VIA ELECTRONIC MAIL

February 25, 2014

Marilyn Tavenner, RN, BSN, MHA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Draft 2015 Letter to Issuers in the Federally-Facilitated Marketplaces

Dear Ms. Tavenner:

The Obesity Care Continuum (OCC) is pleased to submit comments on the proposed guidance contained in the draft *2015 Letter to Issuers in the Federally-facilitated Marketplaces*.

The Obesity Care Continuum was established in 2011 and currently includes the Obesity Action Coalition, The Obesity Society, the Academy of Nutrition and Dietetics, the American Society for Metabolic and Bariatric Surgery, and the American Society of Bariatric Physicians. With a combined membership of over 125,000 healthcare professionals, researchers, educators and patient advocates, the OCC is dedicated to promoting access to, and coverage of, the continuum of care surrounding the treatment of overweight and obesity.

Our comments will focus on issues related to patient access to clinically appropriate services in the federally-facilitated marketplaces (FFMs) and are organized according to the following sections of the Letter:

- Chapter 2, Section 3: Network Adequacy,
- Chapter 3, Section 1: Discriminatory Benefit Design: 2015 Approach, and
- Chapter 6, Section 5: Summary of Benefits and Coverage and Section 6: Transparency.

Chapter 2, Section 3: Network Adequacy

While we are pleased that CMS is proposing to implement additional safeguards to ensure the adequacy of provider networks in the FFMs, we are concerned that that the agency may not be going far enough in terms of protecting patient access to obesity treatment services.

One such area where we believe CMS could be stronger revolves around Qualified Health Plans (QHP) meeting appropriate standards of “reasonable access.” For example, we would recommend that CMS include surgeons in the list of focus areas, in addition to hospital systems, mental health providers, oncology providers, and primary care providers. While ensuring adequate representation of hospitals can help to ensure the adequacy of the surgeon network, it is not sufficient in itself. There are a number of critical specialty surgical areas that may not be captured in a provider network review that focuses on hospital systems. Examples of surgical services that might not be captured in network adequacy

reviews focused on hospital systems include bariatric surgery, complex vascular surgical procedures, and minimally invasive surgical procedures, among others. These services, though essential, are not provided by all hospital systems as they involve specialized training, equipment, and experience. By adding surgeons to the areas of review for provider network adequacy, CMS can ensure that patients have access to the full range of appropriate surgical services.

In addition, we believe CMS' provider network adequacy reviews need to carefully evaluate how QHPs may circumvent the Affordable Care Act (ACA) protections against discriminatory benefit design by limiting provider networks in certain areas of care. For example, to ensure that FFM QHPs do not discriminate against individuals affected by obesity, it is critical not only to ensure appropriate coverage of obesity treatment, but also to guarantee that these individuals have access to providers who are capable of offering these treatments.

Another prime example of an area of obesity treatment where this is relevant is medical weight management, nutrition, and lifestyle/behavioral therapy. Despite the United States Preventive Services Task Force (USPSTF) recommendations that adults be screened for obesity and referred for intensive behavioral therapy, provider networks often do not include a sufficient number of obesity medicine specialists, clinical psychologists or registered dietitians who have specific training in this area. While many health plans rely on primary care physicians to provide these services, the USPSTF found that primary care providers are limited in their time, training and skills to conduct the high-intensity interventions that are scientifically proven to be the most effective to produce the greatest results.

Finally, we would encourage CMS to recognize the recent FDA approval of a number of promising obesity drugs – medications that are best managed by obesity medicine specialists. Just like with any other chronic disease, patients need access to providers who have the education and experience to provide pharmacotherapy for those with obesity.

Therefore, we strongly recommend that CMS place special focus on provider areas that may play a role in discriminatory benefit design as part of the provider network adequacy review process.

Chapter 3, Section 1: Discriminatory Benefit Design: 2015 Approach

The issue of how the ACA provisions prohibiting discriminatory benefit design will treat the millions of Americans affected by obesity continues to be an extremely frustrating area for obesity advocates. While we have taken every opportunity (numerous face-to-face meetings with CMS and HHS and submission of formal comments on the EHB proposed regulations, and comments regarding federal oversight of State EHB benchmark plan selection) to secure federal guidance specific to this issue, HHS continues to side step our concerns regarding clear discriminatory practices that are being employed by the QHPs. (see appendix)

Both our initial review of state EHB benchmark plan submissions and our latest analysis of QHP plans currently being offered in state marketplaces continue to include clear discriminatory benefit design language. For example, some plans are limiting bariatric surgical procedures to one per lifetime (New Mexico: ChoiceConnect PPO and CareConnect HMOs as well as Blue Care Network of Michigan and MSSP-Blue Cross Blue Shield of Michigan). Some plans are imposing excessive cost sharing compared to other covered surgical services such as 50 percent or higher cost sharing (Blue Care Network of Michigan and MSSP-Blue Cross Blue Shield of Michigan). Finally, some plans are denying coverage for all obesity treatment services even if medically necessary such as the Humana plan in Louisiana, which states:

"Any treatment for obesity, regardless of any potential benefits for co-morbid conditions, including but not limited to: a. surgical procedures for morbid obesity; b. services or procedures for the purpose of

treating a sickness or bodily injury caused by, complicated by, or exacerbated by the obesity; or c. complications related to any services rendered for weight reduction."

Given the above, we are very concerned over CMS suggesting that oversight of QHP discriminatory benefit design is largely a state responsibility. In reviewing the Georgetown University Health Policy Institute's Center on Health Insurance Reforms (CHIR) July 2013 report entitled, "Nondiscrimination under the Affordable Care Act," it appears that the obesity community is not alone in its trepidation.

The findings of the CHIR report "suggest that new nondiscrimination standards have not significantly changed the way that state regulators or insurers approach benefit design and that regulators face practical limitations in trying to implement these requirements. Further, some regulators may not be willing to assume a much broader role in defining discriminatory benefit design without clearer federal standards. In light of such limitations, ensuring that the ACA's nondiscrimination standards are met likely requires ongoing monitoring of consumer complaints, the development of new infrastructure such as tracking systems, robust grievance and appeals processes, and clarification of federal requirements."

To "prevent vulnerable consumers from falling through the cracks," CHIR urged HHS to clarify these requirements and recommended that HHS:

- Issue guidance with specific examples of benefit design features that would be considered discriminatory under the ACA and define key terms such as "disability" and "medical necessity." Examples could address all of the types of benefit design with the potential to be discriminatory, including exclusions, cost-sharing, narrow or tiered networks, drug formularies, visit limits, restrictive medical necessity definitions, utilization management, waiting periods, service areas, rating, marketing of products, and benefit substitution.

- Collaborate with state regulators before issuing guidance to leverage state expertise and experience in identifying discriminatory benefit design and better assess and understand emerging compliance issues under the ACA.

- Use feedback from state regulators, exchange officials, agents and brokers, and navigators, as well as analysis of appeals data and information collected under Sections 1311(e) and 2715A of the ACA to monitor implementation of nondiscrimination standards, assess whether further adjustments are necessary, and identify additional examples of discriminatory benefit design.

In addition, the CHIR report suggested "that the essential health benefits benchmark plan approach may have perpetuated the inclusion of discriminatory benefit designs in at least some states by requiring the selection of benchmark plans that were not designed to be in compliance with the ACA's most significant reforms. In reevaluating essential health benefits standards for 2016, HHS should consider whether the benchmark plan approach adequately protects against discrimination."

We are concerned that the CMS "suggested strategies" outlined in the draft letter are insufficient to preclude QHPs from creating benefit designs that discourage enrollment of individuals with significant health needs. Experience from the current 2014 plan year underscores the need for safeguards beyond the reviews that CMS outlines in the draft letter; i.e., outlier analysis of QHP cost-sharing and information contained in the Plans and Benefits Template. Therefore, we recommend that CMS establish additional review mechanisms to ensure that QHP benefit designs are non-discriminatory and that these additional safeguards be required of states in their review of QHP benefit designs.

The complex nature and prevalence of obesity prompted the AMA earlier this year to join other leading organizations in recognizing that obesity is a "disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention."[1]

Despite the prevalence of obesity and its toll on health care outcomes and expenditures, the anti-discrimination measures currently in place have not been successful in preventing issuers in the FFMs from creating benefit designs that discriminate against individuals with obesity. An analysis conducted by Avalere Health shows that in 2014, only 37 percent of issuers in the FFMs cover bariatric surgery, and bariatric surgery is covered in at least one plan in only 29 states.[2] Of the 34 states participating in the FFMs (including the 7 states with a partnership model), only half (17 states) offer at least one plan that covers bariatric surgery. One of the states that offers a plan with bariatric surgery coverage, Virginia, only covers surgical treatment (though not medical treatment) for obesity with the purchase of a costly "morbid obesity" rider. Finally, an OAC analysis of state benchmark plan submissions found that over 90 percent of these plans specifically exclude coverage of "weight loss programs" – in direct contradiction of the USPSTF recommendations regarding obesity screening and referral for intensive behavioral therapy.

Clearly, the current approach to ensuring non-discriminatory benefit design in the FFMs has not been successful in preventing QHPs from issuing plans with benefit designs that discourage enrollment of individuals with obesity. Given the prevalence of obesity and its cost to society, additional measures are needed to ensure that such discriminatory benefit designs do not persist in 2015. We recommend the following approach:

- *Go beyond an outlier test in the review of QHP Plans and Benefits Templates.* While an outlier test is useful in cases where discriminatory benefit design is an exception, it is less useful in cases such as obesity where discriminatory benefit designs are, unfortunately, not uncommon among QHPs. For conditions such as obesity, CMS should ensure that all plans offer access to medically appropriate treatments.
- *Go beyond an outlier test in the review of QHP cost-sharing.* As noted above, an outlier test is only useful in preventing discriminatory benefit design when the discriminatory behavior is an exception. Unfortunately, as with benefit designs that exclude coverage of obesity treatment altogether, a number of plans that cover obesity treatments impose additional cost sharing for these services, particularly for obesity surgery. Virginia's approach, only covering bariatric surgery with the purchase of a very expensive plan rider, may be identified in an outlier analysis. However, other, more common practices, such as differential (and higher) cost sharing for obesity treatments may not be identified in an outlier analysis. Nevertheless, these practices serve equally to discourage individuals with obesity from enrolling and thus are clearly discriminatory. Cost sharing reviews should be comprehensive enough to ensure that such cost sharing practices do not occur in the FFMs.
- *Include specific language in the final 2015 Letter to Issuers in the FFM that underscores the importance of coverage of obesity treatments*. CMS should adopt the language contained in Section III.B. of the MSP Program Benefits and Initiatives section of the Office of Personnel Management's (OPM) 2015 Multi-State Plan Issuer Letter:

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[1] American Medical Association, Press Release: AMA Adopts New Policies on Second Day of Voting at Annual Meeting. Accessed on July 19, 2013 at http://www.ama-assn.org/ama/pub/news/news/2013/2013-06-18-new-ama-policies-annual-meeting.page.

[2] Avalere Health analysis, updated February 11, 2014. Avalere analyzed Summaries of Benefits and Coverage (SBCs) for 254 plans to review coverage of bariatric surgery. Analysis includes every issuer participating in each state, except for 12 issuers where information is not available.

"The United States Preventive Services Task Force recommends screening adults and children for obesity and providing referrals for behavioral change interventions where applicable, and issuers are required to cover these services without cost-sharing. We appreciate the efforts of issuers to ensure these services are available. Given the impact of obesity on individual and population health, we also encourage issuers to provide enrollees with access to a full range of weight reduction treatment interventions. Issuers that specifically exclude coverage for weight reduction and/or management interventions should review the clinical rationale for those exclusions and document how enrollees will receive appropriate care to achieve and sustain a healthy weight."[3]

These three steps, accompanied by appropriate monitoring and enforcement by CMS and states, are essential to eliminate benefit designs – highly prevalent in 2014 - that discriminate against individuals with obesity.

Chapter 6, Section 5: Summary of Benefits and Coverage and Section 6: Transparency

For the 2015 certification year, we recommend that CMS expand the requirements for plans regarding information on coverage of medical services. While CMS has imposed requirements for posting detailed formulary information, the requirements for coverage of medical services are quite limited. For example, beyond the limited information on exclusions and inclusions listed in the Summary of Benefits and Coverage (SBC), individuals have access to almost no information on whether specific non-pharmaceutical services are covered by a QHP. This information is typically only made available to enrollees in a QHP, if at all. In contrast, in the employer insurance market, such information is typically accessible during the annual plan selection process, either in plan materials distributed by the employer during the open enrollment period, or at a minimum the information is available to employees upon request.

In the absence of data regarding coverage of medical services, individuals are at an enormous disadvantage when selecting a health plan in the FFMs. In particular, individuals with medical issues; i.e. those most in need of affordable coverage in the FFMs, often do not have the information they need to determine whether a QHP will cover needed services.

To address this concern, we strongly recommend that CMS require QHPs participating in the FFMs to make medical policy information available to individuals prior to enrollment. While it is not feasible for health plans to maintain a comprehensive list of covered (and non-covered) medical services, health plans typically maintain a list of medical policies, which address coverage of non-pharmaceutical services for which there are specific medical necessity criteria or for which coverage is limited or unavailable. This information is far more detailed than that provided in the Inclusions and Exclusions section of the SBC. Ideally, such information would be made accessible via the online Marketplace tool, via the same mechanism through which individuals can download SBCs and plan brochures for QHPs of interest. At a minimum, QHPs should be required to post this information on a publically accessible section of their websites. In addition, QHPs should be required to make available a phone number that potential enrollees may call to obtain additional coverage information, to the extent services of interest are not addressed in the medical policy documentation.

Requiring QHPs to provide baseline information on medical policy to individuals shopping for QHPs in the FFMs will allow individuals to operate as more informed consumers in the FFMs and will help prevent unpleasant surprises after enrollment. Given that plans already maintain such information, it should not create undue burden to make it available to individual shoppers in the FFMs.

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[3] United States Office of Personnel Management. Multi-State Plan Program Issuer Letter (Number 2014-002), February 4, 2014.

For more information about the Obesity Care Continuum, please contact me at 571-235-6475 or via email at chris@potomaccurrents.com. Thank you.

Sincerely,

Christopher Gallagher
Washington Coordinator
Obesity Care Continuum

About the Obesity Care Continuum

The Obesity Care Continuum was established in 2011 and currently includes the Obesity Action Coalition, The Obesity Society, Academy of Nutrition and Dietetics, the American Society for Metabolic and Bariatric Surgery, and the American Society of Bariatric Physicians. With a combined membership of over 125,000 healthcare professionals, researchers, educators and patient advocates, the OCC is dedicated to promoting access to, and coverage of, the continuum of care surrounding the treatment of overweight and obesity. The OCC also challenges weight bias and stigma oriented policies – whenever and wherever they occur.

SEE APPENDIX FOLLOWING PAGE

August 21, 2013

RE: Federal Oversight of State Essential Benefit Benchmark Plan Selection

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius,

The Obesity Care Continuum (OCC) and the undersigned organizations urge federal and state policymakers to recognize that obesity is a serious chronic disease and deserves to be treated seriously in the same fashion as diabetes, heart disease or cancer. Those affected by obesity should have access to the same medically necessary and covered treatment avenues afforded to all others who suffer from chronic disease. Therefore, we are deeply troubled that the Department of Health and Human Services (HHS) continues to remain silent on some of the key issues facing patient access to obesity treatment services in the new state healthcare exchange plans.

The Obesity Care Continuum was established in 2011 and currently includes the Obesity Action Coalition, The Obesity Society, Academy of Nutrition and Dietetics, the American Society for Metabolic and Bariatric Surgery, and the American Society of Bariatric Physicians. With a combined membership of over 125,000 healthcare professionals and patient advocates, the OCC is dedicated to promoting access to, and coverage of, the continuum of care surrounding the treatment of overweight and obesity. The OCC also challenges weight bias and stigma oriented policies – whenever and wherever they occur.

Over the last 18 months, member groups of the Obesity Care Continuum have had encouraging meetings with the Department of Health and Human Services (HHS) and its Center for Consumer Information and Insurance Oversight (CCIIO) regarding possible avenues for addressing coverage for evidence-based obesity treatments such as intensive behavioral counseling, FDA-approved obesity drugs, and bariatric surgery. Unfortunately though, HHS failed to even address specific questions raised by the obesity community regarding these critical treatment services as part of the proposed rulemaking process on the essential health benefit package for state exchange plans. Specifically, whether or not HHS defines management of obesity and metabolic disorders as part of "chronic disease management" or, at a minimum, a serious medical condition worthy of protection under the Department's regulations regarding pre-existing conditions or discriminatory benefit designs.

The obesity community reiterated these concerns to staff from CCIIO and the Office of Health Reform during an April 15, 2013 meeting and received feedback from your staff that the obesity community should provide HHS with examples of discriminatory benefit designs. Since that meeting, the Obesity Action Coalition (OAC) has researched all the information on the 50 state (and DC) benchmark plans that is currently available via the websites of both CCIIO and the National Association of Insurance Commissioners (NAIC) and have identified a number of egregious examples of benchmark plan policy language (see Appendix I) that we believe clearly violate the discrimination provisions of the ACA as outlined in HHS's final regulations, which state:

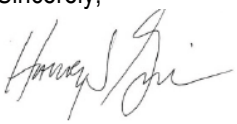
"To address potentially discriminatory practices, we proposed in paragraph (a) that an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, or present or predicted disability, degree of medical dependency, quality of life, or other health conditions. In paragraph (b), we proposed that §§ 156.200 and156.225 also apply to all issuers required to provide coverage of EHB, prohibiting discrimination based on factors including but not limited to race, gender, disability, and age as well as marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs."

The OAC's analysis reveals benchmark benefit plan language that would either violate pre-existing condition protections or explicitly deny coverage for obesity treatment services EVEN when medically necessary or because of any related condition or diagnosis. While we understand that the plan language cited in the attached document is merely a "snapshot" of coverage policies in place in 2012, how will HHS assure the obesity community that state exchange plans will be in compliance with protecting patient access to all medically necessary obesity treatment services?

Our country is facing an epidemic – with over two-thirds of Americans currently being affected by overweight or obesity. The complex nature and prevalence of obesity prompted the AMA earlier this year to join other leading organizations in recognizing that obesity is a "*disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.*" HHS must speak up on this issue. Failure to do so could leave millions of Americans without access to the full range of treatment tools available to others affected by chronic disease.

Should you have any questions, please feel free to contact the Obesity Care Continuum through the OCC's Washington Coordinator, Chris Gallagher, at (571) 235-6475 or chris@potomaccurrents.com.

Sincerely,



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About Obesity Care Continuum

The Obesity Care Continuum was established in 2011 and currently includes the Obesity Action Coalition, The Obesity Society, Academy of Nutrition and Dietetics, the American Society for Metabolic and Bariatric Surgery, and the American Society of Bariatric Physicians. With a combined membership of over 125,000 healthcare professionals and patient advocates, the OCC is dedicated to promoting access to, and coverage of, the continuum of care surrounding the treatment of overweight and obesity. The OCC also challenges weight bias and stigma oriented policies – whenever and wherever they occur.

Obesity Treatment Services Exclusion Language

The following language is found under the exclusion sections of the state EHB benchmark plans.

Alabama
Services or expenses for treatment of any condition including, but not limited to, **obesity**, diabetes, or heart disease, which is based upon weight reduction or dietary control or services or expenses of any kind to treat obesity, weight reduction or dietary control. This exclusion includes bariatric surgery and gastric restrictive procedures and any complications arising from bariatric surgery and gastric restrictive procedures.

Alaska
Surgical or drug treatment of obesity

Benefits are not provided for treatment, surgery, services, drugs or supplies for any of the following:
Obesity/morbid obesity

Arkansas
Weight Control. Medications prescribed, dispensed or used for the treatment of obesity, or for use in any program of, weight control, weight reduction, weight loss or dietary control are not covered. Weight loss surgical procedures, including complications relating thereto, are not covered.

Colorado
Bariatric Surgery and Cosmetic Surgery Related to Bariatric Surgery.

Connecticut
Weight loss/control treatment, programs, clinics, medications, and surgical treatment for morbid obesity.

DC
Medical and surgical treatment for obesity and weight reduction, including Morbid Obesity

Florida
Bariatric Surgery

Georgia
Obesity – Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription Drugs, or dietary control (except as related to covered nutritional counseling) and listed under Covered Services. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it is the sole means of nutrition. Food supplements. Services for Inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric care or counseling. Weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature. Excluded procedures include but are not limited to bariatric services, bariatric surgery (e. g., gastric bypass or vertically banded gastroplasty, liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw).

Idaho
For weight control or treatment of obesity or morbid obesity, even if Medically Necessary, including but not limited to Surgery for obesity. For reversals or revisions of Surgery for obesity, except when required to correct a life endangering condition.

Indiana
For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous Anthem plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self funded plan prior to coverage under this Certificate. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post operative time frame.

Kansas
Any service or supply provided directly for or relative to the medical management 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.

Kentucky
For bariatric surgery, regardless of the purpose it is proposed or performed. This includes Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous Anthem plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self funded plan prior to coverage under this Certificate. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post operative time frame.

Louisiana
Regardless of Medical Necessity, Benefits are not available for any of the following, except as specifically provided under this Benefit Plan:
a. weight reduction programs;
b. removal of excess fat or skin, or services at a health spa or similar facility; or
c. obesity or morbid obesity.

Minnesota
Bariatric surgery

Mississippi
Weight reduction programs or treatment for obesity including any Surgery for morbid obesity or for removal of excess fat or skin following weight loss, regardless of Medical Necessity, or Services at a health spa or similar facility (except as provided in this Benefit Plan).

Missouri
For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Certificate. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co- morbid medical conditions during the procedure or in the immediate post-operative time frame.

Montana
Services, supplies, drugs and devices for the surgical treatment of any degree of obesity, whether provided for weight control or any medical condition.

Nebraska
Treatment and monitoring for obesity or for weight reduction, regardless of diagnosis, including surgical operations.

Ohio
For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous Anthem plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self funded plan prior to coverage under this Certificate. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post operative time frame.

Oklahoma
For treatment of obesity, including morbid obesity, regardless of the patient's history or diagnosis, including but not limited to the following: weight reduction or dietary control programs; surgical procedures; prescription or nonprescription drugs or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complications resulting from weight loss treatments or procedures.

Oregon
Obesity (including all categories) or weight control treatment or surgery, even if there are other medical reasons for you to control your weight.

Pennsylvania
Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction**,** regardless of the existence of comorbid conditions. This exclusion does not apply to nutritional supplements (formulas) as **Medically Necessary** for the therapeutic treatment of phenylketonuria. See the Covered Benefits section of this **Certificate** for a description of nutritional supplements coverage.

South Carolina
Any treatment or Surgery for obesity (even if morbid obesity is present), weight reduction, weight control such as gastric by-pass, insertion of stomach (gastric) banding, intestinal bypass, wiring mouth shut, liposuction or complications from it. This includes any reversal or reconstructive procedures from such treatments.

Tennessee
Services or supplies, including bariatric Surgery, for weight loss or to treat obesity, even if You have other health conditions that might be helped by weight loss or reduction of obesity. This exclusion applies whether You are of normal weight, overweight, obese or morbidly obese;

Texas
Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight, except for healthy diet counseling and obesity screening/counseling as may be provided under **Preventive Services**.

Utah
Obesity surgery, such as gastric bypass, lap-band surgery, etc., including any present and future complications, are not covered.

Complications relating to services and supplies for or in connection with gastric bypass or intestinal bypass, gastric stapling, or other similar surgical procedure to facilitate weight loss, or for or in connection with reversal or revision of such procedures, or any direct complications or consequences thereof;

Virginia
Your coverage does not include benefits for services and supplies related to **obesity** or services related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Notwithstanding provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies, and lipectomies), are not covered services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery.

Washington
Obesity or Weight Reduction/Control: Medical treatment, medication, surgical treatment (including reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions.

West Virginia
Surgical and non-surgical treatment of obesity.