Your Health Care Benefit Program

Oklahoma Higher Education
Employee Insurance Group

BlueChoice
Certificate of Benefits

BlueCross BlueShield of Oklahoma
Experience. Wellness. Everywhere.℠

1400 South Boston | P.O. Box 3283 | Tulsa, Oklahoma | 74102-3283

600600.0114

Effective January 1, 2014

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Certificate

This Certificate is issued according to the terms of your Group Health Plan. It contains the principal provisions of the Group Contract and its ***Schedule of Benefits***. In the event of conflict between the Contract and this Certificate, the terms of the Contract will prevail.

If a word or phrase starts with a capital letter, it has a special meaning in this Certificate. It is defined in the ***Definitions*** section, where used in the text, or it is a title.

Your Group has contracted with **Blue Cross and Blue Shield of Oklahoma** (called the Plan, we, us, or our) to provide the Benefits described in this Certificate. Blue Cross and Blue Shield of Oklahoma having issued a Group Contract to the Group, certifies that all persons who have:

- applied for coverage under the Contract;
- paid for the coverage;
- satisfied the conditions specified in the ***Eligibility, Enrollment, Changes and Termination*** section; and
- been approved by the Plan;

are covered by the Group Contract. Covered persons are called Subscribers (or you, your).

Beginning on your Effective Date, we agree to provide you the Benefits described in this Certificate.

President of Blue Cross and Blue Shield of Oklahoma

Your Subscriber Identification Number: _____

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

Important Information

PLEASE READ THIS SECTION CAREFULLY! It explains the role the Blue Cross and Blue Shield of Oklahoma Provider networks play in your health care coverage. It also explains important cost containment features in your health care program. Together, these features allow you to receive quality health care in cost-effective settings, while helping you experience lower out-of-pocket expenses.

By becoming familiar with these programs, you will be assured of receiving the maximum Benefits possible whenever you need to use your health care services.

THE BLUECHOICE PROVIDER NETWORK

BlueChoice is a Preferred Provider Organization (PPO) plan that offers a wide choice of network Providers. Blue Cross and Blue Shield of Oklahoma has negotiated special agreements with Hospitals, Outpatient facilities, Physicians and other health care professionals from many specialties. These participating health care Providers work with Blue Cross and Blue Shield of Oklahoma to help keep down the cost of health care. Although you are free to choose any health care Provider for your services, your BlueChoice coverage will provide the highest level of Benefits if you use a BlueChoice Provider.

BlueChoice Providers are not employees, agents or other legal representatives of Blue Cross and Blue Shield of Oklahoma.

HOW YOUR BLUECHOICE COVERAGE WORKS

Your BlueChoice coverage is designed to give Subscribers some control over the cost of their own health care. Subscribers continue to have complete freedom of choice in their Provider selection. However, the program offers considerable financial advantages to Subscribers who choose to use a BlueChoice Provider.

In contrast, when care is received from an Out-of-Network Provider a higher Coinsurance will apply to most Covered Services. Generally, Benefits for Out-of-Network Provider services are provided only after you have satisfied your Deductible in full, and a *higher* Coinsurance and Out-of-Pocket Limit will apply to most Covered Services.

IMPORTANT: Keep in mind that all Covered Services (including ancillary services such as x-ray and laboratory services, anesthesia, etc.) must be performed by a BlueChoice Provider in order to receive the highest level of Benefits under this Certificate. If your Physician prescribes these services, request that he/she refer you to a BlueChoice Provider whenever possible.

COST SHARING FEATURES OF YOUR COVERAGE

As a participant in this Group Health Plan, you have the responsibility for sharing in a portion of your health care costs. You are responsible for the applicable Copayment, Deductible and Coinsurance provisions of your coverage, as well as any charges for which Benefits are not provided. You may also be responsible for a portion of your health care premiums, depending upon the terms of your Group Health Plan. Check with your Group Administrator for specific premium amounts applicable to the coverage you have selected for you and your family.

Selecting a Provider

There are several ways to find out whether or not a Hospital, Physician, or other Provider is a network Provider.

Upon enrollment, you will receive a directory of network Providers at no charge to you. Providers are listed alphabetically and by specialty. The directory also indicates the Hospitals where each Physician practices. A listing of Oklahoma network Providers is also available on-line through the Blue Cross and Blue Shield of Oklahoma Web site at www.bcbsok.com.

Although every effort is made to provide an accurate listing of network Providers, additions and deletions will occur. Therefore, you should check with Blue Cross and Blue Shield of Oklahoma or the Provider to be sure of the Provider's network status.

When you call Blue Cross and Blue Shield of Oklahoma, ask our Customer Service Representative whether or not the Provider is a network Provider. Simply call our toll-free number at 1-800-942-5837.

Of course, you may ask the Provider directly if they are a network Provider. **Be sure they understand you are inquiring about the Blue Cross and Blue Shield of Oklahoma BluePreferred, BlueChoice or BlueTraditional Provider networks**.

The BlueCard® Program

As a Blue Cross and Blue Shield Plan Member, you enjoy the convenience of carrying your Identification Card — The BlueCard. The BlueCard Program allows you to use a Blue Cross and Blue Shield Physician or Hospital outside the state of Oklahoma and to receive the advantages of Network Provider Benefits and savings.

- **Finding a Physician or Hospital**

  When you're outside of Oklahoma and you need to find information about a Blue Cross and Blue Shield Physician or Hospital, just call the BlueCard Doctor and Hospital Information Line at 1-800-810-BLUE (2583), or you may refer to the BlueCard Doctor and Hospital Finder at http://www.bluecares.com. We will help you locate the nearest Network Physician or Hospital. *Remember, you are responsible for receiving Preauthorization, if applicable, from Blue Cross and Blue Shield of Oklahoma*. As always, in case of an emergency, you should seek immediate care from the closest health care Provider.

- **Available Care Coast to Coast**

  Show your Identification Card to any Blue Cross and Blue Shield Physician or Hospital across the USA. The Physicians and Hospitals can verify your membership eligibility and coverage with Blue Cross and Blue Shield of Oklahoma and submit your claims for you.

- **Remember to Always Carry the BlueCard**

  Make sure you always carry your Identification Card — The BlueCard. And be sure to use Blue Cross and Blue Shield Physicians and Hospitals whenever you are outside the state of Oklahoma and need health care.

Some local variations in Benefits do apply. If you need more information, call Blue Cross and Blue Shield of Oklahoma today.

NOTE: Blue Cross and Blue Shield of Oklahoma may postpone application of any Deductible, Copayment and/or Coinsurance amounts whenever it is necessary so that we may obtain a Provider discount for you on Covered Services you receive outside the state of Oklahoma.

How The BlueCard Program Works

- You're outside the state of Oklahoma and need health care.
- Call 1-800-810-BLUE (2583) for information on the nearest PPO Physicians and Hospitals, or visit the BlueCard Web site at http://www.bluecares.com.
- You are responsible for Preauthorization, if applicable, from Blue Cross and Blue Shield of Oklahoma.
- Visit the PPO Physician or Hospital and present your Identification Card.
- The Physician or Hospital verifies your membership and coverage information.
- After you receive medical attention, your claim is electronically routed to Blue Cross and Blue Shield of Oklahoma, which processes it and sends you a detailed Explanation of Benefits. You are only responsible for meeting your Deductibles, Copayments and/or Coinsurance payments, if any.
- All PPO Physicians and Hospitals are paid directly.

Your Prescription Drug Program

Blue Cross and Blue Shield of Oklahoma has contracted with a network of Participating Pharmacies to help hold the line on the increasing costs of Prescription Drugs. When you present your Identification Card to your Participating Pharmacy, your claim will be processed electronically. Your pharmacist will be able to tell immediately which charges count toward your Prescription Drug Copayment or Coinsurance amounts and will collect the appropriate amount from you at the time of purchase. The pharmacist will then be reimbursed directly by the Plan for the balance of covered charges**.**

How Your Prescription Drug Program Works

- Show your Blue Cross and Blue Shield of Oklahoma Identification Card to your Pharmacy.
- If you choose a Participating Pharmacy, you pay your Copayment or Coinsurance amount and your claims are filed automatically!
- If your Pharmacy is not a Participating Pharmacy, you will have to file your own claim.
- **Claims for Prescription Drugs purchased from a Participating Pharmacy are processed at the highest level of Benefits**.

REMEMBER — Using Participating Pharmacies can save you time and money. If you have any questions about your Prescription Drug coverage, please call a Customer Service Representative at 1-800-942-5837.

If you find it necessary to purchase your prescriptions from an Out-of-Network Pharmacy, or if you do not have your Identification Card with you when you purchase your prescriptions, it will be your responsibility to pay the full cost of the Prescription Drugs and to submit a claim form (with your itemized receipt) to receive the Benefits available under this Certificate.

MEDICAL NECESSITY LIMITATION

THE FACT THAT A PHYSICIAN OR OTHER PROVIDER PRESCRIBES OR ORDERS A SERVICE DOES NOT AUTOMATICALLY MAKE IT MEDICALLY NECESSARY OR A COVERED SERVICE.

This program provides Benefits for Covered Services that are Medically Necessary. **"Medically Necessary" is defined as health care services that a Hospital, Physician, or other Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:**

- **in accordance with generally accepted standards of medical practice; and**
- **clinically appropriate,in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and**
- **not primarily for the convenience of the patient, Physician, or other health care Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.**

PREAUTHORIZATION

The Plan has designated certain Covered Services which require *"Preauthorization"* in order for you to receive the maximum Benefits possible under this Certificate.

- **Subscriber Responsibility for Preauthorization**

  The Subscriber is responsible for satisfying the Contract/Certificate requirements for Preauthorization. This means that the Subscriber must request Preauthorization or assure that his/her Physician, Provider of services, or a family member complies with the guidelines below. Failure to Preauthorize services may result in reduction in Benefits as described below under **"Failure to Preauthorize"**.

  If the Subscriber utilizes a network Provider for Covered Services, that Provider ***may*** request Preauthorization for the services. However, it is ***the Subscriber's*** responsibility to assure that the services are Preauthorized before receiving care.

- **Preauthorization Requests for Inpatient Services**

  For an Inpatient facility stay, *the Subscriber must request Preauthorization from the Plan* ***before*** *his/her scheduled admission*. The Plan will consult with the Subscriber's Physician, Hospital, or other facility to determine if Inpatient level of care is required for the illness or injury. The Plan may decide that the treatment you need could be provided just as effectively in a less expensive setting (such as the Outpatient department of the Hospital, an Ambulatory Surgical Facility, or the Physician's office). If the Plan determines that his/her treatment does not require Inpatient care, you and your Provider will be notified of that decision. **If you proceed with an Inpatient stay without the Plan's approval, or if you do not ask the Plan for Preauthorization, your Benefits under this Certificate will be reduced as described below under "Failure to Preauthorize", provided the Plan determines that Benefits are payable upon receipt of a claim.** This reduction applies *in addition to* any Benefit reduction associated with your use of an Out-of-Network Provider.

  For Preauthorization requests related to Urgent Care or Emergency Care, the Subscriber should refer to the procedures outlined below in this section.

- **Preauthorization Requests for Psychiatric Care Services**

  All **Inpatient** services related to treatment of Mental Illness (including severe Mental Illness), drug addiction, substance abuse, or alcoholism must be Preauthorized by the Plan. Preauthorization is also required for the following **Outpatient** Psychiatric Care Services:

— Psychological testing;

— Neuropsychological testing;

— Electroconvulsive therapy;

— Intensive Outpatient Treatment.

Preauthorization is not required for therapy visits to a Physician or other professional Provider licensed to perform Covered Services under this Certificate. However, all services are subject to the Concurrent Review provisions set forth in this Certificate.

To request Preauthorization, the Subscriber or his/her Physician must call the Preauthorization number shown on the Subscriber Identification Care **before** receiving treatment. The Plan will assist in coordination of the Subscriber's care so that his/her treatment is received in the most appropriate setting for his/her condition and that the Subscriber receives the highest level of Benefits under the Contract/Certificate. If the Subscriber does not call for Preauthorization before receiving non-emergency services, Benefits for Covered Services may be subject to a reduction in Benefits, as set forth below.

For Preauthorization requests related to Urgent Care or Emergency Care, the Subscriber should refer tot he Preauthorization procedures outlined in the Contract/Certificate.

- **Preauthorization Process for Other Outpatient Services**

  In addition to the Preauthorization requirements outlined above, the Plan also requires Preauthorization for certain Outpatient services such as Home Health Care and Hospice Services. If you fail to request Preauthorization approval, or to abide by the Plan's determination regarding these services, your Benefits will be denied or reduced. The **Comprehensive Health Care Services** section of this Certificate details the services which are subject to Preauthorization, along with any Benefit reductions which may apply if you fail to comply with those Preauthorization requirements.

- **Preauthorization Requests Involving Non-Urgent Care**

  Except in the case of a Preauthorization Request Involving Urgent Care (see below), the Plan will provide a written response to your Preauthorization request no later than 15 days following the date we receive your request. This period may be extended one time for up to 15 additional days, if we determine that additional time is necessary due to matters beyond our control.

  If the Plan determines that additional time is necessary, we will notify you in writing, prior to the expiration of the original 15-day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which we expect to make the determination.

  If an extension of time is necessary due to our need for additional information, we will notify you of the specific information needed, and you will have 45 days from receipt of the notice to provide the additional information. We will provide a written response to your request for Preauthorization within 15 days following receipt of the additional information.

  The procedure for appealing an adverse Preauthorization determination is set forth in the section entitled, "***Complaint/Appeal Procedure***."

- **Preauthorization Requests Involving Urgent Care**

  A "Preauthorization Request Involving Urgent Care" is any request for Medical Care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

  — could seriously jeopardize the life or health of the Subscriber or the ability of the Subscriber to regain maximum function; or

— in the opinion of a Physician with knowledge of the Subscriber's medical condition, would subject the Subscriber to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Preauthorization request.

In case of a "Preauthorization Request Involving Urgent Care," the Plan will respond to you no later than 72 hours after receipt of the request, unless you fail to provide sufficient information, in which case, you will be notified of the missing information within 24 hours and will have no less than 48 hours to provide the information. A Benefit determination will be made as soon as possible (taking into account medical exigencies) but no later than 72 hours after the initial request, or within 48 hours after the missing information is received (if the initial request is incomplete).

NOTE: The Plan's response to your Preauthorization Request Involving Urgent Care, including an adverse determination, if applicable, may be issued orally. A written notice will also be provided within three days following the oral notification.

- **Preauthorization Requests Involving Emergency Care**

  If you are admitted to the Hospital for Emergency Care and there is not time to obtain Preauthorization, you will not be subject to the Preauthorization "penalty" (if any) outlined in the Plan *if you or your Provider notifies the Plan within two working days following your emergency admission.*

- **Failure to Preauthorize**

  If the Subscriber does not call for Preauthorization for **Inpatient services**, the admission will be subject to a $500 reduction in Benefits, if upon receipt of the claim, it is determined that the services were Medically Necessary. If it is determined that the services were not Medically Necessary or were Experimental/Investigational, it may be the Subscriber's responsible to pay the full cost of the services received.

  If the Subscriber fails to obtain Preauthorization for the **Outpatient** Psychiatric Care Services specified above:

  — The Plan will review the Medical Necessity of the treatment or service prior to the final Benefit determination.

  — If the Plan determines the treatment or service is not Medically Necessary or is Experimental/Investigational, Benefits will be reduced or denied.

Benefit reductions for failure to comply with the Plan's Preauthorization process will apply only when you utilize the services of a Provider who is not a member of the BlueChoice Provider network.

Please keep in mind that any treatment you receive which is not a Covered Service under the Plan, or which is not Medically Necessary, will be excluded from your Benefits. This applies even if Preauthorization approval is requested or received.

Concurrent Review

Whenever it is determined that Inpatient care or an ongoing course of treatment may no longer be Medically Necessary, you, your Provider or your authorized representative may submit a request to the Plan for continued services. If you, your Provider or your authorized representative requests to extend care beyond the approved time limit and it is a Request Involving Urgent Care, the Plan will make a determination on the request/appeal as soon as possible (taking into account medical exigencies) but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

Allowable Charge

To take full advantage of the negotiated pricing arrangements in effect between Blue Cross and Blue Shield of Oklahoma and our network Providers, it is imperative that you use BluePreferred, BlueChoice or BlueTraditional Providers in Oklahoma and BlueCard Providers whenever you are out of state. Using these Providers offers you the following advantages:

- BlueChoice and BlueCard participating Providers have agreed to hold the line on health care costs by providing special prices for our Subscribers. These Providers will accept this negotiated price (called the **"Allowable Charge"**) as payment for Covered Services. This means that, if a network Provider bills you more than the Allowable Charge for Covered Services, ***you are not responsible for the difference*.**

- Blue Cross and Blue Shield of Oklahoma will calculate your Benefits based on this "Allowable Charge". We will deduct any charges for services which aren't eligible under your coverage, then subtract your Copayment, Deductible and/or Coinsurance amounts which may be applicable to your Covered Services. We will then determine your Benefits under this Certificate, and direct any payment to your network Provider.

REMEMBER ...

You receive the maximum Benefits allowed whenever you utilize the services of an Oklahoma BlueChoice or a BlueCard Provider outside the state of Oklahoma.

The following method will be used for determining the Allowable Charge for Providers who do not have a Participating Provider agreement with the Plan (Non-Contracting Providers):

- the allowable Charge for Non-Contracting Providers for Covered Services will be the lessor of:

  — the Provider's billed charges; or

  — the Plan's Non-Contracting Allowable Charge.

  The Non-Contracting Allowable Charge is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusting by a predetermined factor established by the Plan. Such factor will not be less than 100% of the base medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Charge for Non-Contracting Providers will represent an average contract rate for Network Providers adjusted by a predetermined factor established by the Plan and updated on a periodic basis. Such factor shall not be less than 100% of the average contract rate and will be updated not less than every two years. The Claims Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by Non-Contracting Providers which may also alter the Allowable Charge for a particular service. In the event the Plan does not have any claim edits or rules, the Plan may utilize the Medicare claim rules or edits that are used by Medicare in process the claims. The Allowable Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including but not limited to, disproportionate share and graduate medical education payments.

  Any change to the Medicare reimbursement amount will be implemented by the Plan within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

  In the event the Non-Contracting Allowable Charge does not equate to the Non-Contracting Provider's billed charges, you will be responsive for the difference, along with any applicable Coinsurance and Deductible amount. This difference may be considerable. To find out an estimate of the Plan's Non-Contracting Allowable Charge for a particular service, you may call the customer service number shown on the back of your Identification Card.

- Notwithstanding anything in the Group Health Plan to the contrary, for Out-of-Network Emergency Care Services rendered by Non-Contracting Providers, the Allowable Charge shall be equal to the greatest of the following three possible amounts — not to exceed the billed charges:

  — the median amount negotiated with network or contracting Providers for the Emergency Care Services furnished;

— the amount for the Emergency Care Services calculated using the same method the Plan generally uses to determine payments for Out-of-Network Provider services, but substituting the in-network or contracting cost-sharing provisions for the out-of-network or non-contracting Provider cost-sharing provisions; or

— the amount that would be paid under Medicare for the Emergency Care Services.

Each of these three amounts is calculated excluding any network or contracting Provider Coinsurance imposed with respect to the Subscriber.

- When Covered Services are received outside the state of Oklahoma from a Provider who does not have a written agreement with Blue Cross and Blue Shield of Oklahoma or with the local Blue Cross and Blue Shield Plan, the "Allowable Charge" will be determined by the Blue Cross and Blue Shield Plan (Host Plan) servicing the area. This Allowable Charge will be the amount the Host Plan uses for their own local members that obtain services from local Non-Contracting Providers.

When services are received from an Out-of-Network provider, you will be responsible for the following:

- Charges for any services which are not covered under your Group Health Plan.
- Any Deductible or Coinsurance amounts that are applicable to your coverage *(including the higher Coinsurance amounts which apply to Out-of-Network Provider services)*.
- The difference, if any, between your Provider's "billed charges" and the "Allowable Charge" determined by the Host Plan.

Keep in mind that these "Allowable Charge" provisions apply whenever you obtain services outside the BlueChoice or BlueCard Provider networks, including Emergency Care or referral services.

Special Notices

The Plan reserves the right to change the provisions, language and Benefits set forth in this Certificate.

Because of changes in federal or state laws, changes in your health care program, or the special needs of your Group, provisions called "special notices" may be added to your Certificate.

Be sure to check for a "special notice". It changes provisions or Benefits in your Certificate.

Identification Card

You will get an Identification Card to show the Hospital, Physician, Pharmacy, or other Providers when you need to use your coverage.

Your Identification Card shows the Group through which you are enrolled and includes your own personal identification number. All of your covered Dependents share your identification number. Duplicate cards can be obtained for each member of your family.

Carry your card at all times. If you lose your card, you can still use your coverage. You can replace your card faster, however, if you know your identification number. The Certificate page has a space to record it.

Legal requirements govern the use of your card. You cannot let anyone who is not enrolled in your coverage use your card or receive your Benefits.

Designating an Authorized Representative

The Plan has established procedures for you to designate an individual to act on your behalf with respect to a Benefit claim or an appeal of an adverse Benefit determination. Contact a Customer Service Representative for help if you wish to designate an authorized representative. In the case of a Preauthorization Request Involving Urgent Care, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative.

QUESTIONS

Whenever you call our offices for assistance, please have your Identification Card with you.

You usually will be able to answer your health care Benefit questions by referring to this Certificate. If you need more help, please call a Customer Service Representative at 1-800-94 BLUES (1-800-942-5837).

Or you can write:

Blue Cross and Blue Shield of Oklahoma
P.O. Box 3283
Tulsa, Oklahoma 74102-3283

When you call or write, be sure to give your Blue Cross and Blue Shield of Oklahoma Subscriber identification number which is on your Identification Card. If the question involves a claim, be sure to give:

- the date of service;
- name of Physician or Hospital;
- the kind of service you received; and
- the charges involved.

Eligibility, Enrollment, Changes & Termination

This section tells:

- How and when you become eligible for coverage under the Contract;
- Who is considered an Eligible Dependent;
- How and when your coverage becomes effective;
- How to change types of coverage;
- How and when your coverage stops under the Contract; and
- What rights you have when your coverage stops.

WHO IS AN ELIGIBLE PERSON

Unless otherwise specified in the Group Contract, you are an Eligible person if you are a full-time Employee working 30 hours or more per week and on the permanent payroll of the Employer. If you work on a part-time basis you may be considered.

The date you become eligible is the date you satisfy the eligibility provisions specified by your Group. Check with your Group Administrator for specific eligibility requirements which apply to your coverage.

WHO IS AN ELIGIBLE DEPENDENT

An Eligible Dependent is defined as:

- your spouse.
- your natural child, a stepchild, an eligible foster child, an adopted child or child Placed for Adoption (including a child for whom the Member or spouse is a party in a legal action in which the adoption of the child is sought), under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. A child not listed above who is legally and financially dependent upon the Member or spouse is also considered a Dependent child under the Group Health Plan, provided proof of dependency is provided with the child's application.

  A Dependent child who is medically certified as disabled and dependent upon you or your spouse are eligible for coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

  The Plan reserves the right to request verification of a Dependent child's age, dependency, and/or status as a disabled Dependent child upon initial enrollment and from time to time thereafter as the Plan may require.

HOW TO ENROLL

To Enroll in this health care program, you must complete an application form provided by the Plan, including all information needed to determine eligibility. Your membership may include:

- Member Only (Single) Coverage — if only you Enroll.
- Member and Spouse Only Coverage — for you and your spouse.
- Member and Children Coverage — for you and your Dependent children.
- Member, Spouse and Children Coverage (Family Coverage) — for you and all of your Eligible Dependents.

IMPORTANT:

In order to assure your application is processed and your coverage is effective at the earliest possible date, you must Enroll during your first period of eligibility (designated by your Group).

INITIAL ENROLLMENT PERIOD

- **Initial Group Enrollment**

  If you are an Eligible Person on the Group's Contract Date and your application for coverage is received by the Plan during the Group's Initial Enrollment Period, the Effective Date for you and your Eligible Dependents (if applicable) is the Group's Contract Date.

- **Initial Enrollment After the Group's Contract Date**

  If you become an Eligible Person after the Group's Contract Date and your application is received by the Plan within 31 days of being first eligible, the Effective Date for you and your Eligible Dependents (if applicable) will be assigned by the Plan, according to the provisions of the Contract in effect for your Group.

- **Initial Enrollment of New Dependents**

  You can apply to add Dependents to your coverage if we receive your "Request for Change in Membership" form within 31 days after you acquire an Eligible Dependent (see exceptions below for newborn children). The Effective Date for the Eligible Dependent will be the date the Dependent was acquired.

  — **Newborn Children**

  If you have a newborn child while covered under this Certificate, then the following rules apply:

  - If you are enrolled under Member Only (Single) Coverage, you may add coverage for a newborn effective on the date of birth. However, your "Request for Change in Membership" form must be received by the Plan within 31 days of the child's birth. If you choose not to Enroll your newborn child, coverage for that child will be included under the mother's maternity Benefits (provided the mother is enrolled under this Certificate) for 48 hours following a vaginal delivery, or 96 hours following a cesarean section.

  - If you are enrolled under Member and Spouse Only Coverage (if applicable), coverage for the newborn will be effective on the date of birth and continue for 31 days. In order to extend the coverage beyond 31 days, your "Request for Change in Membership" form must be received by the Plan within 31 days of the child's birth.

  - If you are enrolled under Member and Children Coverage, Member, Spouse and Children Coverage or Family Coverage, no application will be required to add coverage for a newborn child. However, you must notify the Plan in writing of the child's birth (please submit a "Request for Change in Membership" form within 31 days). The Effective Date for the newborn will be the child's birth date.

IMPORTANT:

To expedite the handling of your newborn's claims, please make sure the Plan receives your "Request for Change in Membership" form (including your child's name and birth date) within 31 days of the child's birth.

— **Adopted Children**

An adopted child or a child Placed for Adoption may be added to your coverage, provided your "Request for Change in Membership" form is received by the Plan within 31 days of the date the child is placed in your custody. The Effective Date for the child will be the date you assumed the physical custody of the adopted child and the financial responsibility for the support and care of the adopted child. A copy of the court order or adoption papers must be submitted to the Plan with the change form.

Subject to the Exclusions, conditions and limitations of this Certificate, coverage for an adopted child will include the actual and documented medical costs associated with the birth of an adopted child who is 18 months of age or younger. You must provide copies of the medical bills and records associated with the birth of the adopted child and proof that you have paid or are responsible for payment of the medical bills associated with the birth and that the cost of the birth was not covered by another health care plan, including Medicaid.

SPECIAL ENROLLMENT PERIODS

Your Group Health Plan includes Special Enrollment Periods during which individuals who previously declined coverage are allowed to Enroll (without having to wait until the Group's next regular Open Enrollment Period). A Special Enrollment Period can occur if a person with other health coverage loses that coverage or if a person becomes a Dependent through marriage, birth, adoption, or Placement for Adoption. A person who Enrolls during a Special Enrollment Period is not treated as a late enrollee.

- **Special Enrollment For Loss of Other Coverage**

The Special Enrollment Period for loss of other coverage is available to you and your Dependents who meet the following requirements:

— You and/or your Dependent must otherwise be eligible for coverage under the terms of the Group Health Plan.

— When the coverage was previously declined, you and/or your Dependent must have been covered under another Group Health Plan or must have had other health insurance coverage.

— When you declined enrollment for yourself or for your Dependent(s), you stated in writing that coverage under another Group Health Plan or other health insurance coverage was the reason for declining enrollment. This paragraph applies only if:

  ○ the Plan required such a statement when you declined enrollment; and

  ○ you are provided with notice of the requirement to provide the statement in this paragraph (and the consequences of your failure to provide the statement) at the time you declined enrollment.

— When you declined enrollment for yourself or for your Dependent under the Contract:

  ○ you and/or your Dependent had COBRA Continuation Coverage under another plan and COBRA Continuation Coverage under that other plan has since been exhausted; or

- if the other coverage that applied to you and/or your Dependent when enrollment was declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated.

For purposes of the above provision, "exhaustion of COBRA Continuation Coverage" means that the individual's COBRA Continuation Coverage has ceased for any reason other than failure to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). "Loss of eligibility for coverage" includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or any intentional misrepresentation of a material fact in connection with the plan).

— Your application for special enrollment must be received by the Plan within 31 days following the loss of other coverage. Coverage under special enrollment will be effective no later than the first day of the month after the Plan receives your application for enrollment for yourself or on behalf of your Dependent(s).

- **Special Enrollment For New Dependents**

A Special Enrollment Period occurs if a person has a new Dependent by birth, marriage, adoption, or Placement for Adoption. Your application to Enroll or your "Request for Change in Membership" form (if you are already enrolled) must be received by the Plan within 31 days following the birth, marriage, adoption, or Placement for Adoption. To Enroll an adopted child, a copy of the court order or adoption papers must accompany the application or change form. Special enrollment rules provide that:

— You may Enroll when you marry or have a new child (as a result of marriage, birth, adoption, or Placement for Adoption).

— Your spouse can be enrolled separately at the time of marriage or when a child is born, adopted or Placed for Adoption.

— Your spouse can be enrolled together with you when you marry or when a child is born, adopted, or Placed for Adoption.

— A child who becomes your Dependent as a result of marriage, birth, adoption, or Placement for Adoption can be enrolled when the child becomes a Dependent.

— Similarly, a child who becomes your Dependent as a result of marriage, birth, adoption, or Placement for Adoption can be enrolled if you Enroll at the same time.

— Coverage with respect to a marriage is effective no later than first day of the month after the date the request for enrollment is received.

— Coverage with respect to a birth, adoption, or Placement for Adoption is effective on the date of the birth, adoption, or Placement for Adoption.

- **Special Enrollment for Court-Ordered Dependent Coverage**

An Eligible Dependent is not considered a late enrollee if the Member's application to add the Dependent is received by the Plan within 31 days after issuance of a court order requiring coverage be provided for a spouse or minor or Dependent child under the Member's coverage. The Effective Date will be determined by the Plan in accordance with the provisions of the court order.

- **Special Enrollment Related to Medicaid and Child Health Insurance Program (CHIP) Coverage**

A 60-day Special Enrollment Period occurs when Employees and Dependents who are eligible but not enrolled for coverage in the Group Health Plan experience either of the following qualifying events:

— The Employee's or Dependent's Medicaid of CHIP coverage is terminated as a result of loss of eligibility; or

— The Employee or Dependent becomes eligible for a Group Health Plan premium assistance subsidy under Medicaid or CHIP.

An Employee must request this special enrollment into the Group Health Plan within 60 days of the loss of Medicaid or CHIP coverage, and within 60 days of the Employee or Dependent becoming eligible for a Group Health Plan premium assistance subsidy under Medicaid or CHIP. Coverage under special enrollment will be effective no later than the first day of the month after the Plan receives the special enrollment request.

Open Enrollment Period

If you do not Enroll for coverage for yourself or for your Eligible Dependent(s) during the Initial Enrollment Period or during a Special Enrollment Period, you may apply for coverage at any time. However, coverage will be delayed until the Group's next Contract Date Anniversary. In order to verify your coverage election, you and/or your Dependent(s) will be asked to "reapply" for coverage during the Group's Open Enrollment Period. An Open Enrollment Period will be held each year during the 31-day period immediately before the Group's Contract Date Anniversary (renewal date). Your application for coverage must be received by the Plan within this time period.

Qualified Court Orders for Medical Coverage for Dependent Children

The Plan will honor certain qualified medical child support orders (QMCSO). To be qualified, a court of competent jurisdiction must enter an order for child support requiring coverage under the Group Health Plan on behalf of your children. An order or notice issued through a state administrative process that has the force of law may also provide for such coverage and be a QMCSO.

The order must include specific information such as:

- your name and address;
- the name and address of any child covered by the order;
- a reasonable description of the type of coverage to be provided to the child or the manner by which the coverage is to be determined;
- the period to which the order applies; and
- each Group Health Plan to which the order applies.

To be a qualified order, the order cannot require the Plan to provide any type or form of Benefits or any option not otherwise provided by the Group Health Plan, except as otherwise required by law. You will be responsible for paying all applicable premium contributions, and any Deductible, Coinsurance or other cost sharing provisions which apply to your and your Dependent's coverage.

The Plan has to follow certain procedures with respect to qualified medical child support orders. If such an order is issued concerning your child, you should contact a Customer Service Representative at 1-800-94 BLUES (1-800-942-5837).

Delayed Effective Date

If you apply for coverage and are not Actively at Work on what would be your Effective Date, then the Effective Date will be delayed until the date you are Actively at Work.

This provision will not apply if you were:

- absent from work due to a health status factor; or
- enrolled under the Employer's Group Health Plan in force immediately before the Contract Date; or
- covered under BlueLincs HMO coverage (if applicable) and you transfer coverage to this Certificate:
  - — during the Annual Transfer Period; or
  - — within 31 days of the date you move your residence outside the BlueLincs HMO service area.

In no event will your Dependents' coverage become effective prior to your Effective Date.

Deleting a Dependent

You can change your coverage to delete Dependents. The change will be effective at the end of the coverage period during which eligibility ceases.

Transfers From Alternate Coverage Options

Some Groups offer coverage through an alternate program provided by Blue Cross and Blue Shield of Oklahoma, and/or through BlueLincs HMO, a subsidiary of Health Care Service Corporation. Check with your Group Administrator to see what coverage options are available to you.

If your Group does offer coverage options other than this health care program, there are certain periods during which you can transfer coverage from one program to another:

- An Annual Transfer Period will be held each year during the 31-day period immediately before your Group's Contract Date Anniversary (see your Group Administrator for specific dates). During this period, you may transfer your coverage to this program if you are currently enrolled under your Employer's alternate Plan Group Contract or BlueLincs HMO. Your Effective Date will coincide with your Group's Contract Date Anniversary.
- If you have coverage through BlueLincs HMO and you move outside the BlueLincs HMO service area, you may also apply for coverage under this Certificate. Be sure your application is received by the Plan within 31 days of the date you move your residence outside the BlueLincs HMO service area.

Your Effective Date will be the first billing cycle coinciding with or next following the date your application is approved by the Plan.

When Eligibility Continues

- TOTAL DISABILITY

  If you, the Eligible Person, become Totally Disabled, your eligibility under this Certificate will continue for a period which shall be the lesser of:

  - — six months following the date you become disabled; or
  - — the uninterrupted duration of your Total Disability.

- OTHER

  Check with your Group Administrator for eligibility provisions unique to your Group's coverage.

COBRA Continuation Coverage

THIS PROVISION MAY NOT APPLY TO YOUR GROUP'S COVERAGE. PLEASE CHECK WITH YOUR GROUP ADMINISTRATOR TO DETERMINE IF YOUR GROUP IS SUBJECT TO COBRA* REGULATIONS.

- **Eligibility for Continuation Coverage**

  When a Qualifying Event occurs, eligibility under this Certificate may continue for you and/or your Eligible Dependents (including your widow/widower, your divorced or legally separated spouse, and your children) who were covered on the date of the Qualifying Event. A child who is born to you, or Placed for Adoption with you, during the period of COBRA Continuation Coverage is also eligible to elect COBRA Continuation Coverage.

  You or your Eligible Dependent is responsible for notifying the Employer within 60 days of the occurrence of any of the following events:

  — your divorce or legal separation; or

  — your Dependent child ceasing to be an Eligible Dependent under the Plan; or

  — the birth, adoption or Placement for Adoption of a child while you are covered under COBRA Continuation Coverage.

- **Election of Continuation Coverage**

  You or your Eligible Dependent must elect COBRA Continuation Coverage within 60 days after the later to occur of:

  — the date the Qualifying Event would cause you or your Dependent to lose coverage; or

  — the date your Employer notifies you, or your Eligible Dependent, of your COBRA Continuation Coverage rights.

- **COBRA Continuation Coverage Period**

  You and/or your Eligible Dependents are eligible for coverage to continue under your Group's coverage for a period not to exceed:

  — 18 months from the date of a loss in coverage resulting from a Qualifying Event involving your termination of employment or reduction in working hours; or

  — 36 months from the date of a loss in coverage resulting from a Qualifying Event involving:

    ○ your death, divorce or legal separation, or your loss of coverage due to becoming entitled to Medicare; or

    ○ the ineligibility of a Dependent child;

  provided the premiums are paid for the coverage as required.

- **Disability Extension**

  — COBRA Continuation Coverage may be extended from 18 months to 29 months for you or an Eligible Dependent who is determined by the Social Security Administration to have been disabled on the date of a Qualifying Event, or within the first 60 days of COBRA Continuation Coverage. This 11-month disability extension is also available to nondisabled family members who are entitled to COBRA Continuation Coverage.

** Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.*

— To request the 11-month disability extension, you or your Dependent must give notice of the disability determination to the Employer before the end of the initial 18-month COBRA Continuation Coverage period, and no later than 60 days after the date of the Social Security Administration's determination. In addition, you or your Dependent must notify the Employer within 30 days after the Social Security Administration makes a determination that you or your Dependent is no longer disabled.

- **Multiple Qualifying Events**

  In the event an Eligible Dependent experiences a second Qualifying Event after onset of COBRA Continuation Coverage resulting from your termination or reduction in work hours, the maximum period of coverage is 36 months from the date of a loss in coverage resulting from the first Qualifying Event. This extension is available to the Eligible Dependent only.

- **Special TAA/ATAA Election Period**

  An Employee who loses his/her job due to a trade-related reason may be entitled to a second 60-day COBRA election period if the Employee did not elect COBRA Continuation Coverage when initially eligible to do so. In order to qualify for this election period, the U. S. Department of Labor (or a state labor agency) must issue a certification showing that the job loss was due to trade-related reasons and that the employee is entitled to "trade adjustment assistance" (TAA) or "alternate trade adjustment assistance" (ATAA). The special 60-day election period begins on the first day of the month in which the Employee becomes eligible for trade adjustment assistance, as determined by the Department of Labor or state labor agency. The Employee is not eligible for the special election period if the TAA/ATAA eligibility determination is made more than six months after termination of employment.

When Coverage Under This Certificate Ends

When a Subscriber is no longer an Eligible Person or Eligible Dependent, coverage stops at the end of the coverage period during which eligibility ceases, except in the following cases:

- In the case of an Employee whose coverage is terminated, such Employee and his/her Dependents shall remain insured under the Contract for a period of 31 days after such termination, unless during such period the Employee and his/her Dependents shall otherwise become entitled to similar insurance from some other source.
- When a Subscriber ceases to be an Eligible Dependent by reason of death, coverage for that Subscriber will cease on the date of death.
- A Subscriber's COBRA Continuation Coverage, when applicable, will cease on the earliest to occur of the following dates:

  — the date the coverage period ends following expiration of the 18-month, 29-month, or 36-month COBRA Continuation Coverage period, whichever is applicable;

  — the first day of the month that begins more than 30 days after the date of the Social Security Administration's final determination that the Subscriber is no longer disabled (when coverage has been extended from 18 months to 29 months due to disability);

  — the date on which the Group stops providing any Group Health Plan to any Employee;

  — the date on which coverage stops because of a Subscriber's failure to pay to the Group any premiums required for the COBRA Continuation Coverage;

  — the date on which the Subscriber first becomes (after the date of the election) covered under any other Group Health Plan which does not contain any exclusion or limitation with respect to a preexisting condition applicable to the Subscriber (or the date the Subscriber has satisfied the preexisting condition exclusion period under that plan); or

  — the date on which the Subscriber becomes (after the date of the election) entitled to benefits under Medicare.

Your coverage will terminate retroactive to your Effective Date if you or the Group commits fraud or material misrepresentation in applying for or obtaining coverage under the Group Contract. Your coverage will end immediately if you file a fraudulent claim.

If your premiums are not paid, your coverage will stop at the end of the coverage period for which your premiums have been paid.

Termination of the Group Contract automatically ends all of your coverage at the same time and date. It is the responsibility of your Group to tell you of such termination.

What We Will Pay for After Your Coverage Ends

- If your coverage ends for any reason, your Benefits will end on the effective date and time of such termination. However, termination will not deprive you of Benefits to which you would otherwise be entitled for Covered Services Incurred during a Hospital confinement which began before the date and time of termination. Benefits will be provided only for the lesser of:

  — a period of time equal to the length of time you were covered under the Contract; or

  — the duration of the Hospital confinement; or

  — 90 days following termination of coverage; or

  — the date the Subscriber becomes entitled to similar insurance through some other source.

- If your coverage ends because the Member terminates employment, or because the Group itself is terminated, your Benefits will end on the effective date and time of the termination of coverage. However, if you were covered under the Group Contract for at least six months before your coverage terminates, then you will be eligible for an extension of Benefits under this Certificate if:

  — Covered Services are Incurred due to illness or injury because of which you are Totally Disabled at the date and time such coverage is terminated; or

  — you have not completed a plan of surgical treatment (including maternity care and delivery expenses) which began prior to the date and time of such termination.

  Coverage for the extension of Benefits will be limited to the lesser of:

  — the uninterrupted duration of the Total Disability or completion of a plan of surgical treatment; or

  — the payment of maximum Benefits; or

  — six months following the date and time your coverage terminates.

  Your premiums must be submitted to us during the period of the extension of Benefits and will be the same premiums which would have been charged for the coverage under the Group Contract had termination not occurred.

We will have no liability for any Benefits under your Certificate after your coverage terminates, except as specified above.

Conversion Privilege After Termination of Group Coverage

If you stop being a Subscriber under the Group Contract, you are eligible for coverage under our Individual Conversion contract.

If you move to an area serviced by another Blue Cross Plan, you may transfer to the Blue Cross Plan serving that area.

When you transfer to an Individual Conversion contract or to a contract offered by another Blue Cross Plan, your coverage may be different from the coverage provided by this Certificate.

Payment for coverage under the conversion contract must be made from the date you cease to be a Subscriber under this Certificate.

Written application for a conversion contract must be received by Blue Cross and Blue Shield of Oklahoma no later than 31 days after your coverage terminates under this Certificate.

A conversion contract will not be available if you are:

- a Member who is eligible for coverage under a group having a contract with us; or
- a Dependent who is covered under any policy of benefits for hospital and surgical/medical care and services provided by an employer or group; or
- any Subscriber who ceases to be eligible due to cancellation of the Contract, unless approved by the Plan.

When You Turn Age 65

Plan coverage is available to you and/or your spouse over age 65. However, the type of coverage you receive will depend upon whether you continue to work and the rules in effect for your particular Group, including federal regulations which apply to working people age 65 and older.

Your coverage may include:

- a continuation of Group Benefits;
- a combination of Group Benefits and Medicare; or
- one of our Medicare Supplement Policies.

Check with your Group Administrator for details regarding the coverage options available to you and your Dependents (if any).

When You Retire

When you retire at or after age 65 and have applied for Medicare, you may apply for our Medicare supplement coverage within 31 days of the day you retire.

If you retire before your 65th birthday, you may convert to an Individual Conversion contract within 31 days of your retirement date. Then when you become age 65, you may apply for our Medicare supplement coverage. Check with your Group Administrator for more information.

NOTE: Some Groups have special eligibility provisions regarding retired Employees. **Check with your Group Administrator for retiree eligibility provisions unique to your Group's coverage.**

IMPORTANT:

You are eligible for Medicare on the first day of the month you become age 65. You should apply for Medicare at least three months before your birthday.

Certificates of Coverage

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a Group Health Plan is required to provide you with a "Certificate of Coverage", without charge, upon the occurrence of any of the following events:

- **Qualified Beneficiaries Upon a Qualifying Event**

  In the case of an individual who is a qualified beneficiary entitled to elect COBRA Continuation Coverage, an automatic certificate is required to be provided at the time the individual would lose coverage under the plan in the absence of COBRA Continuation Coverage or alternative coverage elected instead of COBRA Continuation Coverage.

- **Other Individuals When Coverage Ceases**

  In the case of an individual who is not a qualified beneficiary entitled to elect COBRA Continuation Coverage, an automatic certificate is required to be provided at the time the individual ceases to be covered under the plan.

- **Qualified Beneficiaries When COBRA Ceases**

  In the case of an individual who is a qualified beneficiary and has elected COBRA Continuation Coverage (or whose coverage has continued after the individual became entitled to elect COBRA Continuation Coverage), an automatic certificate is to be provided at the time the individual's coverage under the plan ceases.

- **Any Individual Upon Request**

  Requests for certificates are permitted to be made by, or on behalf of, an individual within 24 months after coverage ceases.

The Certificate of Coverage gives detailed information about how long you had coverage under the plan. This information may be used to demonstrate "Creditable Coverage" to your new health plan or issuer of an individual health policy.

Blue Cross and Blue Shield of Oklahoma has established a toll-free telephone number (1-888-250-2005) to assist Subscribers in obtaining Certificates of Coverage.

Schedule of Benefits
Comprehensive Health Care Services
Basic Option

This section shows how much we pay for Covered Services described in the ***Comprehensive Health Care Services*** section that follows. It also explains the Deductible you must pay before the Plan starts to pay for most Covered Services. **Please note that services must be Medically Necessary in order to be covered under this program.**

BENEFIT PERIOD	Calendar Year
First Dollar Coverage	The Plan pays 100% of the first $500 of eligible medical expenses, whether in-network or Out-of-Network per Benefit Period per Subscriber. Then Benefits will be paid as follows for the remainder of the Benefit Period.
DEDUCTIBLE	
Out-of-Network Hospital Deductible	$300 per Inpatient Hospital Admission. This Deductible applies to all Covered Services Incurred during the Subscriber's admission to a Hospital which is not a BlueChoice or BlueCard facility.
Benefit Period Deductible	$500 per Benefit Period per Subscriber. The Benefit Period Deductible is in addition to the Out-of-Network Hospital Deductible or any other Deductible described above. This Deductible applies to Covered Services received from a BlueChoice or BlueCard Provider. If the Subscriber has Incurred expenses which were applied toward his or her Out-of-Network Provider Services Deductible during the Benefit Period, those expenses will also count toward satisfaction of his or her Deductible amount for BlueChoice or BlueCard Provider Service.
Covered Services ***Not*** Subject to Benefit Period Deductible	The Benefit Period Deductible applies to all Covered Services, except: • Routine Nursery Care ($300 Out-of-Network Hospital Deductible ***does*** apply). • Preventive Care Services received from a BlueChoice or BlueCard Provider. Preventive Care Services received from an Out-of-Network Provider are subject to Deductible, except for : — Routine Diagnostic Medical Procedure/Routine EKG/Routine X-ray/Routine Colorectal Cancer screening X-ray; — Annual routine gynecological/obstetrical examination and Pap smear. — Annual prostate cancer screening.

— Routine Mammogram;

— Covered childhood immunizations (for Subscribers under age 19);

— Any other state or federally mandated Benefits which stipulate a Deductible may not be required.

- Outpatient Prescription Drug Benefits.
- First $500 of eligible medical expenses, as outlined above in First Dollar Coverage.

Out-of-Network Provider Services Deductible

$500 per Benefit Period per Subscriber.

This Deductible applies whenever the Subscriber receives Covered Services from a Provider who is not a member of the BlueChoice or BlueCard Provider Network. If the Subscriber has Incurred expenses which were applied toward his or her BlueChoice or BlueCard Provider Services Deductible during the Benefit Period, those expenses will also count toward satisfaction of his or her Deductible amount for Out-of-Network Provider Services.

Deductible Credit

If your Group changed carriers during your benefit period, expenses you Incurred and which were applied toward your Deductible during the last partial benefit period for services covered by the prior carrier will be applied to the Deductible of your initial Benefit Period under the Plan.

FAMILY DEDUCTIBLE

If your coverage includes your Dependents, then:

- no more than two times the individual Deductible must be satisfied in each Benefit Period for all family members covered under your membership; and
- if two or more Subscribers under your membership incur expenses for Covered Services as a result of injuries received in the same accident, only one Deductible will be applied to the aggregate of such charges.

No family Subscriber will contribute more than the individual Deductible amount.

The Family Deductible provisions described above apply only to the Benefit Period Deductible and do not include any other Deductible applicable to your coverage.

OUT-OF-POCKET LIMIT

BlueChoice Provider Services

When you have Incurred $5,500 including any Copayment and/or Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period.

Out-of-Network Provider Services	When you have paid $5,500 (including any Copayment and/or Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period. The Out-of-Pocket Limit for in-network Provider Services and Out-of-Network Provider Services do cross apply.
FAMILY OUT-OF-POCKET LIMIT	
BlueChoice Provider Services	When you and your Dependents have paid $11,000 (including any Copayment and/or Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of you and your Dependent will increase to 100% during the remainder of the Benefit Period.
Out-of-Network Provider Services	When you and your Dependents have paid $11,000 (including any Copayment and/or Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of you and your Dependent will increase to 100% during the remainder of the Benefit Period. The Out-of-Pocket for in-network Provider Services and Out-of-Network Provider Services do cross apply. The Out-of-Pocket Limits and Benefit percentage amount specified above do not apply to expenses Incurred for: • Outpatient Prescription Drugs. • Any penalty Incurred due to your failure to follow the Plan's guidelines for Preauthorization, as set forth in this Certificate. • Charges in excess of the Allowable Charge.
MAXIMUM	Unlimited per lifetime per Subscriber
BENEFIT PERCENTAGE AMOUNT	The following chart shows the percentage of Allowable Charges covered by your program through payments and/or contractual arrangements with Providers. These percentages apply only after your Copayment, Deductible and/or Coinsurance has been satisfied.

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT: BlueChoice & BlueCard Provider Services	Out-of-Network Provider Services
PREVENTIVE CARE SERVICES		
Covered Childhood Immunizations (limited to Subscribers under age 19)	100%	100%
Routine Diagnostic Services	100%	100%
Routine EKG (Electrocardiography)	100%	100%
Routine X-rays	100%	100%
Routine Mammography	100%	100%
Annual prostate cancer screening	100%	100%
Annual Routine Gynecological/ Obstetrical Examination and Pap Smear	100%	100%
All Other Covered Preventive Care Services	100%	50%
EMERGENCY CARE SERVICES	50%	50%

THE FOLLOWING BENEFIT PERCENTAGES APPLY TO SERVICES THAT ARE NOT CLASSIFIED AS PREVENTIVE CARE SERVICES OR EMERGENCY CARE SERVICES, AS DETERMINED BY THE CLAIMS ADMINISTRATOR

HOSPITAL SERVICES	50%	50%
SURGICAL/MEDICAL SERVICES	50%	50%
OUTPATIENT DIAGNOSTIC SERVICES	50%	50%
OUTPATIENT THERAPY SERVICES	50%	50%
MATERNITY SERVICES	50%	50%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	50%	50%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES	50%	50%

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT: BlueChoice & BlueCard Provider Services	Out-of-Network Provider Services
AMBULATORY SURGICAL FACILITY SERVICES	50%	50%
SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS	50%	50%
PSYCHIATRIC CARE SERVICES	50%	50%
AMBULANCE SERVICES	50%	50%
PRIVATE DUTY NURSING SERVICES	50%	50%
REHABILITATION CARE	50%	50%
SKILLED NURSING FACILITY SERVICES	50%	50%
HOME HEALTH CARE SERVICES	50%	50%
HOSPICE SERVICES	50%	50%
TEMPOROMANDIBULAR JOINT SYNDROME/DYSFUNCTION	50%	50%
ORAL SURGERY/DENTAL SURGERY FOR ACCIDENTAL INJURY	50%	50%
HOSPICE SERVICES	50%	50%
SERVICES RELATED TO CLINICAL TRIALS	50%	50%
ALL OTHER COVERED SERVICES	50%	50%

Schedule of Benefits
Comprehensive Health Care Services
High Option

This section shows how much we pay for Covered Services described in the ***Comprehensive Health Care Services*** section that follows. It also explains the Deductible you must pay before the Plan starts to pay for most Covered Services. **Please note that services must be Medically Necessary in order to be covered under this program.**

BENEFIT PERIOD

Calendar Year

The Copayment applies to charges which are billed as part of your Physician's office visit only and is limited to one Copayment per day per Provider. All other Physician office visit related services are subject to the Deductible and Coinsurance provisions of your coverage.

EXCEPTION: The office visit Copayment does not apply to the following services:

- Surgical services;
- Physical Therapy and Occupational Therapy;
- Chemotherapy;
- Allergy testing and allergy injections;
- Preventive Care Services received from a BlueChoice, or BlueCard Provider.
- Covered childhood immunizations (for Subscribers under age 19);
- Prescription Drugs;
- Durable Medical Equipment.

The Copayment does not count toward the Deductible under this Certificate.

DEDUCTIBLE

Out-of-Network Hospital Deductible	$300 per Inpatient Hospital Admission. This Deductible applies to all Covered Services Incurred during the Subscriber's admission to a Hospital which is not a BlueChoice or BlueCard Provider.
Benefit Period Deductible	$1,000 per Benefit Period per Subscriber. The Benefit Period Deductible is in addition to the Out-of-Network Hospital Deductible or any other Deductible described above.

This Deductible applies to Covered Services received from a BlueChoice or BlueCard Provider. If the Subscriber has Incurred expenses which were applied toward his or her Out-of-Network Provider Services Deductible during the Benefit Period, those expenses will also count toward satisfaction of his or her Deductible amount for BlueChoice or BlueCard Provider Service.

Covered Services ***Not*** Subject to Benefit Period Deductible

The Benefit Period Deductible applies to all Covered Services, except:

- Routine Nursery Care ($300 Out-of-Network Hospital Deductible ***does*** apply).
- Annual routine gynecological/obstetrical examination and Pap smear.
- BlueChoice or BlueCard Physician services which are subject to the office visit Copayment.
- Preventive Care Services received from a BlueChoice or BlueCard Provider. Preventive Care Services received from an Out-of-Network Provider are subject to Deductible, except for :
  - — Routine Diagnostic Medical Procedure/Routine EKG/Routine X-ray/Routine Colorectal Cancer screening X-ray;
  - — Annual routine gynecological/obstetrical examination and Pap smear.
  - — Annual prostate cancer screening.
  - — Routine Mammogram;
  - — Covered childhood immunizations (for Subscribers under age 19);
  - — Any other state or federally mandated Benefits which stipulate a Deductible may not be required.
- Outpatient Prescription Drugs.
- Ambulance Services.

Out-of-Network Provider Services Deductible

$1,000 per Benefit Period per Subscriber.

This Deductible applies whenever the Subscriber receives Covered Services from a Provider who is not a member of the BlueChoice or BlueCard Provider Network. If the Subscriber has Incurred expenses which were applied toward his or her BlueChoice or BlueCard Provider Services Deductible during the Benefit Period, those expenses will also count toward satisfaction of his or her Deductible amount for Out-of-Network Provider Services.

Deductible Credit

If your Group changed carriers during your benefit period, expenses you Incurred and which were applied toward your Deductible during the last partial benefit period for services covered by the prior carrier will be applied to the Deductible of your initial Benefit Period under the Plan.

FAMILY DEDUCTIBLE

No family Subscriber will contribute more than the individual Deductible amount.

If your coverage includes your Dependents, then:

- no more than three times the individual Deductible must be satisfied in each Benefit Period for all family members covered under your membership; and
- if two or more Subscribers under your membership incur expenses for Covered Services as a result of injuries received in the same accident, only one Deductible will be applied to the aggregate of such charges.

The Family Deductible provisions described above apply only to the Benefit Period Deductible and do not include any other Deductible applicable to your coverage.

OUT-OF-POCKET LIMIT

BlueChoice Provider Services

When you have Incurred $3,300 including any Copayment and/or Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period.

Out-of-Network Provider Services

When you have paid $3,800 (including any Copayment and/or Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period.

The Out-of-Pocket Limit for in-network Provider Services and Out-of-Network Provider Services do cross apply.

The Out-of-Pocket Limits and Benefit percentage amount specified above do not apply to expenses Incurred for:

- Outpatient Prescription Drugs.
- Any penalty Incurred due to your failure to follow the Plan's guidelines for Preauthorization, as set forth in this Certificate.
- Charges in excess of the Allowable Charge.

FAMILY OUT-OF-POCKET LIMIT

BlueChoice Provider Services	When you and your Dependents have paid $9,900 (including any Deductible and/or Copayment amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of you and your Dependents will increase to 100% during the remainder of the Benefit Period.
Out-of-Network Provider Services	When you and your Dependents have paid $11,400 (including any Deductible and/or Copayment amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of you and your Dependents will increase to 100% during the remainder of the Benefit Period.
MAXIMUM	Unlimited per lifetime per Subscriber
BENEFIT PERCENTAGE	The following chart shows the percentage of Allowable Charges covered by your BlueChoice program through payments and/or contractual arrangements with Providers. These percentages apply only after your Deductible and/or Coinsurance has been satisfied.

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT: BlueChoice & BlueCard Provider Services	Out-of-Network Provider Services
PREVENTIVE CARE SERVICES		
Covered Childhood Immunizations (limited to Subscribers under age 19)	100%	100%
Routine Diagnostic Services	100%	100%
Routine EKG (Electrocardiography)	100%	100%
Routine X-rays	100%	100%
Routine Mammography	100%	100%
Annual prostate cancer screening	100%	100%
Annual Routine Gynecological/ Obstetrical Examination and Pap Smear	100%	100%
All Other Covered Preventive Care Services	100%	70%
EMERGENCY CARE SERVICES	80%	80%

THE FOLLOWING BENEFIT PERCENTAGES APPLY TO SERVICES THAT ARE NOT CLASSIFIED AS PREVENTIVE CARE SERVICES OR EMERGENCY CARE SERVICES, AS DETERMINED BY THE CLAIMS ADMINISTRATOR

HOSPITAL SERVICES	80%	50%
SURGICAL/MEDICAL SERVICES	80%	50%
Physicians' Office Visits	100%*	50%
All Other Covered Surgical/Medical Services	80%	50%
OUTPATIENT DIAGNOSTIC SERVICES	80%	50%
OUTPATIENT THERAPY SERVICES	80%	50%
MATERNITY SERVICES	80%	50%

* *Applicable only to Covered Services which are subject to the office visit Copayment. For services which are not subject to the office visit Copayment, this percentage amount is reduced to 80% of Allowable Charges after satisfaction of the Deductible.*

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT: BlueChoice & BlueCard Provider Services	Out-of-Network Provider Services
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	80%	50%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES	80%	50%
AMBULATORY SURGICAL FACILITY SERVICES	80%	50%
SERVICES FOR TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS	80%	50%
AMBULANCE SERVICES	80%	50%
PRIVATE DUTY NURSING SERVICES	80%	50%
REHABILITATION CARE	80%	50%
SKILLED NURSING FACILITY SERVICES	80%	50%
HOME HEALTH CARE SERVICES	80%	50%
TEMPOROMANDIBULAR JOINT SYNDROME (TMJ)	80%	50%
HOSPICE SERVICES	80%	50%
ORAL SURGERY/DENTAL SURGERY FOR ACCIDENTAL INJURY	80%	50%
SERVICES RELATED TO CLINICAL TRIALS	80%	50%
ALL OTHER COVERED SERVICES	80%	50%

Comprehensive Health Care Services

This section lists the Covered Services under your health care program. **Please note that services must be Medically Necessary in order to be covered under this program.**

PREVENTIVE CARE SERVICES

NOTE: Preventive Care Services received from BlueChoice or BlueCard Providers are not subject to Deductible, Copayment, Coinsurance or dollar maximum. Preventive Care Services received from Out-of-Network Providers may be subject to Copayment, Deductible and/or Coinsurance, except for certain state-mandated Benefits (for example: covered childhood immunizations for Subscribers under age 19).

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
- Evidenced-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents: and
- With respect to women, such additional preventive care and screenings, not described in the first bullet above, as provided for in comprehensive guidelines supported by the HRSA.
  - — Breast-feeding Support, Services and Supplies – Benefits will be provided for breast-feeding counseling and support services rendered by a Provider for pregnant and postpartum women. Benefits include the rental (or, at the Plan's option, the purchase) of manual or electric breast-feeding equipment.
  - — Contraceptive Services – Benefits will be provided for the following contraceptive services when prescribed by a licensed Provider for women with reproductive capacity:
    - ○ contraceptive counseling;
    - ○ FDA-approved prescription devices and medications;
    - ○ over-the-counter contraceptives; and
    - ○ sterilization procedures (tubal ligation), but not including hysterectomy.

    Coverage includes contraceptives in the following categories:
    - ○ progestin-only contraceptives;
    - ○ combination contraceptives;
    - ○ emergency contraceptives;
    - ○ extended-cycle/continuous oral contraceptives;
    - ○ cervical caps;
    - ○ diaphragms;

- implantable contraceptives;
- intra-uterine devices;
- injectables;
- transdermal contraceptives; and
- vaginal contraceptive devices.

NOTE: Prescription contraceptive medications are covered under the ***Outpatient Prescription Drug Benefits*** section of your Certificate**,** *if applicable*.

The contraceptive drugs and devices listed above may change as FDA guidelines are modified. Coinsurance or Copayment amounts will not apply to FDA-approved contraceptive drugs and devices on the Contraceptive Information list. You may access the Web site at www.bcbsok.com or contact customer service at the toll-free number on your Identification Card.

When obtaining the items noted above, you may be required to pay the full cost and then submit a claim form with itemized receipts to the Plan for reimbursement. Please refer to the ***Claims Filing Procedures*** section of your Certificate for claims submission information.

Covered Preventive Care Services received from Out-of-Network Providers and/or Out-of-Network Pharmacies, or other routine Covered Services not provided for under this provision may be subject to Deductible, Copayment, Coinsurance and/or benefit maximums.

For purposes of this Benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The Preventive Care Services described above may change as the USPSTF, CDC and HRSA guidelines are modified. For more information Subscribers may access the Web site at www.bcbsok.com or contact customer service at the toll-free number listed on their Identification Card.

Examples of Covered Services included are routine annual physicals, immunizations, well-child care, cancer screening mammograms, bone density testing, screening for prostate cancer and colorectal cancer, smoking cessation counseling services, healthy diet counseling and obesity screening/counseling.

Examples of covered immunizations included are Diphtheria, Haemophilus influenzae type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella and any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this Benefit provision.

Covered Services ***not*** included in the items listed above ***may*** be subject to Coinsurance, Deductible and/or dollar maximums.

Emergency Care Services

Services provided for treatment of an injury, illness or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in:

- serious jeopardy to the Subscriber's health;
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

Coverage for Emergency Care shall be provided in accordance with the terms and conditions of the appropriate Benefit section of this Contract (for example "Hospital Services," "Surgical/Medical Services" and "Ambulance Services.")

HOSPITAL SERVICES

We pay the scheduled amounts for the following Covered Services you receive from a Hospital or other Provider.

- **Bed and Board**

  Bed, board and general nursing service in:

  — A room with two or more beds;

  — A private room (private room allowance is equal to the most prevalent semiprivate room charges of your Hospital). Private room charges in excess of the semiprivate room allowance will not be eligible for Benefits unless the patient is required under the infection control policy of the Hospital to be in isolation to prevent contagion;

  — A bed in a Special Care Unit which gives intensive care to the critically ill.

  Inpatient services are subject to the Preauthorization guidelines of this Certificate (see *"Important Information"*). If you fail to comply with these guidelines, Benefits for Covered Services rendered during your Inpatient confinement will be reduced by $500, provided the Plan determines that Benefits are payable upon receipt of a claim.

- **Ancillary Services**

  — Operating, delivery and treatment rooms;

  — Prescribed drugs;

  — Whole blood, blood processing and administration;

  — Anesthesia supplies and services rendered by an employee of the Hospital or other Provider;

  — Medical and surgical dressings, supplies, casts and splints;

  — Oxygen;

  — Subdermally implanted devices or appliances necessary for the improvement of physiological function;

  — Diagnostic Services;

  — Therapy Services.

- **Emergency Accident Care**

  Outpatient emergency Hospital services and supplies to treat injuries caused by an accident.

- **Emergency Medical Care**

  Outpatient emergency Hospital services and supplies to treat a sudden and acute medical condition that requires prompt Medical Care.

- **Surgery**

  Hospital services and supplies for Outpatient Surgery furnished by an employee of the Hospital or other Provider other than the surgeon or assistant surgeon.

- **Routine Nursery Care**

  — Inpatient Hospital Services for Routine Nursery Care of a newborn Subscriber.

  — Routine Nursery Care does not include treatment or evaluation for medical or surgical reasons during or after the mother's maternity confinement. In the event the newborn requires such treatment or evaluation while covered under this Certificate:

    ○ the infant will be considered as a Subscriber in its own right and will be entitled to the same Benefits as any other Subscriber under this Certificate; and

    ○ a separate Deductible will apply to the newborn's Hospital confinement.

  Benefits are provided for Routine Nursery Care for an infant born to a Dependent child.

SURGICAL/MEDICAL SERVICES

We pay the scheduled amounts for the following Covered Services you receive from a Physician or other Provider.

- **Surgery**

  Payment includes visits before and after Surgery.

  — If an incidental procedure* is carried out at the same time as a more complex primary procedure, then Benefits will be payable for only the primary procedure. **Separate Benefits will not be payable for any incidental procedures performed at the same time.**

  — When more than one surgical procedure is performed through more than one route of access during one operation, you are covered for:

    ○ the primary procedure; plus

    ○ 50% of the amount payable for each of the additional procedures had those procedures been performed alone.

  — Sterilization, regardless of Medical Necessity.

- **Assistant Surgeon**

  Services of a Physician who actively assists the operating surgeon in the performance of covered Surgery. Benefits will be provided for an assistant surgeon only if determined Medically Necessary by the Plan.

- **Anesthesia**

  Administration of anesthesia by a Physician or other Provider who is not the surgeon or the assistant surgeon.

- **Inpatient Medical Services**

  Medical Care when you are an Inpatient for a condition not related to Surgery, pregnancy, or Mental Illness, except as specified.

  — Inpatient Medical Care Visits

    Inpatient Medical Care visits are limited to one visit or other service per day by the attending Physician.

**A procedure carried out at the same time as a primary surgical procedure, but which is clinically integral to the performance of the primary procedure, and, therefore, should not be reimbursed separately.*

— Intensive Medical Care

Constant Physician attendance and treatment when your condition requires it for a prolonged time.

— Concurrent Care

- Care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery.
- If the nature of the illness or injury requires, care by two or more Physicians during one Hospital stay.

— Consultation

Consultation by another Physician when requested by your attending Physician, **limited to one visit or other service per day for each consulting Physician.** Staff consultations required by Hospital rules are excluded.

— Newborn Well Baby Care

Routine Nursery Care visits to examine a newborn Subscriber, limited to the first 48 hours following a vaginal delivery or 96 hours following delivery by cesarean section. No additional Inpatient visits are covered for well baby care.

- **Outpatient Medical Services**

Outpatient Medical Care that is not related to Surgery, pregnancy, or Mental Illness, except as specified.

— Emergency Accident Care

Treatment of accidental bodily injuries.

— Emergency Medical Care

Treatment of a sudden and acute medical condition that requires prompt Medical Care.

— Home, Office, and Other Outpatient Visits

Visits and consultation for the examination, diagnosis, and treatment of an injury or illness.

— Contraceptive Devices

Contraceptive devices which are:

- placed or prescribed by a Physician;
- intended primarily for the purpose of preventing human conception; and
- approved by the U. S. Food and Drug Administration as acceptable methods of contraception.

— Audiological Services

Audiological services and hearing aids, limited to:

- **One hearing aid per ear every 48 months for Subscribers up to age 18; and**
- **Up to four additional ear molds per Benefit Period for Subscribers up to two years of age.**

Hearing aids must be prescribed, filled and dispensed by a licensed audiologist.

— Infertility Treatment

Physician services and diagnostic testing directly related to the initial diagnosis of infertility, including injections. Treatment and Surgery are not covered.

— Allergy Treatment and Testing

Evaluation, diagnosis and treatment of allergies (immunotherapy). **Benefits are limited to 60 tests every 24 months.**

— Hearing Care Services

Hearing care services are limited to **one screening exam per Benefit Period for Subscribers age 19 and over**.

Outpatient Diagnostic Services

- Radiology, Ultrasound and Nuclear Medicine
- Laboratory and Pathology
- ECG, EEG, and Other Electronic Diagnostic Medical Procedures and Physiological Medical Testing, as determined by the Plan

Outpatient Therapy Services

- Radiation Therapy
- Chemotherapy
- Respiratory Therapy
- Dialysis Treatment
- Physical Therapy

  Physical Therapy is limited to 60 visits per Benefit Period per Subscriber.

- Occupational Therapy

  Occupational Therapy is limited to 60 visits per Benefit Period per Subscriber.

- Speech Therapy

  Speech Therapy is limited to 60 visits per Benefit Period per Subscriber.

Maternity Services

- Hospital Services and Surgical/Medical Services from a Provider to a Member or the Member's covered spouse for:

  — Normal Pregnancy

  Normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but not considered a complication of pregnancy.

— Complications of Pregnancy

Physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.

— Interruptions of Pregnancy

  ○ Miscarriage

  ○ Abortion, if Medically Necessary.

- Covered Maternity Services include the following:

  — A minimum of 48 hours of Inpatient care at a Hospital, or a birthing center licensed as a Hospital, following a vaginal delivery for the mother and newborn infant who are covered under this Certificate after childbirth, except as otherwise provided in this section; or

  — A minimum of 96 hours of Inpatient care at a Hospital following a delivery by cesarean section for the mother and newborn infant who are covered under this Certificate after childbirth, except as otherwise provided in this section; and

  — Postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center. The coverage shall provide for one home visit within 48 hours of childbirth by a licensed health care Provider whose scope of practice includes providing postpartum care. The visits shall include, at a minimum:

    ○ physical assessment of the mother and newborn infant;

    ○ parent education regarding childhood immunizations;

    ○ training or assistance with breast or bottle feeding; and

    ○ performance of any Medically Necessary and appropriate clinical tests.

  At the mother's discretion, visits may occur at the facility of the Provider instead of the home.

- Inpatient care shall include, at a minimum:

  — physical assessment of the mother and newborn infant;

  — parent education regarding childhood immunizations;

  — training or assistance with breast or bottle feeding; and

  — performance of any Medically Necessary and appropriate clinical tests.

- The Plan may provide coverage for a shorter length of Hospital Inpatient stay for services related to maternity/obstetrical and newborn infant care provided:

  — The licensed health care Providers determine that the mother and newborn infant meet medical criteria contained within guidelines, developed by or in cooperation with licensed health care Providers, which recognize treatment standards, including, but not limited to, the most current treatment standards of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, that determine the appropriate length of stay based upon:

    ○ evaluation of the antepartum, intrapartum, and postpartum course of the mother and newborn infant;

- the gestational age, birth weight and clinical condition of the newborn infant;
- the demonstrated ability of the mother to care for the newborn infant postdischarge; and
- the availability of postdischarge follow-up to verify the condition of the newborn infant in the first 48 hours after delivery; and

— The Plan covers one home visit, within 48 hours of discharge, by a licensed health care Provider whose scope of practice includes providing postpartum care. Such visits shall include, at a minimum:

- physical assessment of the mother and newborn infant;
- parent education regarding childhood immunizations;
- training or assistance with breast or bottle feeding; and
- performance of any Medically Necessary and appropriate clinical tests.

At the mother's discretion, visits may occur at the facility of the Provider instead of the home.

Maternity Services for Dependent children are covered, including complications of pregnancy.

Mastectomy and Reconstructive Surgical Services

Hospital Services and Surgical/Medical services for the treatment of breast cancer and other breast conditions, including:

- Inpatient Hospital Services for:
  — not less than 48 hours of Inpatient care following a mastectomy; and
  — not less than 24 hours of Inpatient care following a lymph node dissection for the treatment of breast cancer.

  However, coverage may be provided for a shorter length of Hospital Inpatient stay where the attending Physician, in consultation with the patient, determines that a shorter period of Hospital stay is appropriate.
- Coverage for reconstructive breast Surgery performed as a result of a partial or total mastectomy. Covered Services shall consist of the following, when provided in a manner determined in consultation with the attending Physician and the patient:
  — reconstruction of the breast on which the mastectomy has been performed;
  — Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  — prostheses and physical complications at all stages of mastectomy, including lymphedema.

Breast reconstruction or implantation or removal of breast prostheses is a Covered Service only when performed solely and directly as a result of mastectomy which is Medically Necessary.

Human Organ, Tissue and Bone Marrow Transplant Services

All transplants are subject to Preauthorization and must be performed in and by a Provider that meets the criteria established by the Plan for assessing and selecting Providers for transplants.

Preauthorization must be obtained at the time the Subscriber is referred for a transplant consultation and/or evaluation. It is the Subscriber's responsibility to make sure Preauthorization is obtained. Failure to obtain

Preauthorization will result in denial of Benefits. The Plan has the sole and final authority for approving or declining requests for Preauthorization.

- **DEFINITIONS**

  In addition to the definitions listed under the ***Definitions*** section of this Certificate, the following definitions shall apply and/or have special meaning for the purpose of this section:

  — **Bone Marrow Transplant**

  A medical and/or surgical procedure comprised of several steps or stages including:

  - the harvest of stem cells or progenitor cells, whether from the bone marrow or from the blood, from a third-party donor (allogeneic transplant) or from the patient (autologous transplant);
  - processing and/or storage of the stem cells or progenitor cells after harvesting;
  - the administration of High-Dose Chemotherapy and/or High-Dose Radiation Therapy, when this step is prescribed by the treating Physician;
  - the infusion of the harvested stem cells or progenitor cells; and
  - hospitalization, observation and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts.

  The above definition of autologous Bone Marrow Transplant specifically includes transplants wherein the transplant component is derived from circulating blood in lieu of, or in addition to, harvested directly from the bone marrow, a procedure commonly known as peripheral stem cell or progenitor cell transplant or rescue procedure. This definition further specifically includes all component parts of the procedure including, without limitation, the High-Dose Chemotherapy and/or High-Dose Radiation Therapy.

  — **High-Dose Chemotherapy**

  A form of Chemotherapy wherein the dose exceeds standard doses of Chemotherapy to the extent that virtually all patients who receive High-Dose Chemotherapy sustain destruction of the bone marrow to the point that bone marrow or peripheral stem cells or progenitor cells must be implanted or infused to keep the patient alive.

  — **High-Dose Radiation Therapy**

  A form of Radiation Therapy wherein the dose exceeds standard doses of Radiation Therapy resulting in destruction of the bone marrow to the point that bone marrow or peripheral stem cells or progenitor cells must be implanted or infused to keep the patient alive.

  — **Preauthorization**

  Certification from the Plan that, based upon the information submitted by the Subscriber's attending Physician, Benefits will be provided under the Contract. Preauthorization is subject to all conditions, exclusions and limitations of the Contract. Preauthorization does not guarantee that all care and services a Subscriber receives are eligible for Benefits under the Contract.

  — **Procurement Services**

  The services provided to search for and match the human organ, tissue, bone marrow, peripheral stem cells, or progenitor cells donated to the transplant recipient, surgically remove the organ, tissue, bone marrow, peripheral stem cells, or progenitor cells from the donor and transport the organ, tissue, bone marrow, peripheral stem cells, or progenitor cells to the location of the recipient within 24 hours after the match is made.

- **TRANSPLANT SERVICES**

  Subject to the Exclusions, conditions, and limitations of the Contract, Benefits will be provided for Covered Services rendered by a Hospital, Physician, or other Provider for the human organ and tissue transplant procedures set forth below.

  — Musculoskeletal transplants;

  — Parathyroid transplants;

  — Cornea transplants;

  — Heart-valve transplants;

  — Kidney transplants;

  — Heart transplants;

  — Single lung, double lung and heart/lung transplants;

  — Liver transplants;

  — Intestinal transplants;

  — Small bowel/liver or multivisceral (abdominal) transplants;

  — Pancreas transplants;

  — Islet cell transplants; and

  — Bone Marrow Transplants.

- **EXCLUSIONS AND LIMITATIONS APPLICABLE TO ORGAN/TISSUE/BONE MARROW TRANSPLANTS**

  — The transplant must meet the criteria established by the Plan for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures, as set forth in the Plan's written medical policies.

  — In addition to the Exclusions set forth elsewhere in this Certificate, no Benefits will be provided for the following organ or tissue transplants or Bone Marrow Transplants or related services:

    ○ Adrenal to brain transplants.

    ○ Allogeneic islet cell transplants.

    ○ High-Dose Chemotherapy or High-Dose Radiation Therapy if the associated autologous or allogeneic Bone Marrow Transplant, stem cell or progenitor cell treatment or rescue is not a Covered Service.

    ○ Small bowel transplants using a living donor.

    ○ Any organ or tissue transplant or Bone Marrow Transplant from a non-human donor or for the use of non-human organs for extracorporeal support and/or maintenance.

    ○ Any artificial device for transplantation/implantation, except in limited instances as reflected in the Plan's written medical policies.

    ○ Any organ or tissue transplant or Bone Marrow Transplant procedure which the Plan considers to be Experimental or Investigational in nature.

- Expenses related to the purchase, evaluation, Procurement Services, or transplant procedure if the organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Subscriber recipient.

- All services, provided directly for or relative to any organ or tissue transplant, or Bone Marrow Transplant procedure which is not specifically listed as a Covered Service in this Certificate.

— The transplant must be performed in and by a Provider that meets the criteria established by the Plan for assessing and selecting Providers in the performance of organ or tissue transplants, or Bone Marrow Transplant procedures.

• **DONOR BENEFITS**

If a human organ, tissue or Bone Marrow Transplant is provided from a ***living*** donor to a human transplant recipient:

— When both the recipient and the living donor are Subscribers, each is entitled to the Benefits of the Contract.

— When only the recipient is a Subscriber, both the donor and the recipient are entitled to the Benefits of the Contract. The donor Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or other Blue Cross or Blue Shield coverage or any government program. Benefits provided to the donor will be charged against the recipient's coverage under the Contract.

— When only the living donor is a Subscriber, the donor is entitled to the Benefits of the Contract. The Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or other Blue Cross or Blue Shield coverage or any government program available to the recipient. There are no Covered Services for the non-Subscriber transplant recipient.

— If any organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Subscriber recipient, no Covered Services will be provided for the purchase price, evaluation, Procurement Services or procedure.

— The Plan is not liable for transplant expenses incurred by donors, except as specifically provided.

• **RESEARCH-URGENT BONE MARROW TRANSPLANT BENEFITS WITHIN NATIONAL INSTITUTES OF HEALTH CLINICAL TRIALS ONLY**

Bone Marrow Transplants that are otherwise excluded by the Contract as Experimental or Investigational (see ***Definitions*** and ***Exclusions***) are eligible for Benefits if the Bone Marrow Transplant meets all of the following criteria:

— It is therapeutic (not diagnostic or supportive) treatment used to directly improve health outcomes for a condition that is life threatening and that has a poor prognosis with the most effective conventional treatment. For purposes of this provision, a condition is considered life threatening if it has a substantial probability of causing premature death and all other conventional treatments have failed, or are not medically appropriate;

— The Bone Marrow Transplant is available to the Subscriber seeking it and will be provided within a clinical trial conducted or approved by the **National Institutes of Health**;

— The Bone Marrow Transplant is not available free or at a reduced rate; and

— The Bone Marrow Transplant is not excluded by another provision of the Contract.

Ambulatory Surgical Facility Services

Ambulatory Hospital-type services, not including Physicians' services, given to you in and by an Ambulatory Surgical Facility only when:

- Such services are Medically Necessary;
- An operative or cutting procedure which cannot be done in a Physician's office is actually performed; and
- The operative or cutting procedure is a Covered Service under this Certificate.

Services Related to Treatment of Autism and Autism Spectrum Disorders

Evaluation and management procedures, including Speech Therapy, Physical Therapy and Occupational Therapy, for treatment of autism and autism spectrum disorders, limited to the following diagnoses:

- Autistic disorder – childhood autism, infantile psychosis and Kanner's syndrome;
- Childhood disintegrative disorder – Heller's syndrome;
- Rett's syndrome; and
- Specified pervasive developmental disorders – Asperger's disorder, atypical childhood psychosis and borderline psychosis of childhood.

Speech Therapy, Physical Therapy and Occupational Therapy visits related to treatment of autism or autism spectrum disorders are not subject to the limitations specified under "Outpatient Therapy Services" as set forth in the ***Comprehensive Health Care Services*** section of this Certificate.

Benefits for treatment of autism and autism spectrum disorders are limited to Subscribers as follows:

- **Subscribers under age six shall be entitled to a combined maximum of 390 visits for Physical Therapy, Occupational Therapy and Speech Therapy per Benefit Period.**
- **Subscribers age six and older are subject to the limitations specified under "Outpatient Therapy Services" as set forth in the *Comprehensive Health Care Services* section of this Certificate.**

Psychiatric Care Services

We pay the scheduled amounts for the following Covered Services you receive from a Provider to treat Mental Illness.

- Inpatient Facility Services

  Covered Inpatient Hospital Services provided by a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider.

- Inpatient Medical Services

  Covered Inpatient Medical Services provided by a Physician or other Provider:

  — Medical Care visits **limited to one visit or other service per day**;

  — Individual Psychotherapy;

  — Group Psychotherapy;

— Psychological Testing; and

— Convulsive Therapy Treatment.

Electroshock treatment or convulsive drug therapy including anesthesia when given together with treatment by the same Physician or other Provider.

Benefits will not be provided for both an Inpatient Medical Care visit and Individual Psychotherapy when performed on the same day by the same Physician.

- Outpatient Psychiatric Care Services

  — Facility and Medical Services

  Covered Inpatient Facility and Medical Services when provided for the Outpatient treatment of Mental Illness by a Hospital, Psychiatric Hospital, Residential Treatment Center, Physician, or other Plan-approved Provider.

  — Day/Night Psychiatric Care Services

  Services of a Plan-approved facility on a day-only or night-only basis in a planned treatment program.

- Drug Abuse and Alcoholism

  Your Benefits for the treatment of Mental Illness include treatments for drug abuse and alcoholism.

Ambulance Services

- Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

  — From your home to a Hospital;

  — From the scene of an accident or medical emergency to a Hospital;

  — Between Hospitals;

  — Between a Hospital and a Skilled Nursing Facility; or

  — From the Hospital to your home.

- Ambulance Services means local transportation to the closest facility that can provide Covered Services appropriate for your condition. If none, you are covered for trips to the closest such facility outside your local area.

Private Duty Nursing Services

Services of a practicing RN, LPN or LVN when ordered by a Physician and when Medically Necessary. The nurse cannot be a member of your immediate family or usually live in your home.

Benefits for Private Duty Nursing Services are limited to 85 visits per Benefit Period per Subscriber.

Rehabilitation Care

Inpatient Hospital Services, including Physical Therapy, Speech Therapy and Occupational Therapy, provided by the rehabilitation department of a Hospital, or other Plan-approved rehabilitation facility, after the acute care stage of an illness or injury.

Rehabilitation Care is limited to 30 days of Inpatient care per Benefit Period per Subscriber.

Rehabilitation Care is subject to the Preauthorization guidelines of this Certificate (see "*Important Information*"). Failure to comply with these guidelines will result in a $500 reduction in Benefits for Rehabilitation Care if, upon receipt of a claim, Benefits are payable under this Certificate.

Skilled Nursing Facility Services

Covered Inpatient Hospital Services and supplies given to an Inpatient of a Plan-approved Skilled Nursing Facility.

Skilled Nursing Facility Services are limited to 100 days of Inpatient care per Benefit Period per Subscriber.

Skilled Nursing Facility Services are subject to the Preauthorization guidelines of this Certificate (see "*Important Information*"). Failure to comply with these guidelines will result in a $500 reduction in Benefits for Skilled Nursing Facility Services if, upon receipt of a claim, Benefits are payable under this Certificate.

No Benefits are payable:

- Once you can no longer improve from treatment; or
- For Custodial Care, or care for someone's convenience.

Home Health Care Services

We pay the scheduled amounts for the following Covered Services you receive from a Hospital program for Home Health Care or Community Home Health Care Agency, provided such program or agency is a Plan-approved Provider and the care is prescribed by a Physician:

- Medical and surgical supplies;
- Prescribed drugs;
- Home Infusion Therapy;
- Oxygen and its administration;
- **Up to 100 visits per Benefit Period per Subscriber, limited to the following:**
  - — Professional services of an RN, LPN, or LVN;
  - — Medical social service consultations;
  - — Health aide services while you are receiving covered nursing or Therapy Services;
  - — Services of a licensed registered dietician or licensed certified nutritionist, when authorized by the patient's supervising Physician and when Medically Necessary as part of diabetes self-management training.

Home Health Care is subject to the Preauthorization guidelines of this Certificate (see "*Important Information*"). Failure to comply with these guidelines will result in a $500 reduction in Benefits for Home Health Care if, upon receipt of a claim, Benefits are payable under this Certificate.

We do not pay Home Health Care Benefits for:

- Dietician services, except as specified for diabetes self-management training;
- Homemaker services;
- Maintenance therapy;
- Physical Therapy, Speech Therapy, or Occupational Therapy;
- Durable Medical Equipment;

- Food or home-delivered meals;
- Intravenous drug, fluid, or nutritional therapy, **except when you have received Preauthorization from the Plan for these services.**

Hospice Services

Care and services performed under the direction of your attending Physician in a Plan-approved Hospital Hospice Facility or in-home Hospice program.

Hospice Services are subject to the Preauthorization guidelines of this Certificate (see "*Important Information*"). Failure to comply with these guidelines will result in a $500 reduction in Benefits for Hospice Services, if, upon receipt of a claim, Benefits are payable under this Certificate.

Temporomandibular Joint Syndrome/Dysfunction

Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology. **Benefits for Temporomandibular Joint Dysfunction and related disorders are limited to $3,000 per Benefit Period per Subscriber.**

Oral Surgery/Dental Services for Accidental Injury

- Dental Services for accidental injury to the jaws, sound natural teeth, mouth or face. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an accidental injury, regardless of whether you knew the object or substance was capable of causing such injury if chewed or bitten.
- Surgery needed to cut out teeth completely impacted in the bone of the jaw, other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues; or to cut into gums and tissues of the mouth when not done in connection with the removal, replacement, or repair of teeth.

Diabetes Equipment, Supplies and Self-Management Services

- The following equipment, supplies and related services for the treatment of Type I, Type II, and gestational diabetes when Medically Necessary and when recommended or prescribed by a Physician or other Provider:
  - — Blood glucose monitors;
  - — Blood glucose monitors to the legally blind;
  - — Test strips for glucose monitors;
  - — Visual reading and urine testing strips;
  - — Insulin;
  - — Injection aids;
  - — Cartridges for the legally blind;
  - — Syringes;
  - — Insulin pumps and appurtenances thereto;

— Insulin infusion devices;

— Oral agents for controlling blood sugar;

— Podiatric appliances for prevention of complications associated with diabetes; and

— Other diabetes equipment and related services that are determined Medically Necessary by the Oklahoma State Board of Health, provided such equipment and supplies have been approved by the federal Food and Drug Administration (FDA).

- Diabetes self-management training in an Inpatient or Outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications. Diabetes self-management training must be conducted in accordance with the standards developed by the Oklahoma State Board of Health in consultation with a national diabetes association affiliated with this state and at least three medical directors of health benefit plans selected by the Oklahoma State Department of Health. Coverage for diabetes self-management training, including medical nutrition therapy relating to diet, caloric intake, and diabetes management (excluding programs the only purpose of which are weight reduction) shall be limited to the following:

  — Visits Medically Necessary upon the diagnosis of diabetes;

  — A Physician diagnosis which represents a significant change in the patient's symptoms or condition making Medically Necessary changes in the patient's self-management; and

  — Visits when reeducation or refresher training is Medically Necessary.

  Payment for the coverage required for diabetes self-management training in accordance with this provision shall be required only upon certification by the health care Provider providing the training that the patient has successfully completed diabetes self-management training.

  Diabetes self-management training and training related to medical nutrition therapy, when provided by a registered, certified, or licensed health care professional, shall also include home visits when Medically Necessary and shall include instruction in medical nutrition therapy only by a licensed registered dietician or licensed certified nutritionist when authorized by the patient's supervising Physician and when Medically Necessary.

Coverage for the equipment, supplies and self-management services specified above shall be provided in accordance with the terms and conditions of the appropriate Benefit section of this Certificate (for example: "Durable Medical Equipment" and "Home Health Care Services").

Services Related to Clinical Trials

Benefits for Routine Patient Costs when provided in connection with a phase I, phase II, phase III, or phase IV clinical trial, if the clinical trial is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

- A federally funded or approved trial;
- A clinical trial conducted under an FDA investigational new drug application; or
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

For purposes of this provision, "Routine Patient Costs" generally include all items and services consistent with the coverage provided under this benefit booklet for an individual with a similar condition who is not enrolled in a clinical trial. However, costs associated with the following are ***not*** Covered Services:

- The cost of the investigational item, device or service;
- The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management;
- The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- The cost for a clinical trial that does not meet criteria established by applicable law.

Durable Medical Equipment

The rental (or, at the Plan's option, the purchase if it will be less expensive) of Durable Medical Equipment, provided such equipment meets the following criteria:

- It provides therapeutic benefits or enables the Subscriber to perform certain tasks that he or she would be unable to perform otherwise due to certain medical conditions and/or illness;
- It can withstand repeated use and is primarily and customarily used to serve a medical purpose;
- It is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home; and
- It is prescribed by a Physician and meets the Plan's criteria of Medical Necessity for the given diagnosis.

Examples of Durable Medical Equipment are: wheelchairs, hospital beds, traction equipment, canes, crutches, walkers, kidney machines, ventilators, oxygen, and other Medically Necessary items. Also included are repairs, maintenance, and costs of delivery of equipment, as well as expendable and nonreusable items essential to the effective use of the equipment. Such repair and replacement is not included if the equipment is lost, damaged or destroyed due to improper use or abuse.

Durable Medical Equipment ***does not*** include equipment, or electrical or mechanical features to enhance basic equipment, that serves as a comfort or convenience (such as a computer). In addition, equipment used for environmental setting or surroundings of an individual are not included, such as air conditioners, air filters, portable Jacuzzi pumps, humidifiers, or modifications to the Subscriber's home or vehicle.

Certain items although durable in nature, may fall into other coverage categories, such as prosthetic appliances or orthotic devices.

Prosthetic Appliances

Devices, along with pertinent supplies, which replace all or part of an absent body organ and which are Medically Necessary for the alleviation or correction of conditions arising out of bodily injury or illness covered by this Certificate. Eyeglass lens, soft lens and contact lens are included if prescribed as part of postoperative treatment for cataract extraction. Implantation or removal of breast prostheses is a Covered Service only in connection with reconstructive breast Surgery performed solely and directly as a result of mastectomy which is Medically Necessary.

Benefits for replacement appliances will be provided only when Medically Necessary.

Orthotic Devices

A rigid or semi-rigid supportive device which limits or stops motion of a weak or diseased body part and which is Medically Necessary to restore you to your previous level of daily living activity. **Benefits for replacement of such devices will be provided only when Medically Necessary.**

Benefits will be provided for the following orthotic devices:

- Braces for the leg, arm, neck, back, or shoulder;
- Back and special surgical corsets;
- Splints for the extremities;
- Trusses.

Not covered are:

- Arch supports and other foot support devices;
- Elastic stockings;
- Garter belts or similar devices;
- Orthopedic shoes.

Wigs or Other Scalp Prostheses

Wigs or other scalp prostheses which are necessary for the comfort and dignity of the Subscriber, and which are required due to hair loss resulting from Radiation Therapy or Chemotherapy.

Benefits are limited to two wigs per Benefit Period per Subscriber.

Schedule of Benefits
Outpatient Prescription Drugs

This section shows the Copayment/Coinsurance amounts that apply to the Covered Services described in the ***Outpatient Prescription Drug Benefits*** section that follows**. Please note that services must be Medically Necessary in order to be covered under this program.**

BENEFIT PERIOD Calendar Year

COPAYMENT/COINSURANCE The Copayment or Coinsurance applicable to each Prescription Order is set forth below:

GENERIC & PREFERRED BRAND DRUGS	IN-NETWORK	OUT-OF-NETWORK
Cost of Rx: $100 or less	Member pays lesser of $25 or actual cost	Member pays cost of Rx up to $75 maximum plus dispensing fee
Cost of Rx: Greater than $100	Member pays 25% up to $50 maximum	Member pays cost of Rx up to $75 maximum plus dispensing fee
Out-of-Pocket Maximum	$2,500 per Individual	No maximum
Supply Limit (one month)	Greater of 34 days or 100 units	
Three month supply at retail or mail order for 1 Copayment		
Supply Limit (three month)	Greater of 102 days or 300 units	

NON-PREFERRED BRAND DRUGS	IN-NETWORK	OUT-OF-NETWORK
Cost of Rx: $100 or less	Member pays lesser of $50 or actual cost	Member pays cost of Rx up to $125 maximum plus dispensing fee
Cost of Rx: Greater than $100	Member pays 50% up to $100 maximum	Member pays cost of Rx up to $125 maximum plus dispensing fee
Out-of-Pocket Maximum	No maximum	No maximum
Supply Limit (one month)	Greater of 34 days or 100 units	
Three month supply at retail or mail order for 1 Copayment		
Supply Limit (three month)	Greater of 102 days or 300 units	

Outpatient Prescription Drug Benefits

Subject to the Exclusions, conditions, and limitations of this Certificate, a Subscriber is entitled to the Benefits of this section for covered Outpatient Prescription Drugs and related services, subject to the Copayment or Coinsurance amounts specified in the ***Schedule of Benefits for Outpatient Prescription Drugs.***

Covered Services

Benefits are provided for Outpatient Prescription Drugs and related services, limited to the following:

- Prescription Drugs dispensed for a Subscriber's Outpatient use, when recommended by and while under the care of a Physician or other Provider;
- Injectable insulin and insulin products, but only when dispensed in accordance with a written prescription by a licensed Physician;
- Oral contraceptives, when prescribed by a licensed Physician;
- Prescription smoking cessation products for treatment of nicotine addiction;
- Fertility treatment medications;
- Prescription Drugs prescribed for treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD), subject to the Plan's guidelines for Preauthorization;
- Special Pharmacy Drugs (when dispensed by a Pharmacy participating in the Specialty Pharmacy Network), **limited to a 30-day supply per Prescription Order;**
- Vaccinations (when administered by a participating Retail Pharmacy Vaccination Network Provider). Visit the Plan's Web site at www.bcbsok.com for a current listing of vaccines available through this program;
- Oral Chemotherapy, when prescribed by a license Physician;
- Self-injectable Prescription Drugs (including Chemotherapy), when dispensed by a Pharmacy. Self-injectable drugs purchased from a Physician and administered in his/her office are not covered. **NOTE:** Many self-injectable drugs are classified as "Specialty Pharmacy Drugs" and must be purchased from a Participating Specialty Pharmacy in order for you to receive the maximum Benefits under this program.

Mail-Order Pharmacy Program

All items that are covered under the Mail Order Service are the same items that are covered under the Retail Pharmacy Program and are subject to the same limitations and exclusions. **Items covered through a Specialty Pharmacy may not be covered through the Mail Order Service.** NOTE: Prescription Drugs and other items may not be mailed outside the United States. Extended supplies or vacation overrides required when you are outside the United States may be approved through the Retail Pharmacy Program only.

Only maintenance drugs are available through the Plan's Mail Order Service.

Payment of Benefits

- Benefits are provided for Prescription Drugs dispensed for a Subscriber's Outpatient use when recommended by and while under the care of a Physician or other Provider, provided such care and treatment is Medically Necessary.

- Benefits for Prescription Drugs are available to the Subscriber only:

  — in accordance with a Prescription Order; and

  — after the Subscriber has Incurred charges equal to the Copayment or Coinsurance applicable to each Prescription Order. **If the charge for your Prescription is less than your Copayment or Coinsurance you will pay the lesser amount.**

- When Prescription Drugs are dispensed by a Participating Pharmacy the Plan will pay directly to the Pharmacy the Allowable Charge for the drugs, less the applicable Copayment or Coinsurance specified in the ***Schedule of Benefits for Outpatient Prescription Drugs***.

- If your Prescription Order is filled by an Out-of-network Pharmacy, you will need to pay the full cost of the drugs directly to the Pharmacy and then submit a claim to the Plan in order to receive any Benefits under this program. In addition to any Deductible, Copayment and/or Coinsurance amounts applicable to your coverage, you will be responsible for the cost difference, if any, between the Pharmacy's billed charges and the Allowable Charge determined by the Plan.

- Charges Incurred for Prescription Drugs do not count toward satisfaction of the Deductible or Out-of-Pocket Limit which apply to Comprehensive Health Care Services (set forth in the ***Schedule of Benefits for Comprehensive Health Care Services***).

PRESCRIPTION DRUG SUPPLY/DISPENSING LIMITS

The Plan has the right to determine the day supply or unit dosage limits at its sole discretion. Payment for Benefits covered under your Certificate may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum supply limitations.

- **Benefit Supply Limits per Prescription**

  For each Copayment amount specified for your Prescription Drug Program, you can obtain the following supply of a single Prescription Drug or other item covered under this program (unless otherwise specified).

  Benefits will be provided for Prescription Drugs dispensed in the following quantities:

- Benefits will be provided for Prescription Drugs dispensed in the following quantities:

  — Greater of 34 days or 100 units for a one month supply; or

  — Greater of 102 days or 300 units for a three month supply.

  Prescription Drug Benefits are not provided under this Certificate for charges for Prescription Drugs dispensed in excess of the above stated amounts.

- Benefits will not be provided for a prescription refill until 75% of the previous Prescription Order has been used by the Subscriber.

  For commercially packaged items (such as an inhaler, a tube of ointment, or a blister pack of tablets or capsules), you will pay the applicable Copayment amount for each package, regardless of the days' supply the package represents. For example, if two inhalers are purchased under the retail Pharmacy, two Copayment amounts will apply. Under the mail-order program, you can receive up to three times the number of packages obtainable from a retail Pharmacy for the applicable mail-order Copayment amount.

  Benefits are not provided under your Certificate for charges for Prescription Drugs dispensed in excess of the above stated amounts.

If you are leaving the country or need an extended supply of medication, call Customer Service at least two weeks before you intend to leave. Extended supplies or vacation override are not available through the mail-order program but may be approved through a retail Pharmacy only. In some cases, you may be asked to provide proof of continued enrollment eligibility under this Prescription Drug program.

NOTE: The Prescription Drug quantity limits specified above shall supersede any previous quantity limits specified in your Certificate or in any amendment issued thereto.

- **Clinical Dispensing Limits Applicable to Certain Drugs**

  In addition to the supply limits stated above and regardless of the quantity of a covered drug prescribed by a Physician, the Plan has the right to establish dispensing limits on covered drugs. These limits, which are based upon FDA dosing recommendations and nationally recognized clinical guidelines, identify gender or age restrictions, and/or the maximum quantity of a drug (or member of a drug class) that can be dispensed to you over a specific period of time. Such limits are in place to encourage appropriate drug use, patient safety, and reduce stockpiling. Benefits for a covered drug may also be denied if the drug is dispensed or delivered in a manner intended to avoid the Plan-established dispensing limit. If you need a drug quantity that exceeds the dispensing limit, ask your doctor to submit a request for review to the Plan on your behalf. The Preauthorization request will be approved or denied after the clinical information submitted by the prescribing doctor has been evaluated by the Plan.

EXCLUSIONS AND LIMITATIONS

In addition to the exclusions and limitations specified in the ***Exclusions*** section of your Certificate, no Benefits will be provided under this ***Outpatient Prescription Drug Benefits*** section for:.

- Drugs which by law do not require a Prescription Order from an authorized Provider (except insulin, insulin analogs, insulin pens, and prescriptive and nonprescriptive oral agents for controlling blood sugar level); and drugs, insulin or covered devices for which no valid Prescription Order is obtained.

- Devices or Durable Medical Equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except glucose meters, lancets, test strips and disposable hypodermic needles and syringes for self-administered injections.) However, coverage for prescription contraceptive devices is provided under the ***Comprehensive Health Care Services*** section of your Certificate.

- Administration or injection of any drugs (except for vaccines administered by a Participating Pharmacy).

- Vitamins (**except** those vitamins which by law require a Prescription Order for which there is no non-prescription alternative).

- Drugs dispensed in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.

- Prescription Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, including, but not limited to, any services or supplies for which benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any Prescription Drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that this exclusion shall not be applicable to any coverage held by you for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

- Any services provided or items furnished for which the Pharmacy normally does not charge.
- Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use," or Experimental drugs, even though a charge is made for the drugs.
- Prescription Drugs or devices dispensed in quantities in excess of the amounts stipulated in this ***Outpatient Prescription Drug Benefits*** section; or refills of any prescriptions in excess of the number of refills specified by the Physician or by law; or any drugs or medicines dispensed more than one year following the Prescription Order date.
- Drugs which are not approved by the U.S. food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
- Fluids, solutions, nutrients, medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intravascular (in the joint) injection in the home setting, except as specifically provided in this Certificate. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
- Drugs the use or intended use of which would be illegal unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
- Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
- Athletic performance enhancement drugs.
- Compounded medications. For purposes of this exclusion, "compounded medications" are substances made by mixing, reconstituting or other such acts, not in accordance with directions contained in Food and Drug Administration (FDA) approved labeling provided by the product's manufacturer and other FDA-approved manufacturer directions consistent with that labeling.
- Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced.
- Shipping, handling, or delivery charges.
- Drugs which are repackaged by anyone other than the original manufacturer.

Brand Name Drug Exclusion

Some equivalent drugs are manufactured under multiple brand names and have many therapeutic equivalents. In such cases, the Plan may limit Benefits to only one of the brand or therapeutic equivalents available. If you do not accept the brand or therapeutic equivalent that is covered under your Prescription Drug program, the drug purchased will not be covered under any Benefit level.

Prescription Drug Preauthorization Process

The Plan has designated certain drugs which require prior approval (Preauthorization) in order for Benefits to be available under this Certificate. Preauthorization helps to assure that your Prescription Drug meets the Plan's guidelines for Medical Necessity for the condition being treated.

A form of Preauthorization is our Step Therapy program — a "step" approach to providing Benefits for certain medications your Physician prescribes for you. This means that you may first need to try one or more "prerequisite" medications before certain high-cost medications are approved for coverage under your Prescription Drug program.

If your Physician prescribes a drug requiring prior approval, you may obtain your prescription from a Participating Pharmacy by following one of the following steps:

- **You may obtain approval prior to going to the Pharmacy to have your prescription filled.**

  You can obtain a listing of the drugs which require Preauthorization by contacting a Customer Service Representative at 1-800-94 BLUES (1-800-942-5837). Or, you may request a listing by writing to Blue Cross and Blue Shield of Oklahoma, P. O. Box 3283, Tulsa, Oklahoma 74102-3283.

  Please keep in mind that the listing of drugs requiring Preauthorization will change periodically as new drugs are developed or as required to assure Medical Necessity.

  If your Physician prescribes a drug which requires prior approval, you or the Physician may request Preauthorization by calling the Customer Service number listed above.

  When you present your prescription to a Participating Pharmacy, along with your Blue Cross and Blue Shield of Oklahoma Identification Card, the pharmacist will submit an electronic claim to the Plan to determine the appropriate Benefits.

  If the Preauthorization request is approved prior to your trip to the Participating Pharmacy, your pharmacist will dispense the Prescription Drug as prescribed and collect any applicable Copayment and/or Coinsurance amount.

  If the Preauthorization request was denied, the pharmacist will receive an electronic message indicating that Benefits are not available for the drugs. You will be responsible for the full cost of your prescription.

- **Your Participating Pharmacy may begin the Preauthorization process for you.**

  If you do not request approval of a drug before you go to the Pharmacy to have your prescription filled, your pharmacist will begin the Preauthorization process when you present your Blue Cross and Blue Shield of Oklahoma Identification Card with your Prescription Order. When the pharmacist submits your claim electronically, he/she will receive a message indicating that Preauthorization is required.

  At this point, you may request a three-day supply of the drug while the Plan completes the approval process. Your pharmacist will collect the appropriate Copayment and/or Coinsurance amount from you at the time of purchase.

  Once the three-day supply has been used, you may return to the Pharmacy to obtain the remainder of your Prescription Order. The Participating Pharmacy will resubmit the claim electronically to determine whether the Preauthorization request has been approved or denied.

  — If Preauthorization is approved for the drug, you may return to the Pharmacy to obtain the full Prescription Order, subject to any Copayment and/or Coinsurance amount applicable to the balance of the drug quantity dispensed.

  — If the Preauthorization is denied, you may obtain your Prescription Order by paying the full cost for the drugs.

  — Regardless of the Plan's decision, you will be notified in writing regarding the outcome of your Preauthorization approval request.

  If you purchase your prescriptions from an Out-of-Network (non-participating) Pharmacy, or if you do not have your Identification Card with you when you purchase your prescriptions, it will be your responsibility to pay the full cost of the Prescription Drugs and to submit a claim form (with your itemized receipt) to receive any Benefits available under your Prescription Drug program. Send the completed claim form to:

Blue Cross and Blue Shield of Oklahoma
Prescription Drug Claims
P. O. Box 3283
Tulsa, Oklahoma 74102-3283

If the drug you received is one which requires prior approval, the Plan will review the claim to determine if Preauthorization approval would have been given. If so, Benefits will be processed in accordance with your Prescription Drug coverage. If the Preauthorization approval is denied, no Benefits will be available for the Prescription Order.

To view a listing of the drugs which are included in the Preauthorization/Step Therapy program, please visit our Web site at http://www.bcbsok.com. If you have questions about Step Therapy, or any other aspects of the Preauthorization process, please call 1-800-942-5837 for assistance.

Exclusions

This section lists what is not covered. We want to be sure that you do not expect Benefits that are not included in this Certificate.

WHAT IS NOT COVERED

Except as otherwise specifically stated in this Certificate, we do not provide Benefits for services, supplies or charges:

- Which are not prescribed by or performed by or upon the direction of a Physician or other Provider.
- Which we determine are not Medically Necessary, except as specified.
- Received from other than a Provider.
- Which are in excess of the Allowable Charge, as determined by the Plan.
- Which the Plan determines are Experimental/Investigational in nature.
- For any illness or injury occurring in the course of employment if whole or partial compensation or benefits are or might have been available under the laws of any governmental unit; any policy of workers' compensation insurance; or according to any recognized legal remedy arising from an employer–employee relationship. This applies whether or not you claim the benefits or compensation or recover the losses from a third party.
  - — You agree to:
    - ○ pursue your rights under the workers' compensation laws;
    - ○ take no action prejudicing the rights and interests of the Plan; and
    - ○ cooperate and furnish information and assistance the Plan requires to help enforce its rights.
  - — If you receive any money in settlement of your employer's liability, regardless of whether the settlement includes a provision for payment of your medical bills, you agree to:
    - ○ hold the money in trust for the benefit of the Plan to the extent that the Plan has paid any Benefits or would be obligated to pay any Benefits; and
    - ○ repay the Plan any money recovered from your employer or insurance carrier.
- To the extent payment has been made under Medicare or would have been made if you had applied for Medicare and claimed Medicare benefits, or to the extent governmental units provide benefits (some state or federal laws may affect how we apply this exclusion).
- For any illness or injury suffered after the Subscriber's Effective Date as a result of war or act of war declared or undeclared) when serving in the military or an auxiliary unit thereto.
- For which you have no legal obligation to pay in the absence of this or like coverage.
- Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.

- For cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless:

  — needed to repair conditions resulting from an accidental injury; or

  — for the improvement of the physiological functioning of a malformed body member, except for services related to Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue.

  In no event will any care and services for breast reconstruction or implantation or removal of breast prostheses be a Covered Service unless such care and services are performed solely and directly as a result of mastectomy which is Medically Necessary.

- Received from a member of your immediate family.

- Received before your Effective Date.

- For any Inpatient care and services, including rehabilitation care and services, unless documentation can be provided that, due to the nature of the services rendered or your condition, you cannot receive safe or adequate care as an Outpatient.

- Received after your coverage stops.

- For personal hygiene and convenience items regardless of whether or not recommended by a Physician or other Provider. Examples include: computers; air conditioners, air purifiers or filters; humidifiers; physical fitness equipment, including exercise bicycles or treadmills; or modifications to your home or vehicle.

- For telephone consultations, email or other electronic consultations, missed appointments, or completion of a claim form.

- For Custodial Care such as sitters' or homemakers' services, care in a place that serves you primarily as a residence when you do not require skilled nursing, or for rest cures.

- For foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular and bone Surgery), calluses, toenails, and the like.

- For routine, screening or periodic physical examinations, except as specified in the ***Comprehensive Health Care Services*** section.

- For reverse sterilization.

- For female contraceptive devices when not prescribed by a licensed Provider, including over-the-counter contraceptive products. Contraceptive medication or devices for male use are excluded.

- For Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue (including complications resulting therefrom), except for:

  — the treatment of accidental injury to the jaw, sound natural teeth, mouth or face; or

  — for the improvement of the physiological functioning of a malformed body member.

  Benefits are not provided for dental implants, grafting of alveolar ridges, or for any complications arising from such procedures.

- For or related to Inpatient treatment of any non-covered dental procedure, except that coverage shall be provided for Hospital Services, Ambulatory Surgical Facility Services, and anesthesia services associated with any Medically Necessary dental procedure when provided to a Subscriber who is:

— severely disabled; or

— eight years of age or under;

and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care.

- For eyeglasses, contact lenses or examinations for prescribing or fitting them, except for aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury. Vision examinations not related to the prescription or fitting of lenses will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury. Eye refractions are not covered in any event.
- For eye Surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- For hearing aids, tinnitus maskers, or examinations for prescribing or fitting them, except as specified in the ***Comprehensive Health Care Services*** section. Hearing examinations not related to the prescription or fitting of hearing aids will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury.
- For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
- For treatment or medications for infertility and fertilization procedures. Examples include any form of: artificial insemination; ovulation induction procedures; in vitro fertilization; embryo transfer; or any other procedures, supplies or medications which in any way are intended to augment or enhance your reproductive ability.
- For treatment of sexual problems not caused by organic disease.
- 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.
- For Prescription Drugs prescribed and used for cosmetic purposes.
- For or related to acupuncture, whether for medical or anesthesia purposes.
- For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for Inpatient confinement for environmental change. This exclusion ***shall not*** apply to the following Medically Necessary services:

  — Physicians' services (except for neuropsychological testing) related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) for Subscribers; or

  — Prescription Drug therapy (provided this Certificate includes Benefits for Outpatient Prescription Drugs) for treatment of ADD/ADHD in Subscribers.
- For unspecified developmental disorders or autistic disease of childhood, except as specified.
- For or related to applied behavior analysis.
- For family or marital counseling.
- For hippotherapy, equine assisted learning, or other therapeutic riding programs.
- For which the Provider of service customarily makes no direct charge to a Subscriber.

- Received from a Skilled Nursing Facility, Home Health Care Agency, Hospice, or rehabilitation facility which is not a Plan–approved Provider.
- For treatment of temporomandibular joint dysfunction, including but not limited to diagnostic procedures, splints, orthodontic/orthopedic appliances, restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alteration of teeth or jaws, Physical Therapy, and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.
- For or related to transplantation of donor organs, tissues or bone marrow, except as specified under ***"Human Organ, Tissue and Bone Marrow Transplant Services"***.
- For Physician standby services.
- For Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for the following surgical procedures: total knee arthroplasty, anterior cruciate ligament reconstruction, or open reduction and internal fixation of tibial plateau for distal femur fractures involving the knee joint.
- For ductal lavage of the mammary ducts.
- For extracorporeal shock wave treatment, also known as orthotripsy, using either a high– or low–dose protocol, for treatment of plantar fasciitis and all other musculoskeletal conditions.
- For orthoptic training.
- For thermal capsulorraphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.
- For transcutaneous electrical nerve stimulator (TENS).
- For Inpatient drug and alcohol treatment that is not rendered in a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan–approved Provider.
- For elective abortion, unless the life or health of the mother is endangered.
- For massage therapy, including but not limited to effleurage, petrissage and/or tapotement.
- Which are not specifically named as Covered Services subject to any other specific Exclusions and limitations in this Certificate.

General Provisions

This section tells:

- The Benefits to which you are entitled;
- How to get Benefits;
- Your relationship with Hospitals, Physicians, and other Providers;
- Your relationship with us;
- Coordination of Benefits when you have other coverage.

Benefits to Which You Are Entitled

We provide only the Benefits specified in this Certificate.

Only Subscribers are entitled to Benefits from us and they may not transfer their rights to Benefits to anyone else.

Benefits for Covered Services specified in this Certificate will be covered only for those Providers specified in this Certificate.

Prior Approval

The Plan does not give prior approval or guarantee Benefits for any services through its Preauthorization process, or in any oral or written communication to Subscribers or other persons or entities requesting such information or approval.

Notice and Properly Filed Claim

The Plan will not be liable under this Certificate unless proper notice is furnished to the Plan that Covered Services have been rendered to you. Upon receipt of written notice, the Plan will furnish claim forms to you for submitting a Properly Filed Claim. If the forms are not furnished within 15 days after the Plan receives your notice, you can comply with the Properly Filed Claim requirements by forwarding to the Plan, within the time period set forth below, written proof covering the occurrence, character and extent of loss for which the claim is made.

Your Properly Filed Claim must be furnished to the Plan within 180 days after the end of the Benefit Period for which claim is made.

Failure to provide a Properly Filed Claim to the Plan within the time specified above will not reduce any Benefit if you show that the claim was given as soon as reasonably possible.

Limitation of Actions

No legal action may be taken to recover Benefits within 60 days after a Properly Filed Claim has been made. No such action may be taken later than three years after expiration of the time within which a Properly Filed Claim is required by this Certificate.

PAYMENT OF BENEFITS

You authorize us to make payments directly to Providers giving Covered Services for which we provide Benefits under this Certificate. We also reserve the right to make payments directly to you.

You cannot assign your right to receive payment to anyone else, either before or after Covered Services are received.

Once a Provider gives a Covered Service, we will not honor a request not to pay the claims submitted.

Benefits under this Certificate will be based upon the Allowable Charge (as we determine) for Covered Services. A BlueChoice Provider will accept the Allowable Charge as payment in full and will make no additional charge to you for Covered Services. However, if you receive Covered Services from an Out-of-Network Provider, you may be responsible for amounts which exceed the Allowable Charge, in addition to the Deductible and/or Coinsurance amounts.

In some cases, Covered Services may be rendered by a Provider who has a Participating Provider Agreement (*other than a Provider Agreement)* with the Plan. These Providers (called BlueTraditional Providers) have agreed to charge Plan Subscribers no more than a "Maximum Reimbursement Allowance" for Covered Services. Subscribers who use BlueTraditional Providers are responsible for amounts over the "Allowable Charge," *up to but not exceeding* the "Maximum Reimbursement Allowance" specified in the Provider's Participating Provider Agreement.

OUT-OF-AREA SERVICES

Blue Cross and Blue Shield of Oklahoma has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs". Whenever you obtain health care services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

Typically, when accessing care outside our service area, you will obtain care from health care Providers that have a contractual agreement (i.e., are "participating or network providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating or out-of-network health care Providers. Our payment practices in both instances are described below.

- **BlueCard® Program**

  Under the BlueCard® Program, when you access Covered Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care Providers.

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

  — The billed charges for your Covered Services; or

  — The negotiated price that the Host Blue makes available to us.

  Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

- **Non-Participating Health Care Providers Outside the Blue Cross and Blue Shield of Oklahoma Service Area**

  — **Subscriber Liability Calculation**

  When Covered Services are provided outside of our service area by non-participating health care Providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating health care Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating health care Provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

  If you need Emergency Care, Blue Cross and Blue Shield of Oklahoma will cover you at the highest level that federal regulations allow. You will have to pay for any charges that exceed the Allowable Charge as well as for any Deductibles, Copayments, Coinsurance and amounts that exceed any Benefit maximums.

  — **Exceptions**

  In certain situations, the Host Plan's pricing may be unavailable. In that event, we will calculate the pricing for your claim in accordance with the "Allowable Charge" provisions set forth in the ***Important Information*** and ***Definitions*** sections of your Certificate. In these situations, you may be liable for the difference between the amount that the non-participating health care Provider bills and the payment we make for the Covered Services.

NOTE: Blue Cross and Blue Shield of Oklahoma may postpone application of your Copayment, Deductible and/or Coinsurance amounts whenever it is necessary so that we may obtain a Provider discount for you on Covered Services you receive outside the state of Oklahoma.

Member Data Sharing

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of Oklahoma, a division of Health Care Service Corporation, or, if you do not reside in the Blue Cross and Blue Shield of Oklahoma service area, by the Host Blue whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in various circumstances, such as from involuntary termination of your health coverage sponsored by the Employer. As part of the overall plan of Benefits that Blue Cross and Blue Shield of Oklahoma offers to you, if you do not reside in the Blue Cross and Blue Shield of Oklahoma service area, Blue Cross and Blue Shield of Oklahoma may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this we may (1) communicate directly with you and/or (2) provide the Host Blue whose service area covers the geographic area in which you reside, with your personal information and may also provide other general information relating to your coverage under the Certificate the Employer has with Blue Cross and Blue Shield of Oklahoma to the extent reasonably necessary to enable the relevant Host Blue to offer you coverage continuity through replacement coverage.

Determination of Benefits and Utilization Review

The Plan, as claims administrator, is hereby granted discretionary authority to interpret the terms and conditions of the Contract and to determine its Benefits.

In determining whether services or supplies are Covered Services, the Plan will determine whether a service or supply is Medically Necessary under the Plan or if such service or supply is Experimental or Investigational. Blue Cross and Blue Shield of Oklahoma medical policies are used as guidelines for coverage determinations in health care benefit programs unless otherwise indicated. Medical technology is constantly evolving and these medical policies are subject to change. Copies of current medical policies may be obtained from the Plan upon request and may be found on the Plan's Web site at www.bcbsok.com.

The Plan's medical staff may conduct a medical review of your claims to determine that the care and services received are Medically Necessary. In the case of Inpatient claims, the Plan must also determine that the care and services were provided in the most appropriate level of care consistent with your discharge diagnosis.

The fact that a Physician or other Provider prescribes, orders, recommends or approves a service or supply does not, of itself, make it Medically Necessary or a Covered Service, even if it is not specifically listed as an exclusion under this Certificate.

To assist the Plan in its review of your claims, the Plan may request that:

- you arrange for medical records to be provided to the Plan; and/or
- you submit to a professional evaluation by a Provider selected by the Plan, at the Plan's expense; and/or
- a Physician consultant or panel of Physicians or other Providers appointed by the Plan review the claim.

Failure of the Subscriber to comply with the Plan's request for medical records or medical evaluation may result in Benefits being partially or wholly denied.

Subscriber/Provider Relationship

The choice of a Provider is solely yours.

Providers are not employees, agents or other legal representatives of Blue Cross and Blue Shield of Oklahoma.

We do not furnish Covered Services but only pay for Covered Services you receive from Providers. We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Our reference to Providers as "BlueChoice," "BlueCard" or "Out-of-Network" is not a statement or warranty about their abilities or professional competency.

Agency Relationships

The Group is your agent, not our agent.

Providers are not employees, agents or other legal representatives of Blue Cross and Blue Shield of Oklahoma.

Coordination of Benefits

All Benefits provided under this Certificate are subject to this provision.

- **Definitions**

  In addition to the definitions of this Certificate, the following definitions apply to this provision.

  "Other Contract" means any arrangement, except as specified below, providing health care benefits or services through:

— Group, blanket or franchise insurance coverage;

— Blue Cross Plan, Blue Shield Plan, Health Maintenance Organization, and other prepayment coverage;

— Coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans;

— Coverage toward the cost of which any employer has contributed, or with respect to which any employer has made payroll deduction; and

— Coverage under any tax supported or government program to the extent permitted by law.

Coverage under specific benefit arrangements, such as dental care or vision care benefit plans that are not part of a comprehensive health care benefit plan, shall be excluded from the definition of "Other Contract" herein.

"Covered Service" additionally means a service or supply furnished by a Hospital, Physician, or other Provider for which benefits are provided under at least one contract covering the person for whom claim is made or service provided.

"Dependent" additionally means a person who qualifies as a Dependent under an Other Contract.

- **Effect On Benefits**

  If the total Benefits for Covered Services to which you would be entitled under the Group Contract and all Other Contracts exceed the Covered Services you receive in any Benefit Period, then the Benefits we provide for that Benefit Period will be determined according to this provision.

  When we are primary, we will pay Benefits for Covered Services without regard to your coverage under any Other Contract.

  When we are secondary, the Benefits we pay for Covered Services will be reduced so that the total Benefits payable under the Group Contract and all Other Contracts will not exceed the balance of Allowable Charges remaining after the benefits of Other Contracts are applied to Covered Services.

- **Order Of Benefit Determination**

  — When a person who received care is covered as an employee under one group contract, and as a Dependent under another, then the employee coverage pays first.

  — When a Dependent child is covered under two group contracts, the contract covering the child as a Dependent of the parent whose birthday falls earliest in the Calendar Year pays first. (If one contract does not follow the "birthday rule" provision, then the rule followed by that contract is used to determine the order of benefits.)

    However, when the Dependent child's parents are separated or divorced, the following rules apply:

    ◦ If the parent with custody of the child has not remarried, the coverage of the parent with custody pays first;

    ◦ When a divorced parent with custody has remarried, the coverage of the parent with custody pays first and the stepparent's coverage pays second before the coverage of the parent who does not have custody.

    ◦ Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

    ◦ When none of the above circumstances applies, the coverage you have had for the longest time pays first, except that a contract which covers you as a laid-off or retired employee or as a Dependent of such

person pays after a contract which covers you as other than a laid-off or retired employee or Dependent of such person.

— When the Plan requests information from another carrier to determine the extent or order of your benefits under an Other Contract, and such information is not furnished after a reasonable time, then the Plan shall:

  ○ Assume the Other Contract is required to determine its benefits first;

  ○ Assume the benefits of the Other Contract are identical to the Benefits of this coverage and pay its Benefits accordingly.

  Once the Plan receives the necessary information to determine your benefits under the Other Contract and to establish the order of benefit determination under the rules listed above, prior payments under this coverage will be adjusted accordingly (if the above rules require it).

— If the other carrier reduces your benefits because of payment you received under this coverage and the above rules do not allow such reduction, then the Plan will advance the remainder of its full Benefits under this coverage as if your Benefits had been determined in absence of an Other Contract. **However, the Plan shall be subrogated to all of your rights under the Other Contract.** You must furnish all information reasonably required by the Plan in such event, and you must cooperate and assist the Plan in recovery of such sums from the other carrier.

— If the other carrier later provides benefits to you for which the Plan has made payments or advances under this Coordination of Benefits provision, you must hold all such payments in trust for the Plan and must pay such amount to the Plan upon receipt.

- **Facility Of Payment**

  If payment is made under any Other Contract which we should have made under this provision, then we have the right to pay whoever paid under the Other Contract the amount we determine is necessary under this provision. Amounts so paid are Benefits under the Contract and we are discharged from liability to the extent of such amounts paid for Covered Services.

- **Right Of Recovery**

  If we pay more for Covered Services than this provision requires, we have the right to recover the excess from anyone to or for whom the payment was made. You agree to do whatever is necessary to secure our right to recover the excess payment.

PLAN'S RIGHT OF RECOUPMENT

You agree to reimburse us for Benefits we have paid and for which you were not eligible under the terms of the Contract. This payment is due and payable immediately when you are notified by the Plan. Also, we have the sole right to determine that any overpayments, wrong payments, or any excess payments made for you under this Certificate are an indebtedness which we may recover by deducting it from any future Benefits under this Certificate, or under any other coverage provided by the Plan. Our acceptance of your premiums or payment of Benefits under this Certificate does not waive our rights to enforce these provisions in the future.

To the extent the Plan provides or pays Benefits for Covered Services for any injury, illness or condition which occurs through the omission or commission of any act by another person, each Subscriber agrees that the Plan shall have a first lien on any settlement proceeds, and the Subscriber shall reimburse and pay the Plan, on a first-priority basis, from any money recovered by suit, settlement, judgment or otherwise from another party or his or her insurer or from any carrier providing uninsured/underinsured motorist coverage. Each Subscriber shall reimburse the Plan on a first-priority basis regardless of whether a lawsuit is actually filed or not and, if settled, regardless of how the settlement is structured or which items of damages are included in the settlement, and regardless of whether or not he or she is made whole or is fully compensated for any injuries. The Plan expressly disclaims all make whole and common fund rules and doctrines and any other rule or doctrine that would impair or interfere with the Plan's rights herein.

You must hold in trust for us any money (up to the amount of Benefits we have paid) you recover, as described above. You must give us information and assistance and sign necessary documents to help us enforce our rights.

Limitations on Plan's Right of Recoupment/Recovery

The Plan will not seek recovery of any excess or erroneous payment made under this Certificate more than 24 months after the payment is made, unless;

- the payment was made because of fraud committed by the Subscriber or the Provider; or
- the Subscriber or Provider has otherwise agreed to make a refund to the Plan for overpayment of a claim.

Plan/Association Relationship

Each Subscriber hereby expressly acknowledges his/her understanding that the Group Contract constitutes a contract solely between the Group and Blue Cross and Blue Shield of Oklahoma. Blue Cross and Blue Shield of Oklahoma is a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"). The license from the Association permits Blue Cross and Blue Shield of Oklahoma to use the Blue Cross and Blue Shield Service Marks in the State of Oklahoma. Blue Cross and Blue Shield of Oklahoma is not contracting as the agent of the Association. It is further understood that the Group has not entered into the Group Contract based upon representations by any person other than Blue Cross and Blue Shield of Oklahoma. No person, entity, or organization other than Blue Cross and Blue Shield of Oklahoma shall be held accountable or liable to the Group or its Subscribers for any of Blue Cross and Blue Shield of Oklahoma's obligations to the Group or Subscribers created under the Group Contract. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Oklahoma other than those obligations created under other provisions of the Group Contract.

The Plan's Separate Financial Arrangements with Prescription Drug Providers

The Plan hereby informs you that it has contracts, either directly or indirectly, with Participating Prescription Drug Providers for the provision of, and payment for, Prescription Drug services to all persons entitled to Prescription Drug Benefits under individual certificates, group health insurance policies and contracts to which the Plan is a party, including this Certificate, and that pursuant to the Plan's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, the Plan may receive discounts for Prescription Drugs dispensed to you. Actual discounts used to calculate your share of the cost of Prescription Drugs will vary. Some discounts are currently based on Average Wholesale Price ("AWP") which is determined by a third party and is subject to change.

You understand that Blue Cross and Blue Shield may receive such discounts. You are not entitled to receive any portion of any such discounts. The drug fees/discounts that Blue Cross and Blue Shield has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management ("PBM") Agreement, will be used to calculate your share of the cost of Prescription Drugs for both retail and mail/specialty drugs. Except for mail/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed-through to the Plan (and ultimately to you as described above).

For the mail pharmacy and specialty pharmacy program owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail pharmacy and/or specialty pharmacy program. The Plan pays a fee to Prime for pharmacy benefit services. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, claims processing, customer service response, and mail-order processing.

"Weighted paid claim" refers to the methodology of counting claims for purposes of determining Blue Cross and Blue Shield's fee payment to Prime. Each retail (including claims dispensed through PBM's specialty pharmacy program) paid claim equals one weighted paid claim; each extended supply or mail order (including Mail Service) paid claim equals three weighted paid claims. However, Blue Cross and Blue Shield pays Prime a Program Management Fee ("PMF") on a per paid claim basis. "Funding Levers" means a mechanism through which the Plan funds the fees (net fee, ancillary fees and special project fees) owed to PBM. Funding Levers always include manufacturer administrative fees, mail order utilization, participating pharmacy transaction frees, and, if elected by the Plan, may include rebates and retail spread. The Plan's net fee owed to Prime for core services will be offset by the Funding Levers. The Plan pays Prime the net fee for core services, ancillary fees and special project fees, offset by all applicable Funding Levers as agreed upon under the terms of its agreement with Prime. The net fee is calculated based on a fixed dollar amount per Weighted Paid Claim.

The amounts received by Prime from the Plan, pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to the Plan (as described above), administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of the fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this Certificate. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 3% of the total sales for all rebatable products of such manufacturer dispensed during any given calendar year to members of the Plan and other Blue Plan operating divisions.

The Plan's Separate Financial Arrangements With Pharmacy Benefit Managers

The Plan hereby informs you that it owns a significant portion of the equity of Prime and that the Plan has entered into one or more agreements with Prime or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, Prescription Drug Benefits to all persons entitled to Prescription Drug Benefits under individual certificates, group health insurance policies and contracts to which the Plan is a party, including this Certificate. Pharmacy Benefits managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. In addition, Prime's mail order pharmacy and other PBM services operate through the same entity, Prime Therapeutics LLC.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of the Plan but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). The Plan may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates as they are calculated into the pricing of the product.

Subscriber Rights

Blue Cross and Blue Shield of Oklahoma is happy to be able to serve you and provide the quality health care Benefits you need and deserve. As with any health insurance plan, you, and each of your covered Dependents, have certain rights.

You have the right to:

- confidentiality of health information;
- receive Medically Necessary and appropriate care and service as defined in this Certificate;
- receive courteous and respectful care and services from Blue Cross and Blue Shield of Oklahoma employees and network Providers;
- receive information in clear and understandable terms;
- participate with your Provider in decision-making about your health care treatment;
- refuse treatment;
- file complaints when dissatisfied with the care and treatment received;
- appeal an adverse Benefit determination or a decision regarding a Preauthorization request;
- designate an authorized representative to act on your behalf in pursuing a Benefit claim or appeal of an adverse Benefit determination.

Claims Filing Procedures

This program begins to pay only after the Copayment and/or Deductible amount you incur toward eligible expenses shows on our records. When your Physician, Hospital, or other Provider of health care services submits bills for you, your Copayment and/or Deductible will be recorded automatically and then your program will begin its share of the payment. If you file your own claims, you must submit copies of all your bills, even those you must pay to meet your Copayment and/or Deductible. Then our records will show that you have Incurred the Copayment and/or Deductible amount, and your health care coverage will begin to help pay the balance of your eligible expenses.

Participating Provider Networks

Participating Providers have agreed to submit claims directly to the Plan for you. When you receive Covered Services from a network Provider, simply show your Identification Card, and claims submission will be handled for you. If you must use an Out-of-Network Provider, you should follow the guidelines below in submitting your claims.

REMEMBER . . .

To receive the maximum Benefits under your health care program, you must receive treatment from the network Providers shown in your directory.

Prescription Drug Claims

To be eligible for discounts on Prescription Drugs and automatic claims filing, always use Participating Pharmacies. Keep in mind that you receive the highest Benefits under this program whenever your prescriptions are filled by a Participating Pharmacy.

If you find it necessary to purchase your prescriptions from an Out-of-Network Pharmacy, or if you do not have your Identification Card with you when you purchase your prescriptions, it will be your responsibility to pay the full cost of the Prescription Drugs and to submit a claim form (with your itemized receipt) to receive the Benefits available under your Prescription Drug program. Be sure to include the diagnosis and the payment receipt with your completed claim form. If the Prescription Drug is covered under this program, any payment due will be sent directly to you, after we subtract any shared payment amounts which apply to your coverage.

Hospital Claims

In rare cases when you are admitted as an Inpatient or receive treatment as an Outpatient in a Hospital which does not have an agreement with us (whether in-state or out-of-state), you should pay the Hospital yourself and then file a claim for Covered Hospital Services.

Ambulatory Surgical Facility Claims

If you are treated at a facility which does not have an agreement with us, you should pay the facility and then submit a claim to us for Covered Services.

Physician and Other Provider Claims

If you are treated by a Physician or other Provider who does not have an agreement with us, you ordinarily have to pay the bill and then file the claim yourself, along with an itemized statement from your Physician or other Provider. You will then be paid directly for Covered Services after we subtract your Deductible and/or Coinsurance amounts which apply to your coverage.

Member-Filed Claims

When you must file a claim yourself, you may obtain claim forms by contacting the nearest Plan office.

Be sure to fill out the claim form completely, sign it, and attach the Provider's itemized statement. Send the completed form to:

Blue Cross and Blue Shield of Oklahoma
P.O. Box 3283
Tulsa, Oklahoma 74102-3283

It is important that all information requested on the claim form be given; otherwise, the claim form may be returned to you for additional information before we can process your claim for Benefits.

A separate claim form must be filled out for each Subscriber, along with that person's expenses. A separate claim form must accompany each group of statements (if filed at different times).

IMPORTANT: Remember to send the itemized statement with all your claims. It gives the following necessary information:

- Full name of patient;
- Medical service(s) performed;
- Date of service(s);
- Who rendered service(s);
- Charge for service(s);
- Diagnosis.

Cancelled checks, cash register receipts, personal itemizations and statements that show only the balance due are not acceptable.

When you file claims, be sure to keep copies of all bills and receipts for your own personal records.

Remember, we must receive your claims for Covered Services within 180 days after the end of the Benefit Period for which claim is made.

Benefit Determinations for Properly Filed Claims

Once the Plan receives a Properly Filed Claim from you or your Provider, a Benefit determination will be made within 30 days. This period may be extended one time for up to 15 additional days, if the Plan determines that additional time is necessary due to matters beyond our control.

If we determine that additional time is necessary, you will be notified, in writing, prior to the expiration of the original 30-day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which the Plan expects to make the determination.

Upon receipt of your claim, if the Plan determines that additional information is necessary in order for it to be a Properly Filed Claim, we will provide written notice to you, prior to the expiration of the initial 30-day period, of the specific information needed. You will have 45 days from receipt of the notice to provide the additional information. The Plan will notify you of its Benefit determination within 15 days following receipt of the additional information.

The procedure for appealing an adverse Benefit determination is set forth in the section entitled, "***Complaint/Appeal Procedure***."

DIRECT CLAIMS LINE

We have a direct line for claims and membership inquiries. You may call 1-800-94-BLUES (1-800-942-5837) between 8:00 a.m. and 6:00 p.m., Monday through Friday, whenever you have a question concerning a claim or your membership.

Complaint/Appeal Procedure

Blue Cross and Blue Shield of Oklahoma has established the following process to review your dissatisfactions, complaints and/or appeals. If you have designated an authorized representative, that person may act on your behalf in the appeal process.

If you have a question or complaint, an initial attempt should be made to resolve the problem by directly communicating with a Blue Cross and Blue Shield of Oklahoma Customer Service Representative. In most cases, a Customer Service Representative will be able to provide you with a satisfactory solution to your problem. However, if a resolution cannot be reached in an informal exchange, you may request an administrative review of the problem through our appeal process described below.

You may request to review information used to make any adverse determination. Copies will be provided free of charge.

Claim Determinations

When the Plan receives a Properly Filed Claim, it has authority and discretion under this Certificate to interpret and determine Benefit in accordance with the Certificate provisions. We will receive and review claims for Benefits and will accurately process claims consistent with administrative practices and procedures established in writing.

You have the right to seek and obtain a full and fair review by the Plan of any determination of a claim, and determination of a request for Preauthorization, or any other determination of your Benefits made by the Plan under this Certificate.

If a Claim Is Denied or Not Paid in Full

On occasion, we may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the Explanation of Benefits summary prepared by us; then review this Certificate to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to us and request a review of the decision as described in "Claim Appeal Procedures" below.

If the claim is denied in whole or in part, you will receive a written notice from us with the following information, if applicable:

- The reasons for the determination;
- A reference to the Benefit provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
- A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the

standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

- An explanation of our internal review/appeals and external review processes (and how to initiate a review/appeal or external review);
- In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other Benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English languages(s) that indicates how to access the language services provided by us;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such claims. An urgent care claim decision may be provided orally, so long as a written notice is furnished to the claimant within three days of oral notification; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. Claim refers to a request for Benefits(s). There are three types of claims, as defined below.

- **"Urgent Care Claim"** is any pre-service request for benefits(s) that requires Preauthorization, as described in the Certificate, for Benefits for Medical Care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.
- **"Pre-Service Claim"** is any non-urgent request for Benefits or a determination with respect to which the terms of the Benefit plan condition receipt of the Benefit on approval of the Benefit in advance of obtaining Medical Care.
- **"Post-Service Claim"** is any request for a Benefit that is not a "pre-service" claim, and whereby notification that a service has been rendered or furnished to you is submitted to the Plan in an acceptable form. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which may request in connection with services rendered to you.

Urgent Care Claims*

Type of Notice or Extension	Timing
If your claim is incomplete, we must notify you within:	**24 hours**
If you are notified that your claim is incomplete, you must then provide completed claim information to us within:	**48 hours** after receiving notice
If we deny your initial claim, we must notify you of the denial:	
if the initial claim is complete as soon as possible (taking into account medical exigencies), but no later than:	**72 hours**
after receiving the completed claim (if the initial claim is incomplete), within:	**48 hours**

*You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call us at the toll-free number listed on the back of your Identification Card as soon as possible to appeal an Urgent Care Clinical Claim.

Pre-Service Claims

Type of Notice or Extension	Timing
If your claim is filed improperly, we must notify you within:	**5 days**
If your claim is incomplete, we must notify you within:	**15 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to us within:	**45 days** after receiving notice
If we deny your initial claim, we must notify you of the denial:	
if the initial claim is complete within:	**15 days***
after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**

*This period may be extended one time by the Plan for up to 15 days, provided that the Plan both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

POST-SERVICE CLAIMS

Type of Notice or Extension	Timing
If your claim is incomplete, we must notify you within:	**30 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to us within:	**45 days** after receiving notice
If we deny your initial claim, we must notify you of the denial:	
if the initial claim is complete, within:	**30 days***
after receiving the completed claim (if the initial claim is incomplete), within:	**45 days**

*This period may be extended one time by the Plan for up to 15 days, provided that the Plan both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

CLAIM APPEAL PROCEDURES

- ***Claim Appeal Procedures — Definitions***

  An "**Adverse Benefit Determination**" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental, Investigational or unproven or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by us and reduces or terminates such treatment (other than by amendment or termination of this Certificate) before the end of the approved treatment period, that is also an Adverse Benefit Determination A recision of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

  A "**Final Internal Adverse Benefit Determination**" means an Adverse Benefit Determination that has been upheld by the Plan at completion of the internal review/appeal process.

- ***Urgent Care/Expedited Clinical Appeals***

  If your situation meets the definition of an Expedited Clinical Appeal, you may be entitled to an appeal on an expedited basis. An **Expedited Clinical Appeal** is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care Provider, as well as continued hospitalization. Before authorization of Benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, we will provide you with notice at least 24 hours before the previous Benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

  Upon receipt of an expedited pre-service or concurrent clinical appeal, we will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Plan shall render a determination on the appeal as soon as possible (taking into account medical exigencies) but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

- ***How to Appeal to an Adverse Benefit Determination***

  You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by us in accordance with the Benefits and procedures detailed in your Certificate.

  An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care Provider may appeal on his/her own behalf. Your designation of a representative must be in writing, as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call us at the number on the back of your Identification Card.

  If you believe we incorrectly denied all or part of your Benefits, you may have your claim reviewed. We will review its decision in accordance with the following procedure:

  — Within 180 days after you receive notice of a denial or partial denial, you may call or write to our Administrative Office. We will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

  Appeal Coordinator – Customer Service Department
  Blue Cross and Blue Shield of Oklahoma
  P.O. Box 3283
  Tulsa, Oklahoma 74102-3283]

  — We will honor telephone requests for information. However, such inquiries will not constitute a request for review.

  — In support of your claim review, you have the option of presenting evidence and testimony to us. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

    We will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. Clinical appeal determinations may be made by a Physician associated or contracted with us and/or by external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover Benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by us.

  — If you have any questions about the claims procedures or the review procedure, write to our Administrative Office Customer Service Representative at the number shown on your Identification Card.

- ***Timing of Appeal Determinations***

  Upon receipt of a non-urgent pre-service appeal, we shall render a determination of the appeal as soon as practical, but in no event more than 30 days after the appeal has been received by us.

  Upon receipt of a non-urgent post-service appeal, we shall render a determination of the appeal as soon as practical, but in no event more than 60 days (or 30 days if the determination involves a Medical Necessity/appropriateness or Experimental, Investigational or unproven decision) after the appeal has been received by us.

- ***Notice of Appeal Determination***

  We will notify the party filing the appeal, you, and, if a clinical appeal, any health care Provider who recommended the services involved in the appeal, by a written notice of the determination.

  The written notice will include:

  — A reason for the determination;

  — A reference to the Benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;

  — Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

  — An explanation of our external review processes (and how to initiate an external review);

  — In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other Benefit information may be available (upon request) in such non-English language(s);

  — In certain situations, a statement in non-English languages(s) that indicates how to access the language services provided by us;

  — The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;

  — Any internal rule, guideline, protocol or other similar criterion relied on the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

  — An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;

  — A description of the standard that was used in denying the claim and a discussion of the decision; and

  — Contact information for applicable office of health insurance consumer assistance or ombudsman.

EXTERNAL REVIEW RIGHTS

If you receive an Adverse Benefit Determination, you may have a right to have our decision reviewed by independent health care professionals who have no association with us ***if our decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment.*** The request for an external review by an Independent Review Organization (IRO) must be submitted within four months after you receive notice of the internal appeal determination. You or your authorized representative may file a request for external review by completing the required forms and submitting them directly to the address noted below. We will also provide the forms to you upon request.

Oklahoma Insurance Department
3625 NW 56th Street
Oklahoma City, OK 73112-4511
Telephone: 1-800-522-0071 or 405-521-2828

For a standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for a health care service or course of treatment is based on a determination that the service or treatment is Experimental or Investigational, you also may be entitled to file a request for external review of our denial.

There will be no charge to you for the IRO review. The IRO will notify you and/or your authorized representative of its decision, which will be binding on the Plan and on you, except to the extent you have additional remedies available.

For questions about your rights or for additional assistance, you may contact the Oklahoma consumer assistance program at:

Oklahoma Insurance Department
3625 NW 56th Street
Oklahoma City, OK 73112-4511
http://www.ok.gov/oid/Consumers/index.html
Telephone: 1-800-522-0071 or 405-521-2828

Your ERISA Rights

As a participant in this Group Health Plan, you may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). Check with your Group Administrator to see if your Group Health Plan is governed by ERISA.

ERISA Rights

If your claim for Benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator (your Employer) to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Definitions

This section defines terms that have special meanings in this Certificate. If a word or phrase starts with a capital letter, it has a special meaning. It is defined in this section or where used in the text or it is a title.

Actively at Work

The active expenditure of time and energy in the services assigned by the Employer. You are considered Actively at Work on each day of a regular paid vacation, an Employer holiday, or on a regular nonworking day if you were Actively at Work on the work day before your Effective Date.

Allowable Charge

The charge that the Plan will use as the basis for Benefit determination for Covered Services you receive under the Contract. The Plan will use the following criteria to establish the Allowable Charge for ***Comprehensive Health Care Services***:

- **BlueChoice Provider** — the Provider's usual charge, not to exceed the amount the Provider has agreed to accept as payment for Covered Services in accordance with a BlueChoice Provider Agreement.
- **Out-of-Network (Non-Contracting) Provider** — the lessor of: (a) the Provider's billed charge; (b) the Plan's Non-Contracting Allowable Charge as set forth in the ***"Important Information"*** section.

For Outpatient Prescription Drug Benefits, the Allowable Charge is determined as follows:

- **Participating Pharmacy** — the Pharmacy's usual charge, not to exceed the amount the Pharmacy has agreed to accept as payment for Covered Services in accordance with a Participating Pharmacy Agreement.
- **Out-of-Network Pharmacy** — the Pharmacy's usual charge, up to the amount that the Plan would reimburse a Participating Pharmacy for the same service.

NOTE: For covered healthcare services received outside the state of Oklahoma, the "Allowable Charge" will be determined by the Blue Cross and Blue Shield Plan (Host Plan) servicing the area. Payment will be based upon the Provider payment arrangements in effect between the Provider and the on-site Plan. For out-of-network services, the Allowable Charge will be based upon the amount the Host Plan uses for their own local members that obtain services from local non-contracting Providers.

Ambulatory Surgical Facility

A Provider with an organized staff of Physicians which:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- Does not provide Inpatient accommodations; and
- Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician or other Provider.

Annual Transfer Period

A period of 31 days immediately before the Contract Date Anniversary in which an Eligible Person who has coverage through the Employer's alternate Plan Group contract or BlueLincs HMO (if applicable) can apply to transfer coverage to this Certificate.

Benefit Period

The period of time during which you receive Covered Services for which the Plan will provide Benefits.

Benefits

The payment, reimbursement and indemnification of any kind which you will receive from and through the Plan under this Certificate.

BlueCard Provider

The national network of participating Providers who have entered into an agreement with a Blue Cross and Blue Shield Plan to be a part of the BlueCard program.

BlueChoice Provider

A Provider who has entered into an agreement with the Plan to bill the Plan directly for Covered Services, and to accept the Plan's Allowable Charge as payment for such Covered Services.

Calendar Year

The period of 12 months commencing on the first day of January and ending on the last day of the following December.

Certificate of Coverage

A document providing information which is intended to enable an individual to establish his/her prior Creditable Coverage.

COBRA Continuation Coverage

Coverage under the Group Contract for you and your Eligible Dependent with respect to whom a Qualifying Event has occurred, and consisting of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the Contract to Subscribers to whom a Qualifying Event has not occurred.

Coinsurance

The percentage of Allowable Charges for Covered Services for which the Subscriber is responsible.

Community Home Health Care Agency

A Provider which provides nurses who visit the patient's home to give nursing and other needed care. This agency sees that each patient gets all care ordered by the Physician.

Contract

The agreement (including the Group Application and any endorsements) between your Group and us, referred to as the Master Contract or Group Contract.

Contract Date

The date when coverage for your Group starts.

Contract Date Anniversary

The date the Group Contract will renew and each 12-consecutive-month renewal date thereafter.

Covered Service

A service or supply shown in this Certificate and given by a Provider for which we will provide Benefits.

Creditable Coverage

Coverage of an individual from a wide range of specified sources, including Group Health Plans, health insurance coverage, Medicare, and Medicaid.

Custodial Care

Aid to patients who need help with daily tasks like eating, dressing and walking. Custodial Care does not directly treat an injury or illness.

Deductible

A specified amount of Covered Services that you must incur before the Plan will start to pay its share of the remaining Covered Services.

Dependent

A Subscriber other than the Member as shown in the ***Eligibility, Enrollment, Changes and Termination*** section.

Diagnostic Service

A test or procedure performed when you have specific symptoms to detect or monitor your disease or condition. It must be ordered by a Physician.

- Radiology, ultrasound and nuclear medicine
- Laboratory and pathology
- ECG, EEG, and other electronic diagnostic medical procedures and physiological medical testing, as determined by the Plan

Durable Medical Equipment

Equipment which meets the following criteria:

- It provides therapeutic benefits or enables the Subscriber to perform certain tasks that he or she would be unable to perform otherwise due to certain medical conditions and/or illnesses;
- It can withstand repeated use and is primarily and customarily used to serve a medical purpose;
- It is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home; and
- It is prescribed by a Physician and meets the Plan's criteria of Medical Necessity for the given diagnosis.

Effective Date

The date when your coverage begins.

Eligible Person

A person entitled to apply to be a Member as specified in the ***Eligibility, Enrollment, Changes and Termination*** section.

Emergency Care

Treatment for an injury, illness or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in:

- serious jeopardy to the Subscriber's health;
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

Employee

An Eligible Person as specified in the ***Eligibility, Enrollment, Changes and Termination*** section.

Employer

A Group, as defined, in which there exists an employment relationship between a Member and the Group.

Enroll

To become covered for Benefits under the Contract (i.e., when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to Enroll for coverage.

Enrollment Date

The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period (typically the date employment begins).

Experimental/Investigational

A drug, device, biological product, or medical treatment or procedure is Experimental or Investigational if **the Plan determines** that:

- The drug, device, biological product, or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product, or medical treatment or procedure is furnished; or
- The drug, device, biological product, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
- The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Family Coverage

Coverage under this Certificate for the Member and one or more of the Member's Dependents.

Generic Drug

Pharmaceutically equivalent drug products substituted for the originator/trademarked (brand) drug products.

Group

A classification of coverage whereby a corporation or other legal entity has agreed to establish a premium collection and payment system in order to provide an opportunity for its employees to acquire Plan coverage for health care expenses.

Group Health Plan

A plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

Health Maintenance Organization (HMO)

An organized system of health care providing a comprehensive package of health services, through a group of Physicians, to a voluntarily enrolled membership, within a particular geographic area, on a fixed prepayment basis.

Hospice

A Provider which provides an integrated set of services designed to provide palliative and supportive care to terminally ill patients and their families.

Hospital

A Provider that is a short-term, acute care, general Hospital which:

- Is licensed;
- Mainly provides Inpatient diagnostic and therapeutic services under the supervision of Physicians;
- Has organized departments of medicine and major Surgery;
- Provides 24-hour nursing service; and

- Is not, other than incidentally, a:
  - — Skilled Nursing Facility;
  - — Nursing home;
  - — Custodial Care home;
  - — Health resort;
  - — Spa or sanitarium;
  - — Place for rest;
  - — Place for the aged;
  - — Place for the treatment of Mental Illness;
  - — Place for the treatment of alcoholism or drug abuse;
  - — Place for the provision of Hospice care;
  - — Place for the provision of rehabilitation care; or
  - — Place for the treatment of pulmonary tuberculosis.

Hospital Admission

The period from your entry (admission) into a Hospital for Inpatient treatment until your discharge.

Identification Card

The card issued to the Member by the Plan, bearing the Member's name, identification number, and Group number.

Incurred

A charge is Incurred on the date you receive a service or supply for which the charge is made.

Individual Conversion

A classification of individual coverage other than Group for which the individual Member pays the premiums directly to the Plan or its depository.

Initial Enrollment Period

The 31-day period immediately following the date an Employee or Dependent first becomes eligible to Enroll for coverage under the Contract.

Inpatient

A Subscriber who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made.

Intensive Outpatient Program

A freestanding or Hospital-based program that provides services for at least three hours per day two or more days per week to treat Mental Illness, drug addiction, substance abuse or alcoholism or specializes in the treatment of co-occurring Mental Illness with drug addiction, substance abuse or alcoholism. These programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that the Subscriber will benefit from programs that focus solely on Mental Illness conditions.

Licensed Practical or Vocational Nurse (LPN or LVN)

A licensed nurse with a degree from a school of practical or vocational nursing.

Low-Dose Mammography

The x-ray screening examination of the breast using equipment dedicated specifically for mammography, including but not limited to the x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

Maternity Services

Care required as a result of being pregnant, including prenatal care and postnatal care.

Medical Care

Professional services given by a Physician or other Provider to treat illness or injury.

Medically Necessary (or Medical Necessity)

Health care services that a Hospital, Physician, or other Provider, exercising prudent clinical judgment, would provided to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriated, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, Physician, or other health care Provider, and not more costly than an alternative services or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Medicare

The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Member

An Eligible Person who has enrolled for coverage.

Member and Children Coverage

Coverage under this Certificate for the Member and his or her Dependent child(ren).

Member Only Coverage (or Single Coverage)

Coverage under this Certificate for the Member only.

Member, Spouse and Children Coverage (or Family Coverage)

Coverage under this Certificate for the Member, his or her spouse and Dependent child(ren).

Member and Spouse Only Coverage

Coverage under this Certificate for the Member and his or her spouse only.

Mental Illness

An emotional or mental disorder characterized by an abnormal functioning of the mind or emotions and in which psychological, intellectual, or emotional disturbances are the dominating feature, regardless of whether such disorder is caused by mental, physical, organic, or chemical deficiency.

Non-Preferred Brand Drug

A name-brand Prescription Drug which has not been designated by the Plan as a Preferred Drug.

Open Enrollment Period

A period of 31 days immediately before the Group's Contract Date Anniversary (renewal date) during which an individual who previously declined coverage may Enroll for coverage under the Contract as a late enrollee.

Orthognathic Surgery

Services or supplies received for correction of deformities of the jaw, including the surgical repositioning of portions of the upper or lower jaws or the bodily repositioning of entire jaws.

Out-of-Network Pharmacy

A Pharmacy that has not entered into a Participating Pharmacy Agreement with the Plan.

Out-of-Pocket Limit

The amount of Deductibles, Copayment and/or Coinsurance which must be satisfied during the Benefit Period. Once the Out-of-Pocket Limit has been reached, the amount of Allowable Charges covered by the Plan will increase to 100% during the remainder of the Benefit Period.

The Out-of-Pocket Limit does not include amounts in excess of the Allowable Charge or charges for any services that are not covered under this Certificate.

Outpatient

A Subscriber who receives services or supplies while not an Inpatient.

Participating Pharmacy

A Pharmacy who has entered into an agreement to be part of the Plan's Participating Pharmacy Network.

Pharmacy

A person, firm or corporation duly authorized by state law to dispense Prescription Drugs.

Physician

A person who is a professional practitioner of a Healing Art defined and recognized by law, and who holds a Physician license duly issued by the state or territory of the United States in which the person is authorized to practice medicine or Surgery or other procedures and provide services within the scope of such license.

Placement for Adoption (or Placed for Adoption)

The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's Placement for Adoption with such person terminates upon the termination of such legal obligation.

Plan

Blue Cross and Blue Shield of Oklahoma.

Preauthorization

Authorization from the Plan before the services are rendered that, based upon the information presented by the Subscriber or his/her Provider at the time Preauthorization is requested, the proposed treatment meets the Plan's guidelines for Medical Necessity.

Preauthorization does not guarantee that the care and services a Subscriber receives are eligible for Benefits under the Contract. At the time the Subscriber's claims are submitted, they will be reviewed in accordance with the terms of the Contract.

Preferred Drug

A Prescription Drug which has been designated by the Plan to be a part of its Preferred Prescription Drug Program.

Prescription Drug

A medicinal substance required by the Federal Food, Drug and Cosmetic Act to bear the following legend on its label: "Caution: Federal Law prohibits dispensing without a prescription."

Prescription Order

A written order, and each refill, for a Prescription Drug issued by a Physician or other Provider.

Preventive Care Services

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
- Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and
- With respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA, including breast-feeding support, services and supplies and contraceptive services, as set forth in the ***Comprehensive Health Care Services*** section.

The Preventive Care Services described above may change as the USPSTF, CDC, and HRSA guidelines are modified.

Properly Filed Claim

A formal statement or claim regarding a loss which provides sufficient, substantiating information to allow the Plan to determine its liability for Covered Services. This includes: a completed claim form; the Provider's itemized statement of services rendered and related charges; and medical records, when requested by the Plan.

Provider

A Hospital, Physician, or other practitioner or Provider of medical services or supplies licensed to render Covered Services and performing within the scope of such license.

Psychiatric Hospital

A Provider that is a state-licensed Hospital that primarily specializes in the treatment of severe Mental Illnesses and/or substance abuse disorders.

Qualifying Event

Any one of the following events which, but for the COBRA Continuation Coverage provisions of this Certificate, would result in the loss of a Subscriber's coverage:

- The death of the covered Employee;
- The termination (other than by reason of a covered Employee's gross misconduct), or reduction of hours, of the covered Employee's employment;
- The divorce or legal separation of the covered Employee from the Employee's spouse;
- The covered Employee becoming entitled to benefits under Medicare;
- A Dependent child ceasing to be eligible as defined under the Contract.

Registered Nurse (RN)

A licensed nurse with a degree from a school of nursing.

Residential Treatment Center

A state-licensed and/or state-certified facility that provides a 24-hour level of residential care to patients with long-term or severe Mental Illnesses and/or substance abuse disorders. This care is medically monitored, with 24-hour Physician availability and 24-hour onsite nursing services.

Retail Pharmacy Vaccination Network

A network of Participating Pharmacies that have certified vaccination Pharmacists on staff who have contracted to administer vaccinations to Subscribers.

Routine Nursery Care

Ordinary Hospital nursery care of the newborn Subscriber.

Skilled Nursing Facility

A Provider which mainly provides Inpatient skilled nursing and related services to patients who need skilled nursing services around the clock but who do not need acute care in a Hospital bed. Such care is given by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

- Custodial Care, ambulatory, or part-time care; or
- Treatment for Mental Illness, alcoholism, drug abuse or pulmonary tuberculosis.

Special Enrollment Period

A period during which an individual who previously declined coverage is allowed to Enroll under the Contract without having to wait until the Group's next regular Open Enrollment Period.

Subscriber

The Member and each of his or her Dependents (if any) covered under this Certificate.

Surgery

- The performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Usual and related preoperative and postoperative care.

Therapy Service

The following services and supplies ordered by a Physician when used to treat and promote your recovery from an illness or injury:

- **Radiation Therapy** — the treatment of disease by x-ray, radium, or radioactive isotopes.
- **Chemotherapy** — the treatment of malignant disease by chemical or biological antineoplastic agents, but not including High-Dose Chemotherapy. High-Dose Chemotherapy is specifically addressed in certain sections under ***"Human Organ, Tissue and Bone Marrow Transplant Services."***
- **Respiratory Therapy** — introduction of dry or moist gases into the lungs for treatment purposes.
- **Dialysis Treatment** — the treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis.
- **Physical Therapy** — the treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.
- **Occupational Therapy** — treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
- **Speech Therapy** — treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

Total Disability (or Totally Disabled)

A condition resulting from disease or injury in which, as certified by a Physician:

- The Subscriber is unable to perform the substantial duties of any occupation or business for which he/she is qualified and the Subscriber is not in fact engaged in any occupation for wages or profit; or

- If the Subscriber does not usually work for wages or profit, the Subscriber cannot do the normal activities of a person of the same age and sex.

The Plan reserves the right to review a Physician's certificate of disability and/or request medical records and/or require a medical examination by an independent Physician to verify disability at the Subscriber's expense. The Plan will make the final determination as to whether the Subscriber is Totally Disabled.

WAITING PERIOD

The period that must pass before an Eligible Person or Dependent is eligible to Enroll under the terms of a Group Health Plan. If an Eligible Person or Dependent Enrolls as a late enrollee or during a Special Enrollment Period, any period before such late or special enrollment is not a Waiting Period.

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