

KANSAS HEALTH INSURANCE ASSOCIATION

This Policy is issued to You by the Kansas Health Insurance Association “KHIA” in accordance with Kansas law.

The premium You paid and the application You completed put this Policy in force as of the Effective Date shown on the Schedule of Benefits. A copy of Your application is attached.

This Policy has cost containment provisions, which may affect Your benefits as described in Part L.

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READ CAREFULLY THIS POLICY IS RENEWABLE AS STATED IN PART A.

PART A. RENEWAL AGREEMENT

We will renew Your Policy each time You pay Us the premium until the earliest of:

- (a) the date the Lifetime Maximum benefit has been paid to You under this Policy or in Aggregate with any Policy issued by Us;

- (b) the date You are no longer eligible for coverage under the Kansas Health Insurance Association Policy;
- (c) the date You fail to respond within 30 days of Our inquiry regarding Your place of residency;
- (d) the date Kansas statutes require cancellation of this Policy;
- (e) the date You become eligible for Medicare or Medicaid as described in Part G; or
- (f) the date You have access to Health Insurance through an employer sponsored group or self-insured plan.

You will receive notice of the date Your premium is due. The premium must be paid on or before that date. However, this Policy includes a 31 day grace period following the premium Renewal Date during which the premium can be paid.

Upon termination of this Policy, We will return any Unearned Premium to You.

PART B. 10-DAY RIGHT TO EXAMINE THIS POLICY

We want You to fully understand and be entirely satisfied with Your Policy. If You are not satisfied for any reason, You may return this Policy to Us or provide Us with written notice within 10 days of receipt that the Policy is not acceptable. We will then refund any premiums You have paid. This Policy will then be considered never to have been issued.

PART C. PLEASE READ YOUR APPLICATION

Please read the copy of Your application. If anything contained in the application is not correct or if any past medical history has been left out, You should tell Us. Your Policy was issued on the basis that all information in the application is correct and complete. If not, Your Policy may not be valid.

PART D. PREMIUM CHANGE

Your premium is expected to change each January 1. The change will be based on Your attained age on January 1 or on a revised table of premium rates, or both. We can apply revised rates only if We do the same on all of Our policies with the same provisions and benefits, issued to persons of the same classification. We will notify You of any premium change in advance of the change.

PART E.

POLICY CHANGE

Any provision of this Policy (including a benefit reduction) is subject to change as determined by the Kansas Health Insurance Association. You will receive written notice of any Policy change in advance of the change.

PART F.

DEFINITIONS

Administrator means the Insurer or Third Party Administrator designated by the Kansas Health Insurance Association Board of Directors.

Admission Information means the following information, which the attending Practitioner must provide to the Utilization Review Organization (URO) before a period of confinement is approved:

- (a) the diagnosis or reason for the confinement;
- (b) any proposed treatment or surgical procedure; and
- (c) the expected days of confinement.

Aggregate means all totals collected from different sources and considered together to get the overall cost or total.

Annual Maximum means the maximum dollar amount We will pay in any Calendar Year for Eligible Expenses incurred by You.

Board means the Board of Directors of the Kansas Health Insurance Association.

Brand Name Drug means a trade name medication.

Calendar Year means the period beginning on January 1 and ending on December 31 of the same year. The first Calendar Year begins on the date this Policy becomes effective for You as shown on the Schedule of Benefits and ends on December 31 of the same year.

Calendar Year Deductible means the initial amount of Eligible Expense incurred for Covered Services and Supplies You must incur each Calendar Year before benefits are eligible for reimbursement under this Policy. For all Insureds under coverage that covers two or more Insureds (in Aggregate), the Calendar Year Deductible shall be two times the individual Calendar Year Deductible except Family Policy I, in which one Insured may meet the entire Deductible amount.

Amounts in excess of the Usual and Customary charge for Covered Services and Supplies will not apply towards satisfaction of Your Calendar Year Deductible.

Church Plan means the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974.

Co-insurance/Co-payment/Co-pay means the portion of a Practitioner's Usual and Customary Charge that is Your financial responsibility. Co-insurance/Co-payment/Co-pay does not include any Deductibles.

Congenital Birth Defect means a medical condition that existed at birth and is diagnosed within the first five years of life.

Cosmetic means medically unnecessary treatment or surgical procedures performed primarily:

- (a) to improve physical appearance or to change or restore bodily form without materially correcting a body malfunction; or
- (b) to prevent or treat a mental or nervous disorder through a change in bodily form.

Coverage Types:

1. **Single Coverage** and **Insured Only Coverage** mean only the Insured is covered.
2. **Two-Party Coverage** means the Insured and one other eligible Dependent are covered.
3. **Family Coverage** and **Insured/Spouse/Child (Children) Coverage** mean the Insured, his/her eligible Spouse, and one or more Dependent children who are eligible for the Policy and who qualify under the definition of Dependent are covered.

Creditable Coverage means with respect to an individual, coverage of the individual under any of the following:

- (a) a Group Health Plan;
- (b) Health Insurance coverage;
- (c) Part A or Part B of Title XVIII of the Social Security Act; (Medicare Hospital or Medicare Medical Coverage);
- (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (Medicaid, State Medical Assistance Program);
- (e) Chapter 55 of Title 10, United States Code; (former Military);
- (f) a medical care program of the Indian Health Service or of a tribal organization;
- (g) a state health benefit risk pool; (length of residency requirement is waived, Pre-existing Condition limitation is waived under certain rules);

- (h) a health plan offered under Chapter 89 of Title 5, United States Code;
- (i) a public health plan as defined under regulations promulgated by the Secretary of Health and Human Services; and
- (j) a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(d)).

Custodial Care means services or supplies provided when there is not a reasonable expectation of a measurable, progressive improvement in the patient's condition during the course of or immediately following use of such services. Custodial Care includes services or supplies which:

- (a) are furnished mainly to train or assist in personal hygiene or the activities of daily living rather than to provide therapeutic treatment;
- (b) can safely and adequately be provided by persons without professional license;
- (c) are requested by or for the convenience of the patient or the patient's family; and
- (d) enable family members to work outside the home. Activities of daily living include assistance with such things as:
 - (1) bathing or dressing;
 - (2) assistance with mobility;
 - (3) eating or taking oral medicines.

This Policy does not provide benefits for Custodial Care regardless of who recommends, provides, or directs such care.

Deductible means the amount of Eligible Expenses You must pay before any benefits are eligible for reimbursement under this Policy.

Dependent means:

- (a) a Resident Spouse or Resident unmarried child under the age of 19;
- (b) a child who is a student under the age of 23 years and who is financially dependent upon You for support and maintenance, or
- (c) a child of any age who is disabled and dependent upon You, provided that proof of such incapacity is submitted to the Administrator within 31 days of the child's attainment of age 19 and, thereafter, as requested by Us.

Durable Medical Equipment means equipment which:

- (a) can withstand repeated use;
- (b) is primarily and customarily used to serve a medical purpose;
- (c) generally is not useful to a person in the absence of an illness or Injury; and
- (d) is appropriate for use in the home.

The Policy will consider expenses associated with rental of Durable Medical Equipment up to the purchase price. An item for which rental is not available will be considered for purchase only. Durable Medical Equipment must be Medically Necessary, and if the cost is in excess of \$500, the rental or purchase must be pre-authorized. Prosthetic devices are not considered Durable Medical Equipment.

Eligible Expense means the expense incurred for a Covered Service or Supply. Expense is considered incurred on the date the service or supply is received. The fact that a Practitioner may prescribe, order, recommend, or approve a service or supply does not, of itself, make it Medically Necessary or an Eligible Expense. Eligible Expense does not include any charge:

- (a) for a service or supply which is not Medically Necessary; or
- (b) which is in excess of Usual and Customary Charges.

Experimental or Investigational means the status of a drug, device, medical treatment or procedure:

- (a) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished; or
- (b) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials; or
- (c) if Reliable 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 or treatment or diagnosis.

NOTE: Prescription drugs for cancer treatment will not be considered Experimental or Investigational on the grounds that the prescription drug has not been approved by the FDA for the covered indication if 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. If requested by Us, the prescribing Practitioner must submit documentation supporting the proposed off-label use or uses.

Federally Defined Eligible Individual means an individual:

- (a) for whom, as of the date on which the individual seeks coverage under this Policy, the Aggregate of the periods of Creditable Coverage is 18 or more months and whose most recent prior coverage was under a Group Health Plan, a Governmental Plan, or a Church Plan;
- (b) who is not eligible for coverage under a Group Health Plan, Part A or part B of Title XVIII of the Social Security Act (Medicare), or a state plan under Title XIX (Medicaid) of the Social Security Act, or any successor program, and who does not have other Health Insurance coverage in which a permanent Pre-existing condition exclusion applies;
- (c) whose most recent coverage was not terminated for factors relating to non-payment of premiums or fraud; and
- (d) if offered the option of continuation coverage under COBRA or under a similar program, must have elected and exhausted such continuation coverage.

Federally Defined Eligible Individuals for FTAA means an individual who is:

- (a) Legally Domiciled in this state; and
- (b) eligible for the credit for Health Insurance costs under Section 35 of the Internal Revenue Code of 1986. (Health Care Tax Credit (HCTC) or Pension Benefit Guaranty Corp (PBGC)).

FTAA means Federal Trade Adjustment Assistance under the Federal Trade Adjustment Assistance Reform Act of 2002, Public Law 107210.

Generic Drug means a drug prescribed by a Practitioner:

- (a) that meets all Federal Drug Administration standards;
- (b) that does not have a registered trade mark; and
- (c) whose name can be used by more than one drug company.

Governmental Plan means the definition given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any Federal Governmental Plan.

Group Health Plan means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care as defined in Section 3N and including terms and services paid for as medical care to

employees or their Dependents as defined under the terms of the plan directly through insurance, reimbursement, or otherwise.

Health Insurance means any Hospital or medical expense policy, health, Hospital or medical service corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans. Health Insurance does not include policies or certificates covering only:

- (a) accident;
- (b) credit;
- (c) dental;
- (d) disability income;
- (e) long term care;
- (f) Hospital indemnity;
- (g) Medicare supplement;
- (h) limited benefit;
- (i) fixed indemnity;
- (j) specified disease;
- (k) vision care;
- (l) coverage issued as a supplement to liability insurance;
- (m) insurance arising out of a workers compensation or similar law;
- (n) automobile medical-payment insurance; or
- (o) insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

Home Health Care Agency means an agency that meets the following criteria:

- (a) its main function is to provide Home Health Care Services and Supplies;
- (b) it is federally certified as a Home Health Care Agency; and

(c) it is licensed (if required) by the state in which it is located.

Home Health Care Services and Supplies means:

- (a) part-time or intermittent nursing care by or under the supervision of a registered nurse;
- (b) part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services);
- (c) physical, occupational and speech therapy;
- (d) medical supplies; and
- (e) laboratory services by or on behalf of the Hospital.

Hospice Agency means an agency whose main function is to provide Hospice Care Services and Supplies, and is licensed (if required) by the state in which it is located.

Hospice Care Services and Supplies means services and supplies provided through a Hospice Agency including:

- (a) inpatient care in a Hospice Unit or other licensed facility;
- (b) pain management and palliative care;
- (c) home care; and
- (d) bereavement counseling.

Hospital means a place licensed or recognized as a Hospital by the proper authority of the state where located. When treatment is needed for a mental disease or disorder, Hospital can also mean any of the following places when licensed by the proper authority of the state in which they are located:

- (a) a medical care facility;
- (b) a psychiatric Hospital;
- (c) a community mental health center or clinic.

In no event will a convalescent, nursing, or rest home be deemed to be such a place.

Incurred Expenses mean expenses will be deemed incurred on the date the Insured receives the treatment, service, or supply that gives rise to the expense.

Injury means an accidental bodily Injury, which requires treatment by a Practitioner.

Insured means the person(s) shown on the Schedule of Benefits who are eligible to receive benefits while this Policy is in force.

Insurer means any entity that provides Health Insurance in this state. For the purposes of this Act, Insurer includes:

- (a) an insurance company;
- (b) a health maintenance organization; and
- (c) any other entity providing Health Insurance or health benefits subject to state insurance regulation.

Legally Domiciled means living in a place of permanent habitation in this state and one of the following:

- (a) obtaining a valid Kansas Motor Vehicle Operators License;
- (b) being registered to vote in Kansas; or
- (c) filing a Resident Kansas Income Tax Return.

A child is Legally Domiciled in this state if the child lives with a custodial parent or legal guardian who is Legally Domiciled in this state.

Lifetime means the period of time an Insured is covered under this Policy.

Lifetime Maximum means the maximum dollar amount We will pay for Eligible Expenses incurred by You while insured under this Policy or any Policy issued by Us. A benefit change from one Policy option to another Policy option will not increase Your Lifetime Maximum.

Medicaid means the medical assistance program operated by the state under title XIX of the Federal Social Security Act.

Medical Emergency means the sudden, unexpected onset of a health condition that requires immediate medical attention, and 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.

Medically Appropriate Hospital Confinement means confinement for medical or surgical services that are Medically Necessary and could not be provided without adversely affecting the Insured's condition or the quality of medical care:

- (a) on an outpatient basis; or

(b) in a less costly type of facility available in the area.

Medically Necessary Service or Supply means a service or supply that:

- (a) is appropriate and consistent with the diagnosis in accordance with generally accepted standards of medical practice as determined by a Utilization Review Organization;
- (b) is not considered Experimental or Investigative;
- (c) could not have been omitted without adversely affecting the Insured person's condition or quality of medical care; and
- (d) is the most appropriate supply or level of service that can be provided on a cost effective basis.

Medicare means coverage under both Parts A and B of title XVIII of the Federal Social Security Act, 42USC 1395.

Mental Disorder means a disorder specified in the Diagnostic and Statistical Manual of the American Psychiatric Association.

Mental Disorder does not include conditions attributable to a Mental Disorder that is a focus or attention treatment.

Network Provider means a health care facility, Practitioner, or other entity that has entered into a contract, either directly or indirectly, with Us that defines the method We will use to determine benefits payable. It is Your responsibility to verify that Your provider is a Network Provider each time You receive services.

Out of Pocket Expense means the amount of Eligible Expense for Covered Services and Supplies that You must pay each Calendar Year. Out of Pocket Expense does not include the Deductible, Co-payment/Co-pay, and expenses disallowed for services that are received contrary to any provisions of this Policy.

Policy means the Kansas Health Insurance Association (KHIA) Policy created pursuant to K.S.A. 40-2119. The Policy includes Your Schedule of Benefits and any amendments at the time:

- (a) Your insurance is effective with Us;
- (b) You elect to change Policy coverage; and
- (c) when KHIA makes a material change to the eligibility and/or benefits of the Policy.

Policy Year means the remainder of the Calendar Year following the Effective Date of this Policy and ends on December 31. Thereafter, Policy Year means January 1 through December 31 each Calendar Year. If a Dependent is added to Your Policy at any time after Your original Effective Date, their Policy Year will begin on their respective Policy Effective Date.

Practitioner means a health care professional whose licensure or certification authorizes the professional to render health care services covered under this Policy. A Practitioner does not include a person who lives with You or is part of Your family (You, Your Spouse, or a child, brother, sister, or parent of You or Your Spouse).

Pre-existing Condition means any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnoses, care, or treatment was recommended or received from a medical Practitioner within the six-month period ending on the Effective Date of this Policy.

Prescription Network Provider means an entity or pharmacy that has entered into a contract with Us. Claims **MUST** be submitted by a Prescription Network Provider on Your behalf in order to receive prescription drug benefits. There is no coverage for prescription drug claims not submitted through a Prescription Network Provider.

Preventive Services means a medically accepted method of prophylaxis or diagnosis, which prevents Sickness or provides early diagnosis of Sickness; including pap smears and mammograms.

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

Prostheses means the initial and subsequent prosthetic devices pursuant to an order of Your Practitioner.

Reconstructive Surgery means any surgical procedure and related services performed primarily to:

- (a) improve/restore bodily function resulting from disease, trauma, congenital or developmental anomalies, or previous therapeutic processes; or
- (b) prevent or treat a mental or nervous disorder through a change in bodily form.

Reliable Evidence shall mean:

- (a) published reports and articles in the authoritative medical and scientific literature;
 - (b) the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure;
- or

- (c) the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Renewal Date means the date on which any premium is due.

Resident means a person who has been Legally Domiciled in Kansas for a period of at least six months immediately prior to application for coverage under this Policy.

NOTE: The six month Resident requirement does not apply to a Federally Defined Eligible Individual.

Sickness means a disease, disorder, or condition that requires treatment by a Practitioner.

Spinal Manipulation means physical medicine modalities including, but not limited to: correction or adjustment by manual, mechanical, electrical, or physical means (including use of light, heat, water, exercise, or decompression) of structural imbalance, distortion, subluxation, or misplaced tissue of any kind or nature of the human body.

Such treatment is done by a Practitioner to remove nerve interference resulting from or related to: distortion, misalignment, or subluxation of, or in, the vertebral columns. Nutritional supplements are not covered.

Spouse means a legally recognized marital partner in the state in which You live.

Substance Abuse means habitual, excessive or compulsive drinking of alcohol, and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Symmetrical Appearance related to a mastectomy means in addition to prosthetic devices and Reconstructive Surgery for the diseased breast that the mastectomy was performed, prosthetic devices and Reconstructive Surgery for a healthy breast if, in the opinion of the Practitioner, surgery is necessary to achieve normal Symmetrical Appearance.

Unearned Premium means the amount of premium You paid in advance of the termination date of this Policy.

Usual and Customary means:

- (a) for Network Providers, the expense incurred for medical services or supplies which are in an amount determined by agreement between the Network Provider and Us;
- (b) for non-Network Providers, an amount not exceeding the rate regularly charged and received for a given service or supply by Practitioners or other providers of medical services.

The payment of benefits for non-Network Providers are based on the most frequently charged fees by providers in the same geographical location for a comparable service or supply. In the event of multiple surgeries or multiple surgeons in attendance during one operation, or for service or supplies for which data is unavailable, Usual and Customary charges will be determined by the charges generally incurred for conditions of comparable nature and severity in the particular geographical area.

Utilization Review Organization (URO) means an entity that evaluates the necessity, appropriateness, and efficiency of the use of health care services and providers and pre-certifies an admission, extension of stay, or other health care services.

We, Our or Us means the Kansas Health Insurance Association.

You or Your means the Insured and Dependents named on the Schedule of Benefits. If the Insured is a minor, any rights under this Policy will belong to the Insured's parent or legal guardian.

PART G. ELIGIBILITY AND TERMINATION

1. Any person who has been a Resident of this state for at least six months prior to making application for coverage, or any Federally Defined Eligible Individual, or any person whose most recent coverage was that of another state's high risk pool, and who is a Resident of this state shall be eligible for Policy coverage if the person is able to provide evidence of meeting the following criteria:
 - (a) any person who is Legally Domiciled in this state who previously was covered under the high risk pool of another state, provided they apply for coverage within 63 days of losing such coverage for reasons other than fraud or non-payment of premiums;
 - (b) such person has had Health Insurance involuntarily terminated for any reason other than non-payment of premium;
 - (c) such person has applied for Health Insurance and been rejected by two carriers because of health conditions (a written certification from an agent licensed to write accident and health business in Kansas that such person will be rejected by two carriers because of health conditions will satisfy this requirement);
 - (d) such person has been quoted a premium for Health Insurance with a comparable Deductible, and that premium is in excess of this Policy's premium;
 - (e) such person has been accepted for Health Insurance subject to a permanent exclusion of a Pre-existing disease or medical condition; or
 - (f) any Federally Defined Eligible Individual who is and continues to be a Resident shall be eligible for Policy coverage.

2. Each Resident Dependent of a person who is eligible for Policy coverage shall also be eligible for Policy coverage.
3. Each Resident Dependent of a Dependent, is eligible for Policy coverage. The newly born child shall be covered from the moment of birth provided an application is made within 31 days of birth. The first month's premium shall be prorated by the number of days covered in the month; thereafter, premium shall be charged at the scheduled fee for the Policy chosen by You. The following rules apply:
 - (a) the newly born child shall be enrolled in their own Policy and will not be covered under the Policy of its Dependent mother as a Dependent;
 - (b) a newly born child shall be eligible for coverage under their own Policy if an application is made for coverage of the child provided:
 - (1) the newly born child has been denied coverage under two carriers; or
 - (2) has received a letter from an agent licensed in the state of Kansas that coverage is not available for such child.

A person shall not be eligible for this Policy if:

- (a) the person is eligible for Medicare (Parts A or B) or is eligible for Medicaid benefits;
- (b) the person had coverage under the Policy terminated less than 12 months prior to the date of the current application, except that this provision shall not apply with respect to an applicant who is a Federally Defined Eligible Individual;
- (c) the Policy has paid out \$2,000,000 in benefits on behalf of the person;
- (d) the person has access to accident and Health Insurance through an employer-sponsored group or self-funded plan, including coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), except that the requirement for exhaustion of any available COBRA or state continuation is waived whenever such person:
 - (1) is eligible for the credit for health care costs under Section 35 of the Internal Revenue Code of 1986 (FTAA, PBGC); and
 - (2) has three months of prior Creditable Coverage as described in subsection (c) of K.S.A. 40-2124.
- (e) the person is eligible for any other public or private program that provides or indemnifies for health services.

A person may maintain other Health Insurance for the period of time that person is satisfying any Pre-existing Condition exclusion period under this Policy, and may maintain this Policy

for the period of time the person is satisfying a Pre-existing Condition exclusion period under other Health Insurance intended to replace this Policy. During the time a person maintains other Health Insurance, benefits will be coordinated with the other insurance carrier and We will pay benefits as a secondary payer. Any person who ceases to meet the eligibility requirements of this section will be terminated on the next premium Renewal Date.

When an Insured's Medicare effective date is retroactive or when the Administrator is not advised in advance of the Insured's Medicare eligibility, the Administrator shall schedule termination of this Policy at the end of the month following the Administrator's receipt of written notification of the Insured's Medicare award.

When an Insured's Medicaid effective date is retroactive or when the Administrator is not advised in advance of the Insured's Medicaid eligibility, the Administrator shall schedule termination of this Policy at the end of the month following the Administrator's receipt of written or verbal notification of the Insured's Medicaid award. If the notification of Medicaid eligibility comes from a third party, the Administrator shall contact the Insured by phone or letter for verification of Medicaid eligibility and effective date. Upon verification from the Insured, the Administrator shall schedule termination of this Policy at the end of the month following verification. If the Insured does not respond to the letter or phone calls, the Administrator shall terminate this Policy at the end of the month following the last requested response date in the letter to the Insured.

For all other termination requests, the administering carrier shall schedule termination of the Policy the latest of the date We receive written notification or the date requested. An exception shall be granted upon the Insured's death; the termination date shall be effective the day following the Insured's death, and the administering carrier shall reimburse any Unearned Premium.

Coverage shall cease on the date state law requires cancellation of this Policy.

PART H. ENROLLMENT AND EFFECTIVE DATES

1. If You were an Insured of KHIA on the day before this Policy becomes effective, Your coverage will be continuous. This Policy replaces any prior Policy of the Kansas Health Insurance Association that You held on the day before the date this new coverage becomes effective.
2. The unborn baby of a Dependent who is covered under her parent's Policy is eligible for coverage from the date of birth. We must receive an application within 31 days of birth in order for the newly born child to be eligible for coverage from the date of birth. The newly born child shall be enrolled in its own Policy. The first month's premium shall be prorated by the number of covered days in the month; thereafter, the premium shall be charged at the scheduled fee for the Policy.
3. Insured Only Coverage may be changed to another type of coverage that includes Dependents subject to the conditions that follow. Dependents proposed for coverage must

complete an application and be accepted for coverage by the Administrator, except in the following situations when coverage changes from Insured Only to a type that includes Dependent children:

- (a) a newborn of a natural parent-insured when the written request to add such child is received within 31 days of the child's birth;
 - (b) an adopted newborn when the written request to add such a child is received within 31 days of the date the petition for adoption is filed, and that petition is filed with the state within 31 days of the child's birth;
 - (c) an adopted child other than a newborn when the written request to add such a child is received within 31 days of the date the petition for adoption is filed with the state; or
 - (d) a child placed in the Insured's home by a child placement agency, as defined by state law for the purpose of adoption, when the written request to add such a child is received within 31 days of the date of placement as certified by the Insured.
4. Two-Party Coverage may be changed to another type of coverage that includes other Dependents. Dependents proposed for coverage must complete an application and be accepted for coverage by the Administrator, except that coverage will be provided for 31 days for the following:
- (a) a newborn of a natural parent-insured when the written request to add such child is received within 31 days of the child's birth;
 - (b) an adopted newborn when the written request to add such a child is received within 31 days of the date the petition for adoption is filed, and that petition is filed with the state within 31 days of the child's birth;
 - (c) an adopted child other than a newborn when the written request to add such a child is received within 31 days of the date the petition for adoption is filed with the state; or
 - (d) a child placed in the Insured's home by a child placement agency, as defined by state law for the purpose of adoption, when the written request to add such a child is received within 31 days of the date of placement as certified by the Insured.

In order to continue coverage beyond the first 31 days, the Administrator must receive the written request to add the child within 31 days of the child's birth; in the case of an adoption, within 31 days of the date the petition for adoption is filed with the state; or in the case of a child placed in the Insured's home by a child placement agency, as defined by state law for the purpose of adoption, within 31 days of the date of placement as certified by the Insured. If such request is not made within the required time frame coverage for the child will terminate at the end of the initial 31 day period.

5. Family (Insured/Spouse/Child/Children) Coverage may add additional Dependents. Additional Dependents proposed for coverage must complete an application and be accepted for coverage by the Administrator, except for:
 - (a) a newborn of a natural parent-insured when the written request to add such child is received within 31 days of the child's birth;
 - (b) an adopted newborn when the written request to add such a child is received within 31 days of the date the petition for adoption is filed, and that petition is filed with the state within 31 days of the child's birth;
 - (c) an adopted child other than a newborn when the written request to add such a child is received within 31 days of the date the petition for adoption is filed with the state; or
 - (d) a child placed in the Insured's home by a child placement agency, as defined by state law for the purpose of adoption, when the written request to add such a child is received within 31 days of the date of placement as certified by the Insured.

In order to continue coverage beyond the first 31 days, the Administrator must receive the written request to add the child within 31 days of the child's birth; in the case of adoption, within 31 days of the date the petition for adoption is filed with the state; or in the case of a child placed in the Insured's home by a child placement agency, as defined by state law for the purpose of adoption, within 31 days of the date of placement as certified by the Insured. If such request is not made within the required time frame coverage for the child will terminate at the end of the initial 31 day period.

The Administrator requires that each person covered be recorded on the Administrator's records. Claims for Dependents not on record will be denied until it has been established that the person is an eligible Dependent. When a new Dependent is to be added to coverage, the Insured named on the Schedule of Benefits must notify the Administrator in writing of the Dependent's name, date of birth, gender and relationship.

EFFECTIVE DATES

1. Establishing Effective Date. When coverage is subject to acceptance by the Administrator, coverage will be effective the first day of the month following receipt of the application by the Administrator, except in the following situations.
2. Changing Insured Only Coverage to a type of coverage that includes Dependents.
 - (a) In those situations when an application is not required by the Administrator, any change in coverage will be effective as follows and premiums will be charged from the date the new coverage becomes effective as follows:
 - (1) natural newborns, adopted newborns, and newborns placed in the Insured's home by a child placement agency, as defined by the state law for the purpose

of adoption, the new coverage which includes Dependent children will be effective from the moment of birth;

(2) for adopted children other than newborns, the new coverage which includes Dependent children will be effective on the first date the petition for adoption is filed with the state; or

(3) for children other than newborns placed in the Insured's home by a child placement agency, as defined by state law for the purpose of adoption, the new coverage which includes Dependent children will be effective on the date the placement occurred as certified by the Insured.

(b) In all those situations when an application is required for enrollment of the proposed Insured, coverage will be effective on the first day of the month following the date the Administrator receives the application. An incomplete application may jeopardize Your intended effective date. Premiums for the new coverage will be charged from the date the change in coverage becomes effective.

3. Changing Two-Party Coverage to a type of coverage that includes other Dependents.

(a) In those situations when an application is not required by the Administrator, the change in coverage will be effective and premiums for the new coverage will be charged from the date the new coverage becomes effective as follows:

(1) natural newborns, adopted newborns, and newborns placed in the Insured's home by a child placement agency, as defined by state law for the purpose of adoption, the new coverage which includes Dependent children will be effective on the 32nd day following the date the child is born.

(2) for adopted children other than newborns, the new coverage which includes Dependent children will be effective on the 32nd day following the day the petition for adoption is filed with the state.

(3) for children other than newborns placed in the Insured's home by a child placement agency, as defined by state law for the purpose of adoption, the new coverage which includes Dependent children will be effective on the 32nd day following the date of placement as certified by the Insured.

(b) In all those situations when an application is required for enrollment of the proposed Insured, coverage will be effective on the first day of the month following the date the Administrator receives the application. An incomplete application may jeopardize Your intended effective date. Premiums for the new coverage will be charged from the date the change in coverage becomes effective.

4. Changing existing coverage that includes Dependent children.

(a) In those situations when an application is not required by the Administrator, the change in coverage will be effective and premiums for the new coverage will be charged from the date the new coverage becomes effective as follows:

(1) natural newborns, adopted newborns and newborns placed in the Insured's home by a child placement agency, as defined by state law for the purpose of adoption, the coverage will be effective the date the child is born.

(2) for adopted children other than newborns, the coverage will be effective on the date on which the petition for adoption is filed with the state.

(3) for children other than newborns placed in the Insured's home by a child placement agency, as defined by state law for the purpose of adoption, the coverage will be effective on the date of placement as certified by the Insured.

(b) In all those situations when an application is required for enrollment of the proposed Insured, coverage will be effective on the first day of the month following the date the Administrator receives the application. An incomplete application may jeopardize Your intended effective date. Premiums for the new coverage will be charged from the date the change in coverage becomes effective.

5. Changing between tobacco and non-tobacco classes.

(a) If You enrolled under a tobacco-user rate class but remain tobacco free for 12 months, then You may request a change in Your rate class. The change will become effective on January 1 following the date Your request is received by US.

(b) If We determine Your status in a tobacco-user rate class is incorrect, we will retroactively collect historical differences in premiums before claims will be paid, and we will start applying the tobacco-user rate.

PART I. PRE-EXISTING CONDITION EXCLUSION

Your Policy will not cover expenses incurred during the first 90 days after the Effective Date for a Pre-existing Condition. We will pay only for Eligible Expenses incurred after such 90 day period. Payment will be in accordance with the provisions of this Policy.

If You were covered under other Health Insurance that terminated less than 32 days prior to the Effective Date of this Policy, the 90 day period will be waived to the extent the Pre-existing Condition exclusion period was satisfied under the previous coverage.

No Pre-existing Condition exclusion shall be applied to:

- (a) a Federally Defined Eligible Individual;
- (b) a person who has had their most recent coverage with another state high risk pool provided that application for coverage is made not later than 63 days following the applicant's most recent prior Creditable Coverage; or
- (c) a person who is eligible for the credit for Health Insurance costs under Section 35 of the Internal Revenue Code of 1986 (FTAA/PBGC). The Pre-existing Condition exclusion will not apply whenever such individual has maintained Creditable Health Insurance Coverage for an Aggregate period of three months, not counting any period prior to a 63 day break in coverage, as of the date on which such individual seeks to enroll in coverage provided by this Policy.

Credit for a newly born child's Pre-existing Condition exclusion period will be offset by the number of days the parent of the newly born child can demonstrate Creditable Coverage. If the parent of the child does not have Creditable Coverage then the child shall be subject to the Pre-existing Condition exclusion period as outlined in this Policy.

PART J. BENEFITS

Benefits for Eligible Expenses are subject to:

- (a) the applicable Deductibles shown in the Schedule of Benefits;
- (b) the Co-insurance percentage; and
- (c) the maximums, limitations, conditions and other provisions of this Policy.

All benefits provided while You are insured under this Policy are limited to \$2,000,000. The accumulation of the Lifetime Maximum began the date Your Policy became effective

Your Calendar Year Deductible may not be decreased; however, You may elect to increase Your Calendar Year Deductible. The adjusted Calendar Year Deductible amount You choose must be a Calendar Year Deductible option We offer on the date the change becomes effective. The change will become effective on January 1 following the date Your request is received, and You will be advised of any change in premium.

The Schedule of Benefits shows the Policy You chose, designated as Policy H, Policy I, Policy J, or Policy K. The Schedule of Benefits also shows the Calendar Year Deductible and the Lifetime Maximum amount that applies to this Policy.

In Network Benefits are as follows:

- (a) For Policy H, after You have paid the Calendar Year Deductible of \$1,500, We will pay 70% of the next \$5,000 of Eligible Expenses. Thereafter, when the amount You have paid in Co-insurance in a Calendar Year reaches \$1,500 for any one Insured or \$3,000 for all Insureds on a type of coverage that covers two or more Insureds (in Aggregate), We will pay 100% of the Eligible Expenses up to the Lifetime Maximum.
- (b) For Policy I, after You have paid the Calendar Year Deductible of \$2,500, We will pay 70% of the next \$8,333 of Eligible Expenses. Thereafter, when the amount You have paid in Co-insurance in a Calendar Year reaches \$2,500, We will pay 100% of the Eligible Expenses up to the Lifetime Maximum. (Policy I Deductibles and Co-insurance are subject to change according to Internal Revenue Service Code Section 220 in relation to the CPI.)

For Policy I Family Policy, after You have paid the Aggregate Calendar Year Deductible of \$5,000, We will pay 70% of the next \$16,666 of Eligible Expenses. Thereafter, when the amount You have paid in Co-insurance in a Calendar Year reaches an Aggregate of \$5,000, We will pay 100% of the Eligible Expenses up to the Lifetime Maximum. (Policy I Deductibles and Co-insurance are subject to change according to Internal Revenue Service Code Section 220 in relation to the CPI.)

- (c) For Policy J, after You have paid the Calendar Year Deductible of \$5,000, We will pay 70% of the next \$5,000 of Eligible Expenses. Thereafter, when the amount You have paid in Co-insurance in a Calendar Year reaches \$1,500 for any one Insured or \$3,000 for all Insureds on a type of coverage that covers two or more Insureds (in Aggregate), We will pay 90% of the Eligible Expenses up to the Lifetime Maximum.
- (d) For Policy K, after You have paid the Calendar Year Deductible of \$10,000, We will pay 70% of the next \$15,000 of Eligible Expenses. Thereafter, when the amount You have paid in Co-insurance in a Calendar Year reaches \$4,500 for any one Insured or \$9,000 for all Insureds on a type of coverage that covers two or more Insureds (in Aggregate), We will pay 90% of the Eligible Expenses up to the Lifetime Maximum.

Out of Network Benefits are as follows:

- (a) After the Deductible has been met, Eligible Expenses received from other than a Network Provider will be reimbursed at 50% of Usual and Customary charges. Out of Network Co-insurance expense will not be applied toward the satisfaction of the Out of Pocket Expense.

Covered Services and Supplies

NOTE: The following Covered Services and Supplies are subject to the Lifetime Maximum. Please refer to Your Schedule of Benefits to determine Deductible and Co-insurance percentages applicable to Your Policy.

1. **Ambulance Service for:**
 - (a) local ground professional ambulance service; and
 - (b) one-way transportation within the United States by professional ground or air ambulance, not to exceed \$5,000 for any one transport, when:
 - (1) transportation is Medically Necessary;
 - (2) transportation is to the nearest Hospital equipped to furnish the services; and
 - (3) any other mode of transport would endanger the health or safety of the Insured.
2. **Anesthesia and its administration.**
3. **Daily room and board and other Hospital services.** Payment rate for daily room and board is the semi-private room rate unless a private room is prescribed as Medically Necessary by a Practitioner or by the licensing authority of a health care facility. Room charges made by a Hospital having only private rooms will be paid at the private room rate. Refer to the Mental Disorder or Substance Abuse benefit for additional inpatient limitations applicable to these conditions.
4. **Diabetes Treatment.** Coverage for diabetes outpatient self-management training and education is only eligible when provided by a certified, registered or licensed healthcare professional with expertise in diabetes. The Policy only provides benefits when covered services are ordered by a Practitioner legally authorized to prescribe such services and the diabetic:
 - (a) is treated at an approved program;
 - (b) is treated by a person certified by the National Certification Board for Diabetes Educators, or
 - (c) is, as to nutritional education, treated by a licensed dietitian pursuant to an approved treatment plan.
5. **Drugs and medicines requiring a written prescription by a Practitioner.**
 - (a) Inpatient: Payable on the same basis as any other covered service and supplies.
 - (b) Outpatient: Coverage is only available through the Prescription Network Provider. The name of the Prescription Network will be on the identification card issued to You by the Policy. The member pharmacy **Must** file the prescription claim on Your behalf. There is no coverage for claims not filed by a member pharmacy. Coverage will be based on the cost of a Generic Drug, if available. If not available or the

prescription requires a Brand Name Drug, coverage will be based on the Usual and Customary Charge of the prescription. Eligible prescription expenses apply to Your Calendar Year Deductible. After You have satisfied Your Calendar Year Deductible, We will reimburse You 50% of the eligible prescription cost until You have satisfied Your Out of Pocket Expense; thereafter, prescriptions will be reimbursed at the percentage payable under this Policy subject to the Lifetime Maximum.

6. **Emergency care, surgery and treatment of acute episodes of illness or disease.** Coverage will not be denied for emergency services if symptoms presented by an Insured and recorded by the attending Practitioner indicate that a Medical Emergency condition exists.
7. **Home Health Care Agency Services**, excluding Custodial Care, up to a maximum of 40 visits per Calendar Year. Home Health is subject to prior authorization.
8. **Hospice Care Services and Supplies.**
9. **Mastectomy and breast reconstruction** as outlined in the Women's Health & Cancer Rights Act. We will pay the expense incurred for a mastectomy and breast reconstruction on the same basis as any other covered service. Reconstruction benefits include:
 - (a) reconstruction of the breast on which the mastectomy has been performed;
 - (b) surgery and reconstruction of the other breast to produce a Symmetrical Appearance; and
 - (c) Prostheses and physical complications of all stages of mastectomy, including lymphedemas.
10. **Maternity** expenses for an Insured.
11. **Mental Disorders or Substance Abuse.** Eligible Expenses for treatment of mental and nervous disorders or chemical dependency conditions are set forth below; if You are treated for a Mental Disorder or Substance Abuse, We will pay as follows:
 - (a) **Inpatient Benefits:** Benefits are payable on the same basis as any other Sickness for Mental Disorders and Substance Abuse combined, for the lesser of 30 days or \$7,500 in benefits for inpatient care and treatment per Calendar Year. Inpatient stays require prior authorization.
 - (b) **Outpatient Benefits, except Policy I:** Benefits are payable for Mental Disorders and Substance Abuse combined subject to the following:
 - (1) Eligible Expenses for the first visit are reimbursed at 100%. The Deductible is waived;

- (2) Eligible Expenses for visits 2 through 20 are subject to a \$25 Co-payment and then reimbursed at 100%. The Deductible is waived; and
 - (3) the maximum number of outpatient visits allowed for each Insured each Calendar Year is 20 for all conditions combined.
- (c) **Outpatient Benefits for Policy I Mental Disorders and Substance Abuse** will be paid on the same basis as any other illness. Such outpatient coverage will be subject to the Calendar Year Deductible and Co-insurance percentage.

Daily room and board and other Hospital services for Mental Disorders are as provided under Mental Disorders or Substance Abuse Benefits.

Mental Disorders and Substance Abuse Benefits are limited to:

- (1) screening, evaluation and referral;
- (2) outpatient treatment for Mental Disorders and Substance Abuse; and/or
- (3) day treatment consisting of Hospital services or their equivalent provided for Mental Disorders and/or Substance Abuse but excluding room and related inpatient charges.

Services must be provided by a Practitioner, psychologist, clinical social worker (MSW), or community mental health agency professional under the direction of a Practitioner.

12. **Non-surgical Spinal Treatment.** Benefits for non-surgical spinal treatment are subject to all Policy provisions. Benefits are limited to 20 visits each Calendar Year (applies to all Policies).
13. **Oral surgery** for excision of partially or completely un-erupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.
14. **Organ Transplant Services.** The following transplant procedures will be covered when such surgery is not considered Experimental or Investigational for the diagnosis or condition being treated. Covered Services are limited to services and supplies for organ transplants when ordered by a Practitioner. These services must be approved in advance by Us through our Utilization Review Organization. Such services include, but are not limited to:
- (a) Hospital charges;
 - (b) Practitioner charges;

- (c) organ procurement, tissue typing; and
- (d) ancillary services.

Coverage is provided for:

- (a) Cornea;
- (b) Kidney;
- (c) Kidney/Pancreas;
- (d) Liver;
- (e) Heart;
- (f) Heart/Lung;
- (g) Lung;
- (h) Bone Marrow (allogenic and autologous); and
- (i) stem cell transplants for breast cancer and certain other conditions, when such transplants are Medically Necessary. All other transplants not specifically mentioned, which are considered Experimental or Investigational, will be excluded.

Organ and Tissue Transplants must be pre-certified by the Utilization Review Organization (URO) listed on Your current member identification card. Transplant services may be provided by a Center of Excellence, which may be outside The Policy's Provider Network. These services will be arranged by the URO to maximize Your transplant benefit dollars and assure that You receive quality care at only the best transplant facilities. Benefits for transplants, when performed at a Center of Excellence, will be paid as if services were performed at a Network Provider (70 % of the negotiated rate after Deductible has been met). Centers of Excellence are facilities that are rigorously evaluated and provide access to clinically superior, cost effective transplants and health care.

Network Providers: After satisfaction of Your Calendar Year Deductible, benefits will be paid at 70% of Usual and Customary only if organ transplant services are provided by a Network Provider. Covered Services do not include travel expenses.

Non-Network Providers: If organ transplant services are provided at a facility that is NOT a Network Provider, covered services will be subject to the following limitations except when received under the direction of the URO at a Center of Excellence:

- (a) after satisfaction of Your Calendar Year Deductible, benefits will be provided at 50% of Usual and Customary Charges;
- (b) the Co-insurance level for organ transplant services received from non-Network Providers will always be paid at the non-Network benefit level; and
- (c) Covered Services do not include travel expenses.

Donor Covered Services: The following will apply when a human organ transplant is provided from a living donor to a transplant recipient:

- (a) when both the recipient and the donor are covered under this Policy, Covered Services received by the donor and recipient will be combined and applied to the organ recipient's applicable Policy maximums;
- (b) when only the recipient is covered under this Policy, both the donor and the recipient are entitled to the Covered Services of this Policy. The donor's Covered Services are limited to only those benefits that are not provided by, or available to, the donor from any other source. This includes, but is not limited to, other Health Insurance coverage or any Governmental Plan. Covered Services provided to a donor will be applied towards the recipient's Policy maximums under this Policy; to the extent Covered Services are provided to the donor;
- (c) when only the donor is covered under this Policy, Covered Services are limited to only those services which are not provided by, or available to, the donor from any other source. This includes, but is not limited to, other Health Insurance coverage or any Governmental Plan. No Covered Services will be provided to a transplant recipient who is not covered under this Policy; and
- (d) if any organ or tissue is sold rather than donated to a recipient covered under this Policy, no Covered Services will be provided for the purchase price of such organ or tissue. However, other costs related to evaluation and organ Procurement Services are covered and subject to the applicable Policy maximums.

Immunosuppressant Drugs are considered a part of transplant costs.

Multiple Organ Transplants performed at the same time such as heart/lung are considered one procedure.

An Insured is eligible for re-transplantation if deemed Medically Necessary and appropriate by Us. Re-transplantation must be approved in advance by Us. In no event will We cover more than one re-transplantation per Insured.

You have no benefit for a non-human or mechanical organ transplant. You have no benefit for transplant services that are Experimental or Investigational.

The benefit for the costs associated with the acquisition of bone marrow or peripheral stem cells or a donor search when a related HLA genotypically identical donor is not available are limited to \$30,000 per Insured per transplant and subject to the Lifetime Maximums of Your Policy.

15. Other Medical Services and Supplies:

- (a) **oxygen** and the rental of equipment for its administration;
- (b) **casts, splint, braces and crutches;**
- (c) rental (up to the purchase price) of **Durable Medical Equipment**. The Policy will consider expenses associated with rental of Durable Medical Equipment up to the purchase price. An item for which rental is not available will be considered for purchase only. Durable Medical Equipment must be Medically Necessary. If the cost is in excess of \$500, the rental or purchase must be pre-authorized. Prosthetic devices are not considered Durable Medical Equipment.
- (d) initial placement of **contact lenses or eye glasses** (frames and lenses) required because of cataract surgery;
- (e) initial **lens implant** required because of cataract surgery; and
- (f) **dental services by a Practitioner for the treatment of a dental Injury** to sound natural teeth (including the initial replacement of the injured teeth and any necessary dental x-rays) provided the treatment plan begins within 90 days of the Injury and is completed within one year after the Injury.

16. **Practitioner's services** for the care of Preventive Services and for the diagnosis or treatment of Injuries or Sickness, other than dental services otherwise provided.

17. **Preventive Services** are covered subject to the following:

- (a) services are subject to the Co-pay and Co-insurance specified on Your Schedule of Benefits;
- (b) coverage for services is subject to the Lifetime Maximum shown in the Schedule of Benefits;
- (c) routine physical exams are limited to general health check-ups, x-rays, blood pressure checks, urine tests, tuberculosis tests, prostate exams, rectal exams, and diagnostic tests including, but not limited to, mammograms, Pap smears, and PSA tests;
- (d) routine physical exams are limited to:
 - (1) one every three years if You are seven to 40 years of age;

- (2) one every two years if You are 40 to 55 years of age; and
 - (3) one per year if You are age 55 and older;
- (e) children's preventive care services provided or supervised by a Practitioner (this would include a nurse Practitioner acting under direct supervision or an established treatment protocol). Services include:
- (1) a history; physical exam;
 - (2) developmental assessment; anticipatory guidance; and
 - (3) lab tests.

To be covered, well childcare services must be in keeping with prevailing medical standards. Routine immunizations for all covered Dependent children of the Insured shall be provided and consist of at least five doses of vaccine against diphtheria, pertussis, tetanus; at least four doses of vaccine against polio, and Haemophilus B (Hib); and three doses of vaccine against Hepatitis B; two doses of vaccine against measles, mumps and rubella; one dose of vaccine against varicella and such other vaccines and dosages as may be prescribed by the Secretary of Health and Environment. These benefits shall be provided to each covered Dependent child from birth to 72 months of age and are not subject to any Deductible, Co-payment or Co-insurance requirements.

- 18. **Professional services of Advanced Registered Nurse Practitioners** who hold a certificate of qualification from the Board of Nursing to practice in an expanded role or Practitioner Assistant under the direction of a Practitioner.
- 19. **Prostheses** other than dental. We cover the initial purchase, fitting, repair and replacement of fitted prosthetic devices, which replace body parts. Replacement devices must be Medically Necessary due to growth; other physiologic change; change in the Insured's condition; or deterioration of the device, which renders repairs unacceptable. Benefits are not payable for special or extra-cost convenience features.
- 20. **Radium or other radioactive materials.**
- 21. **Registered physical therapist**, which includes aqua-therapy, **speech and occupational** therapy services.
- 22. **Skilled Nursing Services** of a licensed skilled nursing facility for not more than 120 days during a Calendar Year.
- 23. **Colorectal Cancer Screening.** For insured persons age 50 and older, screening includes:

- (a) an annual fecal occult blood test;
- (b) a flexible sigmoidoscopy every five years;
- (c) a colonoscopy every ten years; or
- (d) a double barium enema every five years.

Screenings may be more frequent for Insureds that a medical Practitioner determines to be at high risk for Colorectal Cancer.

PART K. EXCEPTIONS AND LIMITATIONS

We will not pay for:

- (a) any expense for services for which no charge would be made in the absence of insurance or for which the Insured bears no legal obligation to pay;
- (b) acupuncture, homeopathy and naturopathy;
- (c) any expense for illness or Injury due to an act of war;
- (d) any expense for service of a blood donor and any fee for failure of the Insured to replace the first three pints of blood provided in each Calendar Year;
- (e) any expense or charge for oral contraceptives used for birth control or any other temporary birth control measures;
- (f) any expense related to Cosmetic services or Reconstructive Surgery except when the service is one of the following:
 - (1) repair due to an illness or resulting from an accidental Injury
 - (2) Reconstructive breast surgery following or coinciding with a Medically Necessary mastectomy that resulted from a medical illness or Injury. This includes Reconstructive Surgery on a breast on which a mastectomy was not performed to produce a Symmetrical Appearance.
 - (3) repair of Congenital Birth Defects or abnormalities and hereditary complications or conditions, limited to:
 - a. cleft lip or palate;
 - b. birthmarks on head or neck;
 - c. webbed fingers or toes;

d. supernumerary digits or toes.

All other Cosmetic and Reconstructive services not shown above require prior authorization by Us for determination of coverage. If, through the prior authorization process, a service is determined to be Cosmetic in nature, it shall be considered non-covered.

- (g) any expense for court ordered testing or rehabilitation;
- (h) any expense for care, which is primarily Custodial or Domiciliary in nature;
- (i) dental care except as specifically provided under the Policy;
- (j) any drug, device, medical treatment or procedure and related services that are Experimental or Investigational;
- (k) outpatient Drugs and medicines requiring a written prescription by a Practitioner that were not processed for payment on Your behalf by a Prescription Network Provider;
- (l) any expense for services rendered prior to the Effective Date of coverage under this Policy;
- (m) any expense for Experimental or Investigational services or supplies (NOTE: Prescription drugs for cancer treatment will not be considered Experimental or Investigational on the grounds that the prescription drug has not been approved by the FDA for the covered indication if 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. If requested by Us, the prescribing Practitioner must submit documentation supporting the proposed off-label use or uses);
- (n) eyeglasses and hearing aids (one set of eye glasses, lenses and frames, following cataract surgery will be covered);
- (o) any expense or charge for fertility testing, in vitro fertilization, artificial insemination or any other artificial means used to cause pregnancy;
- (p) any Group, Family or Marriage Counseling;
- (q) any expense for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental) health condition.

- (r) any expense for services or supplies not Medically Necessary;
- (s) any expense for services or charges incurred by You which are otherwise covered by:
 - (1) Medicare or state law or programs;
 - (2) medical services provided for members of the United States armed forces and their Dependents or for employees of such armed forces;
 - (3) military service-connected disability benefits;
 - (4) other benefit or entitlement programs provided for by the laws of the United States or any state;
 - (5) workers compensation or similar programs addressing injuries, diseases or conditions incurred in the course of employment covered by such programs;
 - (6) benefits payable without regard to fault pursuant to any motor vehicle or other liability insurance policy or equivalent self-insurance.

NOTE: This exclusion shall not apply to services or charges which exceed the benefits payable under the applicable programs listed above and which are otherwise eligible for payment under this section.

- (t) any expense for personal supplies or services provided by a health care facility or any other non-medical or non-prescribed supply or service;
- (u) any expense or charge for routine physical examinations or tests; except where otherwise specified;
- (v) any expense for services the provision of which is not within the scope of the license or certificate of the institution or individual rendering such service;
- (w) any expense or charge for sterilization or sterilization reversals;
- (x) charges for visits in excess of visit limits described elsewhere in the Policy.
- (y) that part of any charge for services rendered or articles prescribed by a Practitioner, dentist or other health care personnel which exceeds the Usual and Customary Charge or for any charge not Medically Necessary; or
- (z) any expense or charge for weight loss programs, exercise equipment or treatment of obesity, except when determined Medically Necessary by our Utilization Review Organization to achieve a medically recommended body weight for a person of the same gender, height, age and mobility as the Insured.

PART L. COST CONTAINMENT PROVISIONS

Expenses for medical care are covered only if the care is Medically Necessary. A Utilization Review Organization (URO) will perform pre-admission review for the following service:

- (a) Hospital confinement;
- (b) all services performed by a Home Health Care Agency;
- (c) rental or purchase of Durable Medical Equipment (DME) ordered by, or at the direction of, a Practitioner with a cost of more than \$500. Prosthetic devices are not considered Durable Medical Equipment.

Utilization Review will also perform a review of services during such treatment or equipment usage.

RULES FOR PRE-ADMISSION REVIEW AND EFFECT ON BENEFITS

You must call the Utilization Review Organization (URO) listed on Your Policy identification card.

1. For a Non-emergency Admission. If You are advised by a Practitioner to enter a Hospital as a resident patient for a reason other than:
 - (a) childbirth; or
 - (b) a Medical Emergencyat least 72 hours prior to the scheduled Hospital admission.

Within one business day after the URO receives the required notice and obtains the Admission Information from the attending Practitioner, You, the Practitioner, and the Hospital will be sent written notice of any period of confinement that is certified as Medically Appropriate.

2. For a Medical Emergency Admission. If You enter a Hospital as a resident patient for childbirth or because of a Medical Emergency, then You or the attending Practitioner must notify the URO by phone:
 - (a) within 48 hours after a weekday admission;
 - (b) within 72 hours after an admission on a weekend or on a legal holiday; or
 - (c) as soon as reasonably possible.

On the same business day that the URO receives the required notice and obtains the Admission Information from the attending Practitioner, the Practitioner or Hospital will be phoned (and You, the Practitioner, and the Hospital will be sent written notice) to confirm any additional days of confinement that are certified as Medically Appropriate.

3. For Continued Confinement. Before the approved period of confinement ends, the URO will phone the attending Practitioner to determine whether You require further Hospital confinement. On the same business day, You, the Practitioner, and the Hospital will be sent written notice to confirm any additional days of confinement that are certified as Medically Appropriate.
4. For Home Health Care Agency Services. If Your Practitioner has recommended the services of a Home Health Care Agency, You, the Practitioner, or the provider of service must notify the URO by phone as soon as reasonably possible PRIOR to the start of the Home Health Care Services.
5. For Durable Medical Equipment with a cost of more than \$500. If Your Practitioner has recommended the use of Durable Medical Equipment, You, the Practitioner, or the provider of service must notify the URO by phone as soon as reasonably possible PRIOR to the receipt of the Durable Medical Equipment.
6. Alternate Medical Treatment. In some cases alternate medical care, which provides a cost-effective alternative to Covered Services, may be recommended. If the attending Practitioner selects an alternate medical treatment, which the Utilization Review Agency certifies under Your Policy, We may consider those services for payment.

Effect on Benefits

1. For expenses incurred for days of Hospital confinement, services of a Home Health Care Agency, and for Durable Medical Equipment that are certified as Medically Necessary, benefits will be payable in accordance with Policy provisions.
2. For expenses incurred for days of Hospital confinement for which pre-admission review does not occur within the time frame required in the Policy, all benefits otherwise payable under the Policy will be reduced by a \$1,000 penalty. The penalty is separate and distinct from any Deductible or Co-insurance amount required under this Policy and does not accumulate toward Your Out of Pocket Expense or Lifetime Maximum. After the penalty and Your Calendar Year Deductible have been met, benefits will be paid at the applicable percentage payable required under this Policy.
3. Expenses incurred for Home Health Care Agency Services for which pre-certification does not occur prior to the beginning of the service will be denied until certification occurs through the Utilization Review Organization. No coverage will be provided for services determined by Us not to be Medically Necessary.

4. Expenses incurred for Durable Medical Equipment with a cost of more than \$500 for which pre-certification does not occur prior to the beginning of the rental or purchase will be denied until certification occurs through the Utilization Review Organization. No coverage will be provided for services determined by Us not to be Medically Necessary.
5. For expenses incurred for days of Hospital confinement, Home Health Care Agency services, and Durable Medical Equipment in which review does occur but which are not certified as Medically Necessary, no benefits will be payable.

The amount of reduction of benefits as stated above will not be used to satisfy any Deductible or Out of Pocket Expense. Any reduction in benefits will be based on Usual and Customary charges rather than benefits paid.

In accordance with Policy provisions, benefits will not be payable when days of Hospital confinement are for medical or surgical services, which:

- (a) are not Medically Necessary; or
- (b) are not covered by this Policy.

PART M. NON-DUPLICATION OF BENEFITS

This Policy is the last payer of benefits whenever any other benefit is available. Benefits otherwise payable under this Policy shall be reduced by all amounts paid or payable, or reimbursed directly by or under any other form of Health Insurance or health benefit plan, whether insured or otherwise.

The Kansas Health Insurance Association reserves the right of recovery for any payments We made for a loss that is payable by any other Health Insurance or insurance plan; all Hospital and medical expense benefits paid or payable under any workers compensation coverage, automobile medical payment, or liability insurance whether provided on the basis of fault or no-fault; and by any Hospital or medical benefits paid or payable under, or provided pursuant to, any state or federal law or program. Benefits due from Us may be reduced or refused as an offset against any amount otherwise recoverable.

Non-duplication of Medicare benefits. If an Insured is awarded Medicare benefits retroactively or We are not notified in advance of the Insured's Medicare award, then We will terminate this Policy in accordance with the regulations outlined in Part G Eligibility and Termination. The Administrator will ask the providers to refund the amount the Policy has paid for the period the Insured had Medicare benefits. We will then pay the remainder or unpaid portion according to the Policy benefits after Medicare has adjudicated the claim under their primary responsibility.

Non-duplication of Medicaid benefits. If an Insured is awarded Medicaid benefits retroactively or We are not notified in advance of the Insured's Medicaid award, then We will terminate this Policy in accordance with the regulations outlined in Part G Eligibility and Termination. The Administrator will process all eligible claims as the primary payer.

PART N. HOW TO FILE A CLAIM

Notice of Claim. You must give the Administrator written notice of a claim within 90 days after it starts or as soon as You can. You must give the notice or You may have someone do it for You. The notice should give Your name and Policy number as shown on the Schedule of Benefits. The notice should be mailed to the Administrator's designee noted as "Send Medical Claims to" on Your Policy identification card. This does not waive the pre-admission review of Hospital confinement requirements shown in Part L.

Claim Form. When the Administrator receives Your notice, You will be sent, upon request, forms for filing proof of loss. If these forms are not sent to You in 15 days, You will have met the proof of loss requirements if within 90 days after the loss began You give the Administrator a written statement of what happened.

Proof of Loss. You must give the Administrator written proof of Your loss in 90 days or as soon as You can. Proof must, however, be furnished within 12 months, except in the absence of legal capacity.

PART O. PAYMENT OF CLAIMS

All benefits will be paid as soon as the Administrator receives acceptable proof of loss. Any benefits for Hospital, medical, or surgical services You have assigned will be paid to the Hospital or the provider of the services. If You have not assigned the benefits or requested in writing that You be paid, the Administrator, at their option, will pay You, the Hospital, or the provider of the services.

Benefits unpaid at Your death that would have otherwise been paid directly to You will be paid to Your beneficiary (Your estate if no beneficiary is named).

PART P. TERM OF COVERAGE

Your coverage starts on the Effective Date as shown on the Schedule of Benefits at 12:01a.m., Standard Time where You live. It ends at 12:01a.m. Standard Time, on the Renewal Date, unless otherwise terminated in accord with applicable provisions of this Policy. A new term begins each time You renew Your Policy by paying the premium no later than the end of the 31-day grace period.

PART Q. GENERAL PROVISIONS

Cancellation by You. You may cancel this Policy at any time by giving Us written notice. It will be effective when We receive Your notice or on a later date that You may specify. Upon cancellation or upon death, We will promptly return any Unearned Premium, which will be based on a pro rata calculation. Cancellation will not affect an existing claim. Retroactive

termination will not be allowed except in the event of a death or as otherwise allowed in this Policy. Non-payment of premium constitutes voluntary termination.

Conformity with State Statutes. This Policy shall be construed in accordance with the laws of the state of Kansas.

Entire Contract: Changes. This Policy, Your application, and any riders are the entire contract of insurance. No agent may change it in any way. Only the Kansas Health Insurance Association Board of Directors can approve a change. Any such change must be shown in Your Policy.

Grace Period. The premium for Your Policy is due on the Renewal Date. You can pay Your premium on the Renewal Date or within 31 days after the date it is due. This 31-day period is the Grace Period; claims incurred during the Grace Period are not reimbursable until sufficient premium has been received by US to renew this Policy. If We do not receive Your payment during the Grace Period, Your Policy will lapse as of the Renewal Date.

Legal Action. You cannot start a legal action to recover under Your Policy until 60 days after You have filed Your proof of loss. No such legal action may be brought after five years from the time Your written proof of loss is required to be filed.

Misstatement of Age. The premium for this Policy is based on age. If We determine Your age was misstated on the application, it may result in the premium being adjusted. If this Policy would not have been issued at Your correct age, We will refund all premiums paid, less the amount of all claims paid. This Policy will then be considered terminated.

Physical Examinations. We, at Our expense, have the right to have You examined when and as often as is reasonable during the handling of a claim.

Reinstatement. We do not provide for the reinstatement of this Policy if it lapses due to non-payment of premium. If You mail or deliver a premium to Us after the Grace Period, We will return it to You as soon as We determine the premium is late.

You may reapply for coverage under the Kansas Health Insurance Association Policy if You again become eligible, provided 12 months have elapsed since You voluntarily terminated this Policy. The 12 month time period does not apply to the Federally Defined Eligible Individual. Non-payment of premium constitutes a voluntary termination.

Time Limit on Certain Defenses: After two years from the date You become covered under this Policy, We cannot use misstatements, except fraudulent misstatements on Your application, to void coverage or deny a claim for loss that happens after the two-year period.

No claim for loss commencing after 90 days from the date of the issuance of this Policy shall be reduced or denied on the grounds that a disease or a physical condition had existed six months prior to the Effective Date of this Policy.

If You already satisfied the Pre-existing Condition exclusion period of another Health Insurance coverage that terminated less than 31 days prior to the Effective Date of this Policy then no claim for loss commencing after the Effective Date will be reduced or denied on the grounds that a disease or physical condition existed prior to the Effective Date. This provision does not apply to Federally Defined Eligible Individuals.

PART R. COMPLAINT, GRIEVANCE AND EXTERNAL REVIEW PROCEDURES

1. Definitions.

For the purpose of this Complaint, Grievance and External Review Procedures Section, the following terms and their definitions apply only when a proposed or delivered health care service that would otherwise be covered under this Policy is denied (or partially denied) or was not Medically Necessary or has been determined by Us to be Experimental or Investigational:

Complaint means an oral or written expression of dissatisfaction.

Grievance means a request to change a previous complaint decision made by Us.

External Review means the review of a Final Adverse Decision by an External Review Organization.

External Review Organization means an entity that conducts independent external reviews of Final Adverse Decisions pursuant to a contract with the Kansas Insurance Department.

Final Adverse Decision means:

- (a) in the case of other than a Medical Emergency, a utilization review determination by the Grievance Committee of the Kansas Health Insurance Association Board of Directors (Grievance Committee), or Our designee, that a proposed or delivered health care service that would otherwise be covered under this Policy is not or was not Medically Necessary or has been determined by Us to be Experimental or Investigational and the requested service is provided in a manner that leaves You with a financial obligation or the Final Adverse Decision is the reason for You not receiving the requested service, or
- (b) in the case of a Medical Emergency, an initial determination by Us that a proposed health care service that would otherwise be covered under this Policy is not Medically Necessary or the health care treatment has been determined by Us to be Experimental or Investigational and the requested service would leave You with a financial obligation or the Final Adverse Decision would prevent You from receiving the requested service.

2. Procedure for Filing a Complaint or Grievance for Claim Denial.

We provide a two-level Grievance process for disputed claims. The first level is via a complaint to the Administrator and the second level is a review by the Grievance Committee. If Your claim is denied or partly denied, a written explanation will be sent from the Administrator. You may request a review of the denial within 60 days of receiving this notice. You must first direct a Complaint to the Administrator expressing the details of Your concern. A Complaint may be made by telephone, in person, or in writing. The Administrator will handle the Complaint quickly and courteously. The Administrator will attempt to complete a review of the request within 10 days of its receipt. If You do not receive prompt resolution, or wish to express Your concern to a higher level of authority, a Grievance may be filed with the Administrator. The Grievance will be forwarded to the Grievance Committee for review and resolution.

Upon receipt of a Grievance, the Grievance Committee (or its designee) will conduct a review within 20 working days. If the review cannot be completed within 20 working days of its receipt, You will be notified in writing within 30 working days time, and every 30 working days thereafter until the review is complete. The review must be completed within 60 days. Following completion of the review, the Grievance Committee will decide upon an appropriate resolution of the Grievance. A written response will be prepared and You will be notified within five working days following completion of the review. In the event of a Final Adverse Decision, an External Review Procedure may be pursued to resolve disputes regarding medical necessity or services deemed Experimental or Investigational.

3. Procedure for Pursuing an External Review.

You have the right to request an External Review after a Final Adverse Decision has been rendered, or if You have not received a Final Adverse Decision within 60 days of seeking such review, unless the delay was requested by You. In the case of a request for an External Review involving a Medical Emergency, such request may be made before You have exhausted other available review procedures. The Grievance Committee will notify You in writing regarding a Final Adverse Decision and the opportunity to request an External Review.

Within 90 days of receipt of notice of a Final Adverse Decision, You, the Practitioner or health care provider acting on Your behalf with Your written authorization, or Your legally authorized designee must make a written request for an External Review to the Kansas Insurance Commissioner.

If any party is not satisfied with the decision of the External Review Organization they may pursue normal remedies of law. Prior to the institution of any legal proceeding or suit against Us, the foregoing Complaint, Grievance and External Review Procedures shall be utilized by any party alleging a claim. In all events, such suit or proceeding must be commenced no later than five years after the date the written decision of the External Review Organization is transmitted to such party.

The right to External Review shall not be construed to change the terms of coverage under this Policy. In no event shall more than one External Review be available for any request arising out of the same set of facts. You may not pursue, either concurrently or sequentially, an external review under both federal and state law. In the event External Review processes are also available pursuant to federal law, You have the option of designating which external review process will be utilized.

4. Right to Waive a Second Appeal or Internal Review and Employ External Review.

The Administrator will notify You of Your right to waive the review by the Grievance Committee and proceed directly to the external review.

If the Administrator provides an internal appeal or review of a health care decision which is adverse to You, the Administrator shall allow You to voluntarily waive Your right to the Grievance Committee review. Such waiver shall be made in writing to the Administrator and shall constitute the exhaustion of all available internal appeal or review procedures.

If You elect to request the Grievance Committee review of a health care decision which is adverse to You, You have the right to appear in person before a designated representative or representatives of the Administrator or Utilization Review Organization at the Grievance Committee meeting. If a majority of the designated representatives of the Grievance Committee who will be deciding the second internal appeal or review cannot be present in person, by telephone or by other electronic means, at least one of those designated representatives who will be deciding the Grievance shall be a Practitioner and shall be present in person, by telephone or by other electronic means. No Practitioner or other health care provider serving as a reviewer in an internal Grievance shall be liable in damages to You or Us for any opinion rendered as part of the review of the Grievance.

All Grievance Committee reviews provide that You have a right to:

- (a) Receive from the Administrator or Utilization Review Organization, upon request, copies of all documents, records and other information that are not confidential or privileged relevant to Your request for benefits;
- (b) have a reasonable and adequate amount of time to present Your case to a designated representative or representatives of the Administrator or Utilization Review Organization who will be deciding the Grievance Committee review;
- (c) submit written comments, documents, records and other material relating to the request for benefits for the Grievance Committee to consider when conducting the Grievance Committee review, both before and, if applicable, at the Grievance Committee meeting;
- (d) prior to or during the Grievance Committee meeting ask questions relevant to the subject matter of the internal appeal or review of any representative of the Administrator or Utilization Review Organization serving on the Grievance Committee, provided that such representative may respond verbally if the question

is asked in person during Your appearance before the Grievance Committee or in writing if the questions are asked in writing, not more than 30 days from receipt of such written questions;

- (e) be assisted or represented at the Grievance Committee meeting by an individual or individuals of Your choice; and
- (f) record the proceedings of the Grievance Committee meeting at Your expense.

You, or Your authorized representative, wishing to request to appear in person before the second Grievance Committee shall make the request to the Administrator within five working days before the date of the scheduled review meeting, except that in the case of an Medical Emergency condition, such request must be made no less than 24 hours prior to the scheduled review meeting.

The Grievance Committee shall provide You a written decision setting forth the relevant facts and conclusions supporting its decision within:

- (a) 72 hours if the Grievance involves a Medical Emergency condition;
- (b) 15 business days if the Grievance involves a pre-service claim; and
- (c) 30 days if the Grievance involves a post-service claim.