's agent or employee; (2) any Physician or Physician's agent or employee; (3) any other providers of services or their agent or employee; or (4) You. |
| **9. Clerical Errors** | Clerical errors shall not deprive any individual of coverage under the Contract or create a right to additional coverage. |
| **10. Notice** | Written notice given by Us to the Contractholder is deemed notice to the Contractholder and the Contractholder's covered Dependents in the administration of the Contract, including termination of the Contract. |
| **11. Authority to Change the Contract** | None of Our agents, employees or representatives, other than the President and Chief Executive Officer or the Board of Directors, are authorized to change the Contract or waive any of its provisions. |
| **12. Assignment** | The Contract and all the rights, responsibilities and Covered Services under it are personal to You. Except for assignment of Claim payment to Preferred or Participating Providers, You may not assign them in whole or in part, either before or after services have been received, to any other person, firm, corporation or entity.<br><br>However, any Covered Services provided under the Contract and furnished by a facility of the uniformed services of the United States will be paid to that facility if a proper Claim is submitted by the provider. Such Claim will be paid with or without an assignment from You. |

In addition, any Covered Services provided under the Contract and furnished by a public Hospital or clinic will be paid to that public Hospital or clinic if a proper Claim is submitted by the provider and processed before We have made Our payment. Such Claim will be paid with or without an assignment from You.

No payment for Covered Services will be made to the public Hospital or clinic if payment for Covered Services has been made to You prior to Our receipt of a Claim from the public Hospital or clinic. Any payment made to the public Hospital or clinic will satisfy Our liability to the extent of that payment.

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**13. Medicaid**

The Covered Services provided under the Contract shall in no way be excluded, limited or restricted because Medicaid benefits, as permitted by title XIX of the Social Security Act of 1965, are or may be available for the same accident or illness.

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**14. Special Programs**

As an individual covered under the Contract, You may have the opportunity to take advantage of special programs offered at no additional costs to You. These programs are designed to help You with Your health care and/or related expenses. Special features of these programs are described in separate material provided to You.

These programs are made possible through arrangements with various providers and cooperating businesses. Changes in these arrangements and/or their discontinuance may occur at any time in the future at Our discretion.

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**15. Independent Licensee**

The Contract constitutes a Contract solely between Contractholder and Blue Cross and Blue Shield of Kansas City. Blue Cross and Blue Shield of Kansas City is an independent corporation operating under an agreement with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Blue Cross and Blue Shield of Kansas City to use the Blue Cross and Blue Shield Service Mark in a portion of the States of Missouri and Kansas. Blue Cross and Blue Shield of Kansas City is not contracting as the agent of the Association. No person, entity, or organization other than Blue Cross and Blue Shield of Kansas City shall be held accountable or liable to Contractholder for any of Blue Cross and Blue Shield of Kansas City's obligations to Contractholder created under the Contract. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Kansas City other than those obligations created under other provisions of the Contract.

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| **16. Gender** | Any use of the male pronoun in the Contract shall also apply equally to the female gender. |
| **17. Titles** | Titles used throughout the Contract are for convenience purposes only and do not change the terms of the Contract. |
| **18. Second Opinion Policy** | You have the right to seek a second medical opinion from a Preferred or Non-Preferred Provider. Benefits will be provided at the same level as for any other Covered Service rendered by that provider. |
| **19. Entire Contract** | The applications are incorporated by reference in this document and made a part of the Contract. The definitions contained in the Contract will have the defined meaning when used in this document with the first letter capitalized. The Contract and any amendments or riders thereto constitute the entire agreement between the parties and any change in the Contract must be signed by an officer of the Company to be valid. No agent or representative has the authority to change the Contract or waive any of the provisions. |
| **20. Time Limit on Certain Defenses** | In the absence of fraud, all statements made by the Covered Person are considered representations and not warranties and no statement made by the Covered Person voids coverage or reduces Benefits unless the statement is material to the risk assumed and contained in the written application. Furthermore, after the Covered Person's coverage has been in force for two (2) years from the Effective Date, no statement except fraudulent statements he has made will void the coverage or reduce the Benefits. A copy of the written application form is provided to You. |
| **21. Cancellation by You** | You may cancel this policy at any time by written notice delivered or mailed to Us. Such termination will be effective on the date We receive the notice or on a later date as may be specified in the notice. In the event of cancellation or death of the Covered Person, We will promptly return the unearned portion of any premium paid. Any premium refund will be calculated on a pro rata basis, based on the date of termination. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. |
| **22. PPO Provider** | At no additional cost, PPO Provider Directories are provided by Us and |

**Directory**

upon request when You call Us at the telephone number listed on Your ID card. In addition, You may access Our PPO Provider Directory on Our website at www.BlueKC.com.

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**23. Incentives**

We are committed to ensuring Your health and wellness. We may offer incentives to encourage You to access certain medical services and/or to participate in various wellness or disease management programs. Incentives may include, but are not limited to: services / supplies provided at no or minimal cost to You; gift cards; entries for a prize drawing; and/or merchandise. Eligibility for these incentive programs may be limited to Covered Persons with particular health factors. Participation in such programs has the potential to promote better health and to help prevent disease.

Certain incentives may be considered taxable income. You may wish to consult with Your tax advisor or legal counsel for further guidance.

## SECTION J. UTILIZATION REVIEW

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Utilization Review is undertaken for all medical/surgical inpatient Admissions, including acute care, skilled nursing and medical rehabilitation. Such review is performed using nationally licensed medical criteria. Our toll free telephone number for Utilization Review is on Your identification card.

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**1. Initial Determination**

For initial determinations, We will make the determination within 2 working days of obtaining all necessary information regarding a proposed Admission, procedure or service requiring Prior Authorization.

In the case of a determination to certify an Admission, procedure or service, We will notify the provider rendering the service by telephone within 24 hours of making the initial Certification, and provide written or electronic confirmation of the telephone notification to the Covered Person and provider within 2 working days of making the initial Certification.

In the case of an Adverse Determination, We will notify the provider rendering the service by telephone within 24 hours of making the Adverse Determination, and will provide written or electronic confirmation of the telephone notification to the Covered Person and the provider within one working day of making the Adverse Determination.

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**2. Concurrent Review Determination**

For Concurrent Review determinations, We will make the determination within one working day of obtaining all necessary information.

In the case of a determination to certify an extended stay or additional services, We will notify by telephone the provider rendering the service within one working day of making the Certification, and provide written or electronic confirmation to the Covered Person and the provider within one working day after the telephone notification. The written notification will include the number of extended days or next review date, the new total number of days or services approved, and the date of Admission or initiation of services.

In the case of an Adverse Determination, We will notify by telephone the provider rendering the service within 24 hours of making the Adverse Determination, and provide written or electronic notification to the Covered Person and the provider within one working day of the telephone notification. The service will be continued without liability to the Covered Person until the Covered Person has been notified of the determination.

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**3. Reconsideration**

In the case of an initial determination or a Concurrent Review determination the provider may request a reconsideration of an Adverse

Determination. This reconsideration will occur within one working day of the receipt of the request.

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**4. Retrospective Review Determinations**

For Retrospective Review determinations, We will make the determination within 30 working days of receiving all necessary information. We will provide notice in writing of Our determination to the Covered Person within 10 working days of making the determination.

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**5. Case Management**

Case Management focuses primarily on providing an appropriate level of care in a non-acute setting. The intent of Case Management is to ensure the provision of Medically Necessary care in the most appropriate setting for a Covered Service.

Case Management may approve an extension of Covered Services' Benefits beyond the limits specified in the Contract. In addition to the Covered Services specified in the Contract, Case Management may approve other Medically Necessary services when warranted by the Covered Person's particular needs.

It may also include any plan of care set forth to promote health and prevent illness and injury of the Covered Person. This Case Management plan is not designed to extend Covered Services' Benefits or provide other Medically Necessary services to persons who do not meet the Case Management plan standards and criteria. We may elect to provide Benefits furnished by any provider pursuant to Our approved treatment plan for Case Management.

We shall provide any extension of Covered Services' Benefits or other Medically Necessary services when We determine the person meets the appropriate standards and criteria, and only when and for so long as it is determined that the extension of Benefits for Covered Services or provision of other Medically Necessary services is appropriate, Medically Necessary and cost effective. Such Benefits shall count toward a Covered Person's Calendar Year Maximum (if applicable).

The implementation of a Case Management plan shall require the approval of the affected Covered Person or his legal representative and the affected person's Physician.

If We elect to extend Benefits for Covered Services or provide other Medically Necessary services for a Covered Person in one instance, it shall not obligate Us to provide the same or similar services for any Covered Person in any other instance, nor shall it be construed as a waiver of Our right to thereafter administer the Covered Service in strict accordance with the terms of the Contract.

## SECTION K. COMPLAINT AND GRIEVANCE PROCEDURES

We have a formal process that gives You the right to express Complaints, either by telephone, or in writing, regarding Our claim payment decisions or other aspects of Our service, and to receive a response from Us explaining Our actions. This feedback is a valuable tool that helps Us enhance the quality of Our products and services and serve You as effectively as possible. The following procedures will be used to address any Complaints that You or any other Covered Person may have.

### 1. Definitions Applicable to this Section

**Inquiry** means a question or request for information or action. Usually an Inquiry can be resolved on initial contact with no follow-up action required.

**Complaint** means an oral allegation made by a Covered Person of improper or inappropriate action, or an oral statement of dissatisfaction with Covered Services, Claims payment, or policies that do not fall within the definition of a Grievance.

**Grievance** means a written Complaint submitted by or on behalf of a Covered Person regarding (a) the availability, delivery or quality of Covered Services, including a Complaint regarding an Adverse Determination made pursuant to Utilization Review; (b) Claims payment, handling or reimbursement for Health Care Services; or (c) matters pertaining to the contractual relationship between a Covered Person and Us. A Grievance may be submitted by a Covered Person, a Covered Person's representative, or a provider acting on behalf of a Covered Person.

**Expedited Review** means the procedure for the review of a Grievance (which may be submitted either orally or in writing) involving a situation where the time frame of the standard Grievance procedure would seriously jeopardize the life or health of a Covered Person or would jeopardize the Covered Person's ability to regain maximum function. However, for purposes of the Grievance register requirements, the request will not be considered a Grievance unless the request is submitted in writing.

**Expedited Review Emergency Medical Condition** means:

a. The sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part or would place a person's health in serious jeopardy;

b. a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the insured or would jeopardize the insured's ability to regain maximum function; or

c. a medical condition for which coverage has been denied based on a determination that the recommended or requested Health Care Service or treatment is experimental or investigational, if the insured's treating physician certifies, in writing, that the recommended or requested Health Care Service or treatment for the medical condition would be significantly less effective if not promptly initiated.

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**2. Complaint Procedures**

Our customer service representatives are available to answer Inquiries about claims and Benefits. However, You are encouraged to discuss Complaints concerning medical care with the Physician or other health care provider.

A Covered Person should refer to his ID card for a toll-free number to call for instruction or any questions regarding Benefits, Claims, appeals or Grievance procedures.

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**3. Procedures for Filing a Grievance**

If You prefer to file a formal Grievance, You may do so by requesting a Member Grievance form from Us by calling the telephone number on Your ID card, and submitting the form to Us. In order to request a first level Grievance, Your request must be filed within three hundred sixty-five (365) days from the date: (a) You received notice of an Adverse Determination made pursuant to Utilization Review, or (b) for Post-Service Claims, You received the Explanation of Benefits.

**The Grievance form must be sent to the attention of the Appeals Department.** We will acknowledge receipt of the Grievance within 10 working days unless it is resolved within that period of time. Upon request, We will provide You with copies of all documents, records, and other information relating to the Claim for Benefits. You have the opportunity to submit written comments, documents, records and other information relating to the Claim for Benefits. We must receive such documents prior to Our review of Your Claim. We will take into account all comments, documents, records and other information from You or Your authorized representative, regardless of whether the information was considered in the initial Benefit determination.

We will conduct a complete investigation of the Grievance within 20 working days or 30 calendar days, whichever is less, after receipt of the Grievance for Pre-Service Claims and within 20 working days after receipt of the Grievance for Post-Service Claims, unless the investigation of the Post-Service Claim cannot be completed within this period of time. If the investigation for Post-Service Claims cannot be completed within the 20 working days, We will notify You in writing before the 20th working day. The notice will state the reasons for which additional time is needed for the investigation. The investigation will be completed within 30 working days thereafter, but no more than 60 calendar days after receipt of the

Grievance for Post-Service Claim. We will notify You and/or Your representative and the person who submitted the Grievance, provided such disclosure does not violate Title II of HIPAA, in writing of Our decision within 5 working days from the day We make a determination. If the denial is upheld, the notification will include the principal reason for the denial and any clinical rationale. The notification will also explain Your additional appeal rights.

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**4. Procedures to Request an Expedited Review**

If the time frame of the standard Grievance procedure would jeopardize the life or health of the Covered Person, a request for an Expedited Review may be submitted orally or in writing. We will notify You orally within 72 hours after receiving a request for an Expedited Review of Our decision. We will send written confirmation of Our decision within 3 working days of providing oral notification of Our decision.

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**5. External Review of Adverse Determination**

You have the right to request an independent external review of an Adverse Determination by the external review organization established by the Commissioner of Insurance. Your right to request an independent external review of an Adverse Determination applies only if:

a. You have exhausted all available review procedures listed above, unless You have an Emergency Medical Condition in which case the Expedited Review is utilized; or

b. You have not received a final decision from Us within 60 days of seeking the above available review procedures, except to the extent that the delay was requested by You.

Within 120 days of receiving a notice of an Adverse Determination, You, Your Provider with Your written authorization, or Your legally authorized representative may request an external review in writing to the Commissioner of Insurance. Your request shall include all information in Your possession pertaining to the Adverse Determination, an appeal form and a fully executed medical records release for the Commissioner of Insurance and the external review organization to obtain any necessary medical records.

The Commissioner of Insurance will determine whether Your request for an external review will be granted within 10 business days after receiving all necessary information. If granted, the external review organization will issue a written decision regarding Your Adverse Determination to You within 30 business days. In the event that an Expedited Review Emergency Medical Condition exists, the external review organization will issue such decision not more than 72 hours after the date of receipt of the request for an expedited external review, or as expeditiously as the Covered Person's medical condition or circumstances require.

In no event shall the Covered Person be held responsible for any portion of the external review organization's fee for performance.

Only 1 external review is available for any request arising out of the same set of facts during a period of 12 consecutive months beginning on the date of the initial request for external review. If We fail to strictly adhere to all appeal procedure requirements as prescribed by law, then You shall be deemed to have exhausted all available review procedures. You have the right to request an independent external review of an adverse decision when any error We committed was de minimis.

The decision of the external review organization may be reviewed directly by the district court at the request of You or Us. The review by the district court shall be de novo.

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**6. Department of Insurance**

You may also contact the Kansas Insurance Department by mail or telephone at 420 S.W. 9th Street, Topeka, KS 66612-1678 or toll free at 1-800-432-2484.

**The following pages are not a part of this Contract, but contain important information and are provided here for your convenience in locating this information if needed.**

## COVERED PERSON'S RIGHTS AND RESPONSIBILITIES

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**1. You have the right to:**

a. Receive considerate and courteous care with respect and recognition of personal privacy, dignity and confidentiality.

b. Have a candid discussion of medically necessary and appropriate treatment options or services for your condition from any participating physician, regardless of cost or benefit.

c. Receive Medically Necessary and appropriate care or services from any participating Physician or other participating health care provider from those available as listed in Your managed care plan directory or from any Non-Participating physician or other health care provider.

d. Receive information in clear and understandable terms, and ask questions to ensure You understand what You are told by Your Physician and other medical personnel.

e. Participate with practitioner in making decisions about Your health care, including accepting and refusing medical or surgical treatments.

f. Give informed consent to treatment and make advance treatment directives, including the right to name a surrogate decision maker in the event You cannot participate in decision making.

g. Discuss Your medical records with Your Physician and have health records kept confidential, except when disclosure is required by law or to further Your treatment.

h. Be provided with information about Your PPO managed health care plan, its services and the practitioners and providers providing care as well as the opportunity to make recommendations about your rights and responsibilities.

i. Communicate any concerns with Your PPO managed health care plan regarding care or services You received, receive an answer to those concerns within a reasonable time, and initiate the complaint and grievance procedure if You are not satisfied.

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**2. You have the responsibility:**

a. Respect the dignity of other members and those who provide care and services through Your PPO managed health care plan.

b. Ask questions of Your treatment Physician or treatment provider until You fully understand the care You are receiving and participate in developing mutually agreed upon treatment goals to the degree possible.

c. Follow the mutually agreed upon plans and instructions for care that you have discussed with your health care practitioner, including those regarding medications. Comply with all treatment follow-up plans, and be aware of the medical consequences of not following instructions.

d. Communicate openly and honestly with Your treatment provider regarding Your medical history, health conditions, and the care You receive.

e. Keep all scheduled health care appointments and provide advance notification to the appropriate provider if it is necessary to cancel an appointment.

f. Know how to use the services of Your PPO managed health care plan properly.

g. Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

**AMENDMENT ISSUED BY**
**BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

AMENDMENT: PPOI-203-16-K

It is mutually understood and agreed that the Contract is amended as follows:

**In Section C., Covered Services, under Pediatric Vision, the following is added:**

> Covered Services also include fitting for contact lenses. Such services will be subject to the applicable Cost-Sharing indicated for All Other Covered Services in the Benefit Schedule.

This amendment is attached to and made part of Your Contract. Except as specifically stated, nothing contained in this amendment will be deemed to alter any of the provisions of Your Contract.

Danette Wilson
President and Chief Executive Officer
Blue Cross Blue Shield of Kansas City

**AMENDMENT ISSUED BY**
**BLUE CROSS AND BLUE SHIELD OF KANSAS CITY**

AMENDMENT: PPOI-200-16-MK

It is mutually understood and agreed that the Contract is amended as follows:

## Inter-Plan Arrangements

### I. Out-of-Area Services

#### Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area We serve, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of Our service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how We pay both kinds of providers.

#### Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by Us to provide the specific service or services.

#### A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, We will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive Covered Services outside Our service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a

discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price We have used for your claim because they will not be applied after a claim has already been paid.

### B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, We may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) made available to Us by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, you will incur no liability, other than any related patient cost sharing under this contract.

### C. Special Cases: Value-Based Programs

*BlueCard® Program*

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Us through average pricing or fee schedule adjustments.

### D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

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

### E. Nonparticipating Providers Outside Our Service Area

#### 1. Member Liability Calculation

When Covered Services are provided outside of Our service area by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment We will make for the Covered Services as set

forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

**2. Exceptions**

In certain situations, We may use other payment methods, such as billed charges for Covered Services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount We will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment We will make for the Covered Services as set forth in this paragraph.

**F. BlueCard Worldwide® Program**

- **Emergency Care Services**

This contract covers only limited health care services received outside of the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands. These Covered Services include emergency care and urgent care. Follow-up care following an emergency is also available provided the services are preauthorized by Blue Cross and Blue Shield of Kansas City. Any other services will not be eligible for benefits unless authorized by Blue Cross and Blue Shield of Kansas City.

This amendment is attached to and made part of Your Contract. Except as specifically stated, nothing contained in this amendment will be deemed to alter any of the provisions of Your Contract.

Danette Wilson
President and Chief Executive Officer
Blue Cross Blue Shield of Kansas City

GENERAL PURPOSES AND LIMITATIONS OF THE
KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
K.S.A. 40-3001, et. seq.

**DISCLAIMER**

THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR ALL OR A PORTION OF THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS AND EXCLUSIONS, AND IS CONDITIONED UPON RESIDENCY IN THIS STATE. THEREFORE, YOU SHOULD NOT RELY UPON COVERAGE BY THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELLING YOU ANY FORM OF AN INSURANCE POLICY, OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU HAVE REGARDING THIS DOCUMENT.

Kansas Life and Health Insurance Guaranty Association
2909 SW Maupin Lane
Topeka, KS 66614
Ph.: 785-271-1199
Fax: 785-272-0242

Kansas Insurance Department
420 SW 9th Street
Topeka, KS 66612
Ph.: 785-296-3071

This is a brief summary of the Kansas Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. If there is any inconsistency between this notice and Kansas law, then Kansas law will control.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Kansas law, with funding from assessments paid by other insurance companies. This safety net was created under Kansas law, which determines who and what is covered and the amounts of coverage. The basic protections provided by the Association are:

- **Life Insurance**
  $300,000 in death benefits
  $100,000 in cash surrender or withdrawal values
- **Health Insurance**
  $500,000 in hospital, medical and surgical insurance benefits
  $300,000 in disability insurance benefits
  $300,000 in long-term care insurance benefits
  $100,000 in other types of health insurance benefits
- **Annuities**
  $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits, as well as certain aggregate limits.

# BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

# PRIVACY PRACTICES NOTICE

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**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.**

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## Summary of Our Privacy Practices

We may use and disclose your medical information, without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We may disclose to your employer whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose summary health information to your employer for certain limited purposes. We may disclose your medical information to your employer to administer your group health plan if your employer explains the limitations on its use and disclosure of your medical information in the plan document for your group health plan.

We will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

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## Contact Information

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Office.

Contact Office: Privacy Office
Blue Cross and Blue Shield of Kansas City
P. O. Box 417012
Kansas City, MO 64141

Telephone: 816-395-3784 or toll free at 1-800-932-1114
Fax: 816-395-2862
E-Mail: privacy@bluekc.com

## Organizations Covered by this Notice

This notice applies to the privacy practices of the organizations listed below. They may share with each other your medical information, and the medical information of others they service, for the health care operations of their joint activities.

Blue Cross and Blue Shield of Kansas City

Good Health HMO, Inc.

Blue-Advantage Plus of Kansas City, Inc.

Missouri Valley Life and Health Insurance Company

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## Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 1, 2006 and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our health plan subscribers at the time of the change.

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## Uses and Disclosures of Your Medical Information

**Treatment:** We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

**Payment:** We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

**Health Care Operations:** We may use and disclose your medical information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

**Your Authorization:** You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice.

**Family, Friends, and Others Involved in Your Care or Payment for Care:** We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

**Your Employer:** We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan. Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the summary health information as yours.

We may disclose your medical information and the medical information of others enrolled in your group health plan to your employer to administer your group health plan. Before we may do that, your employer must amend the plan document for your group health plan to establish the limited uses and disclosures it may make of your medical information. Please see your group health plan document for a full explanation of those limitations.

**Health-Related Products and Services:** We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

**Public Health and Benefit Activities:** We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

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## Your Rights

If you wish to exercise any of the rights set out in this section, you should submit your request in writing to our Privacy Office. You may obtain a form by calling Customer Service at the phone number on the back of your ID card to make your request.

**Access:** You have the right to examine and to receive a copy of your medical information, with limited exceptions.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Office for information about our fees.

**Disclosure Accounting:** You have the right to a list of instances after April 13, 2003, in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to your additional requests. Contact our Privacy Office for information about our fees.

**Amendment:** You have the right to request that we amend your medical information.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

**Restriction:** You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. Any agreement we may make to a request for restriction must be in writing signed by a person authorized to bind us to such an agreement.

**Confidential Communication:** You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request.

We will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

**Electronic Notice:** If you receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Privacy Office to obtain this notice in written form.

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## Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information, you may complain to our Privacy Office.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.