GROUP: 0944803 – HDHP

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ISSUED TO: SISTERS OF CHARITY OF LEAVENWORTH 12/21/2017
GROUP ID: 0944803 INSURED ID:

An Independent Licensee of the
Blue Cross Blue Shield Association.

COMPREHENSIVE MAJOR MEDICAL GROUP CONTRACT

This Contract describes the benefits provided by Blue Cross and Blue Shield of Kansas, Inc. (herein called "Blue Cross and Blue Shield of Kansas" or "the Company") Topeka, Kansas, and the exclusions and limitations. This Contract is guaranteed to be renewable by the Contract Holder and cannot be cancelled by Blue Cross and Blue Shield of Kansas except for specified situations described in the Cancellation section of this Contract.

Blue Cross and Blue Shield of Kansas
Home Office: 1133 SW Topeka Boulevard, Topeka, Kansas 66629

This Group Contract is issued to

SISTERS OF CHARITY OF LEAVENWORTH
(called the Contract Holder in this Contract)

Group Number: 0944803

In consideration of the payment of premiums by the Contract Holder, Blue Cross and Blue Shield of Kansas agrees to provide the benefits described in this Contract. Coverage under this contract begins at 12:01 a.m. Central Time at Leavenworth, KS on January 01, 2018 (called the Contract Date in this Contract) and continues after that from month to month, unless the Contract is terminated. Premiums are due and payable in advance of the Contract Date and after that by the first day of each successive month, unless the group is billed quarterly or semi-annually, in which case premiums are due and payable in advance of the Contract Date and after that by the first day of the month in which the premium is due.

Blue Cross and Blue Shield of Kansas signed this Contract on December 06, 2017.

To the extent that benefits of this Contract are part of an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act (commonly known as ERISA), Blue Cross and Blue Shield of Kansas shall have the full and exclusive authority to construe covered benefits that are stated in the Contract.

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

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

Form FL-911 1/17

What's Available To You:

The following information is either provided to You as an insured, or is available to You upon request:

- A complete description of the health care services, items and other benefits to which You are entitled.
- A complete description of limitations, exceptions and exclusions of Your health benefit plan.
  - A listing of contracting providers, their business addresses, telephone numbers, availability and any network limitations.
  - A notification in advance of any changes in the health benefit plan which either reduces coverage or benefits, or increases the cost of the plan.
  - A description of the appeal procedures available under the health benefit plan and Your rights regarding termination, disenrollment, nonrenewal or cancellation of coverage.

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

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

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

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

Form FL-895 1/17

Privacy of financial information is of concern to all of us, and in response to these concerns, the federal government has required states to adopt laws that require insurance companies to explain their privacy practices. This federal law is commonly referred to as Gramm-Leach-Bliley and is separate from the federal law commonly referred to as HIPAA Privacy which became effective on 4/14/2003 and for which You have been sent the Notice of Privacy Practices concerning protected health information as required by that law. Our privacy practices for "non-public personal financial information" are set out below. We want to assure You that we take Your privacy concerns seriously, and join with Your lawmakers in believing this disclosure of such practices is an important idea.

OUR PRIVACY PRACTICES REGARDING FINANCIAL INFORMATION

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

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

We collect such information from the following sources:

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

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

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

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

Form FL-12 5/08

GENERAL DEFINITIONS

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

A. Accidental Injury: an unintended injury to Your body caused through external means. "Accidental Injury" does not include: injuries that occur before the date from which You have had continuous coverage with the Company; disease or infection (except for infection that occurred from an accidental cut or wound); hernia; injuries to the teeth caused by biting or chewing.

B. Alternate Recipient: any child of an Insured who is recognized under a Qualified Medical Child Support Order as having a right to enrollment under this Contract.

C. Benefit Period: the length of time during which a benefit is paid.

D. Blue Cross Company and/or Blue Shield Company: the Company and any other corporation approved or licensed by the Blue Cross Blue Shield Association to use the registered service marks and names.

E. Certificate: a document describing the benefits and provisions of the Group Contract which is issued to each Insured.

F. Coinsurance: the percentage of the allowable charge You pay for covered services per Benefit Period.

G. Company: Blue Cross and Blue Shield of Kansas.

H. Company Service Area: the State of Kansas except Johnson and Wyandotte Counties.

I. Contract or Group Contract: the Contract between the Company and the Contract Holder and includes: all of the forms issued to the Contract Holder by the Company, including endorsements, amendments, and riders.

J. Contracting Provider: an Eligible Provider who has entered into a Contracting Provider Agreement with the Company.

K. Convalescent Care, Custodial/Maintenance Care or Rest Cures: treatment or services, regardless of by whom recommended or where provided, in which the service could be rendered safely and reasonably by self, family, or other caregivers who are not Eligible Providers. The purpose of the services are designed mainly to help the patient with daily living activities, to maintain their present physical and mental condition, or provide a structured or safe environment.

L. Copayment: a fixed amount of the allowable charge You pay for a covered service per instance of that service.

M. Credible Evidence: scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations or consensus among experts.

N. Deductible: a fixed amount of the allowable charge You pay for covered services per Benefit Period.

O. Designated Telehealth Provider: the Eligible Provider contracting with the telehealth entity designated by the Company.

P. Eligible Provider: any of the following providers when services provided are within the scope of the licensure of the provider. NOTE: Providers recognized by Medicare as Independent Diagnostic Testing Facilities (IDTFs) are not considered Eligible Providers unless they meet the applicable criteria as set out in the definitions below.

1. **Ambulance Service:** any form of transportation specially designed, equipped, and intended to be used for the purpose of transporting ill or injured persons and is operated according to state and local laws which control the issuing of valid licenses or permits for the operation of an Ambulance Service.
2. **Ambulatory Surgical Center:** a facility that meets all of the following criteria:
   a. is licensed by the proper licensing agency as an ambulatory surgical center
   b. is not a part of a Hospital
   c. provides hospital-type services for Outpatient surgery
3. **Professional Provider:** any of the following health practitioners licensed or certified to provide health services in the state of Kansas:
   a. Advanced Registered Nurse Practitioner (ARNP)/Advanced Practice Registered Nurse (APRN)
   b. Any of the following when authorized to engage in private, independent practice under the laws of the state in which covered services are received:
      (1) Licensed Clinical Marriage and Family Therapist (LCMFT)
      (2) Licensed Clinical Professional Counselor (LCPC)
      (3) Licensed Clinical Psychotherapist (LCP)

(4) Licensed Marriage and Family Therapist (LMFT)

(5) Licensed Professional Counselor (LPC)

(6) Licensed Specialist Clinical Social Worker (LSCSW)

c. Athletic Trainer (AT)
d. Audiologist (AUD)
e. Autism Specialist or Intensive Individual Service Provider as defined by the Kansas Department for Aging and Disability Services
f. Certified Diabetes Educator (CDE)
g. Certified Nurse-Midwife
h. Certified Registered Nurse Anesthetists (CRNA)
i. Doctor of Chiropractic (DC)
j. Doctor of Dental Surgery (DDS)
k. Doctor of Medicine (MD)
l. Doctor of Optometry (OD)
m. Doctor of Osteopathy (DO)
n. Doctor of Podiatric Medicine (DPM)
o. Licensed Acupuncturist (LAC)
p. Licensed Addiction Counselor (LAC)
q. Licensed Bachelor's Social Worker (LBSW)
r. Licensed Dental Hygienist (LDH)
s. Licensed Dietitian (LD)
t. Licensed Master's Level Addiction Counselor (LMAC)
u. Licensed Master's Level Psychologist (LMLP)
v. Licensed Master's Social Worker (LMSW)
w. Licensed Mental Health Technician (LMHT)
x. Licensed Naturopathic Doctor (LND)
y. Licensed Physical Therapist (LPT)
z. Licensed Practical Nurse (LPN)
aa. Licensed Radiological Technologist (LRTC)
bb Licensed Respiratory Therapist (LRT)
cc. Occupational Therapist (OT)
dd. Oral Surgeon
ee. Physician Assistant (PA)
ff. Psychologist licensed to practice under the laws of the state in which covered services are received
gg. Registered Nurse (RN)
hh. Registered Pharmacist (RPH)
ii. Speech-Language Pathologist (SLP)

4. **Free-Standing Birthing Center:** a facility, operated by a licensed physician, that performs uncomplicated normal/routine (i.e., non-Cesarean) deliveries of newborns.
5. **Free-Standing Cardiac Catheterization Laboratory:**
   a. A facility approved by Medicare to perform diagnostic cardiac catheterization procedures
   b. Performs only diagnostic cardiac catheterization procedures
   c. Does so in a non-Hospital outpatient setting

6. **Free-Standing Dialysis Center:** a facility approved by Medicare to perform dialysis and related services.
7. **Free-Standing Imaging Center:** a facility operated by a licensed physician and approved by Medicare to perform specialized diagnostic and radiologic tests.
8. **Free-Standing Sleep Center/Laboratory:** a facility that only performs sleep studies.
9. **Home Health Agency:** a public agency or private organization which is primarily engaged in providing Skilled Nursing Care services and other therapeutic services in the patient's place of residence that:
   a. Has policies established by a group of professional personnel which governs the Skilled Nursing Care and therapeutic services which it provides;
   b. Maintains clinical records on all patients;
   c. Is licensed according to state and local laws;
   d. Is certified by Medicare.
10. **Hospital:** any of the following types of institutions:
    a. The acute care, psychiatric, rehabilitation and long-term acute care sections of a licensed general hospital
    b. Other facilities licensed by their state of operation as a hospital that provide acute care services
    c. Licensed privately operated psychiatric hospitals
    d. Health care institutions operated by the State of Kansas or the United States government

    Hospital does **not** include any of the following, even if licensed as a hospital:
    a. Ambulatory Surgical Centers
    b. Clinics
    c. Doctors' offices
    d. Facilities that are primarily for the care of convalescents
    e. Health resorts
    f. Nursing homes
    g. Private homes
    h. Residential or transitional living centers
    i. Residential treatment centers or similar facilities
    j. Rest homes
    k. Skilled Nursing Facilities
11. **Independent Laboratory:** a medical laboratory that is CLIA-certified Medicare to perform diagnostic and/or clinical tests and is independent of an Institutional Provider or a Professional Provider's office.
12. **Institutional Provider:** a Hospital, Medical Care Facility, or Ambulatory Surgical Center.
13. **Medical Care Facility:** a facility that is not a Hospital (see definition) but that is: an alcoholic treatment facility; a drug abuse treatment facility; or a community mental health center. To qualify as a Medical Care Facility, the facility must also be licensed by the State of Kansas to provide diagnosis and/or treatment of a Mental Illness or Substance Use Disorder.
14. **Other Eligible Providers** (as limited herein)**:**
    a. Adjunct Providers: only the following providers that perform Covered Services under the direction of a Professional Provider.
       (1) Certified Occupational Therapy Assistant
       (2) Certified Physical (Therapy) Therapist Assistant
    b. Orthopedic/Prosthetic Device Supplier
    c. Home Medical Equipment Supplier
    d. Infusion Therapy Providers licensed to provide infusion therapy in the state in which services are received, e.g., infusion suites, home infusion therapy providers.
    e. Specialty Pharmacy for dispensing Specialty Prescription Drugs eligible for coverage under the Comprehensive Program.

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

g. Ancillary Provider: a Home Medical Equipment Supplier, an Independent Laboratory, an Air Ambulance, or a Specialty Pharmacy located outside the Company Service Area.

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

Q. Eligible Provider for Mental Illness or Substance Use Disorders:

1. A Hospital
2. A Medical Care Facility
3. A Licensed Doctor of Medicine or Doctor of Osteopathy
4. A psychologist licensed to practice under the laws of the state in which covered services are received
5. A Licensed Specialist Clinical Social Worker authorized to engage in private, independent practice under the laws of the state in which covered services are received
6. Advanced registered nurse practitioner
7. A Licensed Clinical Marriage and Family Therapist
8. A Licensed Clinical Professional Counselor
9. A Licensed Clinical Psychotherapist

R. Except as limited: a phrase You will see before explanations of Covered Services. It means that all coverage under this Contract is controlled by the conditions described in this Contract, including exclusions.

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

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished and the drug or device is not Research-Urgent as defined in these General Definitions except for Prescription Drugs used to treat cancer when the Prescription Drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or
2. if Credible Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined in these General Definitions except for Prescription Drugs used to treat cancer when the Prescription Drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or
3. if Credible Evidence shows that the consensus among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined in these General Definitions except for Prescription Drugs used to treat cancer when the Prescription Drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or
4. if there is no Credible Evidence available that would support the use of the drug, device, medical treatment or procedure compared to the standard means of treatment or diagnosis except for Prescription Drugs used to treat cancer when the Prescription Drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

T. Identification Card: a card issued to identify You as an Insured of the Company.

U. Inpatient: a setting where services are provided when You have been admitted to a Hospital or Medical Care Facility.

V. Insured: the person named on the Identification Card.

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

1. The spouse of the Insured; and
2. Each dependent of the Insured or the Insured's spouse, by birth, adoption, legal guardianship, or court-ordered custody, who is:

   a. Under 26, or

b. Age 26 or over provided the child is unmarried and covered as a dependent child under a policy or certificate issued by the Company or other creditable coverage (as defined under HIPAA) upon reaching age 26, has no more than a 63-day gap in dependent or handicapped dependent coverage prior to application for coverage hereunder, and is incapable of self-support due to a severe handicap resulting from a physical condition or a Mental Illness or Substance Use Disorder prior to their 26th birthday. For such a child to be an Insured, You must request from and submit to the Company a special application within 63 days of the latter of the following: a) the child's 26th birthday (but no earlier than 60 days prior); or b) the first opportunity for the child to enroll for coverage hereunder or accrual of a special enrollment right pursuant to HIPAA. The Company will then determine the child's eligibility. If the child is eligible, the coverage will be effective according to the specifications set forth in the Enrollment and Effective Dates Section.

The Company will request written proof from time to time related to this child's incapacity and dependence. This child's coverage will end when the child is no longer disabled or dependent.

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

W. Intensive Care Unit: a specialized room or area or section in a Hospital which includes:

1. Beds in a distinctly identifiable unit that are used only for critically ill or injured patients
2. A separate nursing staff, with a qualified Registered Nurse in 24-hour attendance while the unit is occupied ("Qualified" means the nurse has had special training in intensive care nursing.)
3. Special supplies and equipment needed to care for critically ill or injured patients

X. Medical Emergency: a sudden and, at the time, unexpected onset of a health condition that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect to require immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. Medical Emergency does not include the onset of a health condition while an Inpatient. A health condition is no longer considered a Medical Emergency once stabilization (i.e., no material deterioration of the health condition is likely to result from a transfer or during a transfer) has occurred.

Y. Medically Necessary: a service or supply that is:

1. performed, referred, and/or prescribed by a duly licensed provider; and
2. provided in the most appropriate setting and consistent with the diagnosis and treatment of the Insured's condition; and
3. in accordance with the current generally accepted standards of medical practice in the United States based on credible scientific evidence; and
4. not primarily for the convenience of the patient, physician or other health care provider; and
5. not more costly than an alternative service or supply or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the Insured's illness, injury or disease.

Z. Medicare: Title XVIII of the Social Security Act as amended now and in the future, any rules and regulations authorized by any agency authorized to administer that Act.

AA. Member Employer: a participating employer of the organization named as the Contract Holder on the front of the Group Contract.

BB. Mental Illness or Substance Use Disorder: a disorder specified in the Diagnostic and Statistical Manual of the American Psychiatric Association IV (1994). This does not include any condition or problem that is designated in the DSM IV (1994) as a focus of clinical attention.

CC. Non-Contracting Provider: an Eligible Provider who has not entered into a Contracting Provider Agreement with the Company.

DD. Open Enrollment: the period of time during which eligible persons who have not previously enrolled with the Company within the time periods specified, following their first opportunity or an event, as defined by state or federal law, that qualifies them for coverage, may do so. This time period is the 30 days preceding the anniversary month of the Contract Holder. If agreed upon by the Contract Holder and the Company, different, additional or longer Open Enrollment Periods may be established.

EE. Out-of-Pocket Maximum: the total amount of applicable cost sharing under the Comprehensive Program, Prescription Drug Program and/or Mail Order Prescription Drug Program for which You are responsible per Benefit Period. If You are enrolled in a Dental Care Program, the applicable dental cost sharing amounts do not apply to this Out-of-Pocket Maximum. The Out-of-Pocket Maximum never includes Your premium, balance-billed charges, or health care Your health insurance or plan doesn't cover.

FF. Outpatient: a setting where provided services are other than as an Inpatient in a Hospital or Medical Care Facility. These settings include but are not limited to the Outpatient department of a Hospital, an Ambulatory Surgical Center, a clinic or a Professional Provider's office.

GG. Prescription Drug: a drug approved for general use in the United States by the U.S. Food and Drug Administration, assigned a National Drug Code (NDC) number and dispensed in compliance with federal or state laws pursuant to a Prescription Order or refill, and approved by Pharmacy Benefit Manager and/or Pharmacy and Therapeutics Committee. The P & T Committee has up to 120 days to determine a Prescription Drug status on the Formulary.

HH. Rehabilitation Services: therapies that, when provided in an Inpatient or Outpatient setting, are designed to restore physical functions following an Accidental Injury or an illness.

II. Research-Urgent: a drug, device, medical treatment or procedure that is otherwise excluded by this Contract as Experimental or Investigational (see General Definitions and General Exclusions) but meet all the following criteria:

1. It is therapeutic (not diagnostic or supportive) treatment used to directly improve health outcomes for a condition that is either life threatening or severely and chronically disabling and that has a poor prognosis with the most effective conventional treatment.
    a. For purposes of Research-Urgent Benefits a condition is considered life threatening if it has a substantial probability of causing premature death and all other conventional treatments have failed.
    b. For purposes of Research-Urgent Benefits a condition is considered severely and chronically disabling if the individual with the condition is unable to perform even the functions that are required for daily life and if the severe disability is not expected to improve with the most effective conventional treatment.
2. There is Credible Evidence that the treatment may provide a clinically significant and substantial improvement in net health outcome compared to the most effective conventional treatment, or where conventional treatment has failed or is not medically appropriate.
3. Regardless of funding source, the drug, device, medical treatment or procedure is available to the Insured seeking it and will be provided within a well designed clinical trial conducted by the National Institute of Health, Inc. or by an institution or entity which the protocol for the drug, device, medical treatment or procedure has been approved by an Institutional Review Board that is in compliance with the ethical principles in: (a) The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research or the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, or (b) other appropriate ethical standards recognized by federal departments and agencies that have adopted the Federal Policy for the Protection of Human Subjects.

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

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

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

MM. Subscribing Employer to the Trust: a participating unit of the Trust named as the Contract Holder on the front of the Group Contract.

NN. Telehealth Service: the use of person-to-person electronic communication between the Company's Designated Telehealth Provider and the Insured to provide HIPAA-compliant remote access for diagnosis, intervention, consultation, supervision and information in an outpatient setting. Services do not include the means, technology, or support required to receive such services.

OO. Telemedicine Service: provider-initiated use of telecommunications and information technology to provide remote access to health assessment, diagnosis, intervention, consultation, supervision and information, utilizing Company approved technologies between an approved originating site (acute care hospitals, practitioner or physician offices, rural health clinics, Federally Qualified Health Center, Skilled Nursing Facilities, or community mental health centers) and an approved distance site where the physician or practitioner is providing the professional service.

PP. Trust: an arrangement of two or more employers to whom the Group Contract is issued.

QQ. You and Your: refer to the definition of Insured.

Form GD-2234 1/18

ENROLLMENT AND EFFECTIVE DATES

In order to enroll or make a change due to any of the events listed below, an employee or Insured must notify the Company, through their employer or Contract Holder, within 60 days of a triggering event. This may require the submission of a change form. The addition of new Insureds due to one of these triggering events may require a change in coverage type and/or additional premiums.

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

A. Special Enrollment

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

1. Triggering Events effective on the first of the month following the event
   a. Involuntary loss of other medical coverage in which:
      -- The other coverage was the basis for You, Your spouse, and/or dependent(s) declining coverage hereunder; AND
      -- The loss of other coverage occurred solely due to one of the following designated triggering events: loss of eligibility for such coverage or exhaustion of COBRA or state continuation coverage. Note: Special Enrollment Rights are not recognized if coverage and/or eligibility was lost due to any of the following: failure on the part of the employee, spouse, or dependent, as applicable, to pay contributions/premiums on a timely basis, submission of fraudulent claims, or intentional misrepresentation of material information.
   b. Adding a dependent or becoming a dependent through marriage. Applicable to the employee, spouse, and any newly-acquired dependent(s) only.
   c. Complete cessation of employer contributions toward non-continuation group coverage
   d. Becoming eligible for a state premium assistance program under Medicaid or a state Children's Health Insurance Program (CHIP). Applicable to the employee and dependent(s) only.
2. Triggering Events effective the date of the event
   a. Adding a dependent through birth, adoption or placement for adoption: for the employee, spouse, and any newly-acquired dependent(s) only.
      (1) If the current coverage provides benefits for only the parent(s) of the newborn child, coverage must be changed to a type which provides benefits for dependent children within 60 days of a triggering event, in order for the newborn child's coverage to continue beyond the initial 48 or 96 hour period.
      Covered services received by the child prior to coverage being changed to a type that provides benefits for dependent children, will be treated as though they were services received by the parent Insured.
      (2) A newborn, an adopted child (regardless of age) or a child placed in the Insured's home by a child placement agency, as defined by state law for the purpose of adoption, is covered as follows, if the type of coverage is for two or more Insureds:
      (a) Coverage is effective and provided without charge for 31 days beginning on the date of birth for:
      i. natural newborns
      ii. newborns for which the petition for adoption has been filed within 31 days following birth
      Exception: If the petition of adoption is filed after 31 days of birth, coverage will be effective the date the petition for adoption was filed and provided without charge for 31 days.
      iii. newborns placed in the Insured's home within 31 days following birth
      Exception: If a child is placed after 31 days of birth, coverage will be effective the date of placement and provided without charge for 31 days.

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

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

Form EN-889 1/18

COMPREHENSIVE PROGRAM

A. Benefits

1. **Benefit Period:** The 12 month period beginning on January 1.
2. **Deductible per Benefit Period:** $3,000 for any one Insured, not to exceed $6,000 for all Insureds on family coverage. The family Deductible can be met by eligible costs incurred by any combination of Insureds enrolled under the same family plan. However, no one Insured will have to pay more than the per Insured Deductible.
3. **Coinsurance:** Except for Prescription Drugs, the Company will make benefit payments for 100% of the allowable charge after the Deductible has been met.
4. **Out-of-Pocket Maximum:** $6,350 for any one Insured not to exceed $12,700 for all Insureds on family coverage. The family Out-of-Pocket Maximum can be met by eligible costs incurred by any combination of Insureds enrolled under the same family plan. However, no one Insured will have to pay more than the per Insured Out-of-Pocket Maximum. After You have reached the Out-of-Pocket Maximum, eligible services will be paid at 100% of the allowable charge for the remainder of the Benefit Period. If You are enrolled in a dental care program, Coinsurance applicable to the dental care program does not apply to this Out-of-Pocket Maximum.
5. **Accidental Injuries:** The Deductible and/or Coinsurance provisions of this Program do apply to Accidental Injuries.
6. **Preventive Health Benefits:** Each Insured is eligible to receive the following preventive services paid at 100% of the allowable charge when received from a Contracting Provider for preventive (i.e., not diagnostic or treatment) purposes. Preventive Health Services received from a Non-Contracting Provider will be subject to the cost-sharing requirements (including copayments, coinsurance and deductible), applicable hereunder, in a manner consistent with 42 U.S.C. 300gg-13 for:

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

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

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

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

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

   Note: Benefits for any Prescription Drug under this Preventive Health Benefits section will be provided only to the extent they are not available under other drug coverage You have through the Contract Holder.
7. **Any reduction made in allowable charges** due to the provider being non-contracting cannot be used to meet any Deductible, Coinsurance, Copayments and/or the Out-of-Pocket Maximum if applicable.
8. **Mental Illness or Substance Use Disorders:** Covered Services must be provided by an Eligible Provider for Mental Illness or Substance Use Disorders. Benefits for Inpatient and Outpatient Mental Illness or Substance Use Disorder services that are Medically Necessary will be provided at the same payment level that is applicable to the service if it had been provided for a condition other than Mental Illness or Substance Use Disorder. No annual dollar limits will apply.
9. **Diabetic Education**

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

    Benefits will be subject to the Deductible provision listed above. After the Deductible has been met, the Copayment provisions of the Prescription Drug Program and Mail Order Prescription Drug Program will apply.
11. **Speech Therapy:** Benefits are limited to one service per day up to a maximum benefit of 90 daily services per Insured per Benefit Period. Any services for Mental Illness or Substance Use Disorders will apply to

the maximum limit. Once the maximum is met, any services for Mental Illness or Substance Use Disorders will continue to be subject to the cost sharing for this service.

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B. General

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

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C. Covered Services

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

1. **Hospital and Medical Care Facility services for Inpatients --** Except as limited, the following are covered:
   a. Room accommodation, dietary and general nursing service, nursery care.

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

   b. Intensive Care Unit facilities and services.

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

   c. Operating room services.
   d. Delivery room service. (Including the obstetrical and delivery expenses of the birth mother of a child adopted within 90 days of birth of such child).
   e. Surgical preparatory and recovery room services
   f. Clinical laboratory and pathology services.
   g. Diagnostic radiology services and Imaging studies.
   h. Radiation therapy
   i. Drugs approved for use in the United States by the U.S. Food and Drug Administration, except drugs approved for experimental use and drugs for take-home use.
   j. Surgical dressings, splints, and casts.
   k. Chemotherapy, other than High-Dose Chemotherapy, for malignant conditions. (See the Special Situations section for High-Dose Chemotherapy with Hematopoietic Support benefits.)
   l. Prostheses that require surgical insertion into the body and are furnished and billed by the Hospital or Ambulatory Surgical Center. This does not include artificial eyes, ears, and limbs.
   m. Setups for intravenous solutions.
   n. Setups for blood transfusions, (including Blood plasma).
   o. Oxygen and use of equipment for its administration.
   p. Radioactive isotopes.
   q. Electroencephalograms (EEGs) and electrocardiograms (EKGs).
   r. Inhalation therapy/breathing treatment.
   s. Physical or occupational therapy.

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

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

(2) A person who is severely disabled

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

u. Hemodialysis.

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

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

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

Prior Authorization Requirement

Inpatient admissions to Hospitals and Medical Care Facilities require prior authorization by the Company unless the admission is for a Medical Emergency, a life-threatening condition, for obstetrical care or occurs outside the 50 United States.

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

The Company has the right to request and obtain whatever medical information it considers necessary to determine whether admission as an Inpatient is Medically Necessary. If it is, the Company will notify You, the Hospital and the admitting physician of approval. If inpatient admission is not deemed Medically Necessary You will be notified, as will be the Hospital and admitting physician. Prior authorization of an admission or any service is related solely to the medical necessity of the service and is not a determination of the eligibility of the service under other provisions of this Contract.

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

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

Except as limited, Covered Services by a Hospital for an Outpatient will include all services listed in C.1.c through v when the service is received in the Outpatient department of the Hospital.

3. **Ambulatory Surgical Center Services.**

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

4. **Professional Provider Services.**

a. Except as limited, the following are covered:

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

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

(b) A person who is severely disabled

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

(2) Treatment of fractures and dislocations.

(3) Biopsies and aspirations.

(4) Endoscopic (scope) procedures.

(5) Maternity services (including the obstetrical and delivery expenses of the birth mother of a child adopted within 90 days of birth of such child).

(6) Medical (non-surgical) services for Inpatients in a Hospital or Medical Care Facility. (See 4.b for details of this benefit.)

(7) Diagnostic radiology services and Imaging studies.

(8) Diagnostic laboratory services.

(9) Radiation therapy.

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

(11) Diagnostic radio isotope studies.

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

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

(14) Home and office visits.

(15) Immunizations, injections and infusions subject to any prior authorization requirements of this Contract that are otherwise applicable to these services.

(16) Allergy testing.

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

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

(19) Pap Smears.

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

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

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

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

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

(25) Diagnosis and treatment of cause of infertility

b. The covered Medical (Non-Surgical) Services for Hospital or Medical Care Facility Inpatients include:

(1) Visits by the attending Doctor.

Limitations:

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

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

(2) Consultations.

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

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

(3) Well Baby Care.

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

c. Chemotherapy for malignant conditions.

(1) Chemotherapy administration services.

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

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

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

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

(1) Surgical procedures of the jaw and gums.

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

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

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

(5) Surgical removal of impacted teeth.

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

(7) Intra oral dental imaging services in connection with covered oral surgery if such oral surgery occurs within 30 days of the imaging service(s.)

(8) General anesthesia.

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

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

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

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

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

(2) Speech therapy

(3) Respiratory therapy.

(4) Neuropsychological testing.

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

(6) Pulmonary rehabilitation program or provider approved by the Company.

(7) Manipulations

Limitations:

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

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

Exclusions:

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

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

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

f. Services for Autism Spectrum Disorder

(1) Definitions:

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

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

(2) Covered Services:

(a) ASD services include:

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

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

(b) ABA therapy is limited to 1,300 hours per Benefit Period for four years beginning on the later of the date of diagnosis or January 1, 2015, for any covered individual diagnosed with Autism Spectrum Disorder between birth and five years (prior to the attainment of 60 months) of age; and

(c) 520 hours of ABA therapy per Benefit Period for any covered individual less than 12 years of age.

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

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

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

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

(3) Exclusions:

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

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

g. Orthopedic, orthotic and prosthetic devices and appliances, including orthopedic braces, artificial limbs, artificial eyes, auditory osseointegrated devices.

Limitations:

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

Exceptions:

(a) Benefits are available for the initial eyeglasses/contacts following surgery for cataracts, aphakia or pseudophakia.

(b) An Insured under 12 years of age is eligible for subsequent eyeglasses/contacts following cataract surgery when there is a minimum change of .25 diopter.

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

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

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

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

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

h. Medical Equipment and Supplies.

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

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

(b) Not provided by a Hospital

(c) Serves a medical purpose and is

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

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

Limitations:

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

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

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

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

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

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

i. Allergy Antigens

j. Services associated with intravenous drug treatment, intralesional drug treatment, intratympanic drug treatment, and hemodialysis, including Prescription Drugs, supplies, equipment and nursing services by Eligible Providers.

k. Diabetic Management.

(1) Equipment used exclusively with diabetes management.

Limitations:

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

(2) Supplies: Coverage for diabetic supplies is provided under the Comprehensive Program only if the Insured does not have Prescription Drug coverage for such supplies. For purposes of this provision, diabetic supplies means syringes, needles, lancets, test strips and solutions, calibration strips, solutions and insulin pump supplies used exclusively with diabetic management.

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

l. Genetic Molecular Testing only in the following situations:

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

(2) BRCA 1 and/or BRCA 2 testing when there are signs and/or symptoms of an inherited disease as specified above, or when signs and/or symptoms are not present but the testing has been prior authorized according to the criteria established by the Company.

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

m. Telemedicine Services

n. Telehealth Services are covered only when obtained from the Company's Designated Telehealth Provider.

5. **Emergency Services.** Services necessary to provide an Insured with evaluation and stabilizing treatment when provided for a Medical Emergency.

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

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

b. To a Hospital for care as an Inpatient

c. From a Hospital where You have been an Inpatient

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

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

7. **Skilled Nursing Care**

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

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

An Insured will be considered to be homebound if they have a condition due to illness or injury for which leaving the home is medically contraindicated. The Company has the right to determine whether the patient is homebound.

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

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

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

(1) Home care education associated with diabetes, colostomy care, wound care, IV therapy or any other condition or treatment which the Company has determined is appropriate for home care education, when provided by a Medicare certified Home Health Agency. Benefits for educational services will

be limited to no more than three home care education visits per Benefit Period for which home care education is appropriate.

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

c. Skilled Nursing Care services do not include:

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

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

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

D. Special Situations

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

1. **Case Management**

Case Management is a process conducted by the Company which:

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

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

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

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

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

If the Company elects to provide benefits for an Insured in one case, it shall not obligate the Company to provide the same or similar benefits for the same or another Insured in the same or another case.

Participation in Case Management is voluntary. The Insured may withdraw at any time and return to the stated benefits of this Contract.

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

3. **Penile Prosthesis for Physiological Impotence.**

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

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

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

4. **Home Social Work Visits**

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

An Insured must be homebound for services to be eligible. An Insured will be considered to be homebound if they have a condition due to illness or injury for which leaving the home is medically contraindicated. The Company has the right to determine whether the patient is homebound.

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

5. **Hospice Care**

Definitions

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

b. **Palliative Care:** treatment directed at controlling pain, relieving other physical and emotional symptoms and focusing on the special needs of the Hospice Patient and the Hospice Patient's Family, as they experience the dying process rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

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

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

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

Election of Hospice Benefits

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

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

Eligibility of Services

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

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

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

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

Covered Services

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

a. Nursing care.

b. Home health aide services.

c. Social work services.

d. Pastoral services.

e. Volunteer support.

f. Bereavement services.

g. Counseling services.

h. Dietary and nutritional counseling/services.

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

j. Speech therapy.

k. Occupational therapy.

l. Physical therapy.

m. Lab fees.

n. Medical equipment.

o. Educational services.

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

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

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

a. Cornea

b. Heart

c. Heart-lung

d. Kidney

e. Kidney-liver

f. Liver

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

h. Multivisceral transplants

i. Pancreas

j. Pancreas-kidney

k. Small intestine

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

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

NOTE: See Prior Authorization Requirement below.

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

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

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

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

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

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

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

a. Provider and facility qualifications

b. Comparative costs of the proposed providers and facility

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

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8. **Temporomandibular Joint Dysfunction Syndrome.**

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

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

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

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

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

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

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

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

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

(a) Panoramic radiographs

(b) Cephalometric radiographs with tracing

(c) Temporomandibular joint tomography

(d) Temporomandibular joint arthrography

(e) Skull series; computerized tomography of temporomandibular joint

(f) Manual muscle testing procedures

And one of the following:

(g) Electromyography of cranial supplied nerves

(h) Electronic computerized neuromuscular testing

(i) Oscilloscopic neuromuscular testing

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

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

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

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

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

(d) Trigger point injections

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

Exclusions: benefits do not include:

(a) Equilibration of occlusion

(b) Massage, either manual or by machine

(c) Coronoplasty

(d) Acupuncture or dry needling

(e) Occlusal adjustment

(f) Cold packs

(g) Slides and/or photographs

(h) Range of motion treatments

(i) Non-Prescription Drugs

(j) Diet survey

(k) Vitamins

(l) Nutrition counseling

(m) Nutrition supplements

(n) Office visits

(o) Stretching and other exercises

(p) Hot packs

(q) Coolant sprays

(r) Moist heat therapy

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

(t) Rental or purchase of transcutaneous electrical nerve stimulators

(u) Periapical, bitewing and full-mouth radiographs

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

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

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

PRESCRIPTION DRUG PROGRAM

A. General

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

B. Definitions

These definitions are in addition to the Health Benefits General Definitions and apply to the Prescription Drug Program. Inclusion of a definition does not imply coverage. To determine if a specific service is covered under Your benefits, refer to the Covered Services and Exclusions sections of this program, and the Health Benefit General Exclusions.

1. **Brand:** a Prescription Drug that is or has been marketed under patent protection.
2. **Compound:** a Prescription Drug: a) that is manufactured by a Pharmacy when no suitable commercial alternative is available; b) for which the main active ingredient is a covered Prescription Drug; and c) for which the purpose is solely to prepare a dose form that is Medically Necessary.
3. **Copayment:** the portion of the charge for a covered Prescription Drug You are responsible for each time Your Prescription Order is filled or refilled.
4. **Diabetic Supplies:** syringes, needles, lancets, test strips and solutions, calibration strips, solutions, and insulin pump supplies used exclusively with diabetic management.
5. **Formulary:** a list of both Brand and Generic Prescription Drugs reviewed and updated by a Pharmacy and Therapeutics Committee. The Formulary is subject to periodic review and modification.

   The Formulary applies only to Prescription Drugs covered under this Program. The Formulary does not apply to Inpatient medications or to medications administered by a Professional Provider. The level of benefits You receive under this Program will be affected by a Prescription Drug's Generic/Brand status on the Formulary.
6. **Generic:** a Prescription Drug that: a) is equivalent to a Brand Drug, b) is available after the patent on that Brand Drug has expired and c) is available from more than one source. Equivalent means therapeutic equivalent as determined by the U.S. Food and Drug Administration.
7. **Pharmacist:** a person registered or licensed under his or her State's laws to dispense Prescription Drugs and/or administer vaccines and immunizations.
8. **Pharmacy:** an establishment, registered or licensed, where Prescription Drugs are dispensed by a Pharmacist. Pharmacies are further classified as:
   a. **Contracting Pharmacy:** a Pharmacy which has entered into a written network participation agreement with the Company and/or a Pharmacy Benefit Manager.
   b. **Contracting Specialty Pharmacy:** a Contracting Pharmacy which has entered into a written network participation agreement with the Company and/or a Pharmacy Benefit Manager to provide Specialty Prescription Drugs.
      (1) **Designated Specialty Pharmacy:** the Specialty Pharmacy designated by the Company from which You may receive benefits for Specialty Prescription Drugs.
   c. **Non-Contracting Pharmacy:** a Pharmacy which has not entered into a written network participation agreement with the Company or a Pharmacy Benefit Manager.
9. **Pharmacy Benefit Manager (PBM):** an entity with which the Company contracts for the provision of administrative, utilization review and network services for the covered drug and supplies under this Program.
10. **Pharmacy and Therapeutics (P & T) Committee:** an independent committee, including but not limited to practicing physicians in various medical specialties and pharmacists. This committee reviews scientific literature and reports, consults with other health care professionals, and uses their expertise to determine which medications should be added to or deleted from the Formulary. This committee evaluates drugs for safety, efficacy (ability in treating a disease or symptoms), and cost effectiveness.
11. **Prescription Drug:** a drug approved for general use in the United States by the U.S. Food and Drug Administration, assigned a National Drug Code (NDC) number and dispensed in compliance with federal

or state laws pursuant to a Prescription Order or refill, and approved by Pharmacy Benefit Manager and/or Pharmacy and Therapeutics Committee. The P & T Committee has up to 120 days to determine a Prescription Drug status on the Formulary.

12. **Prescription Order:** the request Your Doctor may legally issue for a Prescription Drug.
13. **Prior Authorization:** the process of determining whether certain Prescription Drugs are Medically Necessary based on criteria established by the Company.
14. **Specialty Prescription Drug:** Prescription Drugs or classes of Prescription Drugs that are designated by the Company as Specialty Drugs. These include, but are not limited to, drugs that are self-administered by injection, inhaled or taken orally; drugs that may require special handling and storage; drugs that may require strict compliance and patient support; and drugs that may be available through limited distribution arrangements. The list of Specialty Prescription Drugs is on the Formulary. To find this list, go to www.bcbsks.com and log in to Your BlueAccess account. You may also contact Customer Service at the telephone number listed on Your Identification Card.

C. Cost Sharing

1. **Deductible**

   The Deductible amounts are: $3,000 for any one Insured, not to exceed $6,000 for all Insureds on family coverage. The family Deductible can be met by eligible costs incurred by any combination of Insureds enrolled under the same family plan. However, no one Insured will have to pay more than the per Insured Deductible. This is not a separate Deductible from the Comprehensive Program Deductible.

2. **Copayment**

   After the Deductible is met, the Copayment amounts are:

Insulin	$15.00
Generic Prescription Drug	$15.00
Brand Formulary Prescription Drug	$50.00
Brand Non-Formulary Prescription Drug	$75.00
Compound Prescription Drug	$75.00

3. **Designated Specialty Pharmacy Mandatory:** If a Specialty Prescription Drug is obtained from a Pharmacy other than the Company's Designated Specialty Pharmacy, the drug will not be covered.
4. **Preventive Immunizations** (as described in Preventive Health Benefits in the Comprehensive Program section of this document) are paid at 100% of the allowable charge when received from a Network Provider.
5. **Out-of-Pocket Maximum:** The Out-of-Pocket Maximum in the Comprehensive Program section is applicable to Prescription Drug benefits.

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D. Covered Services

Except as limited, Prescription Drugs are covered when ordered by Your Doctor and dispensed by a Pharmacy based on a Prescription Order.

The covered Prescription Drug services include:

1. The filling of the initial Prescription Order. To determine if Your specific prescription is covered on the Formulary, go to www.bcbsks.com and log in to Your BlueAccess account. You may also contact Customer Service at the telephone number listed on Your Identification Card.
2. Refills of the Prescription Order as authorized by Your Doctor within one year from the date of the initial Prescription Order but not before at least two-thirds (2/3) of the previously purchased supply has been exhausted. Authorization for an early refill to accommodate a vacation supply may be obtained by contacting the Company, but not more often than two times per Insured during any 12-month period.
3. The reissue of a Prescription Order by Your Doctor for a medication previously ordered, but not before at least two-thirds (2/3) of the previously purchased supply has been exhausted. Authorization for an early reissue to accommodate a vacation supply may be obtained by contacting the Company, but not more often than two times per Insured during any 12-month period.

Limitations:

a. The benefit for Prescription Drugs pursuant to a Prescription Order shall be limited to a supply sufficient for 34 consecutive days of therapy based on criteria established by the Company, except Prescription Drugs designated by the Company, that are prescribed for certain chronic conditions, may be dispensed

in supplies up to a maximum of 100-unit dose quantities, but not to exceed a supply sufficient for 100 consecutive days of therapy, if such is greater than a 34 consecutive day supply.

b. Prior Authorization is required in order for some Prescription Drugs to be covered under this Program. Prescription Drugs requiring Prior Authorization are listed on the Formulary. Prescription Drugs may be added or deleted from the list on a quarterly basis.

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

d. Coverage for Specialty Prescription Drugs will be limited to a supply sufficient for 34 consecutive days of therapy. These Prescription Drugs are listed on the Formulary. A list of these Prescription Drugs may also be obtained by contacting Customer Service at the number listed on Your Identification Card. Prescription Drugs may be added or deleted from the list on a quarterly basis.

4. Growth hormone therapy is covered only under one of the following circumstances:

If under age 18 and diagnosed with:

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

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

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

d. Panhypopituitarism; or

e. Neonatal hypoglycemia related to growth hormone deficiency.

If age 18 and over with:

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

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

Children, Adolescents and Adults:

a. AIDS wasting syndrome

b. Short bowel syndrome

c. Severe burn patients

5. Diabetic Supplies and Insulin.

6. Oral anticancer medication, used to kill or slow the growth of cancerous cells, is subject to the same cost sharing provisions as other Prescription Drugs.

7. Psychotherapeutic drugs used for the treatment of Mental Illness and Substance Use Disorders under terms and conditions not less favorable than coverage provided for other Prescription Drugs.

8. Generic oral contraceptives will be covered at 100%.

9. Off-label Prescription Drugs used for the treatment of cancer.

E. Payment of Benefits

Subject to the payment provisions of this Prescription Drug Program, benefits are based on the following allowable charges:

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

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

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

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

F. Exclusions

Benefits are not provided for:

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

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

    This exclusion applies whether or not You choose to waive Your rights to these services except for those services that would be eligible for benefits under Medicare Part D Prescription Drug coverage. Such benefits shall only be excluded if You are enrolled in Part D.
15. Any service provided through a district pursuant to an Individual Education Plan (IEP) as required under any federal or state law. This exclusion applies whether or not You choose to waive Your rights to these services.
16. Health services associated with accidental bodily injuries arising from a motor vehicle accident to the extent such services are payable under medical expense payment provision of any automobile insurance policy.
17. Services not prescribed by a Doctor or continued after a Doctor has advised that further care is not necessary.
18. Services that are not Medically Necessary, as defined in this Contract.
19. Prescription Drugs utilized primarily for stimulation of hair growth. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth.
20. Charges for completion of insurance claim forms.
21. Any drug, device or medical treatment or procedure and related services that are, as of the date of service, Experimental or Investigational as defined in the General Definitions section. This exclusion does not apply to routine patient care services (as defined in Kansas Administrative Regulation 40-4-43) provided in an approved cancer clinical trial for which benefits would otherwise be available for the same services when not provided in connection with such clinical trial.

22. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression.
23. Any drug or supply associated with the medical management and treatment of obesity. This includes, but is not limited to, nutrients and Prescription Drugs prescribed for purposes other than the treatment of obesity.
24. Appetite suppressants.
25. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would not have been provided and which is provided on whether an Inpatient or Outpatient basis by any Eligible Provider.
26. Growth hormone therapy or other drugs used to treat growth failure except in those situations specifically set out as eligible for benefits.
27. Certain Prescription Drugs that have therapeutically equivalent or interchangeable drugs that are available over the counter (OTC) and may be obtained without a Prescription Order. This would include drug products from the same therapeutic class containing different chemical entities, but which would provide similar effects or the same pharmacological action when administered in therapeutically equivalent doses. These drugs are listed on the Formulary.
28. To determine if Your specific prescription is excluded, go to www.bcbsks.com and log in to Your BlueAccess account. You may also contact Customer Service at the telephone number listed on Your Identification Card.
29. Prescription Drugs prescribed by You.

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MAIL ORDER PRESCRIPTION DRUG PROGRAM

A. General

The Company has contracted with a Mail Order Pharmacy to make available to eligible Insureds, Prescription Drugs subject to the provisions of this Mail Order Prescription Drug Program. The benefits specified in this Mail Order Prescription Drug Program are only applicable to Prescription Drugs ordered through the Mail Order Pharmacy. Nothing in this Mail Order Prescription Drug Program requires You to utilize the Mail Order Pharmacy when filling an order for a Prescription Drug.

NOTE: All products may not be available from the Mail Order Pharmacy. The Mail Order Pharmacy may determine that certain Prescription Drugs will not be dispensed by the Mail Order Pharmacy when the product cannot be safely delivered to the Insured's home, the product is not available to the Pharmacy or the product is not commercially available.

B. Definitions

These definitions are in addition to the Health Benefits General Definitions and apply to the Mail Order Prescription Drug Program. Inclusion of a definition does not imply coverage. To determine if a specific service is covered under Your benefits, refer to the Covered Services and Exclusions sections of this program, and the Health Benefit General Exclusions.

1. **Brand:** a Prescription Drug that is or has been marketed under patent protection.
2. **Compound:** a Prescription Drug: a) that is manufactured by a Pharmacy when no suitable commercial alternative is available, b) for which the main active ingredient is a covered Prescription Drug and c) for which the purpose is solely to prepare a dose form that is Medically Necessary.
3. **Copayment:** the portion of the charge for a covered Prescription Drug You are responsible for each time Your Prescription Order is filled or refilled through the Mail Order Pharmacy. The amount of Copayment is determined by whether the order is filled with a Generic or with a Brand Drug.
4. **Diabetic Supplies:** syringes, needles, lancets, test strips and solutions, calibration strips, solutions, and insulin pump supplies used exclusively with diabetic management.
5. **Formulary:** a list of both Brand and Generic Prescription Drugs reviewed and updated by a Pharmacy and Therapeutics Committee. The Formulary is subject to periodic review and modification.

   The Formulary applies only to Prescription Drugs covered under this Program. The Formulary does not apply to Inpatient medications or to medications administered by a Professional Provider. The level of benefits You receive under this Program will be affected by a Prescription Drug's Generic/Brand status on the Formulary.
6. **Generic:** a Prescription Drug that: a) is equivalent to a Brand Drug, b) is available after the patent on that Brand Drug has expired and c) is available from more than one source. Equivalent means therapeutic equivalent as determined by the U.S. Food and Drug Administration.
7. **Mail Order Pharmacy:** an establishment that is registered or licensed in the state in which it is domiciled, from which Prescription Drugs are dispensed by a Pharmacist, which has entered into a written agreement to provide Prescription Drugs to Insureds of the Company who are eligible under this Program, and which has been separately identified to Insureds in a directory or through some other means. The Mail Order Pharmacy, after receiving and processing Your Prescription Order, will deliver the Prescription Drugs through a parcel delivery service company.
8. **Pharmacist:** a person registered or licensed under his or her State's laws to dispense Prescription Drugs.
9. **Pharmacy Benefit Manager (PBM):** an entity with which the Company contracts for the provision of administrative, utilization review and network services for the covered drug and supplies under this Program.
10. **Pharmacy and Therapeutics (P & T) Committee:** an independent committee, including but not limited to practicing physicians in various medical specialties and pharmacists. This committee reviews scientific literature and reports, consults with other health care professionals, and uses their expertise to determine which medications should be added to or deleted from the Formulary. This committee evaluates drugs for safety, efficacy (ability in treating a disease or symptoms), and cost effectiveness.
11. **Prescription Drug:** a drug approved for general use in the United States by the U.S. Food and Drug Administration, assigned a National Drug Code (NDC) number and dispensed in compliance with federal or state laws pursuant to a Prescription Order or refill, and approved by Pharmacy Benefit Manager and/or Pharmacy and Therapeutics Committee. The P & T Committee has up to 120 days to determine a Prescription Drug status on the Formulary.
12. **Prescription Order:** the request Your Doctor may legally issue for a Prescription Drug.
13. **Prior Authorization:** the process of determining whether certain Prescription Drugs are Medically Necessary based on criteria established by the Company.

C. Cost Sharing

1. **Deductible**

   The Deductible amounts are: $3,000 for any one Insured, not to exceed $6,000 for all Insureds on family coverage. The family Deductible can be met by eligible costs incurred by any combination of Insureds enrolled under the same family plan. However, no one Insured will have to pay more than the per Insured Deductible. This is not a separate Deductible from the Comprehensive Program Deductible.

2. **Copayment**

   After the Deductible is met, the Copayment amounts are:

   Generic Prescription Drug $37.50

   Brand Formulary Prescription Drug $125.00

   Brand Non-Formulary Prescription Drug $187.50

   Compound Prescription Drug $187.50

3. **Out-of-Pocket Maximum:** The Out-of-Pocket Maximum in the Comprehensive Program section is applicable to Prescription Drug benefits.

D. Covered Services

Except as limited, Prescription Drugs are covered when ordered by Your Doctor for a condition You have consulted Your Doctor about, dispensed by the Mail Order Pharmacy based on a Prescription Order, and Medically Necessary.

1. The covered Prescription Drug services include:

   a. The filling of the initial Prescription Order. To determine if Your specific prescription is covered on the Formulary, go to www.bcbsks.com and log in to Your BlueAccess account. You may also contact Customer Service at the telephone number listed on Your Identification Card.

   b. Refills of the Prescription Order as authorized by Your Doctor within one year from the date of the initial Prescription Order but not before at least two thirds (2/3) of the previously purchased supply has been exhausted. Authorization for an early refill to accommodate a vacation supply may be obtained by contacting the Company, but not more often than two times per Insured during any 12-month period.

   c. The reissue of a Prescription Order by Your Doctor for a medication previously ordered, but not before at least two-thirds (2/3) of the previously purchased supply has been exhausted. Authorization for an early reissue to accommodate a vacation supply may be obtained by contacting the Company, but not more often than two times per Insured during any 12-month period.

   d. **Limitations:**

      (1) The benefit for Prescription Drugs pursuant to a Prescription Order filled through the Mail Order Pharmacy shall be limited to a supply sufficient for 90 consecutive days of therapy based on criteria established by the Company.

      (2) Prior Authorization is required in order for some Prescription Drugs to be covered under this Program. Prescription Drugs requiring Prior Authorization are listed on the Formulary. Prescription Drugs may be added or deleted from the list on a quarterly basis.

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

2. Growth hormone therapy is covered only under one of the following circumstances:

   If under age 18 and diagnosed with:

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

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

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

   d. Panhypopituitarism; or

   e. Neonatal hypoglycemia related to growth hormone deficiency.

   If age 18 and over with:

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

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

Children, Adolescents and Adults:

a. AIDS wasting syndrome

b. Short bowel syndrome

c. Severe burn patients

3. Diabetic Supplies and Insulin
4. Oral anticancer medication, used to kill or slow the growth of cancerous cells, is subject to the same cost sharing provisions as other Prescription Drugs.
5. Psychotherapeutic drugs used for the treatment of Mental Illness and Substance Use Disorders under terms and conditions not less favorable than coverage provided for other Prescription Drugs.
6. Generic oral contraceptives will be covered at 100%.
7. Off-label Prescription Drugs used for the treatment of cancer.

E. Payment of Benefits

Subject to the cost sharing above, Your benefits are based on the following allowable charges:

Mail Order Pharmacy -- The allowable charge for a covered Prescription Drug is as provided for in the Mail Order Pharmacy Agreement. The allowable charge minus the applicable cost sharing provision(s) will be paid directly to the Pharmacy.

F. Exclusions

Benefits are not provided for:

1. Prescription Drugs for which normally (in professional practice) there is no charge.
2. Prescription Drugs for other than human use.
3. Orthopedic or prosthetic appliances and devices.
4. Contraceptive devices; therapeutic devices; artificial appliances; hypodermic needles; syringes or similar devices. This exclusion applies regardless of the intended use, unless otherwise indicated as a covered service.
5. Prescription Drugs purchased from other than the Mail Order Pharmacy which is contracting with the Company to provide Prescription Drugs to Insureds under this program. This exclusion applies only to benefits under the Mail Order Prescription Drug Program. Claims for Prescription Drugs obtained via mail order from a pharmacy other than a contracting Mail Order Pharmacy shall be subject to the benefits of the Prescription Drug Program.
6. Charges for delivering any drugs.
7. A drug approved for experimental use.
8. Any drug prescribed or dispensed in a manner that does not agree with generally accepted medical or pharmaceutical practices.
9. Drugs, supplies, and equipment used in intravenous, intralesional, intratympanic, and hemodialysis treatment.
10. Benefits are not available to the extent a Prescription Drug has been covered under another contract, certificate, or rider issued by the Company.
11. Any food item including breast milk, formulas and other nutritional products.
12. Total parenteral nutrition.
13. Drugs available over-the-counter in the equivalent dose which do not require a Prescription Order by federal or state law except those covered under the Preventive Health Benefits section.
14. Charges for services that are not listed as covered services.
15. Services for injuries or diseases related to Your employment to the extent You are covered or are required to be covered by a worker's compensation law. If You enter into a settlement giving up Your right to recover past or future medical benefits under a worker's compensation law, the Company will not pay past or future medical benefits that are the subject of or related to that settlement.

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

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

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

17. Any service provided through a district pursuant to an Individual Education Plan (IEP) as required under any federal or state law. This exclusion applies whether or not You choose to waive Your rights to these services.
18. Health services associated with accidental bodily injuries arising from a motor vehicle accident to the extent such services are payable under medical expense payment provision of any automobile insurance policy.
19. Services not prescribed by a Doctor or continued after a Doctor has advised that further care is not necessary.
20. Services that are not Medically Necessary, as defined in this Mail Order Prescription Drug Program.
21. Prescription Drugs utilized primarily for stimulation of hair growth. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth.
22. Charges for completion of insurance claim forms.
23. Any drug, device or medical treatment or procedure and related services that are, as of the date of service, Experimental or Investigational as defined in the General Definitions section. This exclusion does not apply to routine patient care services (as defined in Kansas Administrative Regulation 40-4-43) provided in an approved cancer clinical trial for which benefits would otherwise be available for the same services when not provided in connection with such clinical trial.
24. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression.
25. Any drug or supply associated with the medical management and treatment of obesity. This includes, but is not limited to, nutrients and Prescription Drugs prescribed for purposes other than the treatment of obesity.
26. Appetite suppressants.
27. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would not have been provided and which is provided on either an Inpatient or Outpatient basis by any Eligible Provider.
28. Growth hormone therapy or other drugs used to treat growth failure except in those situations specifically set out as eligible for benefits.
29. Certain Prescription Drugs that have therapeutically equivalent or interchangeable drugs that are available over the counter (OTC) and may be obtained without a Prescription Order. This would include drug products from the same therapeutic class containing different chemical entities, but which would provide similar effects or the same pharmacological action when administered in therapeutically equivalent doses. These drugs are listed on the Formulary.
30. To determine if Your specific prescription is excluded, go to www.bcbsks.com and log in to Your BlueAccess account. You may also contact Customer Service at the telephone number listed on Your Identification Card.
31. Specialty Prescription Drugs.
32. Prescription Drugs prescribed by You.

ALLOWABLE CHARGES

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

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

A. Contracting Providers of or on behalf of the Company for other than Ancillary Providers, Prescription Drugs or Sleep Studies

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

B. Contracting Providers of the Company for limited services for other than Ancillary Providers, Prescription Drugs or Sleep Studies

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

C. Prescription Drugs

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

D. Contracting Providers of Sleep Studies

1. **Sleep Studies provided within the Company Service Area:**

   a. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Company that are Accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC) and the physicians to be board certified in sleep medicine.**

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

   b. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Company that are Not Accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC) and the physicians to be board certified in sleep medicine.**

   The allowable charge will be the actual charge for covered services up to 60% of the maximum amount allowable to a Contracting Provider that is accredited by the American Academy of Sleep Medicine or Board Certified in Sleep Medicine. Contracting Providers have agreed to accept the Company's determination of Your benefits as payment in full for covered services, except that You are responsible for payment of: Deductible, Coinsurance, Copayment amounts, shared payment amounts, non-covered services, private room charges in excess of the allowable amount stated in this Contract, and amounts in excess of any other benefit limitations of this Contract.

2. **Sleep Studies provided outside the Company Service Area:**

   a. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC) and the physicians to be board certified in sleep medicine.**

   The allowable charge will be the actual charge up to the maximum amount allowable as determined as described in item F.2.a. below.

b. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Not Accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC) and the physicians to be board certified in sleep medicine.**

The allowable charge will be the actual charge for covered services up to 60% of the maximum amount allowable as determined in F.2.a. below. You will be responsible for the difference between the allowable charge and the maximum amount allowable as determined in item F.2.a. below.

E. Non-Contracting Providers

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

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

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

All reimbursement identified in this Section E is paid according to the cost-containment policies and procedures applicable to Contracting Providers. If You receive services from a Non-Contracting Provider, You will be responsible for payment for services for which payment is not made by the Company due to a cost-containment policy or procedure applicable to a Contracting Provider of the same licensure providing the same service. Such cost-containment policies include, but are not limited to, determinations by the Company that the services provided are of such a nature that they should be considered one service with a single payment, or that the billing for service inappropriately categorized the nature of the services performed, in the opinion of the Company, and payments should be made for a different type or different intensity of service.

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

a. **Inpatient Services**

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

(a) the actual charge; or

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

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

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

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

Peer Group Designations

1 = Hospitals with less than 50 beds

2 = Hospitals with 51-99 beds

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

4 = Topeka Hospitals

5 = Wichita Hospitals

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

(a) the actual charge; or

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

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

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

(1) the actual charge; or

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

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

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

The allowable charge will be the lesser of:

a. the actual charge; or

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

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

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

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

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

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

7. **Sleep Studies**

a. **Sleep Studies provided within the Company Service Area:**

(1) **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Company that are Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of the Company that are Board Certified in Sleep Medicine**

The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable as determined in item D.1.a. above.

(2) **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Company that are Not Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of the Company that are Not Board Certified in Sleep Medicine**

The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable as determined in item D.1.b. above.

b. **Sleep Studies provided outside the Company Service Area:**

(1) **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Board Certified in Sleep Medicine**

The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable as determined in item D.2.a. above.

(2) **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Not Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Not Board Certified in Sleep Medicine**

The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable as determined in item D.2.b. above.

8. **Dentists**

a. **Dental Services provided within the Company Service Area:**

The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable for the same procedure by dentists that are Contracting Providers of the Company with the same licensure or certification. If no Contracting Providers provide the same service, the Company will determine an amount to be allowed for the procedure at its discretion.

b. **Dental Services provided outside the Company Service Area:**

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

F. Out-of-Area Services

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

a. When a provider in such class contracts with the Company, the provisions in Section A apply.

b. When a provider in such class does not contract with the Company, the provisions in Section E apply.

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

The Company has a variety of relationships with other Blue Cross and/or Blue Shield Licensees, referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Insureds 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 generally below.

Typically, when accessing care outside the geographic area we serve, obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Insureds may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. We remain responsible for fulfilling our contractual obligations to you. Our payment practices in both instances are described below.

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

The BlueCard Program is an Inter-Plan Arrangement. Under this Arrangement, when Insureds access covered healthcare services within the geographic area served by a Host Blue we serve, the Host Blue will be responsible for contracting and handling all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar copayment, The calculation of the Insured's liability on claims for covered healthcare services will be based on the lower of the participating provider's billed covered charges or the negotiated price made available to us by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to us by the Host Blue may be represented by one of the following:

(1) an actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or

(2) an estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(3) an average price. An average price is a percentage of billed covered charges in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e.,prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard program requires that the amount paid by the Insured is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by us in determining Your premiums.

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to Insured accounts. If applicable, the Company will include any such surcharge, tax or other fee in determining Your premium.

The Company may include a factor for per member per month (PMPM) amounts, not attached to specific claims, billed to us by Host Blues in Your premium for Value-Based Programs, when applicable. Value-Based Program means an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality factors and is reflected in provider payment.

Return of Overpayments

Recoveries from a Host Blue or its participating and nonparticipating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recovery amounts determined in the ways noted above will be applied in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to us, they will be credited to Your account. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to You as a percentage of the recovery.

For Sleep Studies accessed through the BlueCard Program, see D.2 above.

b. **Non-Participating Healthcare Providers Outside the Company Service Area - See Section E, Non-Contracting Providers, above**

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

General Information

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

Inpatient Services

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

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

When Insureds pay for covered healthcare services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Insureds should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center address on the form to initiate claims processing. The claim form is available from us, the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com. If Insureds need assistance with

their claim submissions, they should call the Blue Cross Blue Shield Global Core Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

G. Ancillary Providers

The contracting status of Ancillary Providers is determined as follows:

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

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

Non-Contracting Ancillary Providers - The allowable charge is the actual charge for covered services up to the maximum amount allowable for an Ancillary Provider that is a Contracting Provider.

GENERAL EXCLUSIONS

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

A. Benefits will not be provided for:

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

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

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

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

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

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

34. Any service associated with dental implants, surgical treatment or diagnostic services except as otherwise stated in this Contract.
35. Educational benefits except for those pertaining to diabetic education, colostomy care, wound care, IV therapy, or any other condition or treatment which the Company has determined is appropriate for home care education.
36. Dental appliances or restorations necessary to increase vertical dimensions or restore the occlusion.
37. Any food item including breast milk, formulas and other nutritional products.
38. Appetite suppressants.
39. Drugs which are available in an equivalent dose over-the-counter and which do not require a Prescription Order by federal or state law.
40. Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders IV(1994) which are not attributable to a mental disorder and are a focus of clinical attention, e.g., marriage counseling. This exclusion applies to all benefits provided by this Contract; it is not limited to those benefits listed for Mental Illness or Substance Use Disorders.
41. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would not have been provided and which is provided on either an Inpatient or Outpatient basis by any Eligible Provider.
42. Diagnostic tests and evaluations are ordered, requested or performed solely for the purpose of resolving issues in the context of legal proceedings, including those concerning custody, visitation, termination of parental rights, civil damages or criminal actions.
43. Services, appliances or restorations for altering vertical dimension for restoring occlusion, for replacing tooth structure lost by attrition or abrasion, bruxism, erosion or abfractions; for aesthetic purposes; splinting or equilibration.
44. Temporary or Provisional dental services and procedures, including, but not limited to, Provisional crowns, Provisional splinting, interim complete or partial dentures. "Provisional" means a service or procedure that is provided for temporary purposes or is used over a limited period; a temporary or interim solution; usually refers to a prosthesis or individual tooth restoration.
45. Dental services and prosthodontic devices that are duplicated in whole or in part, due to the Insured failing to complete the initial treatment plan.
46. Pharmacological agent(s) inserted into a periodontal pocket to suppress pathogenic microbiota.
47. Any device used for enhancing or enabling communication except for an electrolarynx.
48. Services provided for a Mental Illness or Substance Use Disorder by a provider that is not an Eligible Provider for Mental Illness or Substance Use Disorders.
49. Non medical services (including but not limited to legal services, social rehabilitation, educational services, vocational rehabilitation, job placement services).
50. Services of volunteers.
51. Any assessment to attend an alcohol and drug safety action program by a diversion agreement or by court order.
52. Prostheses that require surgical insertion into the body and are billed by an entity or person that is not the Hospital or Ambulatory Surgical Center where the surgery was performed.
53. Services for or related to elective abortions.

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

    For the purpose of this provision, "abortion" means as follows: the use or prescription of any instrument, medicine, drug, or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of a child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma, or physical assault on the pregnant woman or her unborn child and which causes the premature termination of the pregnancy.
54. Services related to sexual function unless specifically listed under the Covered Services section.

APPEAL PROCEDURES

A. Purpose. This section outlines the procedures for and the time periods applicable to Claim and Appeal determination decisions for Adverse Decisions. It is the policy of the Company to afford Insureds a full and fair review of Claim decisions and Appeal decisions as a right under applicable federal and state law.

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

B. Definitions. For the purpose of this Appeal Procedures Section, the following terms and their definitions apply:

1. **Adverse Decision:** for the purposes of these Appeals procedures (and ERISA, as applicable), means a denial in whole or in part of a Pre-Service Claim or a Post-Service Claim and for which You are financially responsible or, for a Pre-Service Claim, for which You would be financially responsible, if You obtained the service. Adverse Decision, for the purposes of External Review procedures, is limited to the definition of Adverse Decision Eligible for External Review. Adverse Decision also means any retroactive cancellation of coverage other than for non-payment of premium.
2. **Adverse Decision Eligible for External Review:** (1) in the case of other than an Emergency Medical Condition, a Claim for a proposed or delivered health care service which would otherwise be covered under this Contract but for which the Insured has received an Adverse Decision following an Appeal due to the fact that the service is not or was not Medically Necessary or the health care treatment has been determined by the Company to be Experimental or Investigational and the denial leaves the Insured with a financial obligation or prevents the Insured from receiving the requested service, or (2) in the case of an Emergency Medical Condition, a Claim for which an initial Adverse Decision by the Company that a proposed health care service which would otherwise be covered under this Contract is not Medically Necessary or the health care treatment has been determined by the Company to be Experimental or Investigational and the denial would leave the Insured with a financial obligation or prevents the Insured from receiving the requested service, or (3) a Pre-Service Request for a benefit determination or advance approval a) that is not a Pre-Service Claim; b) which is denied by the Company due to the fact the requested services are not Medically Necessary or are Experimental or Investigational; and c) based upon which You choose not to obtain the requested services. For item (3) above, no Appeals need be submitted to the Company in order for the Adverse Decision to be eligible for External Review. For items (1) and (2) above, the procedure in section D. below applies. Notwithstanding any provision of this Contract to the contrary, the External Review procedure is not available for dental services.
3. **Appeal:** a written request, except in the case of Urgent Care in which case the request may be submitted orally or in writing, for review of an Adverse Decision that is submitted to the Company by an Insured or the Insured's Authorized Representative.
4. **Authorized Representative:** for non-urgent care, a person designated by You in writing as authorized to represent them for Appeals as permitted under ERISA. This may only be achieved through use of a form provided by the Company by contacting Customer Service at the telephone number on the back of Your Identification Card. Any attempt to designate via any other form shall be deemed void and ineffective on its face. For Urgent Care, such written authorization is not required if the Appeal is made on Your behalf by a health care provider with knowledge of Your medical condition.
5. **Claim for Benefits or Claim:** a request for treatment benefit or payment benefits made by an Insured in accordance with the Company's procedure for filing Claims. A Claim includes both Pre-Service Claims and Post-Service Claims. A Claim must have sufficient information upon which to base a decision regarding benefits according to all of the provisions of the Contract.
6. **Emergency Medical Condition:**
   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.
7. **ERISA:** the Employee Retirement Income Security Act of 1974. ERISA is a federal law that applies to employer sponsored health benefit plans if the employer is not a government entity or a church organization.
8. **External Review:** the review of an Adverse Decision by an External Review Organization.
9. **External Review Organization:** an entity that conducts independent External Reviews of Adverse Decisions pursuant to a contract with the Kansas Insurance Department.

10. **Pre-Service Claim:** a request for a Claims decision when prior authorization of the services is required by the Company.
11. **Pre-Service Request:** a request for advance information on the Company's possible coverage of items or services or advance approval of covered items or services that do not constitute Pre-Service Claims. Subsequent inquiries regarding the same service or item shall not be considered a Pre-Service Request unless additional substantive clinical information is provided.
12. **Post-Service Claim:** a request for a Claims decision for services that have been provided.
13. **Urgent Care:** care for a condition that delay in receiving such care could seriously jeopardize the life or health of the Insured or the ability of the Insured to regain maximum function or, in the opinion of a physician knowledgeable of the Insured's condition, would subject the Insured to severe pain that could not be adequately managed without care or treatment. In determining whether a Claim involves Urgent Care, the Company must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of the Insured's medical condition determines that a Claim involves Urgent Care, the claim must be treated as an Urgent Care Claim.

C. Initial Claim Decisions

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

Action	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Initial Benefit Decision (from the date the Claim is received by the Company)	72 hours	15 days	30 days
Extension (from the date the Claim is received by the Company)	None - Notice requesting additional information due - 24 hours*	30 days*	45 days*

* The time periods listed are those required. An Insured may voluntarily agree to provide the Company additional time within which to make a decision.

Time for Insured to Provide more Information (from the date the information was requested by the Company)	48 hours	45 days	45 days

D. Appeal of Initial Adverse Decisions (including Adverse Decisions Eligible for External Review)

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

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

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

* The time periods listed are those required. An Insured may voluntarily agree to provide the Company additional time within which to make a decision.

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

E. Procedure for Pursuing an External Review

1. The Insured has the right to request an External Review of an Adverse Decision Eligible for External Review after an Appeal (where applicable) has been completed or when the Insured has not received a final Adverse Decision within 60 days of seeking such review, unless the delay was requested by the Insured. In the case of a request for an External Review of an Adverse Decision Eligible for External Review involving an Emergency Medical Condition, such request may be made before the Insured has exhausted all the other

available review procedures. The Company will notify the Insured in writing regarding a final Adverse Decision and of the opportunity to request an External Review.

2. Within four (4) months of receipt of the notice of a final Adverse Decision, the Insured, the treating physician or health care provider acting on behalf of the Insured with written authorization from the Insured, or a legally authorized designee of the Insured must make a written request for an External Review to the Kansas Insurance Commissioner, at the Kansas Insurance Department, 420 SW 9th Street, Topeka, KS 66612, (785) 296-3071 or (800) 432-2484.

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

4. For those requests that qualify for External Review, the External Review Organization will issue a written decision to the Insured and the Kansas Insurance Commissioner within 30 business days. The External Review Organization will issue its written decision within 72 hours when the request for External Review involves an Emergency Medical Condition. The standard of review shall be whether the health care service denied by the Company was Medically Necessary or in the case of reviews regarding Experimental or Investigational treatment, whether the health care service denied by the Company was covered or excluded from coverage under the terms of this Contract.

5. The decision of the External Review Organization may be reviewed directly by the district court at the request of either the Insured, insurer, or health insurance plan. The review by the district court shall be de novo. The decision of the External Review Organization shall not preclude the Insured, insurer or health insurance plan from exercising other available remedies applicable under state or federal law. Seeking a review by the district court or any other available remedies exercised by the Insured, insurer or health insurance plan after the decision of the External Review Organization will not stay the External Review Organization's decision as to the payment or provision of services to be rendered during the pendency of the review by the insurer or health insurance plan. All material used in an External Review and the decision of the External Review Organization as a result of the External Review shall be deemed admissible in any subsequent litigation.

The right to External Review shall not be construed to change the terms of coverage under this Contract. In no event shall more than one External Review be available during the same year for any request arising out of the same set of facts.

F. Right to a Judicial Review

You have the right to bring suit (including under ERISA Section 502(a) if applicable) in state or federal court (as appropriate) only after You have exhausted the first level Appeal of an Adverse Decision, whether or not You pursue External Review. However, in the case of an Adverse Decision Eligible for External Review involving an Emergency Medical Condition, no Appeal is necessary and only completion of the External Review process is required in order for the right to bring suit to accrue. In all events, such suit or proceeding must be commenced no later than 5 years after the date from the time written proof of loss is required to be given.

G. Strict Adherence by Company

If for any reason the Company fails to strictly adhere to these appeal procedures as required by state or federal law, the Insured shall be deemed to have exhausted the internal claims and appeals process regardless of whether the Company asserts it substantially complied with appeals procedures or committed any de minimis error.

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GENERAL INFORMATION

A. Company's Right to Determine if Services are Medically Necessary: Benefits are available only for medically necessary services. The Company has the right to require information, including medical records, to make this decision.

B. Insured/Provider Relationship: The choice of a provider is solely that of the Insured.

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

The Company is obligated to provide benefits for the services of Your Eligible Provider only to the extent provided in this Contract. The Company does not guarantee the availability of a provider.

The Company shall not be liable for any acts or admissions of any provider of service. This includes negligence, misconduct, malpractice, refusal to provide a service or breach of contract.

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

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

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

F. Notice of Claim: You are responsible for submitting written notice of claim within 20 days after a covered loss begins or as soon as reasonably possible. If Your provider submits written notice on Your behalf within the time period specified above, such notice will satisfy the requirements of this provision. The notice can be given to the Company at its home office, 1133 SW Topeka Boulevard, Topeka, Kansas 66629. Notice should include Your name and Your identification number as stated on Your Identification Card.

G. Claim Forms: The Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice the claimant shall be deemed to have complied with the claim filing requirements of this Contract.

H. Proof of Loss (Prompt Filing of Claims): Written proof of loss must be furnished to the Company at 1133 SW Topeka Boulevard, Topeka, Kansas 66629, in case of claim for loss for which this Contract provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the Company is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

I. Time of Payment of Claims: Benefits payable under this Contract will be paid immediately upon receipt of proper written proof of loss.

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

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

   Your benefits will be paid directly to You, with such benefits being personal to You and not assignable to any other person or entity.
5. **Covered Provider Outside the Company Service Area:**
   a. Located in an area where the Company offers contracting provider status, directly or through arrangements with another entity, to the provider from whom service was received:
      (1) if the provider is a Contracting Provider, Your benefits will be paid to the provider.

(2) if the provider is a Non-Contracting Provider, Your benefits will be paid directly to You, with such benefits being personal to You and not assignable to any other person or entity.

b. Located in an area where the Company does not offer contracting provider status, either directly or through arrangements with another entity, to the provider from whom service was received:

(1) In instances where the Insured receives service from a provider that is contracting with the Blue Cross and/or Blue Shield Company servicing the area in which the provider is located, payment will be made directly to the provider.

(2) In instances where the Insured receives service from a provider that is not contracting with the Blue Cross and/or Blue Shield Company servicing the area in which the provider is located, Your benefits will be paid directly to You, with such benefits being personal to You and not assignable to any other person or entity.

6. Any benefits unpaid at Your death may be paid to Your estate.

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

K. Physical Examination: The Company, at its expense, has the right to have You examined as often as reasonably necessary while a claim is pending.

L. Legal Actions: No legal action may be brought to recover on this Contract within 60 days after written proof of loss has been given as required by this Contract. No such action may be brought after 5 years from the time written proof of loss is required to be given.

M. Errors Related to Your Coverage: If the Company's records of Your coverage are in error due to a Company error or delay, the record will be corrected after discovery of the error. If Your premiums are affected, the Company may need to make a retroactive change in Your premiums. The Company will make appropriate changes in Your coverage and/or premiums to ensure that You have the coverage You are entitled to under this Contract.

The Company has the right to correct benefit payments which are made in error. Providers and/or You have the responsibility to return any overpayments to the Company. The Company has the responsibility to make additional payments if an underpayment is made.

N. Statements Made by the Contract Holder or the Insured: A copy of the application, if any, of the Contract Holder shall be attached to the Contract when issued. All statements made by the Contract Holder or by the Insured will be deemed representations and not warranties. No statement made by an Insured will be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the Insured.

O. Notice

1. **From the Company to the Contract Holder.** A notice sent to the Contract Holder by the Company is considered given when mailed to the Contract Holder's address as it appears in the records of the Company.
2. **From the Company to an Insured.** A notice sent to an Insured by the Company is considered given when mailed to the Insured's address as it appears in the records of the Company.
3. **From the Contract Holder or an Insured to the Company.** Notice to the Company is considered given when received by the Company at 1133 SW Topeka Boulevard, Topeka, Kansas 66629. Any such notice should include the Insured's name and the identification number on the Identification Card.

P. Changes In this Contract: Benefits and premiums may be changed after approval by the Board of Directors of the Company and filing by the Kansas Insurance Commissioner.

No agent or representative of the Company other than its Board of Directors is authorized to change this Contract or waive any of its provisions.

Q. Notification of Change: The Contract Holder will be given notice of any benefit change by a new Group Contract, rider, amendment, or other means as permitted by law. If substantive changes to the Certificate issued thereunder are made, new Certificates or riders or amendments will also be issued.

R. Acceptance of Change: If premium payment is made to the Company after the effective date of any change to the Group Contract, such payment shall be deemed consent to that change.

S. Information to be Provided by the Parties to this Contract: Each month while this Contract is in force, the Contract Holder shall provide the Company such information as may be reasonably required to enroll Insureds, process terminations of individual coverage, and determine the premiums of this Contract.

The Company will provide the Contract Holder with information concerning enrollment of Insureds and other matters as may reasonably be required.

T. Membership, Voting, Annual Meeting and Participation: The policyholder (the person or entity to which the insurance contract has been issued) is a member of Blue Cross and Blue Shield of Kansas and is entitled to vote in person or by proxy at meetings of policyholders. The annual meeting of policyholders is held on the second Thursday in May of each year at 8:30 o' clock a.m. at the corporation's principal place of business at 1133 SW Topeka Boulevard, Topeka, Kansas 66629, or at such other place as the Chairman of the Board of Directors might designate in a notice of meeting given to policyholders. Printed notice in this shall be sufficient as to notification. If any dividends are distributed, the policyholder will share in them according to law and under conditions set by the Board of Directors.

U. The Contract Holder on behalf of itself and its participants hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Contract Holder and Blue Cross and Blue Shield of Kansas, which is an independent corporation operating under an agreement with the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Blue Cross and Blue Shield of Kansas to use the Blue Cross and/or Blue Shield Service Marks in the State of Kansas and that Blue Cross and Blue Shield of Kansas is not contracting as the agent of the Association. The Contract Holder on behalf of itself and its participants further acknowledges that it has not entered into this Contract based upon representations by any person other than Blue Cross and Blue Shield of Kansas and that no person, entity, or organization other than Blue Cross and Blue Shield of Kansas shall be held accountable or liable to the Contract Holder for any of Blue Cross and Blue Shield of Kansas's obligations to the Contract Holder created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Kansas other than those obligations created under other provisions of this agreement.

V. Claims Recoveries

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

1. In the event such recoveries relate to claims paid more than a year and 90 days before the recovery, no adjustment will be made to any Deductible or Coinsurance paid by an Insured and the Company shall be entitled to retain such recoveries for its own use. If the recovery relates to a claim paid within a year and 90 days and is not otherwise addressed herein, Deductible and/or Coinsurance amounts for an Insured will be adjusted for the applicable Benefit Period if affected by the recovery.
2. Such recoveries (except for recoveries made within a year and 90 days of the date of the error by the Company of overpayments to health care providers or to Insureds by the Company not involving assertion of a mass claim by the Company) will not be applied for the purpose of group rating or divisible surplus calculation, if applicable, in any event. The cost actually paid by the Company to procure such recoveries will be treated as an administrative expense in considering group rating or divisible surplus, if applicable. The amounts of recovery available in any event to be applied to the group claims expense will be reduced by the cost to the Company to procure that recovery, including amounts paid in attorney fees, amounts paid to collection agencies or other entities, where such entities obtain recoveries on a contingency basis.
3. In the event the Company receives from pharmaceutical manufacturers rebates based upon amounts of claims paid by the Company for certain specified pharmaceuticals, the Company shall be entitled to retain such rebates for its own use, and no adjustments will be made to claims paid on behalf of the Contract Holder, to Deductible, Coinsurance or Copayments paid by Insureds, or to other cost-sharing or claims amounts.
4. If an Insured is no longer covered by the Company at the time any such recovery is made, regardless of the amount or of the time of such recovery, the Company shall be entitled to retain such recovery for its own use.
5. If such recovery amounts cannot be attributed on an individual basis, because of having been paid as a lump sum settlement for less than the total amount of claims expense of the Company or otherwise, no adjustments will be made to any Deductible, Coinsurance or Copayment amounts paid by the Insured and the Company shall be entitled to retain such recovery for its own use.
6. The amount of any recoveries which are otherwise available for adjustments to Deductible, Coinsurance or Copayments will be reduced by the cost to the Company to procure that recovery, including amounts paid in attorney fees, amounts paid to collection agencies or other entities obtaining recoveries on a contingency basis.
7. Under no circumstances shall such claim recoveries include subrogation.

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

X. **Certificate of Creditable Coverage:** You have the right to request and obtain a Certificate of Creditable Coverage from the Company while You are an Insured and up to 24 months following the date on which Your coverage cancelled. To request a Certificate of Creditable Coverage contact the Customer Service phone number on Your Identification Card.

Y. **Contract Holder's Responsibilities Concerning Enrollment:** It is the responsibility of the Contract Holder/employer group's Plan Administrator to submit to the Company for enrollment only those employees and dependents who meet the eligibility criteria of the Contract Holder and the Company, and to ensure and verify the continued eligibility status of covered employees and dependents. The Company has the right to recover from Insureds and/or providers any benefit payments paid on behalf of ineligible persons.

Z. **Contract Holder's Responsibilities Concerning Federal Minimum Loss Ratio Rebates**

In the event the Company is required to provide rebates pursuant to 45 CFR 158.240 et.seq., the Contract Holder (and its member employers in the case of an association or multiple employer trust) shall be responsible for calculating the amount of each Certificate Holder's proportionate share and distributing such rebates to Certificate Holders. Contract Holder (including on behalf of any member employers as noted above) also agrees to timely provide Company with rebate verification data required under 45 CFR 158.242 in the manner requested by the Company.

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

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COORDINATION OF BENEFITS WITH OTHER COVERAGE

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

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

A. Definitions

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

   a. Plan includes:

      (1) group insurance and subscriber contracts

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

      (3) health maintenance organizations (HMO) contracts

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

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

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

   b. Plan does not include:

      (1) hospital indemnity coverage or other fixed indemnity coverage

      (2) accident only coverage

      (3) specified disease or specified accident coverage

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

      (5) Medicare supplement policies

      (6) Medicaid policies

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

   Each contract or certificate for coverage under a or b above is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

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

3. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.

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

4. Allowable expense is a health care expense, including Deductibles, Coinsurance and/or Copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses that are not allowable expenses:

   a. The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

   b. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar

reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

c. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

5. Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

6. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

B. Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

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

2. a. Except as provided in Paragraph (b), a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.

b. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

3. A plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

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

a. Non-dependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other plan is the primary plan.

b. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

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

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

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

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

(a) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;

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

(c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of item (1) above shall determine the order of benefits; or

(d) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(i) The plan covering the custodial parent;

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

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

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

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

c. Active Employee or Retired or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled B.4.a can determine the order of benefits.

d. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled B.4.a can determine the order of benefits.

e. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

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

C. Effect on the Benefits of this Plan

1. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the Primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan Deductible any amount it would have credited to its Deductible in the absence of other health care coverage.

2. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

D. Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the Company any facts it needs to apply those rules and determine benefits payable.

E. Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

F. Right of Recovery

If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Form ND-156 1/17

CANCELLATION

A. Cancellation of the Group Contract: The Group Contract can be cancelled effective the date to which premiums have been paid, for several reasons.

Cancellation by the Company:

1. The Company may cancel the Group Contract for the following reasons:
   a. Nonpayment of premiums by the Contract Holder. The Contract Holder has a grace period of 10 days following the due date for payment of premiums. Unless premiums are received by the end of the stated grace period, coverage under this Contract cancels as of the payment-due date.
   b. Fraud or intentional misrepresentation of a material fact by the Contract Holder, or employer.
   c. Non-compliance with provisions of this Contract.
   d. Failure to meet or maintain the participation or employer contribution requirements of the Company.
   e. The Company ceases to offer a particular type of group coverage provided the provisions of Kansas law associated with such action are met, (including but not limited to obligations to provide at least 90 days prior notice to contract holders, certificate holders and employers of the decision to cease to offer such coverage and the option such cancelled groups have to purchase any other group coverage otherwise available from the insurer to a similarly situated group).
   f. If this Contract is issued to a small employer as defined by Kansas or federal law applicable to health insurance, the Company ceases doing business in the small employer market, provided that the provisions of Kansas law associated with such action are met, (including the obligation to provide notices at least 180 days prior to the date of the discontinuation of such coverage, to regulatory authorities, contract holders, certificate holders and employers of the decision to cease to do such business, all group policies are discontinued and not renewed and the Company does not re-enter the small employer marketplace for five years from the date of notice).
   g. When there is no longer any eligible employee, member or dependent enrolled under this Contract who lives, resides or works in the Company Service Area.

   Cancellation for the foregoing reasons will be effective on the date specified by the Company in a written notice of cancellation.

Cancellation by the Contract Holder:

The Contract Holder may cancel the Group Contract by providing notice to the Company prior to the end of the month for which premiums have been paid. Cancellation is effective the date to which premiums have been paid.

B. Cancellation of an Individual Insured's Coverage under the Group Contract: The coverage of an individual Insured will cancel in the following situations:

1. When the Company is notified that an Insured's coverage is to be removed from the group, the Insured's coverage under this Contract will end as of the date the Insured's premiums are paid to. The Insured is not entitled to a grace period or benefits during a grace period.
2. Termination of marriage. The coverage of the spouse of the person named on the Identification Card ends on the last day of the month in which the divorce was granted by court action.
3. Dependents who no longer qualify under the general definition of "Insured".
4. If an Insured permits the use of their or any other Insured's Blue Cross and Blue Shield of Kansas Identification Card by any other person, or uses another Insured's card, all rights of the Insured(s) may be cancelled effective immediately upon written notice.
5. If an Insured fails to disclose information requested by the Company or intentionally misrepresents information provided to the Company, then the rights of such Insured under this Contract may be rescinded with a 30 days minimum written notice. At the effective date of such cancellation, prepayments received on account of such cancelled Insured applicable to periods after the effective date of cancellation shall be refunded less nonrecoverable claims paid and the Company shall have no further liability or responsibility under this Contract.
6. When an Insured is determined to be ineligible for coverage provided by this Contract Holder. All rights of the Insured may be cancelled effective immediately upon written notice and coverage may be retroactively cancelled effective the first day of the month following the date on which the Insured became ineligible for coverage. At the effective date of such cancellation, prepayments received on account of such cancelled Insured applicable to periods after the effective date of cancellation shall be refunded and the Company shall have no further liability or responsibility under this Contract.

C. Reinstatement: If an Insured's coverage is cancelled for non-payment of premiums by the Contract Holder (see A.1.a. above), the Company has the right to decide whether or not to reinstate the Group Contract. If coverage is reinstated, there will be no gap in coverage.

D. Benefits When Your Coverage is Cancelled: Your coverage ends on the date of cancellation, except for an Insured who is receiving Inpatient Hospital services when that person's coverage cancels. In such case, benefits may be extended for that Insured without payment of premium for a period not less than 31 days following the cancellation date of the coverage. This extension of benefits shall be secondary to any subsequent replacement group health benefit plan or policy which is intended to provide continuous coverage.

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

1. the completion of a 31 day period following cancellation of coverage; or
2. the date Hospital confinement ends.

E. Grace Period

When a grace period for payment of premiums is applicable, benefits are provided during the grace period only if premiums are received by the end of the stated grace period. The only Insureds who have a grace period are those cancelled with the whole group under the nonpayment of premiums provision in subsection A.1.a. above.

Form CA-600 1/18

CONTINUED COVERAGE RIGHTS UNDER COBRA AND USERRA, CONTINUED COVERAGE UNDER KANSAS LAW AND CONVERSION

A. COBRA Continuation Coverage - Federal Law

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

CONTINUOUS COVERAGE RIGHTS UNDER COBRA

Introduction

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

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary" You, Your spouse, and Your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

If the group health plan offered by Your employer includes coverage for retired employees, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in

bankruptcy is filed with respect to the entity identified on the face page of this Contract, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

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

How is COBRA Coverage Provided?

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

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

Disability extension of 18-month period of continuation coverage

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

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

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

SISTERS OF CHARITY OF LEAVENWORTH
4100 S 4th St.
Leavenworth, KS

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

1. **Payment of Premiums**

   a. Upon receipt of the COBRA Declaration Form, the Company will send the employee or dependent who qualifies for COBRA continuation of benefits a notice of the amount of premiums needed for the continued benefits.

      (1) Initial premiums - A period of 45 days (from the date of election/declaration) is allowed in which to pay the initial required premiums. The first premium payment will be for a period commencing with the date following the date coverage would otherwise cancel. No gap in coverage will be permitted. The premiums may be higher than for active employees, as permitted by law.

      (2) Subsequent premiums - Subsequent premium payments will be allowed a 30-day grace period after the due date. The Company will bill the Insured directly and payment will be made directly to the Company.

   b. Nonpayment of premiums occurs when:

      (1) Premiums are not paid by the due dates as provided in 1.a. above; and/or

      (2) Premiums are not paid by You, Your relative by blood, marriage or adoption, or an organization specifically designated by federal or state law as an entity from whom the Company must accept premiums.

2. **Enrollment and Benefit Changes**

   a. If the group changes benefits, the COBRA Insured's benefits will also change to match the group's new benefit package.

   b. The COBRA Insured has the same right to change benefit programs as the active group employees during the employer's Open Enrollment period.

   c. If the employer changes insurers during the period of Continued Group Benefits, the COBRA Insured for that group will be cancelled as to coverage under this Contract and become the responsibility of the new insurer.

   d. The Company shall not be obligated to provide COBRA coverage to You if the Contract Holder or Plan Administrator fails to timely notify You of Your rights under COBRA or You fail to timely elect COBRA coverage.

3. **Conversion Privilege**

   COBRA Insureds who complete the COBRA Continuance of Benefits period are then eligible for a conversion contract offered by the Company at the conversion contract rates then in effect. This conversion is only applicable to Insureds whose group offers health insurance with the Company at the time the Insured's eligibility under COBRA ends. Section D describes the conversion privilege in more detail.

B. USERRA Continuation Coverage - Federal Law

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

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

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

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

failure to apply or return terminates the employee's right to reemployment rights under applicable federal law regarding uniformed service.

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

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

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

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

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

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

7. **Reemployment Rights**

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

C. Kansas State Continuation Law

The following provisions of Kansas laws governing group health insurance benefits for hospital, surgical and medical services apply to persons who do not have a right to continue coverage under the federal law.

An employee or such person's covered dependents, whose hospital, surgical or major medical expense insurance (and dental insurance in conjunction with the aforementioned) under the Group Contract has been cancelled for reasons such as discontinuance of the Group Contract in its entirety or with respect to an insured class of persons, is entitled to have such continuation coverage under the Group Contract, subject to the following provisions:

1. The employee or covered dependent must have been continuously insured under the Group Contract (or a group policy providing similar benefits which was replaced by the Group Contract) for at least three (3) months immediately prior to cancellation.

2. Such group benefits may be continued under the Group Contract for a period of 18 months.

   Clarification:

   A dependent whose eligibility as a dependent ceases during the 18-month period may complete the 18-month period under separate coverage.

3. Continuation of group benefits does not apply:

a. Where persons are on continuation coverage and during that 18-month period the Group Contract is replaced. Such persons for that group will be cancelled as to coverage under this Contract and become the responsibility of the new insurer.

b. When cancellation of coverage under the Group Contract occurs because any employee failed to pay any required contribution.

c. When the employee is or could be covered by Medicare.

d. When the employee is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such cancellation.

e. When coverage for an Insured is cancelled pursuant to items B. 5, 6 or 7 of the Cancellation Section.

4. Notice of Right to Continue Group Benefits: The Insured named on the Identification Card will be notified of their right to continue their group benefits. The Insured must provide written notification that they wish to continue their group coverage to the Company within 60 days of the date an event occurs which would qualify an Insured for continuation coverage under this provision.

a. Upon receipt of the written notification from the Insured, the Company will send the employee or dependent who qualifies for continuation of group benefits a notice of the amount of premiums needed for the continuation benefits.

(1) Initial premiums - A period of 45 days from the date the Insured elects to continue group benefits is allowed in which to pay the initial required premiums. The first premium payment will be for a period commencing with the date following the date coverage would otherwise cancel. No gap in coverage will be permitted.

(2) Subsequent premium - Subsequent premium payments will be allowed a 30-day grace period after the due date. The Company will bill the Insured directly and payment will be made directly to the Company.

b. Nonpayment of premiums occurs when:

(1) Premiums are not paid by the due dates as provided in 4.a. above; and/or

(2) Premiums are not paid by You, Your relative by blood, marriage or adoption, or an organization specifically designated by federal or state law as an entity from whom the Company must accept premiums.

D. Conversion Privilege

1. A conversion privilege is available to the following persons:

a. Those who have completed the period of Continued Group Benefits provided for in Section A, B, or C above if the Company is the insurer or administrator of that employer group health plan at the cancellation of such benefits.

b. Those who during the period of Continued Group Benefits provided for in Section A, B, or C above choose to change to the Conversion Contract and so notify the Company. (So doing forever forfeits any right to further Continued Group Benefits.)

c. Those who at the time of initial eligibility for Continued Group Benefits under Section A or B above choose to go directly at that time to the Conversion Contract. (So doing forever forfeits any right to Continued Group Benefits.)

d. Those who do not qualify for Continued Group Benefits under either Section A or B above.

2. A conversion privilege is not applicable to Insureds who have their coverage cancelled pursuant to items B.5, 6, or 7 of the Cancellation Section or to the following persons if the benefits referred to in paragraph b. below for such person or benefits provided or available under the sources referred to in paragraphs c. and d. below for such person, together with the benefits provided by the converted policy, would result in over-insurance based on Company standards as filed with the Kansas Insurance Department:

a. Those who are or could be covered by Medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded).

b. Those who are covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program, or

c. Those who are eligible for similar benefits (whether or not covered therefore) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or

d. Those who have or have available similar benefits pursuant to or in accordance with the requirements of any state or federal law.

3. Conversion Notice

The Company will mail a conversion notice to those persons specified in Section D.1. Within 31 days of receipt of the notice, the person has the right to apply for coverage by remitting the required premiums. The first required premium payment will be for a period commencing with the day following the date coverage would otherwise cancel. No gap in coverage will be permitted.

Persons who are enrolled in Continued Group Benefits will be mailed the conversion notice prior to the end of the period for continued group benefits.

a. Notice to the Insured named on the Identification Card: The notice will be mailed to the Insured's latest address as it appears on the records of the Company.

b. Notice to dependents who cease to be eligible: The notice will be mailed to the dependent at the address provided the Company when the Company is notified that such person is no longer an eligible dependent.

4. The contract does not require evidence of insurability of the person to be covered.

Form CB-237 1/18

BLUE CHOICE RIDER

PART 1. GENERAL

This is a Rider to the Contract. It becomes effective on the date shown in the records of the Company.

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

PART 2. ENROLLMENT IN BLUE CHOICE

The Contract Holder and Insured agree to the following related to the offering of Blue Choice and the Insured's enrollment therein:

A. Blue Choice Providers

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

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

The Company will provide the Contract Holder with listings of the Blue Choice Providers in the Company Service Area. The Insured may call the number listed on the Insured's Identification Card if the Insured wishes to determine if a provider outside the Company Service Area is a Blue Plan Preferred Provider.

B. Use Blue Choice Providers or Blue Plan Preferred Providers

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

C. Additional Coinsurance

The Insured will be responsible for an additional 20% of the Allowable Charge up to a maximum additional Coinsurance of $2,000 per Insured per Benefit Period or $4,000 for all Insureds on family coverage per Benefit Period that would otherwise be allowable if the Insured fails to use a Blue Choice Provider or a Blue Plan Preferred Provider. This additional Coinsurance does not accumulate toward the satisfaction of any other Deductible, Coinsurance or shared payment called for by the Contract, and those other Deductibles, Coinsurances or shared payment amounts called for by this Contract continue to apply.

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

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

RIDER

PART 1. GENERAL

This is a Rider to a Contract issued by the Company and becomes effective on the date shown in the records of the Company.

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

PART 2. PURPOSE AND EFFECTS OF THIS RIDER

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

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

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

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

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

Form RI-454 1/17

SUPPLEMENTAL ENDORSEMENT ISSUED BY BLUE CROSS AND BLUE SHIELD OF KANSAS, INC.

As a Blue Cross and Blue Shield of Kansas Insured You have the opportunity to take advantage of savings programs that are collectively called HealthyOptions which are being offered at no additional cost to You. These programs are not insurance but instead discount programs that will help You with specified expenses for services that are not eligible for coverage under Your Blue Cross Blue Shield of Kansas coverage.

The types of services included are:

- Vision Care
- Hearing Care
- Complementary and Alternative Medicine

Disclaimer

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

Form 80-2115 1/17

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

Kansas Insurance Department
420 SW 9th Street
Topeka, KS 66612

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.

Form 29-446 7/11