

Your Health Care Benefit Program



For Employees of
The City of Oklahoma City

Effective January 1, 2010

Administered by:



BlueCross BlueShield of Oklahoma

Experience. Wellness. Everywhere.™

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Plan Summary

The City of Oklahoma City (called the *Employer*) has established and maintains a self-insured Plan of Comprehensive Health Care Benefits (called the *Plan*) for Covered Persons as designated in its personnel policy or Municipal Code.

The Plan is operated under an Administrative Services Agreement between The City of Oklahoma City and Blue Cross and Blue Shield of Oklahoma, a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, (called **BCBSOK** or the *Claims Administrator*).

Under this Agreement, BCBSOK pays Benefits on behalf of the Employer in accordance with the terms of the Plan and performs certain other services on behalf of the Employer. The Employer reserves the right to amend or cancel any or all provisions of the Plan at any time as it relates to any Covered Person.

The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

This benefit booklet is issued according to the terms of the Plan. It is not a summary plan description. It is only a summary of Benefits, and all statements in this benefit booklet are subject to the terms of the Plan documents on file in your Personnel Services Department, Employee Benefits Division.

This benefit booklet replaces any and all summaries, certificates or benefit booklets previously issued for the Employees under the Plan. It describes the Plan in effect as of January 1, 2010, for all Covered Persons (called “you” or “your”).

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 PPO 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 PPO Provider.

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

HOW YOUR BLUECHOICE PPO COVERAGE WORKS

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

The BlueChoice PPO program operates around a group of Hospitals, Physicians and other Providers who have agreed to accept no more than a reasonable, predetermined fee for their services. When Covered Persons use these BlueChoice PPO Providers, they will have less out-of-pocket expense.

In contrast, when care is received from an Out-of-Network Provider, a higher Coinsurance and Out-of-Pocket Limit will apply to most Covered Services. However, if a Covered Person receives services from an Out-of-Network Provider in a BlueChoice PPO or BlueCard PPO Hospital for anesthesiology, radiology, laboratory or pathology services, Benefits will be provided as if such services were received under the same conditions from a PPO Provider.

COST SHARING FEATURES OF YOUR COVERAGE

As a participant in the 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 the Plan. Check with your Employer for specific premium amounts applicable to the coverage you have selected for you and your family.

SELECTING A PROVIDER

A listing of Oklahoma network Providers is 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 their Customer Service Representative whether or not the Provider is a network Provider. Simply call their toll-free number at 1-877-219-4301.

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 BlueChoice PPO Provider network.**

THE BLUECARD PROGRAM

The BlueCard Program allows you to use a Blue Cross and Blue Shield PPO Physician or Hospital outside the state of Oklahoma and to receive the advantages of PPO benefits and savings.

- **Finding a PPO Physician or Hospital**

When you're outside of Oklahoma and you need to find information about a Blue Cross and Blue Shield PPO Physician or Hospital, just call the BlueCard Doctor and Hospital Information Line at 1-800-810-BLUE (2583), or you may refer to the Blue National Doctor and Hospital Finder at <http://www.bcbs.com/healthtravel/finder.html>. They will help you locate the nearest PPO Physician or Hospital. *Remember, you are responsible for receiving Precertification 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 PPO Physician or Hospital across the USA. The PPO Physicians and Hospitals can verify your membership eligibility and coverage with Blue Cross and Blue Shield of Oklahoma. When you visit a PPO Physician or Hospital, you should have no claim forms to file and no billing hassles.

- **Remember to Always Carry the BlueCard**

Make sure you always carry your Identification Card. Its "PPO in a suitcase" logo shows that you are eligible to receive PPO Benefits and savings through the BlueCard Program. And be sure to use Blue Cross and Blue Shield PPO Physicians and Hospitals whenever you're 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 your Copayment, Deductible and/or Coinsurance amounts whenever it is necessary so that they 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.bcbs.com/healthtravel/finder.html>.
- ✔ You are responsible for Precertification from Blue Cross and Blue Shield of Oklahoma.
- ✔ Visit the PPO Physician or Hospital and present your Identification Card that has the "PPO in a suitcase" logo.
- ✔ 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're only responsible for meeting your Copayment, Deductible and/or Coinsurance payments, if any.
- ✔ All contracting PPO Physicians and Hospitals are paid directly, relieving you of any hassle and worry.

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" or "Medical Necessity" shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treatment an illness, injury, disease or its symptoms, and that are:**

- **in accordance with generally accepted standards of medical practice;**
- **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.**

PRECERTIFICATION

The Plan has designated certain Covered Services which require "*Precertification*" in order for you to receive the maximum Benefits possible under the Plan. To request Precertification, you or your Provider may simply call the telephone number shown on your Identification Card. **If you use a BlueChoice PPO Provider for your services, your Provider will automatically request Precertification for you.**

For an Inpatient facility stay, *you must request Precertification from the Claims Administrator before your scheduled admission.* The Claims Administrator will consult with your Physician, Hospital, or other facility to determine if Inpatient level of care is required for your illness or injury. The Claims Administrator 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 Claims Administrator determines that your 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 Claims Administrator's approval, or if you do not ask the Claims Administrator for Precertification, your Benefits under the Plan will be reduced by 30% for that admission, provided the Claims Administrator 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.

- **Precertification Requests Involving Non-Urgent Care**

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

If the Claims Administrator determines that additional time is necessary, the Claims Administrator 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 the Claims Administrator expects to make the determination.

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

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

- **Precertification Requests Involving Urgent Care**

A “Precertification 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 Covered Person or the ability of the Covered Person to regain maximum function; or
- in the opinion of a Physician with knowledge of the Covered Person’s medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Precertification request.

In case of a “Precertification Request Involving Urgent Care,” the Claims Administrator will respond to you no later than 72 hours after receipt of the request, unless you fail to provide sufficient information to determine whether, or to what extent, Benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator will notify you no later than 24 hours after receipt of your request, of the specific information necessary to complete your Precertification request. You will be given a minimum of 48 hours to provide the specified information. You will be notified of the Claims Administrator’s response to your Precertification request no later than 48 hours after the earlier of:

- the Claims Administrator’s receipt of the specified information; or
- the end of the 48-hour period you were given to provide the specified information.

NOTE: The Claims Administrator’s response to your Precertification 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.

- **Precertification Requests Involving Emergency Care**

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

In addition to Inpatient facility services, some Outpatient services (such as Home Health Care) are also subject to Precertification. If you fail to request Precertification approval, or to abide by the Claims Administrator’s determination regarding these services, your Benefits will be *denied* or *reduced*, as set forth in the ***Comprehensive Health Care Services*** section of the Plan.

Benefit reductions for failure to comply with the Claims Administrator’s Precertification process will apply only when you utilize the services of a Provider who is not a member of the BlueChoice PPO 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 Precertification approval is requested or received.

NOTE: Group Health Plans and health insurance issuers generally may not, under federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

CONCURRENT REVIEW AND CASE MANAGEMENT

As a part of the Precertification process described above, the Claims Administrator will determine an “expected” or “typical” length of stay or course of treatment based upon the medical information given to the Claims Administrator at the time of your Precertification request. These estimates are used for a concurrent review during the course of your admission or treatment in order to determine if Benefits are eligible in accordance with the Medical Necessity provisions of the Plan.

Whenever it is determined that Inpatient care or an ongoing course of treatment may no longer be Medically Necessary, the Claims Administrator’s Medical and Benefits Administration staff will contact you, your Provider or other authorized representative to discuss the Medical Necessity guidelines used to determine Benefits for continuing services. When appropriate, the Claims Administrator will inform you and your Providers whether additional Benefits are available for services you and your Physician may choose to obtain in an alternate treatment setting.

If you or your Provider requests to extend care beyond the approved time limit and it is a Request Involving Urgent Care, the Claims Administrator will notify you of its decision within 24 hours, provided the request is made within 24 hours prior to the expiration of the prescribed period of time or course of treatment.

ALLOWABLE CHARGE

To take full advantage of the negotiated pricing arrangements in effect between the Claims Administrator and their network Providers, it is imperative that you use BlueChoice PPO Providers in Oklahoma and BlueCard PPO Providers whenever you are out of state. Using these Providers offers you the following advantages:

- BlueChoice PPO and BlueCard PPO Providers have agreed to hold the line on health care costs by providing special prices for Covered Persons. 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.***
- The Claims Administrator will calculate your Benefits based on this “Allowable Charge”. The Claims Administrator 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. They will then determine your Benefits under the Plan, and direct any payment to your network Provider.

REMEMBER ...

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

Your PPO program coverage contains special provisions (Benefit reductions) which apply whenever you use Out-of-Network Providers. If you use an Out-of-Network Provider, your Benefits will be determined as follows:

- If you use an Oklahoma Out-of-Network Provider, the Plan will determine the Allowable Charge for your out-of-network claims **based upon the amount the Plan would have reimbursed an Oklahoma BlueTraditional Provider for the same service**. 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” which a BlueTraditional Provider would have accepted for the same services.
- 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, and the claim for those services is filed with the Blue Cross and Blue Shield Plan (Host Plan) servicing the area, the “Allowable Charge” will be determined by the Host Plan. This Allowable Charge will be the amount the Host Plan uses for their own local members that obtain services from local non-contracting Providers. You will be responsible for the following:
 - Charges for any services which are not covered under the 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.
- In instances where the claim is not filed with the Host Plan, the Allowable Charge for your out-of-network claims will be **based upon what the Plan would have reimbursed a BlueTraditional Provider for the same service**. You will be responsible for the following:
 - Charges for any services which are not covered under the 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” which a BlueTraditional Provider would have accepted for the same services.
- In certain instances, your services may be rendered by a Provider who has a Participating Provider Agreement (other than a BlueChoice PPO Participating Agreement) with Blue Cross and Blue Shield of Oklahoma. These Providers (called BlueTraditional Providers) have agreed to charge Covered Persons no more than a “Maximum Reimbursement Allowance” for Covered Services. If you receive Covered Services from a BlueTraditional Provider, you will be responsible for the following:
 - Charges for any services which are not covered under the 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*).
 - Any amounts over the “Allowable Charge”, up to but not exceeding the “Maximum Reimbursement Allowance” specified in their Participating Provider Agreement.

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

SPECIAL NOTICES

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

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

Be sure to check for a “special notice”. It changes provisions or Benefits in the Plan.

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.

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 Claims Administrator 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 Precertification 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 the Claims Administrator’s 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 benefit booklet. If you need more help, please call a Customer Service Representative at 1-877-219-4301.

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 Covered Person 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 Plan;
- 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 Plan; and
- What rights you have when your coverage stops.

WHO IS AN ELIGIBLE PERSON

An Eligible Person is defined as follows:

- A regular, full-time active Employee;
- An Employee on disability leave due to an on-the-job injury on regular, full-time employment on the date the disabling injury or illness occurred;
- A retired Employee who qualifies under Chapter 40 of the Oklahoma City Code, 2007 as amended;
- An elected official of the City of Oklahoma City;
- A regular, full-time active Employee of an approved participating municipal trust;
- A COBRA participant;
- A surviving spouse or surviving minor of a deceased eligible Employee or retiree, but not including new spouses or Dependents of the survivor.

Your Effective Date is the first of the month following one full month of employment (excluding month of hire).

WHO IS AN ELIGIBLE DEPENDENT

An Eligible Dependent is defined as the Eligible Person's:

- legal spouse, as defined by Oklahoma state law, except for a new spouse of a survivor;
- unmarried children to the age of 20 who qualify as dependents under the Internal Revenue Code;
- unmarried children to the age of 24 who are enrolled in an accredited university, college, vocational or trade school nine or more hours per semester who qualify as dependents under the Internal Revenue Service;
- unmarried children who are physically or mentally incapable of self-support on the date coverage would otherwise end.

For purposes of this provision, “children” shall include your natural children, stepchildren, adopted children, children Placed for Adoption, or any other children for whom you or your spouse is the legal guardian and who qualify as a dependent under the Internal Revenue Code.

NOTE: Coverage will continue under this Plan for a Dependent who is unable to attend school as a result of a Medically Necessary leave of absence, provided that:

- the Dependent is enrolled under the Plan on the basis of being a student at a postsecondary education institution; and
- the Dependent was covered under the Plan immediately before the first day of the Medically Necessary leave of absence; and
- the Dependent child’s treating Physician provides to the Plan a written certification stating that the child is suffering from a serious illness or injury and that the leave of absence is Medically Necessary.

Coverage may be continued under the Plan until the date that is the earlier of:

- one year after the first day of the Medically Necessary leave of absence; or
- the date on which such coverage would otherwise terminate under the terms of this Plan.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE OR ADDING DEPENDENTS TO FAMILY COVERAGE

You can change from Individual to Family Coverage or add Dependents to your Family Coverage because of any of the following events:

- Marriage.
- Establishment of a Common Law Marriage.
- Birth, adoption or Placement for Adoption of a child.
- Obtaining legal guardianship of a child.
- Loss of eligibility for other health coverage for you or your Dependent if:
 - The other coverage was in effect when you were first eligible to enroll for this coverage;
 - The other coverage is not terminating for cause (such as failure to pay premiums or making a fraudulent claim); and
 - Where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment in this coverage.

This includes, but is not limited to, loss of coverage due to:

- Legal separation, divorce, cessation of Dependent status, death, termination of employment, or reduction in the number of hours of employment;
 - In the case of HMO coverage, moving out of the HMO service area;
 - Reaching a lifetime limit on all benefits in another group health plan; or
 - Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your Dependent.
- Termination of employer contributions towards your or your Dependent’s other coverage.

- Exhaustion of COBRA Continuation Coverage or state continuation coverage.

WHEN COVERAGE BEGINS

Your Family Coverage or the coverage for your additional Dependents will be effective from the date of the event if you apply for this change within 31 days of any of the following events:

- Marriage.
- Establishment of a Common Law Marriage.
- Birth, adoption, or placement of adoption of a child.
- Obtaining legal guardianship of a child.

NOTE: Coverage for a newborn will be effective on the date of birth and continue for 31 days. In order to extend the coverage beyond 31 days, you must notify your Employer so that your membership records can be adjusted. You must notify your Employer within 31 days even if the addition of a newborn to existing Family Coverage extends beyond 31 days and does not result in an additional premium.

Your Family Coverage or the coverage for your additional Dependents will be effective from the date you apply for coverage if you apply within 31 days of any of the following events:

- Loss of eligibility for other coverage for you or your Dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.
- Termination of employer contributions towards your or your Dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

If coverage is lost in another Group Health Plan because a lifetime limit on all benefits is reached under that coverage and you apply for Family Coverage or to add Dependents within 31 days after a claim is denied due to reaching the lifetime limit, your Family Coverage or the coverage for your additional Dependents will be effective from the date your claim was denied.

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 or 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, or within 60 days of the Employee or Dependent becoming eligible for a Group Health Plan premium assistance subsidy under Medicaid or CHIP. Coverage will be effective from the date your application is received retroactive to the event date.

LATE APPLICANTS

If you do not apply for coverage or add Dependents to your coverage within 31 days of the event (or within 60 days in instances related to Medicaid or CHIP coverage), as described above, you may apply for coverage during the next Open Enrollment Period. An Open Enrollment Period will be held each year at a time designated by your Employer. Your application for coverage must be received by your employer within this time period. Individuals who enroll during an Open Enrollment Period will be considered Late Enrollees under the Plan and will be subject to the 365 days Preexisting Condition waiting period as described in the "Exclusions" section of this benefit booklet.

PREEXISTING CONDITION WAITING PERIOD

Refer to the “Exclusions” section for an explanation of the Preexisting Condition waiting period applicable to your Benefits under this Plan.

MEDICARE ELIGIBLE COVERED PERSONS

If you meet the definition of an Eligible Person stated in this section above and you are eligible for Medicare and not affected by the “Medicare Secondary Payer” (MSP) laws as described below, the Benefits described in the section of this plan document entitled “Benefits for Medicare Eligible Covered Persons” will apply to you and to your spouse and covered Dependent children (if he or she is also eligible for Medicare and not affected by the MSP laws).

A series of federal laws collectively referred to as the “Medicare Secondary Payer” (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, Dependent children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer Group Health Plan (“GHP”) coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

- GHPs that cover individuals with end-stage renal disease (“ESRD”) during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has “current employment status.”
- In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual’s spouse (of any age) has “current employment status.” If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).
- In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual’s family has “current employee status.” If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

PLEASE NOTE: SEE YOUR EMPLOYER OR GROUP ADMINISTRATOR SHOULD YOU HAVE ANY QUESTIONS REGARDING THE ESRD PRIMARY PERIOD OR OTHER PROVISIONS OF MSP LAWS AND THEIR APPLICATION TO YOU, YOUR SPOUSE OR ANY DEPENDENTS.

YOUR MSP RESPONSIBILITIES

In order to assist your employer in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Claim Administrator and/or your employer regarding the Medicare eligibility of you, your spouse and covered dependent children. In addition, if you, your spouse or covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your employer or your group administrator promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

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 Copayment, 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 by calling the telephone number shown on your Identification Card.

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.

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

DELETING A DEPENDENT

A Dependent may be removed from your coverage if you have a change in family status. The change will be effective at the end of the coverage period during which your contributions have been paid.

Failure to notify the Personnel Services Department, Employee Benefits Division, in writing of any change in marital status and/or change in Dependent status, that results in the improper extension of health or welfare benefits, may result in disciplinary action against the employee and/or further legal action against the Covered Person.

COBRA* CONTINUATION COVERAGE

- **Eligibility for Continuation Coverage**

When a Qualifying Event occurs, eligibility under this Plan 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.

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

- **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 the Plan 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.
- 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.

WHEN COVERAGE UNDER THIS PLAN ENDS

Coverage will stop at the end of the month in which an individual ceases to meet the definition of an Eligible Person or Eligible Dependent.

A Covered Person's COBRA Continuation Coverage, when applicable, will cease at the end of the month coinciding with or next following 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 Covered Person is no longer disabled (when coverage has been extended from 18 months to 29 months due to disability);
- the date on which the Employer stops providing any Group Health Plan to any Employee;
- the date on which coverage stops because of a Covered Person’s failure to pay any contribution required for the COBRA Continuation Coverage;
- the date on which the Covered Person 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 Covered Person (or the date the Covered Person has satisfied the Preexisting Condition Waiting Period under that plan); or
- the date on which the Covered Person becomes (after the date of the election) entitled to benefits under Medicare.

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

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this Plan is terminated, Benefits will be provided for, and limited to, the Covered Services of this Plan which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Partial Hospitalization Treatment Program or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your Benefit Period, whichever occurs first.

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. Creditable Coverage may be used to reduce the Preexisting Condition waiting period under the new coverage.

Schedule of Benefits

Comprehensive Health Care Services

This section shows how much the Plan pays for Covered Services described in the *Comprehensive Health Care Services* section that follows. It also explains the Copayment or 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

COPAYMENT

\$5 for each Physician's office visit.

The Copayment applies *before* the Deductible, when applicable.

DEDUCTIBLE

BlueChoice PPO or BlueCard PPO Provider Services Deductible

\$200 per Benefit Period per Covered Person. This Deductible applies to Covered Services received from a BlueChoice PPO or BlueCard PPO Provider.

If your coverage includes your Dependents, then no more than two times the individual Deductible amount must be satisfied in each Benefit Period for all covered family members for Covered Services received from BlueChoice PPO or BlueCard PPO Providers.

No family member will be required to contribute more than his/her individual Deductible amount.

Out-of-Network Provider Services Deductible

\$300 per Benefit Period per Covered Person. This Deductible applies whenever the Covered Person receives Covered Services from a Provider who is not a member of the BlueChoice PPO or BlueCard PPO Provider Network.

If your coverage includes your Dependents, then no more than three times the individual Deductible amount must be satisfied in each Benefit Period for all covered family members for Covered Services received from Out-of-Network Providers.

No family member will be required to contribute more than his/her individual Deductible amount.

Common Accident Provision

If two or more Covered Persons 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.

Covered Services *Not* Subject to Benefit Period Deductible

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

- Preadmission Testing.
- Well Baby Care for Covered Persons up to 24 months of age.
- Well Child Care for Covered Persons age two through 18 (subject to the Wellness Benefit maximum of \$200 per Benefit Period per Covered Person and \$500 per Benefit Period for all covered family members).
- Covered childhood immunizations (for Covered Persons under age 19).
- Wellness Care for Covered Persons age 19 and older (limited to a maximum of \$200 per Benefit Period per Covered Person and \$500 per Benefit Period for all covered family members).
- Annual routine mammography screening (limited to \$115 per screening).
- Annual prostate cancer screening (limited to \$65 per screening).
- Covered Services received from an EMSA Ambulance Provider.

OUT-OF-POCKET LIMIT

- **BlueChoice PPO and BlueCard PPO Provider Services** —When you have paid \$1,000 (in excess of any the Deductible amounts for Covered Services provided by BlueChoice PPO and BlueCard PPO Providers 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 for Covered Services you receive from network Providers.
- **Out-of-Network Provider Services** — When you have Incurred \$3,000 (in excess of any Deductible amounts) for Covered Services provided by Out-of-Network Providers 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 for Out-of-Network Provider services.

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

- Copayments for Physician office visits;
- Benefit reductions for failure to comply with the Plan's Precertification requirements;
- Charges in excess of the Allowable Charge.

MAXIMUM

\$2,000,000 per lifetime per Covered Person, including any other limitations specifically stated in this booklet.

All Benefits payable under this booklet are cumulative. Therefore, in calculating the maximum Benefits payable for a particular Covered Service or in calculating the remaining lifetime maximum available to a Covered Person, the Claims Administrator will include Benefits provided under this and/or any prior or subsequent booklets issued to you as an Eligible Person or a Dependent of an Eligible Person under this Plan.

BENEFIT PERCENTAGE

The following chart shows the percentage of Allowable Charges covered by your BlueChoice PPO program through payments and/or contractual arrangements with Providers. These percentages apply only after your Copayment, Deductible and/or Coinsurance has been satisfied.

If you receive Covered Services which the Claims Administrator determines are unavailable from a BlueChoice PPO or BlueCard PPO Provider, Benefits for the Covered Services you receive from an Out-of-Network Provider will be provided at the payment level described for a BlueChoice PPO or BlueCard PPO Provider.

| COVERED SERVICES (Subject to the <i>Comprehensive Health Care Services</i> section which follows) | BENEFIT PERCENTAGE AMOUNT: | |
|---|---|--|
| | <u>BlueChoice PPO & BlueCard PPO Provider Services</u> | <u>Out-of-Network Provider Services</u> |
| HOSPITAL SERVICES | 90% | 70% |
| Preadmission Testing | 100% | 100% |
| Other Covered Hospital Services | 90% | 70% |
| SURGICAL/MEDICAL SERVICES | | |
| Well Baby Care (For Subscribers from birth to 24 months of age) | 100% | 70% |
| Well Child Care (Subject to Benefit Period maximum for Subscribers age 2 thru 18 years of age) | 100% | 100% |
| Wellness Services (Subject to Benefit Period maximum for Subscribers age 19 or older) | 90% | 70% |
| Covered Childhood Immunizations (Limited to Subscribers under age 19) | 100% | 100% |
| Routine Mammography Services (Limited to \$115 per screening) | 100% | 100% |
| All Other Covered Surgical/Medical Services | 90% | 70% |
| OUTPATIENT DIAGNOSTIC SERVICES | 90% | 70% |
| OUTPATIENT THERAPY SERVICES | 90% | 70% |
| MATERNITY SERVICES | 90% | 70% |
| Services Received at a Freestanding Birthing Center | 100% | 100% |
| All Other Covered Maternity Services | 90% | 70% |
| MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES | 90% | 70% |
| HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES | 90% | 70% |
| AMBULATORY SURGICAL FACILITY SERVICES | 90% | 70% |
| PSYCHIATRIC CARE SERVICES | 90% | 70% |

| COVERED SERVICES (Subject to the <i>Comprehensive Health Care Services</i> section which follows) | BENEFIT PERCENTAGE AMOUNT: | |
|--|--|---|
| | <u>BlueChoice PPO & BlueCard PPO Provider Services</u> | <u>Out-of-Network Provider Services</u> |
| SUBSTANCE ABUSE REHABILITATION TREATMENT | 90% | 70% |
| AMBULANCE SERVICES | 90%* | 70% |
| PRIVATE DUTY NURSING SERVICES | 90% | 70% |
| REHABILITATION CARE | 90% | 70% |
| CARDIAC REHABILITATION SERVICES | 90% | 70% |
| SKILLED NURSING FACILITY SERVICES | 90% | 70% |
| HOME HEALTH CARE SERVICES | 90% | 70% |
| HOSPICE SERVICES | 90% | 70% |
| ALL OTHER COVERED SERVICES | 90% | 70% |

**PRESCRIPTION DRUG PROGRAM BENEFITS (34-DAY SUPPLY)
Administered by Express Scripts**

COPAYMENT

- generic drugs \$10.00 per prescription
- brand name drugs \$25.00 per prescription

HOME DELIVERY PRESCRIPTION DRUG PROGRAM (90-DAY SUPPLY)

COPAYMENT

- generic drugs \$20.00 per prescription
- brand name drugs \$50.00 per prescription

* For Covered Services received from an EMSA Ambulance Provider, the Benefit percentage is increased to 100% of Allowable Charges. No Deductible will be required.

Comprehensive Health Care Services

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

HOSPITAL SERVICES

The Plan pays 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 Precertification guidelines of the Plan (see “Important Information”). If you fail to comply with these guidelines, Benefits for Covered Services rendered during your Inpatient confinement will be reduced by 30%, provided the Claims Administrator 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.

Speech Therapy is covered only when necessary to restore speech to an individual who has lost an existing speech function as a result of disease or injury.

- **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 Covered Person.

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 the Plan:

- the infant will be considered as a Covered Person in its own right and will be entitled to the same Benefits as any other Covered Person under the Plan; and
- a separate Deductible will apply to the newborn's Hospital confinement.

SURGICAL/MEDICAL SERVICES

The Plan pays 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.
- Benefits for oral Surgery are limited to the following services:
 - surgical removal of complete bony impacted teeth;
 - excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
 - excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses);
 - treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

*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.

— Covered Services include 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 Claims Administrator.

- **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.

— 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 Covered Person, 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.

— Routine Gynecological/Obstetrical Examination and Pap Smear

Routine gynecological/obstetrical examination and Pap smear performed in the Physician's office, **limited to once each Benefit Period. Additional exams may be covered under Wellness Care, as set forth below.**

— Routine Mammography Screening

Bilateral mammography screening (two view film study of each breast) for the presence of occult breast cancer, limited to:

- one screening examination every five years for female Covered Persons age 35 through 39; and
- one *annual* screening examination for female Covered Persons age 40 or older.

Benefits for routine Low-Dose Mammography shall be limited to \$115 per screening. Additional exams may be covered under Wellness Care, as set forth below.

— Prostate Cancer Screening

Annual screening for the early detection of prostate cancer in male Covered Persons, including a prostate-specific antigen blood test and a digital rectal examination. **Benefits are limited to one screening exam per Benefit Period and shall not exceed \$65 per screening. Additional exams may be covered under Wellness Care, as set forth below.**

— Colorectal Cancer Screening

Colorectal cancer examinations and laboratory tests for cancer screening for any nonsymptomatic Covered Person, in accordance with standard, accepted published medical practice guidelines. Benefits for colorectal cancer screening will be provided under the Wellness Care provisions, as set forth below. **Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedures will be provided at the Benefit payment level for Surgery described in this booklet.**

• **Wellness Care**

Services performed by a Provider as "routine" or "screening" services, including the following. Except as otherwise specified below, Wellness Care is subject to a **maximum of \$200 per Benefit Period per Covered Person and \$500 per family.**

— Well Baby Care

Routine services performed by a Provider for Covered Persons from birth through 24 months of age. Covered Services are provided in accordance with the Oklahoma State Health Department recommended schedule for immunizations, physical examinations and routine diagnostic tests. **Well baby care is not subject to the Benefit Period maximum of \$200 per Covered Person/\$500 per family.**

— Well Child Care

Routine services performed by a Provider for Covered Persons age two through 18. Covered Services include the periodic review of a child's physical and emotional status by a Physician or other Provider pursuant to a Physician's supervision, including a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards.

Childhood immunizations are not subject to the Benefit Period maximum.

— Adult Wellness Care

Routine services performed by a Provider for Covered Persons age 19 or older, include the following:

- Mammograms which are not included under the “Routine Mammography Screening” services listed above (includes screening for Covered Persons under age 35).
- Routine gynecological/obstetrical examination and Pap smear performed in the Physician’s office, **limited to once each Benefit Period. The initial exam is subject to the Copayment, Deductible and Coinsurance provisions set forth in the Schedule of Benefits. Subsequent exams are subject to the Benefit Period maximum for Wellness Care.**
- Immunizations, including herpes zoster vaccine purchased at a pharmacy or administered in the Physician’s office;
- Routine physical examination;
- Routine diagnostic tests;
- Routine colorectal cancer examinations and laboratory tests;
- Prostate cancer screening, including prostate-specific antigen blood test and a digital rectal examination;
- Bone density testing for individuals age 45 and over.

Benefits for wellness care will be limited to an individual maximum of \$200 per Benefit Period. Benefits for wellness care will be limited to a family maximum of \$500 per Benefit Period.

— 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 Covered Persons up to 18 years of age.** Audiological services include auditory testing, ear molds, Speech Therapy and auditory-verbal therapy. **Audiological services and post-implantation or fitting for hearing aids is limited to a combined maximum of 60 sessions per Benefit Period.**

— Treatment of ADD/ADHD and Autism

Medical Care for the treatment of attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD) and autism.

— Bone Density Testing

Bone density testing when ordered or performed by a Physician or other Provider. **Benefits are limited to \$150 for each bone density test.**

— Infertility Services

Services related to the diagnosis of infertility. **Benefits will not be provided for treatment of infertility.**

OUTPATIENT DIAGNOSTIC SERVICES

- Radiology, Ultrasound and Nuclear Medicine

Radiological services include bilateral mammography screening (two view film study of each breast) for the presence of occult breast cancer, limited to:

- one screening examination every five years for female Covered Persons age 35 through 39; and
- one *annual* screening examination for female Covered Persons age 40 or older.

Benefits for *routine* Low-Dose Mammography shall be limited to \$115 per screening.

- Laboratory and Pathology
- ECG, EEG, and Other Electronic Diagnostic Medical Procedures and Physiological Medical Testing, as determined by the Claims Administrator.

OUTPATIENT THERAPY SERVICES

- Radiation Therapy
- Chemotherapy
- Respiratory Therapy
- Dialysis Treatment
- Physical Therapy and Occupational Therapy
- Speech Therapy

Speech Therapy is covered only when necessary to restore speech to an individual who has lost an existing speech function as a result of disease or injury.

MATERNITY SERVICES

- Hospital Services and Surgical/Medical Services from a Provider 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

- 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 the Plan 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 the Plan 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.

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 Medically Necessary.

HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES

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

Precertification must be obtained at the time the Covered Person is referred for a transplant consultation and/or evaluation. It is the Covered Person's responsibility to make sure Precertification is obtained. Failure to obtain Precertification will result in denial of Benefits. The Plan has the sole and final authority for approving or declining requests for Precertification.

- **DEFINITIONS**

In addition to the definitions listed under the *Definitions* section of the Plan, 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.

— **Precertification**

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

— **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 Plan, 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 Claims Administrator for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures, as set forth in the Claims Administrator’s written medical policies.
- In addition to the Exclusions set forth elsewhere in the Plan, 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 Claims Administrator’s written medical policies.
 - Any organ or tissue transplant or Bone Marrow Transplant procedure which the Claims Administrator 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 Covered Person 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 the Plan.
- The transplant must be performed in and by a Provider that meets the criteria established by the Claims Administrator 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 Covered Persons, each is entitled to the Benefits of the Plan.
- When only the recipient is a Covered Person, both the donor and the recipient are entitled to the Benefits of the Plan. 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 Plan.
- When only the living donor is a Covered Person, the donor is entitled to the Benefits of the Plan. 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-Covered Person transplant recipient.
- If any organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Covered Person 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.

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 the Plan.

PSYCHIATRIC CARE SERVICES

The Plan pays 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 or other 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

Covered Inpatient Facility and Medical Services when provided for the Outpatient treatment of Mental Illness by a Hospital, Physician, or other Provider, including day treatment, residential and freestanding facilities.

SUBSTANCE ABUSE REHABILITATION TREATMENT

Covered Services for the treatment of Mental Illness are also applicable to Substance Abuse Rehabilitation Treatment, including services rendered by a Substance Abuse Treatment Facility.

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, but not including Inpatient care. The nurse cannot be a member of your immediate family or usually live in your home.

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 subject to the Precertification guidelines of the Plan (see “Important Information”). Failure to comply with these guidelines will result in a 30% reduction in Benefits for Rehabilitation Care if, upon receipt of a claim, Benefits are payable under the Plan.

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 120 days of Inpatient care per Benefit Period per Covered Person.

Skilled Nursing Facility Services are subject to the Precertification guidelines of the Plan (see “Important Information”). Failure to comply with these guidelines will result in a 30% reduction in Benefits for Skilled Nursing Facility Services if, upon receipt of a claim, Benefits are payable under the Plan.

No Benefits are payable:

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

CARDIAC REHABILITATION SERVICES

The Plan pays the scheduled amounts for cardiac rehabilitation services, provided such services are administered in a Claims Administrator approved program and are rendered within a six-month period following an eligible Inpatient Hospital admission for either myocardial infarction, coronary artery bypass Surgery or percutaneous transluminal coronary angioplasty.

HOME HEALTH CARE SERVICES

The Plan pays 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;
- Oxygen and its administration;
- **Up to 120 visits per Benefit Period per Covered Person, limited to the following:**
 - Professional services of an RN, LPN, or LVN;
 - Medical social service consultations;
 - Physical Therapy, Speech Therapy or Occupational Therapy, in accordance with the provisions set forth under “Outpatient Therapy Services”;
 - 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 Precertification guidelines of the Plan (see “Important Information”). Failure to comply with these guidelines will result in a 30% reduction in Benefits for Home Health Care if, upon receipt of a claim, Benefits are payable under the Plan.

The Plan does 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.

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 Precertification guidelines of the Plan (see “Important Information”). Failure to comply with these guidelines will result in a 30% reduction in Benefits for Hospice Services, if, upon receipt of a claim, Benefits are payable under the Plan.

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.

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 the Plan (for example: “Durable Medical Equipment” and “Home Health Care Services”).

DURABLE MEDICAL EQUIPMENT

The rental (or, at the Claims Administrator’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 Covered Person 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 Claims Administrator’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 Covered Person’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 the Plan. 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.

Unless Medically Necessary for treatment of diabetes, the following devices are *not* covered:

- 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 Covered Person, and which are required due to hair loss resulting from Radiation Therapy or Chemotherapy.

Benefits are limited to \$150 per Benefit Period per Covered Person.

TEETH, BITE, JAW OR JAW JOINT RELATIONS

Medical Care to prevent, diagnose, or correct a misalignment of teeth, bite, jaws or jaw joint relations by a cutting procedure whether or not for the purpose of relieving pain, but not for therapeutic appliances.

CHRISTIAN SCIENCE SERVICES

Spiritual treatment of an illness or injury when rendered by a qualified Christian Science Practitioner (one who is listed in the Christian Science Journal at the time services are rendered) or an accredited Christian Science Sanatorium (one that is certified by the Mother Church in Boston at the time services are rendered).

Exclusions

This section lists what is not covered. We want to be sure that you do not expect Benefits that are not included in the Plan. It also explains the Preexisting Condition provisions in your coverage.

WHAT IS NOT COVERED

Except as otherwise specifically stated in the Plan, the Plan does 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 the Claims Administrator determines is not Medically Necessary, except as specified.
- Received from other than a Provider.
- Which are in excess of the Allowable Charge, as determined by the Claims Administrator.
- Which the Claims Administrator 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 Covered Person'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 from cosmetic Surgery, 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 contraceptive medications or devices which are sold without a Physician's prescription (including condoms; contraceptive foam, sponges, or cream; or other spermicides).
- 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 Covered Person 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 ***Comprehensive Health Care Services*** related to 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, or as specifically provided under the ***Vision Care Services*** section of the Plan.
- 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 for Covered Persons up to age 18. 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 Speech Therapy when rendered for the treatment of psychosocial speech delay, attention disorder, conceptual handicap or mental retardation.
- For Inpatient Private Duty Nursing Services.
- 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 drugs and medicines purchased by a Covered Person on an Outpatient basis, with or without a Physician's prescription, except for immunosuppressive drugs prescribed in connection with a human organ transplant, or for herpes zoster vaccine.
- For smoking cessation products or programs
- For or related to acupuncture, whether for medical or anesthesia purposes.
- For conditions related to hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for Inpatient confinement for environmental change. This exclusion shall not apply to treatment of attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD) or autism.
- 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 Covered Person.

- Received from a Skilled Nursing Facility, Home Health Care Agency, Hospice, Substance Abuse Treatment Facility or rehabilitation facility which is not a Plan–approved Provider.
- 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 capsulorrhaphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.
- For transcutaneous electrical nerve stimulator (TENS).
- Which are not specifically named as Covered Services subject to any other specific Exclusions and limitations in this benefit booklet.

The Plan may, without waiving these Exclusions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the Exclusions listed above. If it is later determined that the care and services are excluded from your coverage, the Plan will be entitled to recover the amount we have allowed for Benefits under the Plan. You must provide to us all documents needed to enforce our rights under this provision.

PREEXISTING CONDITION WAITING PERIOD

- **Three–month Look–back Rule**

- The Preexisting Condition must relate to a condition (whether physical or mental, and regardless of the cause of the condition) for which medical advice, diagnosis, care, or treatment was recommended or received within the three–month period ending on the Covered Person’s Enrollment Date.
- In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law.
- The three–month look–back period is based on the three–month “anniversary date” of the Enrollment Date.

- **Length of Preexisting Condition Waiting Period**

The waiting period cannot extend for more than 12 months after the Enrollment Date. The 12–month “look forward” period is also based on the anniversary date of the Enrollment Date.

- **Reduction of Preexisting Condition Waiting Period Period by Prior Coverage**

In general, the Preexisting Condition Waiting Period must be reduced by the individual’s days of “Creditable Coverage” as of the Enrollment Date. Creditable Coverage includes coverage from a wide range of specified

sources, including Group Health Plans, health insurance coverage, Medicare, and Medicaid. However, days of Creditable Coverage that occur before a Significant Break In Coverage (63 or more consecutive days) will not be counted in reducing the Preexisting Condition Waiting Period.

In addition, the Preexisting Condition Waiting Period will be *waived* for an individual with prior Creditable Coverage through a Health Maintenance Organization, and who Enrolls under the Plan without a Significant Break In Coverage.

- **Elimination of Preexisting Condition Waiting Period for Pregnancy and for Certain Children**

A Preexisting Condition Waiting Period cannot apply to pregnancy. In addition, a Preexisting Condition Waiting Period will not be applied to a newborn, an adopted child under age 18, or a child Placed for Adoption under age 18, if the child becomes covered within 31 days of birth, adoption, or Placement for Adoption.

- **Notice to Covered Persons**

The Plan may only impose a Preexisting Condition Waiting Period with respect to a Covered Person by notifying the Covered Person, in writing, of the existence and terms of any Preexisting Condition Waiting Period under the Plan and of the rights of the Covered Person to demonstrate Creditable Coverage. The Plan will assist the Covered Person in obtaining a Certificate of Coverage from any prior health plan or issuer, if necessary.

The Plan may, without waiving the above provisions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the above Preexisting Condition limitations. If it is later determined that the care and services are excluded from the Covered Person's coverage, the Plan will be entitled to recover the amount it has allowed for Benefits under this Plan. The Covered Person must provide the Plan with all documents it needs to enforce its rights under this provision.

General Provisions

This section tells:

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

BENEFITS TO WHICH YOU ARE ENTITLED

The Plan provides only the Benefits specified in this benefit booklet.

Only Covered Persons 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 benefit booklet will be covered only for those Providers specified in this benefit booklet.

PRIOR APPROVAL

The Claims Administrator does not give prior approval or guarantee Benefits for any services through its Precertification process, or in any oral or written communication to Covered Persons or other persons or entities requesting such information or approval.

NOTICE AND PROPERLY FILED CLAIM

The Plan will not be liable for Benefits unless proper notice is furnished to the Claims Administrator that Covered Services have been rendered to you. Upon receipt of written notice, the Claims Administrator will furnish claim forms to you for submitting a Properly Filed Claim. If the forms are not furnished within 15 days after the Claims Administrator receives your notice, you can comply with the Properly Filed Claim requirements by forwarding to the Claims Administrator, 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 Claims Administrator within 12 months after the date the Covered Services are Incurred.

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

PAYMENT OF BENEFITS

You authorize the Claims Administrator to make payments directly to Providers giving Covered Services for which the Plan provides Benefits under this benefit booklet. The Claims Administrator 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, the Claims Administrator will not honor a request not to pay the claims submitted.

Benefits under this benefit booklet will be based upon the Allowable Charge (as the Claims Administrator determines) for Covered Services. A BlueChoice PPO 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 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 BlueChoice PPO Provider Agreement*) with the Plan. These Providers (called BlueTraditional Providers) have agreed to charge Plan Covered Persons no more than a “Maximum Reimbursement Allowance” for Covered Services. Covered Persons 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.

BENEFITS FOR SERVICES OUTSIDE THE STATE OF OKLAHOMA

All Blue Cross and Blue Shield Plans participate in a national program called the “BlueCard Program”. This national program benefits Covered Persons who receive Covered Services outside the state of Oklahoma.

When you obtain health care services through BlueCard outside the state of Oklahoma, the amount you pay for Covered Services is calculated on the *lower* of:

- The billed charges for your Covered Services; or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Licensee (“Host Blue”) passes on to us.

Often this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, and other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an *average* expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for overestimation or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Covered Person liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Covered Person liability calculation methods that differ from the usual Blue Cross method noted in the above paragraph or require a surcharge, Blue Cross and Blue Shield of Oklahoma would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

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 they may obtain a Provider discount for you on Covered Services you receive outside the state of Oklahoma.

DETERMINATION OF BENEFITS AND UTILIZATION REVIEW

The Claims Administrator, is hereby granted discretionary authority to interpret the terms and conditions of the Plan and to determine its Benefits.

In determining whether services or supplies are Covered Services, the Claims Administrator will determine whether a service or supply is Medically Necessary under the Plan or if such service or supply is Experimental or Investigational. The Claims Administrator's 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 Claims Administrator upon request and may be found on the Claims Administrator's Web site at www.bcbsok.com.

The Claims Administrator'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 Claims Administrator 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 benefit booklet.

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

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

Failure of the Covered Person to comply with the Claims Administrator's request for medical records or medical evaluation may result in Benefits being partially or wholly denied.

COVERED PERSON/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.

The Claims Administrator does not furnish Covered Services but only pays for Covered Services you receive from Providers. They are not liable for any act or omission of any Provider. They have no responsibility for a Provider's failure or refusal to give Covered Services to you.

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

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to insure that you receive all of the coverage to which you are entitled under this Group Health Care Plan. In other words, the total payment from all of your coverages together will never be less than what would have been paid under this Group Health Care Plan if no other group coverages were involved. It is your obligation to notify the Claims Administrator of the existence of such other group coverages.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

- The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.
- When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
 - However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;
 - when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the Claims Administrator, and upon its request to provide a copy, of such court decree.

- If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary

In order to prevent duplicate payment of benefits for a Claim, the Claims Administrator uses the following process to determine benefits when it is the secondary payor.

- determines what the payment for service would be following the payment provisions of this coverage; and
- deducts from this resulting amount the amount paid by the primary payor. The difference is the amount that will be paid under this coverage.

The Claims Administrator has the right in administering these COB provisions to:

- pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claims Administrator have been made by such other organization under any other group program.
- recover any overpayment which the Claims Administrator may have made to you, any Provider, insurance company, person or other organization.

BENEFITS FOR MEDICARE ELIGIBLE COVERED PERSONS

This section describes the Benefits which will be provided for Medicare Eligible Covered Persons who are not affected by MSP laws, unless otherwise specified in this plan document (see provisions entitled "Medicare Eligible Covered Persons" in the *Eligibility, Enrollment, Changes and Termination* section of this plan document).

The Benefits and provisions described throughout this plan document apply to you, however, in determining the Benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining Benefits under this Plan is as follows:

- determine payment for services eligible under Medicare by deducting from the total Allowable Charges the amount paid by Medicare. The difference, if any, is the amount that will be eligible for payment under this coverage; and
- using the amount determined in accordance with the above paragraph, determine what the payment for a Covered Service would be following the payment provisions of this coverage (for example, any applicable Deductible and/or Coinsurance will be applied to that amount). The resulting amount will be paid under the Health Care Plan up to the Allowable Charge or Medicare approved amount.

When you have a claim, you must send the Claims Administrator a copy of your Explanation of Medicare Benefits (“EOMB”) in order for your claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

PLAN’S RIGHT OF RECOUPMENT (SUBROGATION)

You agree to reimburse us for Benefits we have paid and for which you were not eligible under the terms of the Plan. This payment is due and payable immediately when you are notified by the Claims Administrator. Also, we have the sole right to determine that any overpayments, wrong payments, or any excess payments made for you under this Plan are an indebtedness which we may recover by deducting it from any future Benefits under the Plan, or under any other coverage provided by the Plan. Our acceptance of your premiums or payment of Benefits under this Plan 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 Covered Person agrees that the Plan shall have a first lien on any settlement proceeds, and the Covered Person 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 Covered Person 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.

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.

Failure to comply with the above provisions may result in termination of your coverage and/or legal action to enforce collection.

Failure to notify the Personnel Services Department, Employee Benefits Division, of an accident in which you were injured by the negligence of a third party may result in disciplinary action, up to and including termination and further legal action against the Employee.

LIMITATIONS ON PLAN’S RIGHT OF RECOUPMENT/RECOVERY

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

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

Complaint/Appeal Procedure

The Claims Administrator 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.

APPEAL PROCESS (LEVEL I)

If you are not satisfied with the initial attempt to resolve your problem, or if you wish to request a review of a Benefit determination or Precertification decision, you must request an appeal within 180 days from the date you received notice of the adverse Benefit determination or Precertification notice. A Provider can also appeal the adverse Benefit determination or Precertification decision. The Provider's appeal will be considered an appeal on your behalf.

- **How to File an Appeal Involving a Non-Urgent Request or Claim**

In the case of an appeal involving a non-urgent request or claim, you must submit your request in writing to the following address:

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

The written request should include the name of the Covered Person, the Covered Person identification number, the nature of the complaint, the facts upon which the complaint is based, ***and the resolution you are seeking***. Necessary facts are: dates and places of services, names of Providers of services, place of hospitalization and types of services or procedures received (if applicable). You and/or your Provider should include any documentation, including medical records, that you want to become a part of the review file. The Claims Administrator may request further information if necessary.

— In the case of an appeal involving a non-urgent Precertification request, the Claims Administrator will provide a written response to you no later than 30 days following the date the appeal is received.

— In the case of an appeal involving a claim other than a Precertification request, the Claims Administrator will provide a written response to you no later than 60 days following the date the appeal is received.

- **How to File an Appeal of a Precertification Request Involving Urgent Care**

If you and/or your Provider wish to appeal a Precertification Request Involving Urgent Care, you may appeal by calling the Precertification number shown on your Identification Card.

**The Claims Administrator 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. A Provider or other health care professional with knowledge of your medical condition is permitted to act as your authorized representative or to bring an appeal on your behalf.*

- The Claims Administrator will respond to you no later than 72 hours after the appeal is received.
- The Claims Administrator’s response to a Precertification 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.

VOLUNTARY RE-REVIEW PROCESS (LEVEL II)

If you are not satisfied with the decision concerning the appeal, you may elect to submit an adverse Benefit determination to the Claims Administrator for re-review. The Claims Administrator will provide you with information about the Claims Administrator’s voluntary re-review process.

To request a re-review of the Benefit determination, you should submit the request in writing to the following address:

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

The written request should include the name of the Covered Person, the Covered Person identification number, the nature of the complaint, the facts upon which the complaint is based, *and the resolution you are seeking*. Necessary facts are: dates and places of services, names of Providers of services, place of hospitalization and types of services or procedures received (if applicable). You should include any documentation, including medical records, that you want to become a part of the review file. The Claims Administrator may request further information if necessary.

- **Member Participation and Protection Committee Review**

Your voluntary review will be directed to the Claims Administrator’s Member Participation and Protection Committee. The purpose of this committee is to protect your rights and to provide a mechanism to review and resolve issues that are not resolved to your satisfaction through the Level I appeal process. This committee is comprised of representatives of functional areas of Blue Cross and Blue Shield of Oklahoma, medical staff and insured members who are not employed by the Claims Administrator. The committee’s determination will be made within 60 days following receipt of your request, unless in the Claims Administrator’s opinion, additional time is needed to complete the review. In such case, the Claims Administrator will issue written notice, on or before the 60th day, advising the Covered Person of an extension, not to exceed 60 days. Written notice of the committee’s determination will be issued to the Covered Person.

- **Medical Review**

A review of any adverse Benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, will be referred to a health care professional who has appropriate training and experience in the applicable field of medicine.

FINAL CLAIMS APPEAL PROCEDURES

You must first exhaust your first and second level appeals through the Claims Administrator prior to final appeal process. If your claim is denied, you may appeal the decision. Your written request for review or reconsideration must be made in writing to the Employer at the address listed below within 180 days after you receive notice of a claim denial.

Employee Benefits Manager
City of Oklahoma City
420 West Main, Suite 110
Oklahoma City, OK 73102

As part of your appeal, you have the right to:

- Submit written comments, documents, records and other information relating to your claim for benefits that you wish to have considered.
- Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination
- A review that does not defer to the initial claim determination and that is conducted by someone other than the individual who made the adverse determination and who is not such person's subordinate.
- A review that does not defer to the initial claim determination and that is conducted by someone other than individual who made the adverse determination, and who is not such person's subordinate.
- In cases where the claim denial was based in whole or in part on medical judgement, require the individual reviewing the appeal to consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement, who was not consulted in connection with the initial claim determination, and who is not such person's subordinate.
- In cases of a claim for urgent care, an expedited review process in which you may submit a request (orally or in writing) for an expedited appeal of a denied urgent care claim and where all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and by you by telephone, facsimile or other available similarly prompt method.

The Employer will notify you if your appeal is denied. Such notification will include:

- The specific reason(s) for the denial
- References to the pertinent plan provisions on which the denial is based
- References to any internal rule, guideline or protocol relied upon in making the decision
- If the claim denial is based on a medical necessity or experimental treatment of similar exclusion or limit, either an explanation of the scientific or clinical judgement for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

Claims Filing Procedures

The Plan begins to pay only after the Copayment and/or Deductible amount you incur toward eligible expenses shows on the Claims Administrator's 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 the Plan 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 the Claims Administrator's 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 Claims Administrator 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 a Provider who is not a member of the Claims Administrator's Network, 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.

MEMBER-FILED CLAIMS

When you must file a claim yourself, you may obtain claim forms by contacting the Claims Administrator.

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 the Claims Administrator can process your claim for Benefits.

A separate claim form must be filled out for each Covered Person, 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, the Claims Administrator must receive your claims for Covered Services within 12 months after the date the Covered Services are Incurred.

BENEFIT DETERMINATIONS FOR PROPERLY FILED CLAIMS

Once the Claims Administrator 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 Claims Administrator determines that additional time is necessary due to matters beyond their control.

If the Claims Administrator determines 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 Claims Administrator expects to make the determination.

Upon receipt of your claim, if the Claims Administrator determines that additional information is necessary in order for it to be a Properly Filed Claim, they 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 Claims Administrator 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

The Claims Administrator has a direct line for claims and membership inquiries. You may call 1-877-219-4301 between 8:00 a.m. and 5:00 p.m., Central Standard Time, Monday through Friday, whenever you have a question concerning a claim or your membership:

Definitions

This section defines terms that have special meanings in the Plan. 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 Claims Administrator will use as the basis for Benefit determination for Covered Services you receive under the Plan. The Claims Administrator will use the following criteria to establish the Allowable Charge for *Comprehensive Health Care Services*:

- **BlueChoice PPO 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 PPO Provider Agreement.
- **Out-of-Network Provider** — the Provider’s usual charge, up to the amount that the Plan would reimburse a BlueTraditional Provider for the same service.

NOTE: For covered health care services received outside the state of Oklahoma, if the claim for those services is filed with the Blue Cross and Blue Shield Plan (Host Plan) servicing the area, the “Allowable Charge” will be determined by the on-site Blue Cross and Blue Shield Plan. Payment will be based upon the Provider payment arrangements in effect between the Provider and the on-site Plan. In instances where the claim is not filed with the Host Plan the Allowable Charge for your out-of-network claims will be based upon what the Plan would have reimbursed a BlueTraditional Provider for the same service.

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.

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.

BLUECARD PPO PROVIDER

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

BLUECHOICE PPO PROVIDER

A Provider who has entered into an agreement with the Claims Administrator to bill the Claims Administrator directly for Covered Services, and to accept the Claims Administrator'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 for the purposes of reducing any Preexisting Condition Exclusion imposed on the individual by any subsequent Group Health Plan coverage.

COBRA CONTINUATION COVERAGE

Coverage under the Plan 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 Plan to Covered Persons to whom a Qualifying Event has not occurred.

COINSURANCE

The percentage of Allowable Charges for Covered Services for which the Covered Person 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.

PLAN ANNIVERSARY DATE

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

COPAYMENT

A fixed dollar amount required to be paid by or on behalf of a Covered Person in connection with the delivery of Covered Services in a BlueChoice PPO Physician's office.

COVERED SERVICE

A service or supply shown in the Plan and given by a Provider for which the Plan 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 Covered Person other than the Employee 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 Claims Administrator.

DURABLE MEDICAL EQUIPMENT

Equipment which meets the following criteria:

- It provides therapeutic benefits or enables the Covered Person 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 Claims Administrator’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 Employee 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 Covered Person’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

The City of Oklahoma City

ENROLLMENT DATE

The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

EXPERIMENTAL/INVESTIGATIONAL

A drug, device, biological product, or medical treatment or procedure is Experimental or Investigational if **the Claims Administrator 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 the Plan for the Employee and one or more of the Employee’s Dependents.

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.

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 Employee by the Claims Administrator, bearing the Employee'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 COVERAGE

Coverage under the Plan for yourself but not your spouse or Dependent children.

INITIAL ENROLLMENT PERIOD

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

INPATIENT

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

LATE ENROLLEE

An Eligible Person or eligible Dependent who enrolls under the Plan at a time other than during their Initial Enrollment Period.

LICENSED PRACTICAL OR VOCATIONAL NURSE (LPN OR LVN)

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

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 Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treatment an illness, injury, disease or its symptoms, and that are:

A service or supply given by a Hospital, Physician, or other Provider which the Claims Administrator determines is:

- in accordance with generally accepted standards of medical practice;
- 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.

MEDICARE

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

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.

OPEN ENROLLMENT PERIOD

A period designated by the Employer and held each year during which an individual who previously declined coverage may enroll for coverage under the Plan as a Late Enrollee.

OUT-OF-NETWORK PROVIDER

A Provider that has not entered into an agreement with the Claims Administrator to be a part of its BlueChoice PPO or BlueCard PPO Provider networks.

OUT-OF-POCKET LIMIT

The amount of Deductible and 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 the Plan.

OUTPATIENT

A Covered Person who receives services or supplies while not an Inpatient.

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.

PRECERTIFICATION

Certification from the Claims Administrator before the services are rendered that, based upon the information presented by the Covered Person or his/her Provider at the time Precertification is requested, the proposed treatment meets the Claims Administrator's guidelines for Medical Necessity.

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

PREEXISTING CONDITION

A condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the three-month period ending on the Enrollment Date. In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended by or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by the state law. A Preexisting Condition does not include pregnancy, nor can it be applied to a newborn or adopted child under age 18, as long as the child became covered under the Plan within 31 days of birth or adoption.

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 Claims Administrator.

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.

PSYCHOLOGIST (REGISTERED CLINICAL PSYCHOLOGIST)

A Clinical Psychologist who is registered in a state where statutory licensure exists. The Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

A Clinical Psychologist is a Psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

- has a doctoral degree from a regionally accredited university, college or professional school; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year in an organized health services program; or
- is a Registered Clinical Psychologist with a graduate degree from a regionally accredited university or college; and has not less than six years as a Psychologist with at least two years of supervised experience in health services.

QUALIFYING EVENT

Any one of the following events which, but for the COBRA Continuation Coverage provisions of the Plan, would result in the loss of a Covered Person'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 Plan.

REGISTERED NURSE (RN)

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

ROUTINE NURSERY CARE

Ordinary Hospital nursery care of the newborn Covered Person.

SIGNIFICANT BREAK IN COVERAGE

A period of 63 consecutive days during all of which the individual did not have any Creditable Coverage, except that neither a Waiting Period nor an affiliation period is taken into account in determining a Significant Break In Coverage.

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.

SUBSTANCE ABUSE

The uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develop[s] with continued use of such addictive substances requiring Medical Care as determined by the Physician or Psychologist.

SUBSTANCE ABUSE REHABILITATION TREATMENT

An organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Physician or Psychologist, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correction placement or family retreats.

SUBSTANCE ABUSE TREATMENT FACILITY

A facility (other than a Hospital) whose primary function is the treatment of Substance Abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

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.

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.

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